Home Health Line Fact Sheet

Hospice PEPPER target areas

You can get ahead of compliance concerns by monitoring your results on the Hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER). There are 15 target areas included in the Hospice PEPPER. Here is a breakdown of each area, along with interventions recommended by CMS. (*For home health target areas, see HHL 8/24/26*)

Live discharges

- Live discharges no longer terminally ill
- Live discharges — revocations
- Live discharges with LOS 61-179 days

For all three target areas related to live discharges: 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.

For revocations: The hospice should review instances where occurrence code 42 is applied to ensure that the revocation was initiated by the beneficiary (not by the hospice) and that the revocation was not initiated to avoid costly patient care.

For LOS 61 - 179: A high percentage of live discharges with a LOS between 61 and 179 days could indicate that financial incentives are impacting patient care decisions.

Length of stay

- Long length of stay

Similar to live discharges, CMS recommends providers review medical record documentation for a sample of beneficiaries with long LOSs to determine whether enrollment in the hospice benefit was appropriate and in accordance with Medicare policy.

Routine home care

- Routine home care provided in an assisted living facility
- Routine home care provided in a nursing facility
- Routine home care provided in a skilled nursing facility

The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit appropriately. Medical record documentation should be reviewed to determine whether enrollment in the hospice benefit and services provided are appropriate.

Single diagnosis coded

- Claims with single diagnosis coded

This could indicate that the hospice is not coding all coexisting diagnoses related to the terminal illness and related conditions. All of a patient's coexisting or additional diagnoses related to the terminal illness and related conditions should be reported on the hospice claim. The hospice should review a sample of hospice clams with a single diagnosis coded to ensure that all diagnoses related to the terminal illness and related conditions are reported on the hospice claim.

In order for a diagnosis to be coded as a coexisting condition, it must be substantiated by documentation. *(See more, p. 2.)*

Source: Hospice PEPPER User Guide, 2026

Limited services

- No general inpatient care or continuous home care

This could indicate that the hospice is not providing the full spectrum of services as required by the Medicare program. A sample of records for beneficiaries that did not receive GIP or CHC should be reviewed. The hospice should ensure that processes are in place to assess when beneficiaries need GIP and/or CHC and that the hospice is able to provide these services.

Inpatient care stays

- Long general inpatient care stays

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.

Medicare Part D

- Average number of Medicare Part D claims for beneficiaries residing at home
- Average number of Medicare Part D claims for beneficiaries residing in an assisted living facility
- Average number of Medicare Part D claims for beneficiaries residing in a nursing facility

These could indicate that patients residing at home, in ALFs or in NFs may be receiving drugs that should have been paid for by the hospice organization. A sample of records for beneficiaries should be reviewed. The hospice should ensure that processes are in place to assess medication regimens and that medications related to the terminal condition are provided as part of the hospice benefit. Compare the rate of claims for beneficiaries residing in different settings in order to identify the patient population with the highest rate so that it may be prioritized for intervention.

Medicare Part B

- Average number of Medicare Part B claims for beneficiaries residing at home
- Average number of Medicare Part B claims for beneficiaries residing in an assisted living facility, nursing facility or skilled nursing facility

These could indicate that patients may be receiving services that should have been coordinated by the hospice organization. A sample of records for beneficiaries should be reviewed. The hospice should ensure that processes are in place to coordinate with providers that previously provided services to the beneficiary to ensure that they do not bill Medicare for additional services that are related to the beneficiary's terminal illness and related conditions once the beneficiary has enrolled in hospice. Similar to the Part D targets, compare the rate of claims for beneficiaries residing in different settings.