Hospice Regulatory Update

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Why Everyone Should Care

Hospice billing and payment
Quality (Public reporting)
IRF patient/family care and documentation
Compliance audits
State, Medicare, accreditation survey

FY2018 HOSPICE WAGE INDEX
FINAL RULE
HOSPICE RATES AND CAP

Rate Increase

• 1% -- FY2018 ONLY
• Reduced rate is part of MACRA physician payment agreement
• Other Medicare providers, such as nursing homes, home health, and inpatient rehab facilities, also have a one year 1% maximum increase
• Future years – back to marketbasket formula

FY2018 Final Payment Rates

<table>
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<tr>
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<th>FY2017 Payment Rates</th>
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FY2018 Final Payment HQRP
Non Compliance Penalty

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Hospice Cap Details

- Cap amount: $28,689.04
- Cap accounting year for:
  - inpatient cap
  - Hospice aggregate cap
- Aligned with Federal Fiscal Year (October 1 – September 30) for fiscal year for FY 2017 and later
- Cap report due: February 28, 2018
Part A and B Spending Outside Hospice Benefit

- 25% drop in Part A and B spending since 2012.
- **Not a trivial amount**
- CMS will continue to monitor data regarding this issue

Part D Spending

Source: FY2018 Hospice Wage Index Proposed Rule, April 27, 2017
CMS Concerns

• Current prior authorization process has lowered Part D expenditures for 4 classes
• Increase in beneficiaries filling “maintenance” medications through Part D
• Hospices are responsible for covering drugs and biologicals related to the palliation and management of the terminal illness and while the patient is under hospice care
• Part D coverage: treatment unrelated to the terminal illness or related conditions

Source: FY2018 Hospice Wage Index Proposed Rule, April 27, 2017

SOURCES OF CLINICAL INFORMATION FOR CERTIFYING TERMINAL ILLNESS

There are ongoing CMS concerns that some hospice patients may be inappropriately certified as terminally ill
CMS Current Certification Concerns

- Patient is **not required** to choose an attending physician
- Hospice medical director/hospice physician is **not required** to have face-to-face encounter with the patient **when initially certifying** the patient as terminally ill
- A patient may never be seen by the hospice physician who is certifying that he or she is terminally ill

Source: FY2018 Hospice Wage Index Proposed Rule, April 27, 2017

Outcome in Final Rule

- CMS received many comments on this issue
- Not proposing a change in regulations “at this time”
- CMS will work with the Medicare Administrative Contractors (MACs) to ensure that they are requesting clinical documentation used for eligibility when claims are selected for medical review
No new quality measures for 2018

Measure Concepts Under Consideration for Future Years

Priority Area 1: Potentially avoidable hospice care transitions
• Claims-based measure focusing on transitions of care
• Potentially avoidable hospice care transitions at end of life are burdensome to patients, families, and the health care system at large

Priority Area 2: Access to levels of hospice care
• Claims based measure
• Appropriate use of CHC and GIP
• Measuring use of levels of care will incentivize hospice providers to continuously assess patient and caregiver needs and provide the appropriate level of care to meet these needs
HEART

- Hospice Evaluation & Assessment Reporting Tool (HEART)
- Hospice patient assessment
- Two primary objectives:
  1. Provide the quality data necessary for current and future quality measures
  2. Provide additional clinical data that could inform future payment refinements

HEART

- In the development of the HEART tool, CMS states that they will address “the holistic nature of hospice”
  - Medical
  - Psychosocial
  - Spiritual
  - Other aspects of care that are important for patients and their caregivers

HEART

When ready, HEART

- Would replace the current HIS; but HIS measures would be incorporated
- Would not replace other HQRP data collection efforts (that is, the CAHPS® Hospice Survey)
- Would not replace regular submission of claims data
- Would not replace current CoP requirements for the initial and comprehensive assessments
HEART

• In early stages of development
  – Working on content and feasibility

• Once development has progressed, CMS will announce:
  – Timeline, testing and implementation
  – Communicated in future rulemaking cycles

Technical Expert Panel

• CMS sought a TEP of approximately 14-20 individuals with varying perspectives and different areas of expertise
• Individuals will attend phone and in-person meetings with CMS contractor
• Objectives
  – Gather feedback on the feasibility and usability of the draft HEART instrument
  – Determine potential barriers to implementing the HEART instrument in varying hospice settings and discuss remediation strategies
  – Refine draft HEART patient assessment items
  – Determine the direction of future quality measures based on HEART patient assessment items

Recruitment for Pilot Testing of HEART

• As part of the HEART development process, CMS contractor (RTI) will be pilot testing the draft HEART instrument by conducting two sequential pilot tests
• RTI is currently accepting applications to participate in the pilot test for HEART
• The deadline for applications is October 31, 2017
Recruitment for Pilot Testing of HEART

- If you are interested in participating, please complete the pilot interest form located in the download section of the HQRP Requirements and Best Practices tab on the HQRP website and email it to hospice@rti.org by October 31, 2017.

Public Reporting

CMS Hospice Compare website

- Released August 16th
- All 7 HIS quality measures adopted for the FY 2016 and beyond
- Based on a rolling 12 month data selection period
- Minimum denominator size of 20 patient stays

Find a hospice agency

www.medicare.gov/hospicecompare
What Data are Displayed in Hospice Compare Now?

- The initial launch of Hospice Compare includes individual scores for each of the HIS seven quality measure (QM) scores
  - Patient Treated with an Opioid who are Given a Bowel Regimen (NQF #1617)
  - Pain Screening (NQF #1634)
  - Pain Assessment (NQF #1637)
  - Dyspnea Treatment (NQF #1638)
  - Dyspnea Screening (NQF #1639)
  - Treatment Preferences (NQF #1641)
  - Beliefs/Values Addressed (If Desired by the Patient) (NQF #1647)

Why is My Hospice Not Displayed?

- Hospices with a QM denominator size of fewer than 20 patient stays (based on 12 rolling months of data) will not have the QM score publicly displayed since a score on the basis of small denominator size may not be reliable.

Hospice Compare Datasets

- These official datasets allow a consumer to compare the quality of care provided by Medicare-certified hospice agencies throughout the nation.
Problems with Hospice Compare

- System issues
- Demographic data issues

Data Errors in Hospice Compare

- Providers should review their demographic information on Hospice Compare to ensure it is correct
- In the event that your demographic data is not correct in Hospice Compare, contact your CASPER/ASPEN and Regional Office coordinator with updated information

https://data.medicare.gov/Hospice-Compare/Hospice-CASPER-ASPEN-Contacts/qx7x-wipa/data
Provider Preview Reports – Quality Data

• If errors in measure results are found:
  – Hospices have **30 days** to request review beginning from the date the reports are ready for review
  – CMS will review. If confirms errors CMS will:
    • Suppress the measure on the Hospice Compare website for one time only
    • Display the corrected measure during the subsequent quarterly refresh of the Compare website

Future Information for Hospice Compare

Immediate future

• **The 8 CAHPS® Hospice Survey measures**
  – Included in winter of CY 2018
  – Eight rolling quarters of data
  – Starting with patients who died between April 1, 2015 and March 31, 2017
  – Scored displayed only if **30 or more** completed questionnaires in reporting period

CAHPS Reported Measures

• Hospice Team Communication
• Getting Timely Care
• Treating Family Member with Respect
• Getting Emotional and Religious Support
• Getting Help for Symptoms
• Getting Hospice Care Training

In addition, there are two other measures, also called "global ratings":
• Rating of Hospice
• Willingness to Recommend
Future Information for Hospice Compare

- Composite measure - 2018
- Visits at the end of life – currently under NQF review
  - Need 4 quarters of data for the review
  - Earliest would be 2019

Star Rating System

- Quality rating system that gives each hospice a rating of between 1 and 5 stars
- Timeline to be announced for development and implementation in future rulemaking
- CMS solicit input from the public regarding star rating methodology
- CMS has stated “we will benefit from lessons learned from the development and implementation of the star ratings in other quality reporting programs to help guide development of star ratings for hospice.”

National Percentile

- The Comparison Group National Percentile is provided for your information to let you know where you stand when compared to all other hospices in the Nation
  - i.e. if your report shows that your Comparison Group National Percentile for a measure is 90, you know that 90 percent of all hospices performed the same as or worse than your hospice on this measure for the same period
Extraordinary Circumstances Exemption and Extension

Qualifying Event:
- Acts of nature; systemic issues with CMS data systems, issues outside the control of the hospice

Deadline for submitting exemption or extension request:
- 90 calendar days from the qualifying event (new)

Applies to:
- HIS data submission, submission of the CAHPS® Hospice Survey data and HQRP data submissions
Reducing Regulatory Burden

- Support of the physician-patient relationship in care delivery
- Facilitation of individual preferences
- When and how CMS issues regulations and policies
- How CMS can simplify rules and policies

NHPCO provided a lengthy list of suggestions related to reducing regulatory burden to CMS in our FY 2018 Hospice Wage Index proposed rule comment letter

Reducing Regulatory Burden

- NHPCO Robust Suggestion list
- Examples:
  - CMS should explore options to eliminate sequential billing for hospice
  - Eliminate provider liable days for hospice when there are claims processing issues outside the hospice’s control
  - Allow hospice to contract with nurses for the provision of continuous home care (CHC) and require hospice training as a part of the contractual obligation
NURSING HOME INTERPRETIVE GUIDELINES RELEASED

Nursing Home Interpretive Guidelines Released

- The original NH Requirements for Participation were published in August 2013
- Interpretive Guidelines published in July 2017
- Most difficult compliance issues concern coordination of services through the care plan
- **Take effect November 28, 2017**
- Advance copy of the Guidance to Surveyors for LTC is located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html Scroll down to “Advance Appendix PP including Phase 2
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices.

Review of a Resident at or Approaching End of Life and/or Receiving Hospice Care and Services Assessment

The resident must receive a comprehensive assessment to provide direction for the development of the resident’s care plan to address the choices and preferences of the resident who is nearing the end of life. The facility and the resident’s attending physician/practitioner, should, to the extent possible:

- Identify the resident’s prognosis and the basis for that prognosis

- Initiate discussions/considerations regarding advance care planning and resident choices to clarify goals and preferences regarding treatment

- Consider:
  - Pain management and symptom control
  - Treatment of acute illness
  - Choices regarding hospitalization
Guidance: §483.70(o) Provision Of Hospice Services In A Nursing Home

• As described in §§483.70(o)(1)(i),(ii), there is no requirement that a nursing home allow a hospice to provide hospice care and services in the facility.

• If a nursing home has made arrangements with one or more hospices to provide services in the nursing home, there must be a written agreement describing the responsibilities between each hospice and the nursing home prior to the hospice initiating care for a resident who has elected the hospice benefit.

• The written agreement applies to the provision of all hospice services for any nursing home resident receiving services from the specific hospice and does not need to be rewritten for each resident.

F849 – Hospice Services

• §483.70(o) Hospice services.
  • §483.70(o)(1) A long-term care (LTC) facility may do either of the following:
    i. Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.
    ii. Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.
Hospice Plan of Care in Nursing Home

• Hospice Plan of Care

• As described in §483.70(o)(2)(ii)(B), when a hospice patient is a resident of a nursing home, the hospice must establish the hospice plan of care in coordination with the nursing home, the resident’s nursing home attending physician/practitioner, and to the extent possible, the resident/designated representative.

In order to provide continuity of care:

– Collaboration: Hospice and the nursing home must collaborate in the development of a coordinated plan of care for each resident receiving hospice services.

– Structure: Is established by the nursing home and the hospice.

– Responsibility: must identify the provider responsible for performing each or any specific services/functions that have been agreed upon.

– Maintaining the plan of care: The plan of care may be divided into two portions, one maintained by the nursing home and the other maintained by the hospice.
Nursing Home Designee(s) Responsibilities

- §483.70(o)(3)(i)-(v)
- Nursing home must identify and designate, in writing, an employee of the nursing home to assume the responsibilities for collaborating and coordinating activities between the nursing home and the hospice.
- Nursing home employee must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

Communication Process Between Nursing Home and Hospice

- §483.70(o)(2)(ii)(D)
- Written agreement must specify a process for communicating necessary information regarding the resident’s care between the nursing home and the hospice
- 24-hours a day, 7-days a week
- Includes how these communications will be documented

Responsibilities for Bereavement Services for Nursing Home Staff

- The death of the resident may have a direct impact on identified nursing home staff
- The written agreement should specify when the nursing home should provide information to the hospice regarding nursing home staff that may benefit from bereavement services
§483.45(e) Psychotropic Drugs

• PRN orders for psychotropic drugs are limited to 14 days.

• Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document the rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e) Psychotropic Drugs

• PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

• The hospice nurse/physician would need to meet the documentation guidelines for the nursing home patient to avoid citations.

§483.45(e) Psychotropic Drugs

• This is a regulation for all residents of Nursing Homes and therefore the hospice resident residing in that setting.

• Hospice patients are risk-adjusted for antianxiety and hypnotics, so that quality measure would not be triggered for surveyor review.
Use of PEPPER Reports

- PEPPER
  - Roadmap to help a provider identify potentially vulnerable or improper payments
  - Assist providers in identifying problem areas
- Free comparative report from CMS contractor
- Go to www.PEPPERResources.org
- Click on “PEPPER Distribution … Get your PEPPER”
Hospice Target Areas – 2017 PEPPER

- Live discharges – not terminally ill
- Live discharges – revocations
- Live discharges – 61-179 days
- Long length of stay
- CHC in assisted living facility
- RHC in assisted living facility
- RHC in nursing facility
- RHC in skilled nursing facility
- Episodes with no CHC or GIP
- Long General Inpatient Care Stays (> 5 days)

Long Length of Stay
Sample Data

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:
1. Increasing Target Percents over time resulting in greater risk of improper Medicare payments
2. Your Target Percent (first row in the table below) is above the national 80th percentile

<table>
<thead>
<tr>
<th>YOUR HOSPICE</th>
<th>10/1/13 – 9/30/14</th>
<th>10/1/14 – 9/30/15</th>
<th>10/1/15 – 9/30/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Area Percent</td>
<td>16.0%</td>
<td>18.7%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Target Count</td>
<td>110</td>
<td>146</td>
<td>152</td>
</tr>
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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
- review medical record documentation should be reviewed for a sample of beneficiaries with long lengths of stay to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy.

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.
Why do we care about PEPPER?

• Identifies providers whose data suggests risk of inappropriate Medicare billing
• When hospice’s % is at or above the national 80th percentile is red and bold
• Data identified by PEPPER contractor is shared with
  – MACs
  – ZPIC contractors or other auditors for data mining and follow up
  – Department of Justice for follow up

418.113 – EMERGENCY PREPAREDNESS
THE FINAL PUSH

November 15, 2017
§418.113 Condition of participation: Emergency preparedness

- Addition to CoPs, Subpart D
- The hospice must comply with all applicable Federal, State, and local emergency preparedness requirements.
- The hospice must establish and maintain an emergency preparedness program that meets the requirements of this section.

§418.113 CoP Standards

- (a) Risk assessment and planning
- (b) Policies and procedures
- (c) Communication plan
- (d) Training and testing
- (e) Integrated health systems

Development and Implementation Should be Completed
Threat and Risk Analysis

- Identify risks and hazards
- Select risks to address
- Develop a plan to address selected risks

Collaboration with Community

- Networks, Partnerships, Mutual Aid
- Make sure your patients get counted / your needs addressed
- Social Media
- How to provide support.
  - Your Capabilities
  - Your Availability

(a) Emergency Plan

- Develop an emergency plan based on an all hazard risk assessment focusing on capacities and capabilities
- Update emergency plan at least annually
- Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice’s ability to provide care
Issues for Consideration

• The only way to ask for assistance or offer your assistance before, during, or after an emergency situation is to communicate with others. Identify sources for information, and appoint capable staff to receive and interpret it on behalf of the organization.

(b) Policies and Procedures

• Develop and implement policies and procedures based on the emergency plan and risk assessment
• Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency
• Review and update policies and procedures at least annually

Additional Requirements for Hospice Inpatient Facilities

• A means to shelter in place for patients, hospice employees who remain in the hospice
• Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance
Additional Requirements for Hospice Inpatient Facilities

• A system to track the location of hospice employees’ on-duty and sheltered patients in the hospice’s care during an emergency
  – If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location

Evacuation and Patient Tracking

• Have a system or process in place
• Coordinate with state emergency management agency as part of planning
• Provide information at admission
• Pre-event
• Post event

(c) Communication Plan

• Develop a communication plan that complies with both Federal and State laws.
• Coordinate patient care within the facility, across health care providers, and with state and local public health departments and emergency management systems.
• Home health agencies and hospices required to inform officials of patients in need of evacuation.
• Review and update plan annually.
The Communication Plan Must Include

• Names and contact information for the following:
  – Hospice employees
  – Entities providing services under arrangement
  – Patients’ physicians
  – Other hospices
• Contact information for the following:
  – Federal, State, tribal, regional, and local emergency preparedness staff
  – Other sources of assistance

The Communication Plan Must Include

• Primary and alternate means for communicating with the following:
  – Hospice’s employees
  – Federal, State, tribal, regional, and local emergency management agencies
• A method for sharing information and medical documentation for patients under the hospice’s care, as necessary, with other health care providers to maintain the continuity of care
• A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii)

Who Gets Help in a Disaster?

• Federal, State, and Local disaster responders will do all they can to help those that they know about
• Make sure they know about you
  – Who will be representing health and medical in the Emergency Operations Center? Get to know them.
• Leverage your political or press contacts – If you run out of other options
(d) Training and Testing

- Develop and maintain training and testing programs, that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan

Training Program Requirements

- Initial training in emergency preparedness policies and procedures to all existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles
- Include training to onboarding employees
- Demonstrate staff knowledge of emergency procedures
- Provide emergency preparedness training at least annually

Testing Your Plan

- Participate in full scale community based exercise
- A second full scale exercise or table top exercise
- Analyze response and document the event
Testing Requirements

• Exception:
  – If the hospice experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

Evaluation of Implementation

• Analyze response to drills and actual disasters

• Maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospice’s emergency plan, as needed

(e) Integrated Healthcare Systems

• If a hospice is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the hospice may choose to participate in the healthcare system’s coordinated emergency preparedness program.
Recent Events

Psychology of a Disaster

- The focus narrows significantly
- If you do not make checklists in non-disaster time, you may forget what needs to be completed
- Compliance is not the primary focus during a disaster but you will be surveyed for compliance with requirements

Lead Up to a Disaster

- "Lean forward" – proactive response
- May be conflict with some business models
Things To Consider
Hospice Only Interpretive Guidelines

Healthcare Operations Manual
Appendix Z: Interpretive Guidance - Hospice Only Interpretive Guidelines

Regulatory text is indicated in blue. Major interpretive guidelines are noted in red. Survey procedures are indicated in yellow.

[Image of damaged house and dog in water]
Recent Events

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Hospice Only Interpretive Guidelines

State Operations Manual
Appendix Z. Emergency Preparedness for All Providers and Certified Supplier Types
Interpretive Guidance

489.15. Conditions of Participation for Hospices

Regulatory text is indicated in blue. Explanations of the interpretive guidelines are noted in red. Survey procedures are indicated in italics.
• NHPCO resource
  Emergency Preparedness for Hospice Providers (Feb 2017)

• http://www.nhpco.org/regulatory/emergency-preparedness-0
Implementation Date is November 15, 2017


LAST “TIDBITS”

Transition to New Medicare Numbers and Cards

• CMS is removing Social Security Numbers from Medicare cards to prevent fraud, fight identity theft, and keep taxpayer dollars safe
• New Medicare cards will be mailed beginning in April 2018
• Planning in place to test systems before implementation
• Transition period
  — Can use either the HICN or the MBI to exchange data
  — The transition period will begin no earlier than April 1, 2018 and run through December 31, 2019
Medicare Card New Look

• 11-characters in length
• Made up only of numbers and uppercase letters (no special characters)

Targeted Probe and Educate (TPE)

• Effective October 1, 2017 each Medicare Administrative Contractor (MAC) will begin the implementation of Targeted Probe and Educate for hospice providers, as required in CR 10249
• Each MAC will use analysis of billing data to indicate aberrancies that may suggest questionable billing practices review of service-specific review error rate results, and could include those hospices already on targeted review

Targeted Probe and Educate (TPE)

• Each MAC will mail a letter to those hospices that are selected, which will outline the reasons for selection and provide an overview of the TPE process
• There will up to three rounds of review, with a claim pull of 20-40 claims selected for each round
NHPCO Facts and Figures: Hospice Care in America

This overview provides specific information on:
• Hospice patient characteristics
• Location and level of care
• Medicare hospice spending
• Hospice provider characteristics
• Volunteer and bereavement services
• Currently, most hospice patients have their
NHPCO members enjoy unlimited access to Regulatory Assistance
Feel free to email questions to regulatory@nhpco.org

Keep Calm and Love Hospice

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Regulatory and Compliance Team at NHPCO

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