# CareForum 2022

The WellSky® Conference

# Hospice risk and scrutiny: Engaging your team in a culture of compliance

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## Today's speakers

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# Disclosure

Nicole Chu and Katherine Morrison faculty for this educational event, have no relevant financial relationship(s) with ineligible companies to disclose.

# Learning Outcomes

Upon completing this session, participants will be able to:

1. Describe the current environment of hospice regulatory scrutiny and OIG focus on compliance
2. Explain day to day opportunities to strengthen regulatory compliance
3. Identify practical tips on educating the hospice team on compliance and aligned outcome improvement

# Building a culture of compliance

- When serving hospice, context is critical when evaluating how to approach risk and advocacy
- Hospice is facing high regulatory and payer scrutiny right now – and the focus is increasing
- Within rapidly changing market conditions, strategic skill-stacking builds a resilient and compassionate culture in command of tools needed to optimize risk management

# Why rapid change and need for compliance?

# Hospice growth gaining attention of the OIG

*Vulnerabilities in the Medicare Hospice Program Affect Quality Care and Program Integrity: An OIG Portfolio (2018)*

- Hospices do not always provide needed services to beneficiaries and sometimes provide poor quality care.
  - At some times, hospices were not able to effectively manage symptoms or medications, leaving beneficiaries in unnecessary pain for many days.
  - Beneficiaries and their families and caregivers do not consistently receive crucial information to make informed decisions about their care.
  - Further, hospices' inappropriate billing costs Medicare hundreds of millions of dollars. This includes billing for an expensive level of care when the beneficiary does not need it.

Retrieved from https://oig.hhs.gov/oei/reports/oei-02-16-00570.asp

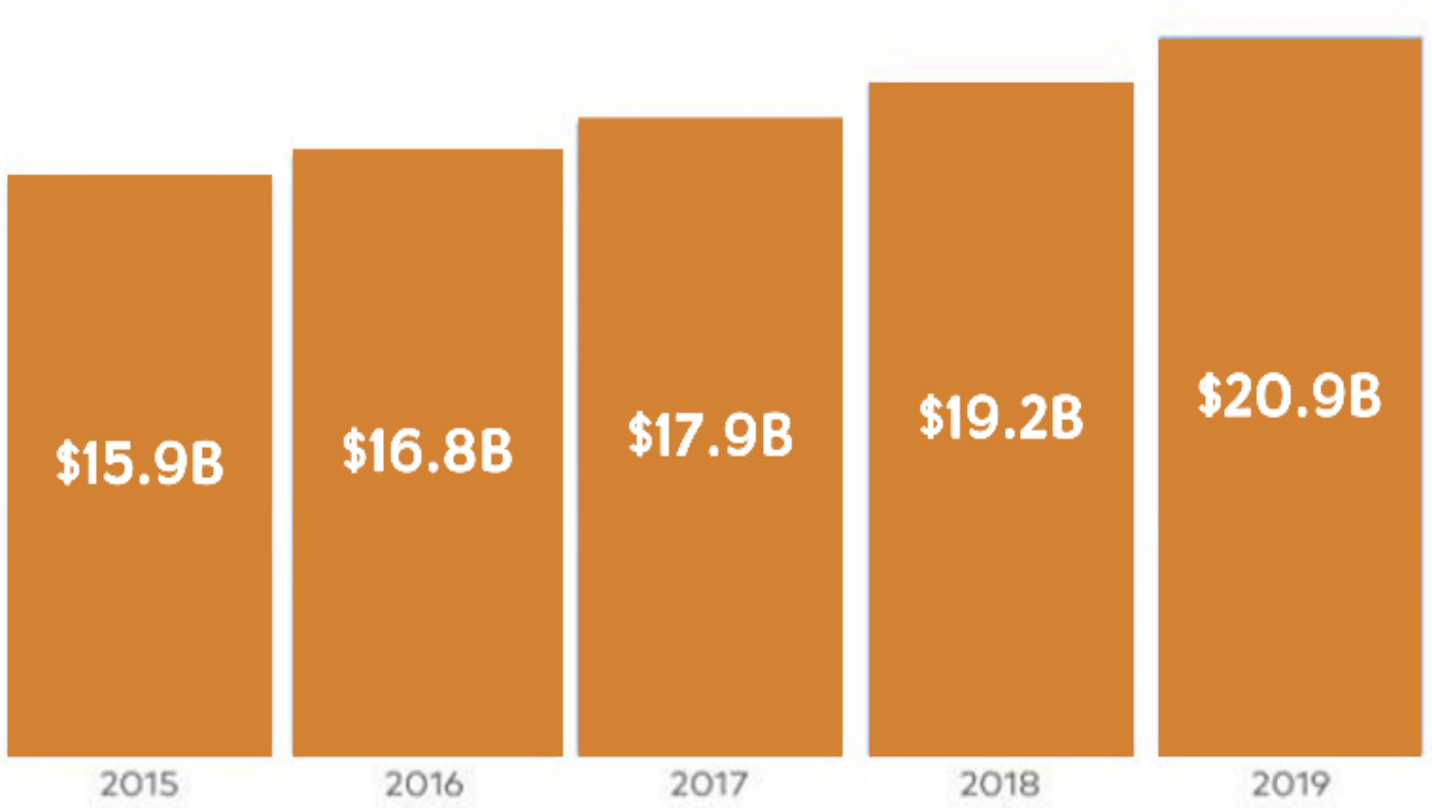
# Hospice growth gaining attention of the OIG

*Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm (2019)*

- Hospices providing poor care to beneficiaries resulted in some instances of harm
  - Abuse by caregivers or others and the hospice failing to take action resulted in some instances of harm
  - Reporting requirements for hospices are insufficient to protect beneficiaries from harm
  - Requirements for surveyors to report are limited
  - Beneficiaries and caregivers face barriers to making complaints
  - Hospices responsible for harming beneficiaries are not always held accountable

# Medicare spending rise continues

**Figure 14: Medicare Spending**




*Source: MedPAC March 2021 Report to Congress, Table 11-3 and MedPAC March 2018 Report to Congress, Table 12-4.*

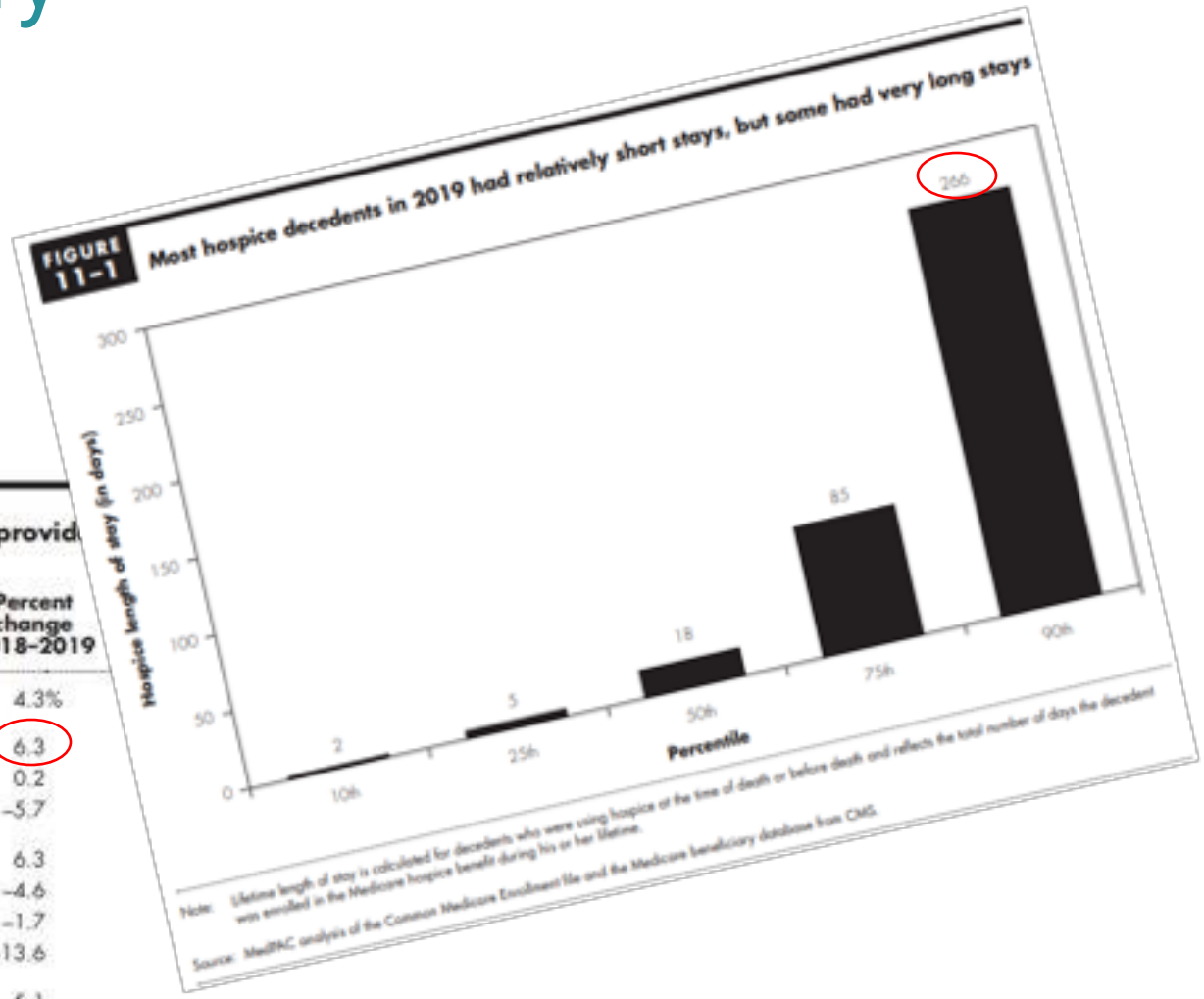
# Medicare Payment Advisory Commission (MedPAC) to Congress

**TABLE 11-1** Increase in total number of hospices driven by growth in for-profit provid

| Category | 2010 | 2016 | 2017 | 2018 | 2019 | Average annual percent change 2010–2018 | Percent change 2018–2019 |
|---|---|---|---|---|---|---|---|
| All hospices | 3,498 | 4,382 | 4,488 | 4,639 | 4,840 | 3.6% | 4.3% |
| For profit | 1,958 | 2,943 | 3,101 | 3,233 | 3,437 | 6.5 | 6.3 |
| Nonprofit | 1,316 | 1,272 | 1,226 | 1,246 | 1,248 | -0.7 | 0.2 |
| Government | 224 | 167 | 161 | 159 | 150 | -4.2 | -5.7 |
| Freestanding | 2,401 | 3,376 | 3,525 | 3,699 | 3,932 | 5.6 | 6.3 |
| Hospital based | 609 | 499 | 470 | 454 | 433 | -3.6 | -4.6 |
| Home health based | 465 | 482 | 471 | 464 | 456 | 0.0 | -1.7 |
| SNF based | 23 | 25 | 22 | 22 | 19 | -0.6 | -13.6 |
| Urban | 2,485 | 3,474 | 3,603 | 3,760 | 3,952 | 5.3 | 5.1 |
| Rural | 950 | 901 | 879 | 872 | 859 | -1.0 | -1.5 |

Note: SNF (skilled nursing facility). Some categories do not sum to total because of missing data for some providers. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census).

Source: MedPAC analysis of Medicare cost reports, Medicare Provider of Services file, and the 100 percent hospice claims standard analytical file from CMS.



# Industry press – telling story of rising hospice scrutiny

Increased hospice scrutiny in several areas – press tells a story compelling attention:

Compliance posing risks for M&A: “Despite soaring valuations, hospice providers will have to tread lightly as they enter deals, particularly when it comes to regulatory issues and compliance, and as value-based care makes its way into hospice this year” – Hospice News, August 5, 2021

Retrieved from: https://hospicenews.com/2021/08/05/quality-compliance-pose-risks-for-hospices-in-ma/

“The U.S. Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health & Human Services (HHS) Office of the Inspector General (OIG) continue to look hard at hospice providers to address concerns ranging from billing and claims to patient eligibility for the hospice benefit”. Interview with Bill Dombi, Hospice News May 14, 2021

Retrieved from: https://hospicenews.com/2021/05/14/civil-rights-disability-laws-of-rising-importance-in-hospice-compliance/

# Survey findings – increasing pressure

CY 2022 Home Health Final Rule – Survey and enforcement requirements for hospices

- The rule addresses a comprehensive strategy to enhance the hospice program survey process, increase accountability for hospice programs, and provide increased transparency to the public.

CMS goals were to:

1. Maintain the public trust through addressing conflicts of interest and improving survey transparency including public reporting of survey findings
2. Addressing inconsistency within the survey process through training and survey team composition and use of common hospice program deficiency reporting mechanisms
3. Ensuring hospice programs are held accountable for addressing identified health and safety issues


# Hospice survey and enforcement

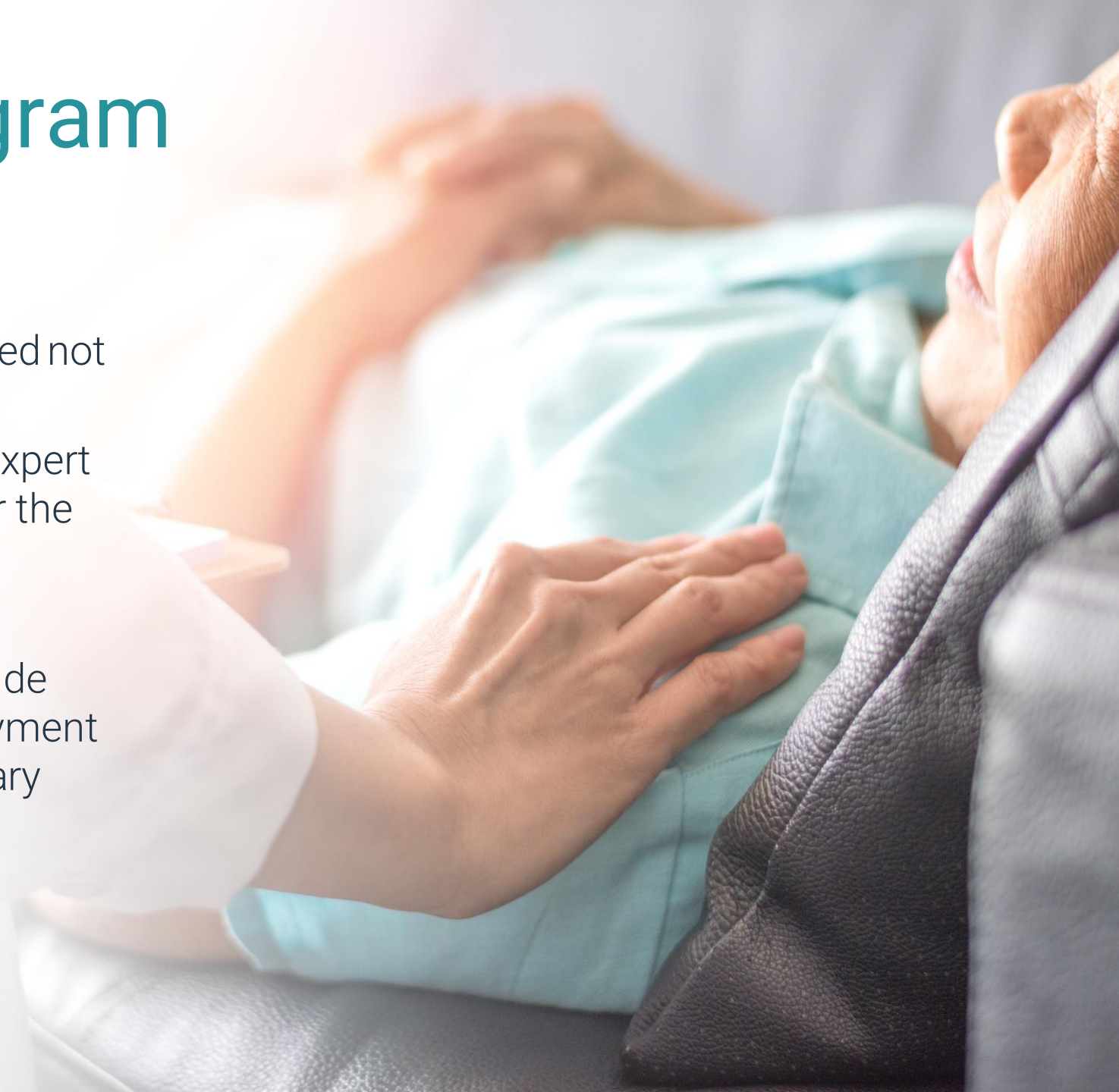
- Survey frequency – no less than once every 36 months
- Public reporting of survey findings by accrediting organizations and state agencies
- Use of the CMS-2567 Form to provide reporting that is standardized across both Accrediting organizations and State Survey Agencies
- Consistency of Surveys – HHS and States must measure and reduce inconsistency in the application of survey results
- Survey teams of more than 1 surveyor must be conducted by a multidisciplinary team of professionals to include an RN (single surveyor must be an RN)

# New Subpart M – Survey and certification of hospice programs

- The state or local agency is responsible for maintaining a toll-free hotline
  - The hotline will:
    a) Collect, maintain, and continually update information on Medicare participating hospice programs to include significant deficiencies regarding patient care, corrective actions, and remedy activity
    b) Receive complaints (and answer questions) with respect to HHAs and hospice programs in the state or locality.
- Surveyor Qualifications and Prohibitions on Conflicts of Interest
  - Surveyor training requirement (surveyor training link: https://qsep.cms.gov)
  - Training emphasis: four "core" hospice CoPs and full involvement of the interdisciplinary team
  - Surveyor conflict of interest

# Special focus program

- CMS to establish a program for poor performing hospices
- Under this program, surveys are conducted not less than once every 6 months
- Final rule: CMS established a Technical Expert Panel (TEP) to develop the framework for the SFP
- Proposed rulemaking for FY2024
- Enforcement remedies expanded to include civil monetary penalties, full or partial payment suspension, and appointment of temporary management oversight



# Opportunities to strengthen regulatory compliance

# Most frequent denials

To help hospices focus on what they should be aware of, MACs frequently put together the most common reason for denials

- These lists are always found on their website and can be accessed by anyone on the team

- Below is a list of those top denials as stated by CGS, NGS, and Palmetto:
  - Notice of election is invalid
  - Certificate of Terminal Illness requirements not met
  - Face-to-face requirements not met
  - Terminal prognosis not supported by documentation (physician and clinicians)
  - General inpatient care was found to be not reasonable or necessary

- Know your MAC and their specific Local Coverage Determination (LCDs)

# Hospice Addendum

**The hospice election statement addendum went into effect October 1, 2020**

- Per CMS, the purpose of the addendum is: *To notify the individual (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions.*
- Right to Immediate Advocacy: The addendum must include language that immediate advocacy is available through the BFCC-QIO if the individual or representative disagrees with the hospice's determination.
- Time frame:
  - Five days from the election date if requested on admission
  - Three days if requested at any other point within the hospice admission/benefit period
  - Must be provided in writing

https://www.cms.gov/files/document/model-hospice-election-statement-and-addendum.pdf

# Certificate of Terminal Illness (CTI)

Hospice episodes are:

- 1st: 90 days; 2nd: 90 days; 3rd and unlimited thereafter: 60 days
- Patient may revoke once per benefit period (will lose remaining days of that episode and start next episode if returns)
- Patient does **not** need to be “homebound”

Initial CTI:

- Patient's attending MD and the Hospice Medical Director (MD) must both sign the initial CTI stating the patient’s terminal condition and prognosis
- If the Medical Director is the patient’s attending MD, then only the one signature is required
- Can be completed up to 15 days before the SOC, but must have VO by the end of the third day of care
- CTI must be signed and dated prior to billing

# Certificate of Terminal Illness (CTI)

**CTI is required for every benefit period:**

- Up to 15 days prior to recert – VO no later than 2 days after recert (end of 3rd day)
- Signed by the Medical Director only after initial episode
- Narrative should support terminal prognosis
- Terminal diagnosis should match primary diagnosis
- CTI must be signed and dated prior to billing

# Certificate of Terminal Illness (CTI)

**Common concerns seen in charts and noted by MACs:**

- Attending (if noted on NOE) and/or Medical Director signatures are missing
- Signing date is missing
- Narrative is blank
- Narrative does not include clinical findings to support eligibility
- Signature of MD is illegible
- Not done timely
- MD did not attest that they composed the narrative

# Hospice face-to-face regulation

- Face-to-face (F2F) required before 3rd episode begins (180 days)
- Can be completed up to 30 days before 3rd episode
- MD must sign directly under narrative that F2F was composed based on visit findings
- Indicates why clinical findings support prognosis of six months or less
- Required for all subsequent episodes (may be on same form as CTI as long as it is signed in both areas)
- May be done by Hospice NP. Document that findings provided to MD for CTI

# Face-to-face

**Common concerns seen in charts and noted by MACs:**

- Narrative is blank
- Face-to-face date is not attested to by MD (if performed by nurse practitioner)
- Statement missing that narrative was composed from clinical findings
- Face-to-face date not on narrative note
- Narrative does not contain clinical findings to support terminal illness
- Face-to-face not done timely

# Anticipate the MAC to defend your work

Hone skills to build understanding of compliant actions and defensive documentation

1. Documentation is best achieved at point of care or adjacent to visit, as well as during the IDT/IDG meeting
2. Goal to gather/capture information on dynamic basis, best supporting:
   - Accuracy
   - IDT/IDG communication
   - Patient and family support/intervention
   - Compliance: clear and measurable indicators of appropriateness of hospice election, continued clinical decline (supported by objective data)

# Eligibility documentation by hospice clinicians

*Objective indicators are the most compelling evidence of decline*

**Infections: Recurrent or intractable** (with or without use of antibiotics)

- Pneumonia
- UTI
- Sepsis

**Progressive inanition as documented by:**

- Weight loss not due to reversible causes ie: depression or diuretics
- Decreased mid-arm circumference or abdominal girth
- Decreasing serum albumin or cholesterol
- Dysphagia leading to recurrent aspiration and/or inadequate oral intake

# Eligibility documentation by hospice clinicians

*Symptoms – dependent on disease process*

Dyspnea

- Changes in respiratory rate
- Decrease in pulse oximetry
- Change in medications or oxygen to manage dyspnea
- Progressive and/or intractable cough

Pain

- Changes in pain character, type, quality, or ratings
- Requires increasing doses of major analgesics more than briefly

Nausea/Vomiting/Diarrhea

- Poorly responsive to interventions
- New onset or increasing in frequency or intensity
- Decrease or change in appetite

# Eligibility documentation by hospice clinicians

*Measurable or visible signs*

Vital Signs

- Decreased blood pressure or progressive postural hypotension
- Increased pulse or irregularity of rhythm

- Ascites
- Edema
- Weakness
- Pleural/pericardial effusion
- Changes in level of consciousness
  - Delirium - Hyper, Hypo, or Mixed
  - Unable to remember family members

  Lab values (when available)
  - Increasing pCO2, decreasing pCO@ or SaO2, increased calcium, creatinine or liver functions, increasing tumor markers, progressively decreasing or increasing serum sodium or serum potassium

# Hospice documentation tools – supporting clear hospice eligibility

- KPS – Karnofsky Performance Status: Similar to PPS: Functional assessment to determine prognosis (should be < 40-50)
- PPS – Palliative Performance scale: Shows activity ability (General guideline =<50)
- FAST score – Alzheimer's/Dementia testing:  Functional Assessment Score
- MAC Measurements – Mid arm circumference measurement (to show weight loss)
- LCD Criteria – Local coverage determination criteria – Hospice eligibility for terminal diagnoses (on MAC's websites per CMS). Not supported by any Medicare regulations at this time.

# PPS & KPS Scales

Palliative Performance Scale (PPS)

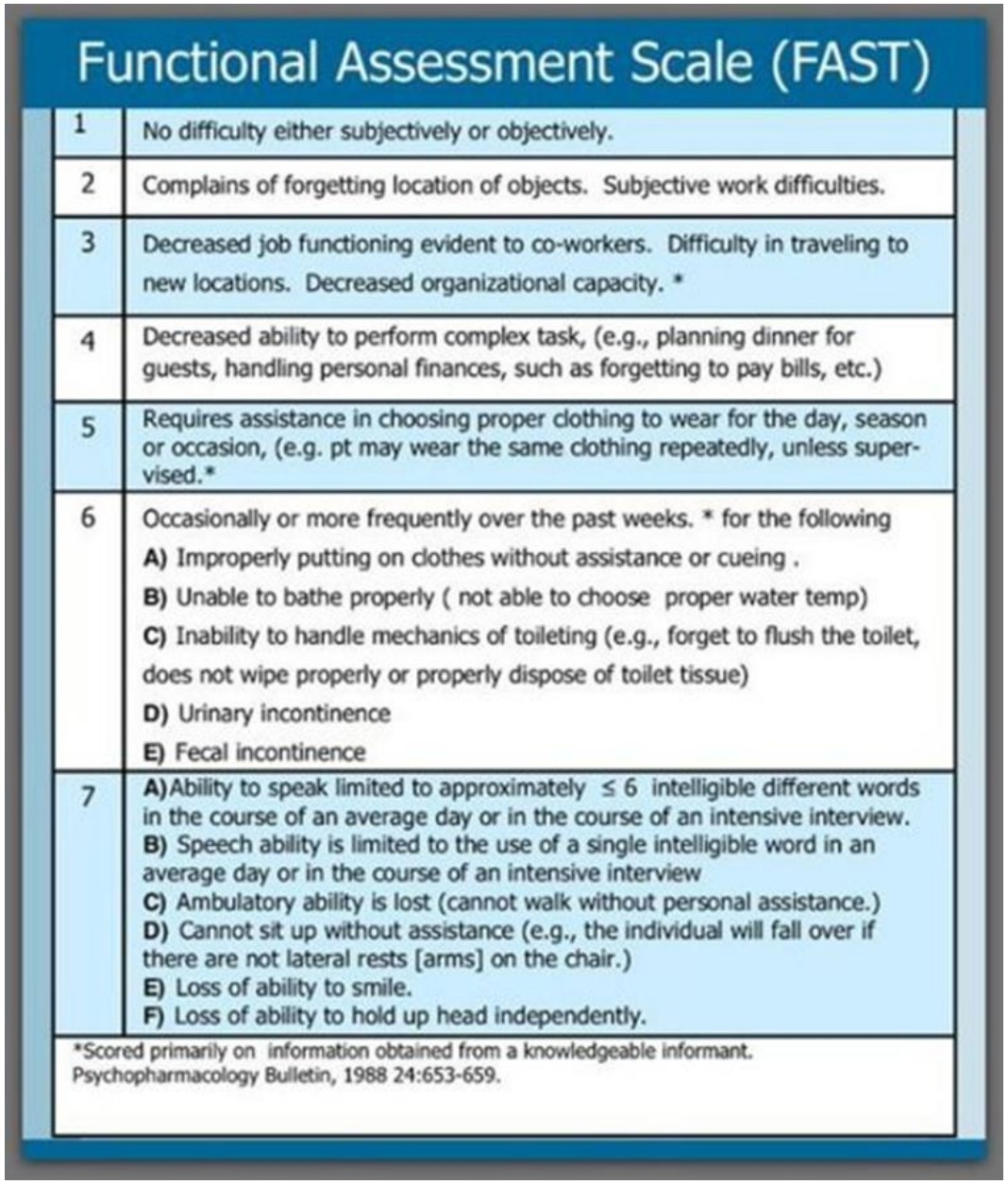
| % | Ambulation | Activity and Evidence of Disease | Self-Care | Intake | Level of Conscious |
|---|---|---|---|---|---|
| 100 | Full | Normal activity, no evidence of disease | Full | Normal | Full |
| 90 | Full | Normal activity, some evidence of disease | Full | Normal | Full |
| 80 | Full | Normal activity with effort, some evidence of disease | Full | Normal or reduced | Full |
| 70 | Reduced | Unable to do normal work, some evidence of disease | Full | Normal or reduced | Full |
| 60 | Reduced | Unable to do hobby or some housework, significant disease | Occasional assist necessary | Normal or reduced | Full or confusion |
| 50 | Mainly sit/lie | Unable to do any work, extensive disease | Considerable assistance required | Normal or reduced | Full or confusion |
| 40 | Mainly in bed | Unable to do any work, extensive disease | Mainly assistance | Normal or reduced | Full, drowsy, or confusion |
| 30 | Totally bed bound | Unable to do any work, extensive disease | Total care | Reduced | Full, drowsy, or confusion |
| 20 | Totally bed bound | Unable to do any work, extensive disease | Total care | Minimal sips | Full, drowsy, or confusion |
| 10 | Totally bed bound | Unable to do any work, extensive disease | Total care | Mouth care only | Drowsy or coma |
| 0 | Death | — | — | — | — |

**KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA**

| | | |
|---|---|---|
| Able to carry on normal activity and to work; no special care needed. | 100 | Normal no complaints; no evidence of disease. |
| | 90 | Able to carry on normal activity; minor signs or symptoms of disease. |
| | 80 | Normal activity with effort; some signs or symptoms of disease. |
| Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed. | 70 | Cares for self; unable to carry on normal activity or to do active work. |
| | 60 | Requires occasional assistance, but is able to care for most of his personal needs. |
| | 50 | Requires considerable assistance and frequent medical care. |
| Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly. | 40 | Disable; requires special care and assistance. |
| | 30 | Severely disabled; hospital admission is indicated although death not imminent. |
| | 20 | Very sick; hospital admission necessary; active supportive treatment necessary. |
| | 10 | Moribund; fatal processes progressing rapidly. |
| | 0 | Dead |

# FAST Scale

- Functional Assessment Staging Tool
- Progression of dementia in patients with Alzheimer's dementia
- Focuses on ability to function and perform tasks of daily living
- Dementia level Stage 7 generally qualify



| Functional Assessment Scale (FAST) | |
|---|---|
| 1 | No difficulty either subjectively or objectively. |
| 2 | Complains of forgetting location of objects. Subjective work difficulties. |
| 3 | Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. * |
| 4 | Decreased ability to perform complex task, (e.g., planning dinner for guests, handling personal finances, such as forgetting to pay bills, etc.) |
| 5 | Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. pt may wear the same clothing repeatedly, unless supervised.* |
| 6 | Occasionally or more frequently over the past weeks. * for the following<br>**A)** Improperly putting on clothes without assistance or cueing .<br>**B)** Unable to bathe properly ( not able to choose proper water temp)<br>**C)** Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue)<br>**D)** Urinary incontinence<br>**E)** Fecal incontinence |
| 7 | **A)** Ability to speak limited to approximately ≤ 6 intelligible different words in the course of an average day or in the course of an intensive interview.<br>**B)** Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview<br>**C)** Ambulatory ability is lost (cannot walk without personal assistance.)<br>**D)** Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair.)<br>**E)** Loss of ability to smile.<br>**F)** Loss of ability to hold up head independently. |
| *Scored primarily on information obtained from a knowledgeable informant.<br>Psychopharmacology Bulletin, 1988 24:653-659. | |

# Local Coverage Determinations (LCDs)

- Provide guidance in determining the necessity of hospice services
- Not supported by Medicare Regulation nor are they a Condition of Participation
- Includes general guidelines as well as disease specific guidance
- Each patient is unique and a particular guideline may not match
  - In these cases, good documentation is important
- Three parts:
  - **Part I** Decline in clinical status guidelines
  - **Part II** Non-disease specific baseline guidelines
    - ❖ Part II has sections A-D
    - ❖ Both A and B must be met
  - **Part III** Disease specific guidelines

# Local Coverage Determinations (LCDs)

**Part III contains the following diseases to reference:**

- Cancer diagnosis
- Non cancer diagnosis:
  - Amyotrophic Lateral Sclerosis
  - Dementia due to Alzheimer's disease and related disorder
  - Heart disease
  - HIV disease
  - Liver disease
  - Pulmonary disease
  - Renal disease
  - Stroke and coma

# Plan of Care documentation at hospice IDT/IDG

- IDT/IDG is a key part of the individual care plan
- A time when all team members can get together and discuss current clients and address items that need adjustment
- Recommendations:
  - Identify a key team member to take notes within the EHR
  - Ensure all team members present and sign in
  - Discuss the past two weeks and the upcoming two weeks
  - Avoid one-line updates
  - Include measurable signs or symptoms for comparison
  - Avoid different disciplines documenting different levels of decline

# Provide mock survey to enhance preparation

- IDENTIFY: Identify and develop a list of key stakeholders within your agency who will be able to represent your agencies QAPI, clinical operations, and field staff to review survey readiness
  - Expand to accreditation standards as indicated by deemed status or affiliation
  - Review previous survey
- ENGAGE: Engage objective review; get your mock survey started
- INTEGRATE: Integrate chart audit, field visits, IDT meeting observation, PEPPER report, PIP review, and walk-through of operational survey readiness
- BUILD: Build action plans for ongoing survey readiness and to maintain compliance. Educate staff and key stakeholders on changing regulation as needed
- RAISE: Raise overall organizational commitment to and awareness of regulatory compliance in day-to-day operations

# Practical tips

# During the IDT/IDG – D.A.R.E. to comply!

## D.A.R.E.: Deaths, Assessments, Recertifications, Evaluations

Deaths:

- Review each death and identify all family/friends who will be followed in bereavement services. It is also critical to discuss and document bereavement risk of each family/friend who will be followed and initiate the bereaved plan of care

Admissions:

- Admitting RN identifies all patients newly admitted since the previous IDT and articulates how they meet hospice admission criteria utilizing the prognostic worksheets specific to the admitting primary diagnosis
- Eligibility criteria are clarified/captured. Discuss last health care encounters and include medications and diagnostic results
- Discuss need for RN visits related to pain/symptom management for the next two weeks
- Discuss psychosocial and emotional needs of the patient and family members: what immediate needs are needed? If social worker assessment has been conducted prior to team meeting, the social worker should communicate key findings during team meeting
- Discuss spiritual needs. Hospice chaplain should discuss findings and further interventions.

# D.A.R.E. – continued IDT/IDG guidance

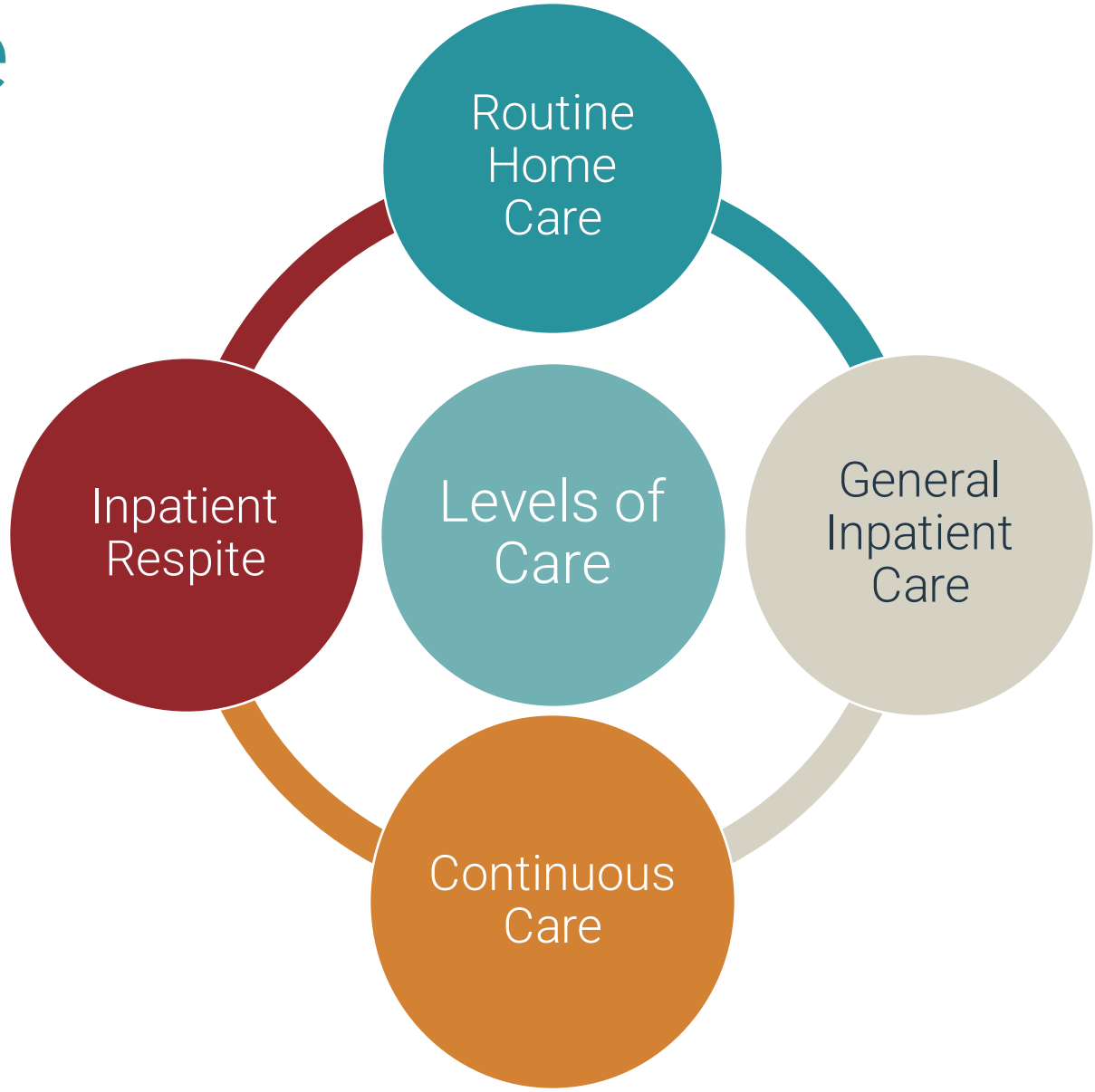
Recertifications:

- Patients recertified for the 1st, 2nd, 3rd and rotating 60-day periods of care need to be discussed, and **documentation needs to support the fiscal intermediaries' criteria for recertification.**
- The 3rd and subsequent certification periods need to have a face-to-face documented by an NP or physician hired by the Hospice

Evaluations (ongoing):

- Discuss patients who have had a change in condition, level of care change, and those who need to be reviewed every 14 days
  - Discuss: What is Most Important to You? (question for the patient).
  - Identify symptom management, emotional and spiritual needs of the patient/family (all members participate RN/LPN/SW/Chaplain), and changes that have occurred – capture in IDT documentation
  - Review medication regime.
  - Identify other disciplines needed i.e., therapy, volunteers, RD, WOCN
  - Identify - What is the problem focus for the next two weeks and discuss interventions for this problem? Identify and state visit frequency and pattern of all visits for the next two weeks. Engage Medical Director in this discussion – documentation to reflect.

# Hospice compliance and levels of care



# Levels of care

The interdisciplinary team (IDG) determines the level of care

Level of care changes require a change to the plan of care (POC)

CMS requires all hospices to provide all levels of care

# Routine home care

The most common level of hospice care

Routine hospice services provided to a patient at their place of residence

# Continuous Care – a period of clinical crisis

When?
Where?
Why?

# Continuous Care

- A continuous care day starts and stops at midnight
- The care must be at least 50% nursing (RN, LPN, or LVN)
- All aide and homemaker services must be counted
- MSW, pastoral care, or counseling hours do not count toward continuous care hours
- Overlapping hours may count if documentation supports the need

# General Inpatient Care (GIP)

## When GIP is appropriate:

- Determined by the IDG
- Usually a sudden change or when CHC has failed
- Symptoms must require frequent evaluation by MD, NP, or RN and/or frequent medication adjustments
  - Examples: Intractable nausea/vomiting, advanced open wounds, unmanageable respiratory distress, delirium with behavior issues, sudden decline necessitating intensive nursing intervention

## When GIP is NOT appropriate:

- Imminent death does NOT qualify a patient for GIP – it is an expected outcome
- It is NOT appropriate to use GIP to address unsafe living conditions or caregiver issues

# General inpatient care

No limit on number of days, but discharge planning starts on Day 1

Hospice is responsible for the professional management of the patient in accordance with the POC

All qualifying days ,except the day of discharge from the GIP facility, may be billed as GIP LOC. (Unless death occurs on the final day)

Coordination with the facility staff must be evident

Average length of stay is 3-7 days

# GIP

## Show compliance in your documentation

- Physician's order is required to change the level of care to GIP
- Must include the onset of symptoms and interventions that have been tried, but unsuccessful
- Create a "snapshot" of who the patient is and what the patient needs to justify each day of GIP
- Don't use general terms, such as "patient is dying" or "general decline" in documentation of GIP
- Ongoing documentation must support the need for GIP, the patient's response to treatments, and the collaboration with the facility staff

# Inpatient respite care

- Does not require a worsening of the patient's condition
- Any number of situations may necessitate respite care
- Not having a regular caregiver does not qualify a patient for respite care
- May not be provided to residents of a nursing facility
- May or may not need 24-hour RN coverage (depending on state requirements)
- More than 1 respite period is allowable in a single billing period

# Inpatient respite care

- Physician orders are recommended for respite care and are required by some state regulations
- Plan of care should remain the same, except for the LOC change
- Coordination with the contracted facility must be documented in the patient record, including orientation of facility staff to the POC, contact phone numbers, IDG visit schedule, and caregiver phone numbers
- Disciplines continue to document as they would if visiting the patient in the home
- Each day of respite care provided should demonstrate continued eligibility for this level of care

# Tools to manage compliance

# PEPPER resources

| What is PEPPER? | | |
|---|---|---|
| Program for Evaluating Payment Patterns Electronic Report | Provides provider specific Medicare data statistics for discharges/services vulnerable to improper payments | Identifies outliers for risk areas |

National Retrieval Rate = 63%

*Leaders can obtain their PEPPER from the PEPPER resource Portal at the following website: https://securefile.tmf.org/#*

# PEPPER resource: Currently focuses on 12 areas, including many of the MAC's targets

- Live discharges not terminally ill
- Live discharges – revocations
- Live discharges – LOS 61-179
- Long lengths of stay
- Continuous home care in assisted living facility
- Routine home care in assisted living facility
- Routine home care in nursing facility
- Routine home care in skilled nursing facility
- Claims with single diagnosis coded
- No GIP or CHC services
- Long GIP stays
- Average Part D Claims

# PEPPER resources

**Hospice PEPPER**

Table 3 Your Hospice Statistics for Live Discharges No Longer Terminally Ill

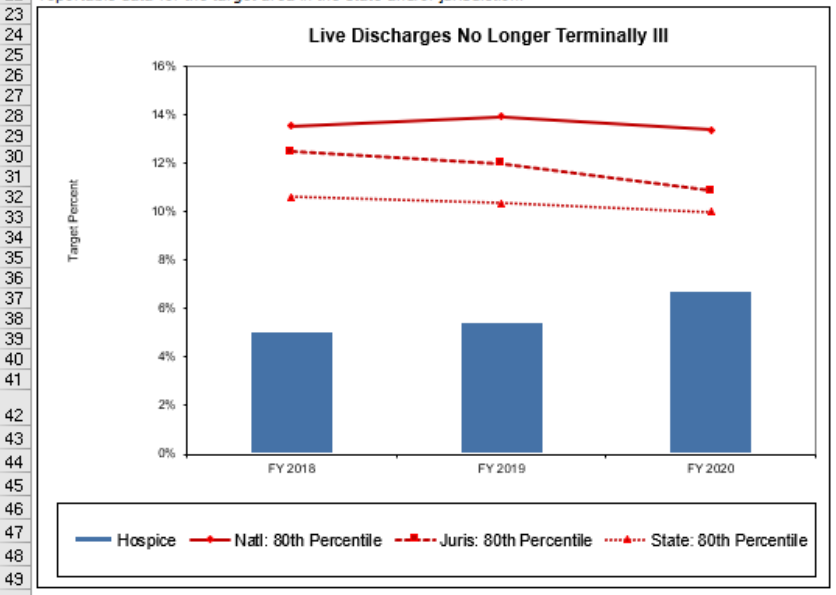
| YOUR HOSPICE | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|
| Outlier Status | Not an outlier | Not an outlier | Not an outlier |
| Target Area Percent | 5.1% | 5.4% | 6.8% |
| Target Count | 46 | 53 | 66 |
| Denominator Count | 909 | 974 | 977 |
| Target (Numerator) Average Length of Stay | 99.3 | 90.9 | 121.3 |
| Denominator Average Length of Stay | 43.0 | 32.4 | 44.9 |
| Target (Numerator) Average Payment | $15,362 | $14,437 | $18,895 |
| Target (Numerator) Sum of Payments | $706,667 | $765,140 | $1,247,049 |

No data: Target or Denominator count is less than 11 and is suppressed due to confidentiality requirements.

Table 4 Comparative Data for Live Discharges No Longer Terminally Ill

| COMPARATIVE DATA | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|
| National 80th Percentile | 13.5% | 13.9% | 13.4% |
| Jurisdiction 80th Percentile | 12.5% | 12.0% | 10.9% |
| State 80th Percentile | 10.6% | 10.4% | 10.0% |

**Note:** State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.




**SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE**

This could indicate that beneficiaries are being enrolled in the Medicare hospice benefit who do not meet the hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. Medical record documentation should be reviewed for beneficiaries discharged alive to determine whether enrollment in the hospice benefit was appropriate and in accordance with Medicare policy.

Compare | Live Disch | Live Disch Rev | Live Disch LOS 61-179 | Long LOS

# PEPPER Report

**Hospice PEPPER**

Table 23 Your Hospice Statistics for Long General Inpatient Care Stays

| YOUR HOSPICE | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|
| **Outlier Status** | High Outlier | High Outlier | Not an outlier |
| **Target Area Percent** | 37.1% | 37.2% | 28.0% |
| **Target Count** | 167 | 148 | 89 |
| **Denominator Count** | 450 | 398 | 318 |
| **Target (Numerator) Average Length of Stay** | Not Calculated | Not Calculated | Not Calculated |
| **Denominator Average Length of Stay** | Not Calculated | Not Calculated | Not Calculated |
| **Target (Numerator) Average Payment** | Not Calculated | Not Calculated | Not Calculated |
| **Target (Numerator) Sum of Payments** | Not Calculated | Not Calculated | Not Calculated |

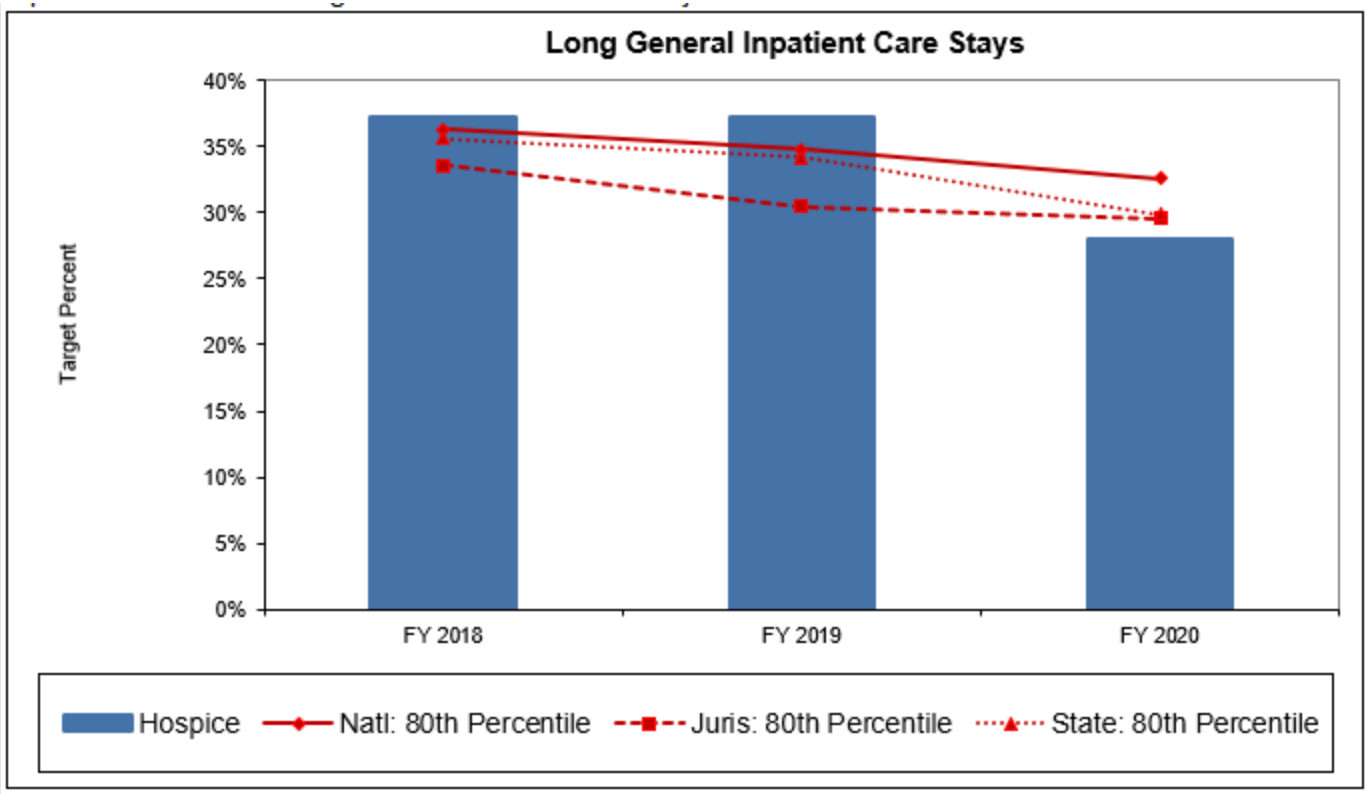
No data: Target or Denominator count is less than 11 and is suppressed due to confidentiality requirements.

Table 24 Comparative Data for Long General Inpatient Care Stays

| COMPARATIVE DATA | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|
| **National 80th Percentile** | 36.3% | 34.8% | 32.6% |
| Jurisdiction 80th Percentile | 33.6% | 30.5% | 29.6% |
| State 80th Percentile | 35.7% | 34.2% | 29.9% |

**Note:** State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

# PEPPER Report




**SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE**

This could indicate that the hospice is initiating GIP services when not indicated/necessary. A sample of records for beneficiaries that had long GIP stays should be reviewed to determine whether GIP was provided in the appropriate setting and was appropriately used for pain control or acute/chronic symptom management that could not be addressed in other settings.

# Workforce challenges bumping into culture of compliance

**Compounded by clinician turnover, fueled by lack of life-work balance**

- Pressure to manage requirements and keep staff going is real
- Documentation time has often tipped the balance for staff
- Documentation methodology training often as variable as the skill of the field preceptor
- Think about focusing where our organizations have supported our staff quite enough… the place where often our clinicians struggle, losing time, energy and accuracy
- Capture documentation at the point of care or adjacent to the visit

# **In summary:** Strong compliance program is a win for patients, providers and payers

- Show your agency's commitment to honest and responsible corporate conduct
- Achieve proactive documentation processes to support ethical billing processes and an efficient and reliable revenue cycle
- Provide education to key stakeholders/employees regarding their obligation to uphold appropriate behavior as it relates to fraud and abuse
- Early identification and prevention of unethical or criminal conduct
- Generation of communication methodology for distribution of information r/t rules and regulatory changes and accompanying guidance for clinical operations
- Encourage key stakeholder involvement in and awareness of the importance of compliance in day-to-day activities
- Develop procedural guidance for investigation of any alleged misconduct by corporate officers, management and employees and initiation of appropriate corrective actions

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# Thank you

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# Resources

Hospice Addendum Example
- https://www.cms.gov/files/document/model-hospice-election-statement-and-addendum.pdf

Conditions of Participation – Federal Register
- https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418?toc=1

State Operations Manual: Appendix M – Guidance to Surveyors - Hospice
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf

MLN Matters – SE1628 Documentation Requirements for Hospice Physician Certification/Recertification
- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1628.pdf

Join Listserv or subscribe to email updates for CMS and for your MAC
- CMS - https://www.cms.gov/Medicare/Coverage/InfoExchange/listserv
- CGS - https://www.cgsmedicare.com/email.html
- NGS - https://www.ngsmedicare.com/web/ngs/get-email-updates?lob=93618&state=97210&rgion=93624
- Palmetto - https://www.palmettogba.com/palmetto/jmhhh.nsf/M/Registration

Youtube channels for each MAC
- https://www.youtube.com/user/cgsmedicare
- https://www.youtube.com/ngsmedicare
- https://www.youtube.com/user/PalmettoGBAEdu

National Organizations
- National Hospice and Palliative Care Organization (NHPCO) - https://www.nhpco.org/
- National Association for Home Care and Hospice (NAHC) - https://www.nahc.org/

Hospice News - https://hospicenews.com/subscribe/?utm_source=hspn-website&utm_medium=nav-link

Program for Evaluating Payment Patterns Electronic Reports (PEPPER) - https://pepper.cbrpepper.org/

Certification And Survey Provider Enhanced Reports (CASPER) - https://qtso.cms.gov/