# Improving Your Agency with CMS Data: Quality Measures (HQRP) and PEPPER

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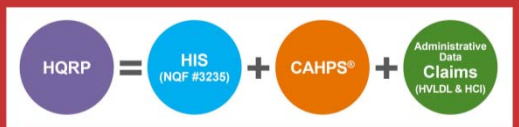
Least You Need to Know Conference


HOSPICE FUNDAMENTALS



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2

## Quality Measures in 2022/2023

- Current Measures for 2022:
  - Comprehensive Assessment completed (HIS composite publicly reported)
  - HVLDL- Previews in QIES available
  - HCI- Previews in QIES available
  - CAHPS Hospice survey
    - Publicly reported
    - CMS trying out web based mode for CAHPS
    - CMS testing a new shorter version

## FY2023 Proposed Payments HQRP Impact

- FY2022 – failure to meet HQRP requirements during CY2020 results in 2% payment reduction over final rates this year
- Consolidated Appropriations Act of 2021 bumps HQRP reporting penalty to 4% beginning FY2024
- – REMEMBER: CY2022 reporting impacts FY2024 payments- So this truly begins THIS year!

## APU Impact

| Report Year | HIS | CAHPS | APU Year | APU% |
|---|---|---|---|---|
| • CY 2021 | 90% | Ongoing Monthly Participation | FY 2023 | 2% |
| • **CY 2022** | 90% | Ongoing Monthly Participation | **FY 2024** | **4%** |
| • **CY 2023** | 90% | Ongoing Monthly Participation | **FY 2025** | **4%** |

## HIS Measures

- ONLY the COMPOSITE is now publicly reported- none of the details
- Patients Treated With An Opioid Who Are Given a Bowel Regimen
- Pain Screening
- Pain Assessment
- Dyspnea Screening
- Dyspnea Treatment
- Treatment Preferences
- Beliefs/Values Addressed (if desired by the patient)
- Maintaining Comprehensive Assessment at Admission

## CAHPS Five Star Rating

- Star new in 2022 (projected August)
- Ratings across 8 measures
- Minimum of 75 completed surveys
- Methodology
- Bell curve
- Future posting www.hospicecahpssurvey.org

## Is there "HOPE"

- Proposed future rulemaking may include Hospice Outcomes and Patient Evaluation (HOPE) -based process measures intended to:
- Provide quality data through standardization of collection to evaluate the rate at which hospices use specific processes of care
- In "Beta testing" with agencies currently
- Determine hospices' compliance with practices that are expected to improve outcomes through survey and certification processes
- **May** see in Proposed Rule Making in Spring of 2023 for FY 2024

Hospice Visits in Last Days of Life (HVLDL)

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9

## Claims-Based Measures

- Hospice Visits Last Days of Life
- Hospice Care Index
- See FYI

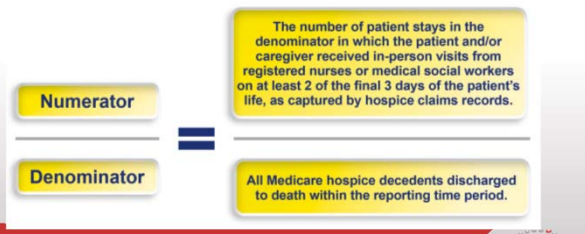

## Hospice Visits Last Days of Life

- "HVLDL" Measure finalized
- Proportion of patients who received visits from a **RN** or a **medical social worker** (non-telephonically) on **at least two of the last three days of life**
- Re-specified Hospice Visits When Death is Imminent (HVWDII)
- Claims-based (Only will include Medicare)

## HVLDL

- Will publicly report no earlier than May 2022
- Utilizing 8 quarters of data, excluding Q1/Q2 2020 claims

## Calculation of HVLDL




## Exclusions to HVLDL

- Same exclusions as HVWDII: Patient did not die under hospice care as indicated by reason for discharge.
- Patient received any continuous home care, respite care, or general inpatient care in the final three days of life.
- Patient was enrolled in hospice less than three days. HVLDL looks at visits in the last three days of life; patients must receive hospice services for **at least three days** to be included in the measure

## Hospice Care Index (HCI)

## Hospice Care Index Measure

- Capture multiple aspects of hospice care with a broad, holistic set of claims-based quality measures
- Multiple indicators- all CLAIMS based
- Threshold for each indicator will be developed using industry percentiles
- Overall score is calculated on the number of instances when the hospice met a set threshold (one point out of 10 possible)
- Public Reporting
- Utilizing up to 8 quarters of claims- but excluding Q1/Q2 2020
- Final HCI score only


## HCI Indicators

- **CHC or GIP Provided**

Identifies hospices that provided at least one day of hospice care under the CHC or the GIP levels of care during the period examined

- **Gaps in Nursing Visits**

Identifies whether a hospice is below the 90th percentile in terms of how often hospice stays of at least 30 days contain at least one gap of eight or more days without a nursing visit. (RN or LPN/LVN)

- **Early Live Discharges**

Identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that occur within 7 days of hospice admission during the fiscal year examined.

## HCI Indicators

- **Late Live Discharges**

Identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that occur on or after the 180th day of hospice.

- **Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission (Burdensome Transitions Type I)**

Identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that are followed by a hospitalization (within 2 days of hospice discharge) and then followed by a hospice readmission (within 2 days of hospitalization) during the FY examined

- **Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital (Burdensome Transitions Type II)**

Identifies whether a hospice is below the 90th percentile in terms of the percentage of live discharges that are followed by a hospitalization (within two days of hospice discharge) and then the patient dies in the hospital

## HCI Indicators

- **Per-beneficiary Medicare Spending**

Identifies whether a hospice is below the 90th percentile in terms of the average Medicare hospice payments per beneficiary

- **Nurse Care Minutes per Routine Home Care (RHC) Day**

Identifies whether a hospice is above the 10th percentile in terms of the average number of nursing minutes provided on RHC days during the reporting period examined

## HCI Indicators

- **Skilled Nursing Minutes on Weekends**

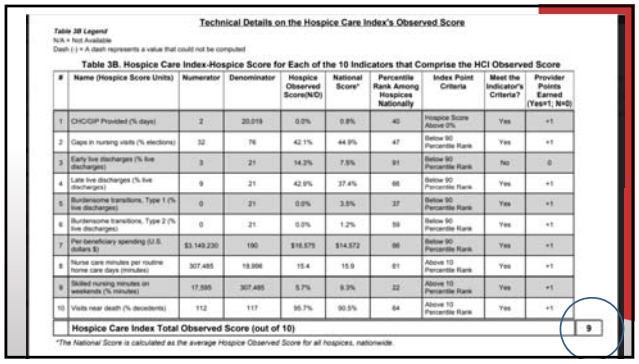
Identifies whether a hospice is at or above the 10th percentile in terms of the percentage of skilled nursing minutes performed on weekends compared to all days during the reporting period examined

- **Visits Near Death**

Identifies whether a hospice is at or above the 10th percentile in terms of the percentage of beneficiaries with a nurse and/or medical social services visit in the last 3 days of life

## HCI calculations

- A hospice is awarded a point for meeting each criterion for each of the ten claims - based indicators.
- A hospice's given indicator score determines whether the hospice earns a point for that individual indicator. Each point earned contributes towards the full index score.
- HCI scores can range from 0 to a perfect 10.
- HCI Indicator = Earned Criterion Point The **SUM** of all ten HCI indicators = HCI Score



Technical Details on the Hospice Care Index's Observed Score

*Table 3B Legend*
N/A = Not Available
Dash (-) = A dash represents a value that could not be computed

**Table 3B. Hospice Care Index-Hospice Score for Each of the 10 Indicators that Comprise the HCI Observed Score**

| # | Name (Hospice Score Units) | Numerator | Denominator | Hospice Observed Score(N/D) | National Score* | Percentile Rank Among Hospices Nationally | Index Point Criteria | Meet the Indicator's Criteria? | Provider Points Earned (Yes=1; N=0) |
|---|---|---|---|---|---|---|---|---|---|
| 1 | CHC/GIP Provided (% days) | 2 | 20,019 | 0.0% | 0.8% | 40 | Hospice Score Above 0% | Yes | +1 |
| 2 | Gaps in nursing visits (% elections) | 32 | 76 | 42.1% | 44.9% | 47 | Below 90 Percentile Rank | Yes | +1 |
| 3 | Early live discharges (% live discharges) | 3 | 21 | 14.3% | 7.5% | 91 | Below 90 Percentile Rank | No | 0 |
| 4 | Late live discharges (% live discharges) | 9 | 21 | 42.9% | 37.4% | 66 | Below 90 Percentile Rank | Yes | +1 |
| 5 | Burdensome transitions, Type 1 (% live discharges) | 0 | 21 | 0.0% | 3.5% | 37 | Below 90 Percentile Rank | Yes | +1 |
| 6 | Burdensome transitions, Type 2 (% live discharges) | 0 | 21 | 0.0% | 1.2% | 59 | Below 90 Percentile Rank | Yes | +1 |
| 7 | Per beneficiary spending (U.S. dollars $) | $3,149,230 | 190 | $16,575 | $14,572 | 66 | Below 90 Percentile Rank | Yes | +1 |
| 8 | Nurse care minutes per routine home care days (minutes) | 307,485 | 19,906 | 15.4 | 15.9 | 61 | Above 10 Percentile Rank | Yes | +1 |
| 9 | Skilled nursing minutes on weekends (% minutes) | 17,595 | 307,485 | 5.7% | 9.3% | 22 | Above 10 Percentile Rank | Yes | +1 |
| 10 | Visits near death (% decedents) | 112 | 117 | 95.7% | 90.5% | 64 | Above 10 Percentile Rank | Yes | +1 |
| | **Hospice Care Index Total Observed Score (out of 10)** | | | | | | | | 9 |

*The National Score is calculated as the average Hospice Observed Score for all hospices, nationwide.

## CMS Use of Data for Claims Based Measures

- Use claims data at least 90 days after the last discharge date in the applicable period
- Update the claims-based measures used for the HQRP at least annually
- Calculate claims-based scores based on one or more years of data
- Two years of data utilized to report HCI and HVLDL

Example of HCI Scoring from CMS

## Hospice Care Index Indicator Scoring

| Indicators (Hospice Score Units) | Index Earned Point Criteria | Points Earned? | Points Awarded |
|---|---|---|---|
| **Provided CHC/GIP** (% days) | Hospice Score Above 0% | Yes | +1 |
| **Gaps in skilled nursing visits** (% elections) | Below 90 Percentile Rank | No | 0 |
| **Early live discharges** (% live discharges) | Below 90 Percentile Rank | Yes | +1 |
| **Late live discharges** (% live discharges) | Below 90 Percentile Rank | Yes | +1 |
| **Burdensome transitions, Type 1** (% live discharges) | Below 90 Percentile Rank | Yes | +1 |
| **Burdensome transitions, Type 2** (% live discharges) | Below 90 Percentile Rank | Yes | +1 |
| **Per-beneficiary Medicare spending** (U.S. dollars, $) | Below 90 Percentile Rank | Yes | +1 |
| **Skilled nursing care minutes per RHC day** (minutes) | Above 10 Percentile Rank | No | 0 |
| **Skilled nursing minutes on weekends** (% minutes) | Above 10 Percentile Rank | Yes | +1 |
| **Visits near death** (% decedents) | Above 10 Percentile Rank | Yes | +1 |
| | | HCI Total Score = | 8 |

The FY 2022 Hospice Final Rule | August 2021

42

# PEPPER Updates

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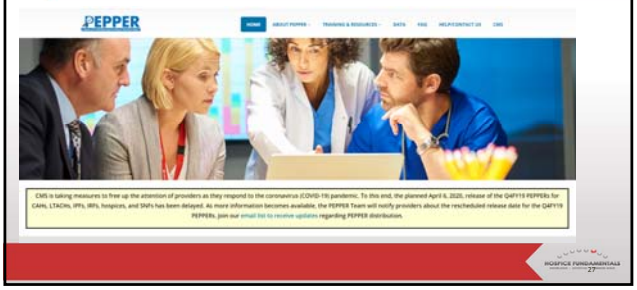
26

PEPPER is Back On Schedule!



## What is PEPPER and Why Should We Care?

**PEPPER** =

**P**rogram for
**E**valuating
**P**ayment
**P**atterns
**E**lectronic
**R**eport

**It's a comparative data report prepared for individual health care providers with data drawn from three years' worth of claims information from the national Medicare claims database.**

**This is provided by a contractor for the Program Integrity**

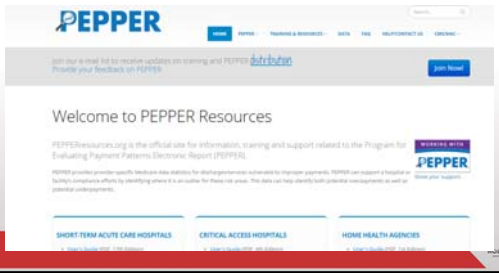
It zeros in on specific target areas that have been determined to be *"at risk for improper Medicare payments." PEPPERs are intended to support a provider's compliance efforts by identifying where billing patterns are different from "the majority of other providers in the nation."*

## How Do I Obtain my PEPPER?

- Obtaining requires the certification by the CEO, President, Administrator, Compliance Officer or Quality Assurance/Performance Improvement Officer
- PEPPER provides reports by state on retrieval rates
- https://pepper.cbrpepper.org/Training-Resources/Hospices

## Obtain Your Report Yearly PEPPER

https://pepper.cbrpepper.org/



## Target Areas-

1. Live Discharges: No Longer Eligible
2. Live Discharges: Revocations
3. Live Discharges: LOS 61-179 Days
4. Long Length of Stay
5. Continuous Home Care in Assisted Facility
6. Routine Home Care in an Assisted Living Facility
7. Routine Home Care Provided in a Nursing Facility
8. Routine Home Care Provided in a SNF
9. Claims with a Single DX Code
10. Claims with No CHC or GIP
11. Long General Inpatient Care Stays
12. Average Part D Claims Paid During Hospice Benefit

31

## Percent vs Percentiles

The Target Area Percent lets the provider know its billing patterns- How often you have X happen, or What percent of your patients care end in revocation? What percent of your patients live in an AL?

The Percentiles give context by helping a provider understand how it compares to other providers- Where does your percent rank compared to your neighbors?

32

## Percentiles- Where do We Land?

- To calculate Percentiles for all providers in a comparison group (nation, jurisdiction or state) the target area percents are sorted from largest to smallest for each time period.
- Example:
  - Hospice ABC has 15% of their patients living in ALFs. If 40% of the providers' target area percent were lower than provider's 15%, then provider ABC would be at the 40th percentile.

33

## Compare Report Example (Tab)

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target discharges) in the most recent time period. Percentiles indicate how a hospice's target area percent compares to the target percents for all hospices in the respective comparison group. For example, if a hospice's jurisdiction (see below) is 80.0, 80% of the hospices in the Medicare Administrative Contractor (MAC) comparison group have a lower percent value than that hospice. The hospice's state percentile (if displayed) and the hospice national percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target areas or at or below the 20th percentile for coding-focused target areas indicate that the hospice may be at a higher risk for improper Medicare payments (outlier status). The greater the percent value, particularly the national and/or jurisdiction percentile, the greater the consideration should be given to the target area.

Table 2 Compare Targets Report

| Target | Number of Target Dischs | You Percent | Hospice National %ile | Hospice Jurisdict. %ile | Hospice State %ile | Sum of Payments |
|---|---|---|---|---|---|---|
| Live Discharges Revocations | 54 | 19.3% | 83.8 | 68.8 | 88.9 | $1,123,681 |
| Live Discharges LOS 61-179 | 30 | 38.0% | 76.1 | 67.5 | 73.4 | $533,610 |
| Long LOS | 65 | 23.2% | 74.4 | 67.1 | 60.6 | $3,390,600 |
| Routine Home Care in Assisted Living Facility | 21,345 | 44.3% | 86.8 | 79.1 | 68.0 | Not Calculated |
| Routine Home Care in Nursing Facility | 251 | 0.5% | 0.4 | 0.4 | 2.8 | Not Calculated |
| Claims w/ Single Diagnosis Coded | 123 | 6.5% | 34.3 | 24.3 | 46.3 | Not Calculated |
| No GIP or CHC | 263 | 93.9% | 42.7 | 41.8 | 28.2 | $5,169,216 |

## Live Discharges- Revocations

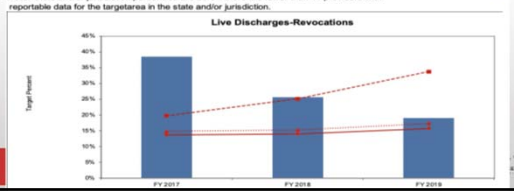
- *N:* count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 [expired at home], 41 [expired in a medical facility], or 42 [expired place unknown]), with occurrence code 42
- *D:* count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)

| YOUR HOSPICE | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|
| Outlier Status | High Outlier | High Outlier | High Outlier |
| Target Area Percent | 38.7% | 25.9% | 19.3% |
| Target Count | 41 | 56 | 54 |
| Denominator Count | 106 | 216 | 280 |
| Target (Numerator) Average Length of Stay | 56.2 | 127.6 | 124.3 |
| Denominator Average Length of Stay | 46.0 | 85.7 | 118.8 |
| Target (Numerator) Average Payment | $9,943 | $20,590 | $20,809 |
| Target (Numerator) Sum of Payments | $407,648 | $1,153,041 | $1,123,681 |

Table 6 Comparative Data for Live Discharges-Revocations

| COMPARATIVE DATA | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|
| National 80th Percentile | 13.8% | 14.1% | 15.8% |
| Jurisdiction 80th Percentile | 19.8% | 25.2% | 33.8% |
| State 80th Percentile | 14.9% | 15.3% | 17.4% |

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



## Live Discharges: No Longer Terminally Ill

- *Numerator (N):* count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 [expired at home], 41 [expired in a medical facility], or 42 [expired place unknown]), excluding:
- • beneficiary transfers (patient discharge status code 50 or 51)
- • beneficiary revocations (occurrence code 42)
- • beneficiaries discharged for cause (condition code H2)
- • beneficiaries who moved out of the service area (condition code 52)
- *Denominator (D):* count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)

## Live Discharges 61-179

- *N:* count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 [expired at home], 41 [expired in a medical facility], or 42 [expired place unknown]), with a length of stay (LOS) of 61 – 179 days
- *D:* count of all beneficiary episodes discharged alive by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)

## Long Length of Stay

- *N:* count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice)
- *D:* count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)

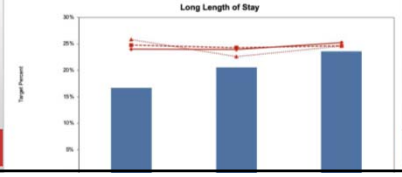
| YOUR HOSPICE | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|
| Outlier Status | Not an outlier | Not an outlier | Not an outlier |
| Target Area Percent | 16.8% | 20.7% | 23.7% |
| Target Count | 56 | 66 | 66 |
| Denominator Count | 333 | 319 | 278 |
| Target (Numerator) Average Length of Stay | 370.0 | 456.7 | 506.6 |
| Denominator Average Length of Stay | 95.9 | 125.0 | 150.8 |
| Target (Numerator) Average Payment | $48,226 | $59,221 | $65,760 |
| Target (Numerator) Sum of Payments | $2,700,646 | $3,908,603 | $4,340,175 |

Table 10 Comparative Data for Long Length of Stay

| COMPARATIVE DATA | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|
| National 80th Percentile | 24.0% | 23.9% | 25.3% |
| Jurisdiction 80th Percentile | 24.8% | 24.3% | 24.6% |
| State 80th Percentile | 25.8% | 22.6% | 24.6% |

**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.

**Long Length of Stay**




## Routine Care in ALF/NF/SNF

- Three separate measures
- *N:* count of Routine Home Care (RHC) days (revenue code = 0651) provided on claims ending in the report period that indicate the beneficiary resided in a/an____ ALF/NF/SNF (Q5002/5003/5004)
- *D:* count of all RHC days (revenue code = 0651) provided by the hospice on claims ending in the report period

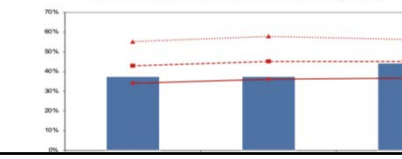
| | | | |
|---|---|---|---|
| Outlier Status | High Outlier | High Outlier | High Outlier |
| Target Area Percent | 37.6% | 37.6% | 44.3% |
| Target Count | 4,266 | 10,939 | 21,345 |
| Denominator Count | 11,339 | 29,092 | 48,140 |
| Target (Numerator) Average Length of Stay | No data | No data | No data |
| Denominator Average Length of Stay | No data | No data | No data |
| Target (Numerator) Average Payment | No data | No data | No data |
| Target (Numerator) Sum of Payments | No data | No data | No data |

Table 14 Comparative Data for Routine Home Care Provided in Assisted Living Facilities

| COMPARATIVE DATA | FY 2017 | FY 2018 | FY 2019 |
|---|---|---|---|
| National 80th Percentile | 34.1% | 36.1% | 36.6% |
| Jurisdiction 80th Percentile | 42.9% | 45.1% | 45.1% |
| State 80th Percentile | 55.1% | 57.8% | 56.3% |

**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.

**Routine Home Care Provided in an Assisted Living Facility**



## SNF vs NF

- Q5004 is used for patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually-certified nursing facility.
  - The beneficiary is receiving hospice care in a solely-certified SNF.
  - The beneficiary is in a SNF receiving SNF care under the Medicare SNF benefit for a condition that is unrelated to the terminal illness, and is under routine home care.
  - The beneficiary is receiving general inpatient care in the SNF.
  - The beneficiary is receiving inpatient respite care in a SNF.
- If the beneficiary is in a nursing facility, but does not meet one of the four situations above, report the place of service as Q5003 (NF)

## Average Part D Claims per Beneficiary

- New Target Area Report as of the FY2020 PEPPER Report
- Numerator: Count of Medicare Part D claims for beneficiaries billed during hospice episodes of **at least 3 days, beginning one day after admission and ending one day before discharge for beneficiaries discharged alive**
- Denominator: Count of all beneficiary episodes discharged (by death or alive, and at least 3 days in length), by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
- **WHY?** In August 2019, the OIG estimated that Medicare Part D spent $160.8M for drugs that should have been paid for by hospice organizations

| YOUR HOSPICE | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|
| Outlier Status | Not an outlier | Not an outlier | Not an outlier |
| Target Area Rate | 4.71 | 4.49 | 6.16 |
| Target Count | 961 | 1,211 | 1,966 |
| Denominator Count | 204 | 270 | 319 |
| Target (Numerator) Average Length of Stay | 126.1 | 163.2 | 217.0 |
| Denominator Average Length of Stay | 90.6 | 123.3 | 147.2 |
| 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 26 Comparative Data for Average Part D Claims

| COMPARATIVE DATA | FY 2018 | FY 2019 | FY 2020 |
|---|---|---|---|
| National 80th Percentile | 10.88 | 11.54 | 12.10 |
| Jurisdiction 80th Percentile | 10.16 | 11.22 | 11.41 |
| State 80th Percentile | 8.71 | 8.89 | 8.67 |

**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.

## Claims with a Single Dx

- 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.

## No GIP or CHC Provided

- *N:* count of beneficiary episodes ending in the report period that had no amount of general inpatient care (revenue code = 0656) or CHC (revenue code = 0652)
- *D:* count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
- This could indicate that the hospice is not providing the full spectrum of services as required by the Medicare program.

## Long GIP Stay

- *N:* count of General Inpatient Care (GIP) stays within episodes ending in the report period with a length greater than five consecutive days
- *D:* count of all GIP stays within episodes ending in the report period, identified as 1+ consecutive days of revenue code 0656
- This could indicate that the hospice is initiating GIP services when not indicated/necessary.

## So, What's the Problem?

- Some of these topics don't indicate the hospice has done something "bad" – it just is an "outlier"
- Operations/processes and trainings ensure a culture of compliance!

## Culture of Compliance

- Marketing/Intake and admissions rely on clear communications of needs/expectations
  - LCDs for six-month guidelines
  - Adequate documentation to support acuity or trajectory

## Staff Training and Competency

- Connection to assessments and care planning
- Accountability to standards
- IDG discussions after each leaving service areas- entering noncontracted facility, revocation, transfer in service area, for cause
  - What could we have done better/differently?

## Auditing for Regulatory Compliance

- Beneficiary initiated
  - *Transfer to another Hospice*
  - *Revocation*
- Hospice Initiated
  - *Out of Service Area both to non-contracted facilities and geographically*
  - *"For cause" discharges*
  - *Medically Ineligible*

52

## Actions of a Prudent Hospice™

1. Download your PEPPER and review with special attention to red areas on the compare worksheet.
2. If you have an area of concern, take time to analyze and put additional actions into place as indicated.
3. Complete a Risk Table for your hospice
4. Think of revocations, discharge for entering noncontract hospitals and transfers within the service area as a service delivery failure and find and address systemic cause(s)

53

## References/Resources

1. Pepper Training Resources https://pepper.cbrpepper.org/Training-Resources/Hospices
2. Medicare Hospice Regulations, Subpart B & C
3. Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

Thank you!

Questions????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55



## To Contact Us


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Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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56