Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Thursday, September 3, 2026
Crockett CD Room
2:45pm-3:45pm

6b. Bridging Gaps Between Hospice Billing & Compliance

Presented by:

M. Aaron Little, CPA, Forvis Mazars
Chris Gallarneau, MAC Legacy

Thank you to our Partners:

Vesta®
HHAeXchange
MAC LEGACY
KanTime How better happens.
United Healthcare Community Plan
AXXESS

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Today's Speakers

M. Aaron Little, CPA
Managing Director
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Chris Gallarneau
Senior Director of Partnerships
chris.gallarneau@mac-legacy.com

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Objectives

1

Latest issues impacting the hospice compliance landscape.

2

Latest data available for monitoring compliance.

3

Implementation of a periodic compliance assessment process.

3

3

Latest Issues

Impacting the Hospice Compliance Landscape

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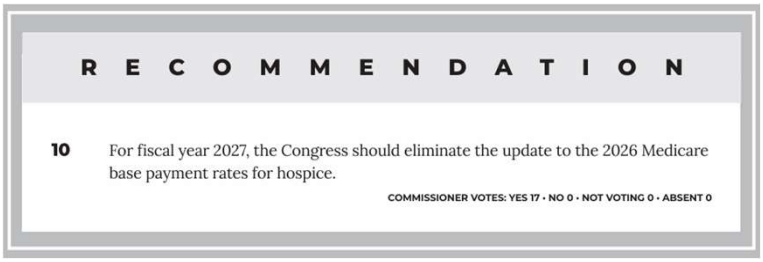
MedPAC Recommendation

In 2024, more than 1.8 million Medicare Beneficiaries received hospice services from about 6,700 Providers, and Medicare hospice expenditures totaled $28.3 billion.



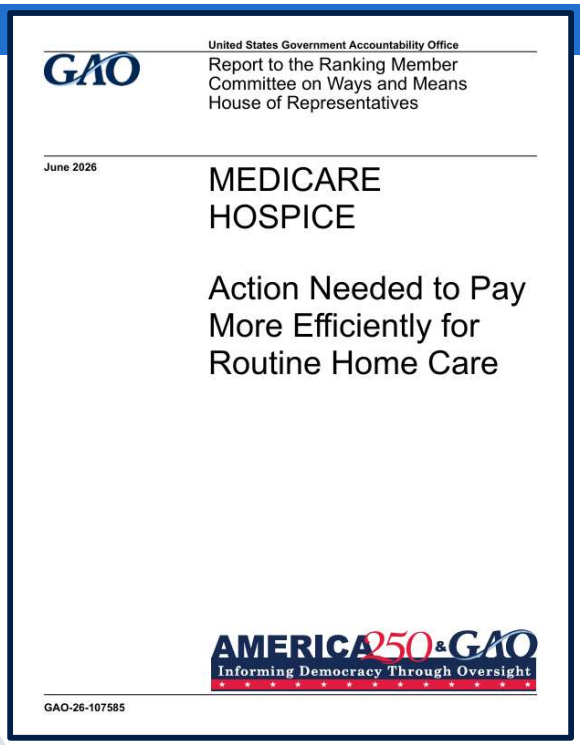
RECOMMENDATION

10 For fiscal year 2027, the Congress should eliminate the update to the 2026 Medicare base payment rates for hospice.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

5 Source: MedPAC Annual Report to Congress, Chapter 10, Hospice Services, March 2026

5



GAO

United States Government Accountability Office

Report to the Ranking Member
Committee on Ways and Means
House of Representatives

June 2026

MEDICARE HOSPICE

Action Needed to Pay More Efficiently for Routine Home Care

AMERICA250 & GAO
Informing Democracy Through Oversight

GAO-26-107585

GAO recommends that Congress consider directing the Secretary of the Department of Health and Human Services (HHS) to revise the hospice payment system for routine home care services to better promote payment efficiency and realize savings for the Medicare program.

6 Source: www.gao.gov/assets/gao-26-107585.pdf

6

FY2027 Hospice Final Rule

2.3%

Overall net payment increase effective 10.01.2027

$755 million estimated aggregate increase in Medicare payments

7

Source: CMS-1851-F 2026-15686.pdf

7

FY2027 Hospice Final Rule

Revenue Code	Description	2026 Rate	2027 Rate	% Change
651	RHC, high rate (days 1-60)	$230.83	$236.35	2.4%
651	RHC, low rate (days 61+)	$181.94	$186.35	2.4%
652	CHC	$69.76 (hourly)	$71.94 (hourly)	3.1%
655	IPR	$532.48	$545.98	2.5%
656	GIP	$1,199.86	$1,231.63	2.6%
----	Hospice cap	$35,361.44	$36,174.75	2.3%

8

Source: CMS-1851-F 2026-15686.pdf

8

FY2027 Hospice Final Rule

CBSA	Name	2026 Wage Index	2027 Wage Index	Wage Index Change	RHC High Rate Change
10180	Abilene, TX	0.9287	0.9786	+5.4%	+5.9%
12420	Austin-Round Rock-San Marcos, TX	0.9660	0.9508	-1.6%	+1.3%
19124	Dallas-Plano-Irving, TX	0.9639	0.9638	0.0%	+2.4%
21340	El Paso, TX	0.8310	0.8054	-3.1%	+0.4%
23104	Fort Worth-Arlington-Grapevine, TX	0.9691	0.9484	-2.1%	+1.0%
26420	Houston-Pasadena-The Woodlands, TX	0.9729	0.9817	+0.9%	+3.0%
28660	Killeen-Temple, TX	0.9463	0.8990	-5.0%	-0.9%
31180	Lubbock, TX	0.8593	0.8528	-0.8%	+1.9%
41700	San Antonio-New Braunfels, TX	0.8526	0.8681	+1.8%	+3.6%
99945	Rural Texas	0.8400	0.8139	-3.1%	+0.4%

Source: CMS-1851-F 2026-15686.pdf

9

9

"Right now, my main focus without any question is to wage a war on fraud, waste and abuse because that's what's required—all hands-on deck.

CMS Administrator
Dr. Oz
4.25.25

10

10

Congress Interest

"It is imperative that we continue to protect timely access to high-quality hospice care for all Americans who need it.

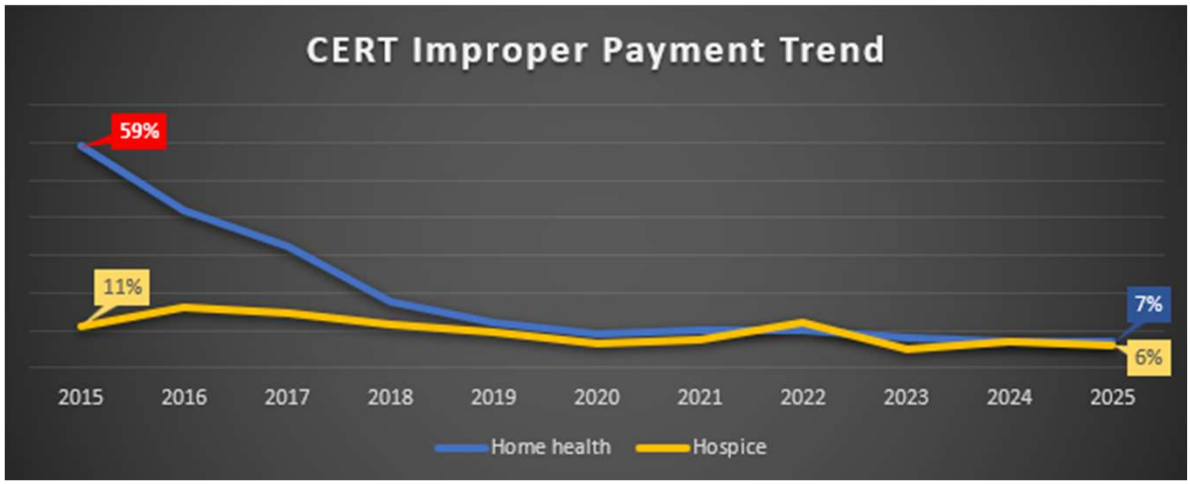
The current hospice benefit has largely proven successful in delivering that compassionate care, and I am working to continue to improve the patient experience."

Congresswoman Beth Van Duyne (R-TX)

11 Source: Hospice News 6.24.25

11

Compliance Environment



12 Source: CERT Medicare Fee-for-Service Supplemental Improper Payment Data

12

Compliance Environment

TPE

PPEO

EPPR

SMRC

Data

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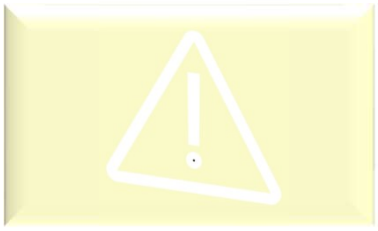
Compliance Environment



TPE

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EPPR

SMRC

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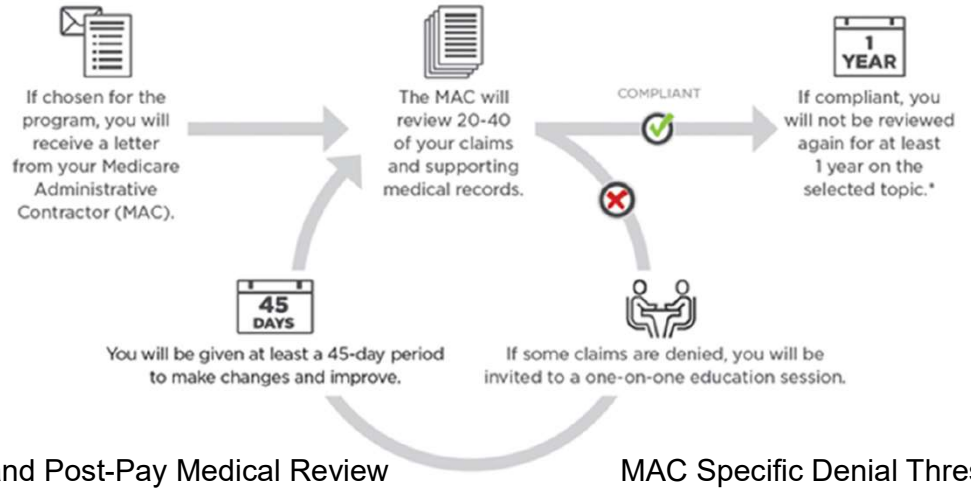
TPE Cycle



Pre-Pay and Post-Pay Medical Review

Up To Three Rounds

MAC Specific Denial Threshold:

- 25% - CGS
- 20% - Palmetto GBA
- 15% - Wellpoint Federal (NGS)

15

15

Compliance Environment - TPE

Code Type	Specific Code	Edit Topic	Edit Description
Bene sharing	All	Hospice services bene sharing	Review of claims submitted for hospice services for eligibility and medical necessity bene sharing
Rev code	GIP	GIP	Review of inpatient claims for inpatient hospice care greater than or equal to 7 days for revenue code 656 and place of service codes Q5004–Q5009
Rev code	New hospice providers	New hospice providers	Review of new hospice provider claims
Rev code	0651, 0652, 0655, 0656	Hospice LOS greater than 365 days	Review of claims submitted for hospice LOS greater than 365 days
Rev code	RHC – 0651	RHC – Rev code 0651	Review of hospice RHC — rev code 0651
Rev code	0652	Hospice services CHC	Review of claims submitted for hospice services CHC

16

Source: Palmetto GBA

16

Compliance Environment – TPE

Code Type	Specific Code	Edit Topic	Edit Description
Diagnosis codes	NCLOS	NCLOS	Review of hospice claims for NCLOS
High risk hospice		High risk hospices in Texas	Review of claims for high-risk hospices in Texas
PPEO for new providers for Texas		PPEO hospices	PPEO for new hospice providers for Texas
Rev code/ place of service	0656, 0651, 0655/Q5005	Hospice place of service	Review of claims submitted for hospice place of service, revenue-specific audit
Rev code/ place of service	0655/Q5003-Q5004	Hospice respite	Review of claims submitted for respite care based on place of service
Rev code	Low biller probe and educate	GIP	GIP

17

Source: Palmetto GBA

17

Compliance Environment – TPE

Edit Topic	Q2 2026 TPE Results
Hospice services bene sharing (*Q1 results*)	120 hospices selected (0 Texas) 97 hospices compliant (0 Texas) 23 hospices non-compliant (0 Texas)
GIP	17 hospices selected (2 Texas) 13 hospices compliant (2 Texas) 4 hospices non-compliant (0 Texas)
New hospice providers	38 hospices selected (10 Texas) 24 hospices compliant (6 Texas) 14 hospices non-compliant (4 Texas)
Hospice LOS greater than 365 days	2 hospices selected (1 Texas) 2 hospices compliant (1 Texas) 0 hospices non-compliant (0 Texas)

Edit Topic	Q2 2026 TPE Results
RHC – Rev code 0651	13 hospices selected (0 Texas) 9 hospices compliant (0 Texas) 4 hospices non-compliant (0 Texas)
Hospice services CHC	7 hospices selected (1 Texas) 4 hospices compliant (0 Texas) 3 hospices non-compliant (1 Texas)
NCLOS (*Q1 results*)	1 hospices selected (0 Texas) 0 hospices compliant (0 Texas) 1 hospices non-compliant (0 Texas)
Hospice place of service	21 hospices selected (0 Texas) 19 hospices compliant (0 Texas) 2 hospices non-compliant (0 Texas)
Hospice respite (*Q1 results*)	36 hospices selected (3 Texas) 27 hospices compliant (3 Texas) 9 hospices non-compliant (0 Texas)

18

Source: Palmetto GBA

18

Compliance Environment - TPE

Hospice Medical Review Top Denial Reason Codes: January to March 2026

We encourage all providers to review this information when filing claims to prevent denials and to ensure their claims are processed timely. The following information affects providers billing 81X bill types.

Rank	Denial Code	Denial Description	# Claims	% Claims Denied
1	5CF36	Not Hospice Appropriate	218	52.3
2	56900	Auto Denial – Requested Records not Submitted	125	30.0
3	5CFTF	Face-to-Face Encounter Requirements Not Met	19	4.6

19

Source: Palmetto GBA

19

Compliance Environment - TPE

5CF36, 5FF36: Not Hospice Appropriate

Published 05/10/2022

A- A+

The claim has been fully or partially denied because the documentation submitted for review did not support prognosis of six months or less.

How to Prevent This Denial

- Ensure a legible signature is present on all documentation necessary to support six-month prognosis
- Submit documentation for review to provide clear evidence the beneficiary has a six-month or less prognoses which supports hospice appropriateness at the time the benefit is elected, and continues to be hospice appropriate for the dates of service billed
- Palmetto GBA has a Local Coverage Determination (LCD) for some non-cancer diagnoses. Submit documentation which supports the coverage criteria outlined in the policy. LCDs may be viewed on the Palmetto GBA Web site at www.PalmettoGBA.com/HHH. If documenting weight loss to demonstrate a decline in condition, include how much weight was lost over what period of time, past and current nutritional status, current weight and any related interventions.
- Document any co-morbidity, which may further support the terminal condition of the beneficiary and the continuing appropriateness of hospice care

20

Source: Palmetto GBA

20

Compliance Environment - TPE

Reason Code 56900

Published 12/16/2019

A- A+

Description
This claim is being denied. The provider failed to respond timely to the request for additional medical documentation. The next level review is done by the redetermination area. Requests for the redetermination department must be received within 120 days of the date of the denial.

Resolution
Medical records were not received by reviewing entity that requested Additional Documentation Request (ADR) within 45 days. If ADR was n received by entity, a Redetermination request should be submitted. In some cases, these will be handled as a reopening rather than a redetermination. Redetermination should include:

- All applicable supporting medical documentation
- Corrected UB-04 form

In some cases timing can be an issue. For example, if you respond to the Recovery Auditor on day 45 and they do not inform the MAC that they have received documents until day 46, claim may have denied 56900 incorrectly. If you have received a results letter from entity and claim is denied, contact Provider Contact Center (PCC).

Providers with Direct Data Entry (DDE) access should check ADR locations frequently. (SB6001) Providers who receive hard copy ADR requests should work within their facility to ensure that letters are reviewed and responded to timely. To avoid 56900 denials, providers are reminded to verify and respond expediently to entity that is requesting ADR.

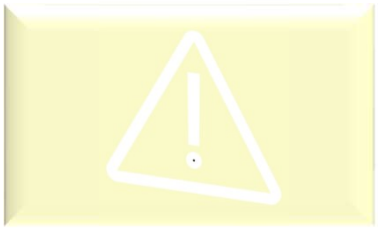
Resource: CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, chapter 34 (PDF).

21

Source: Palmetto GBA

21

Compliance Environment



TPE

PPEO

EPPR

SMRC

Data

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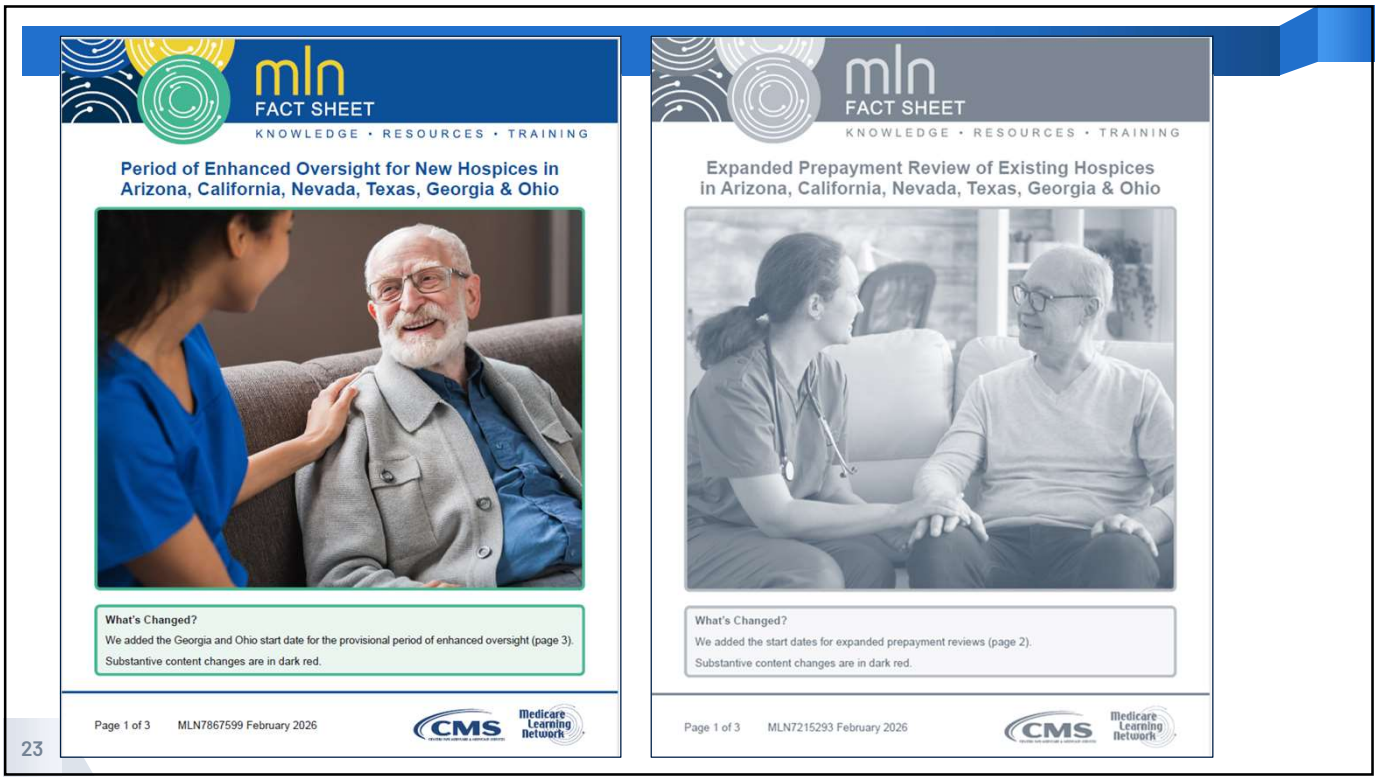


23

Compliance Environment – PPEO

- Provisional Period of Enhanced Oversight (PPEO)

CMS is placing newly enrolling hospices located in Arizona, California, Nevada, Texas, Georgia, and Ohio in a provisional period of enhanced oversight. We received numerous reports of hospice fraud, waste, and abuse. The number of hospices enrolled has increased significantly in these states, raising serious concerns about market oversaturation.

What's the Goal?

The goal of enhanced oversight is to reduce hospice fraud, waste, and abuse.

Am I Considered a New Hospice?

For the period of enhanced oversight, new hospices include those:

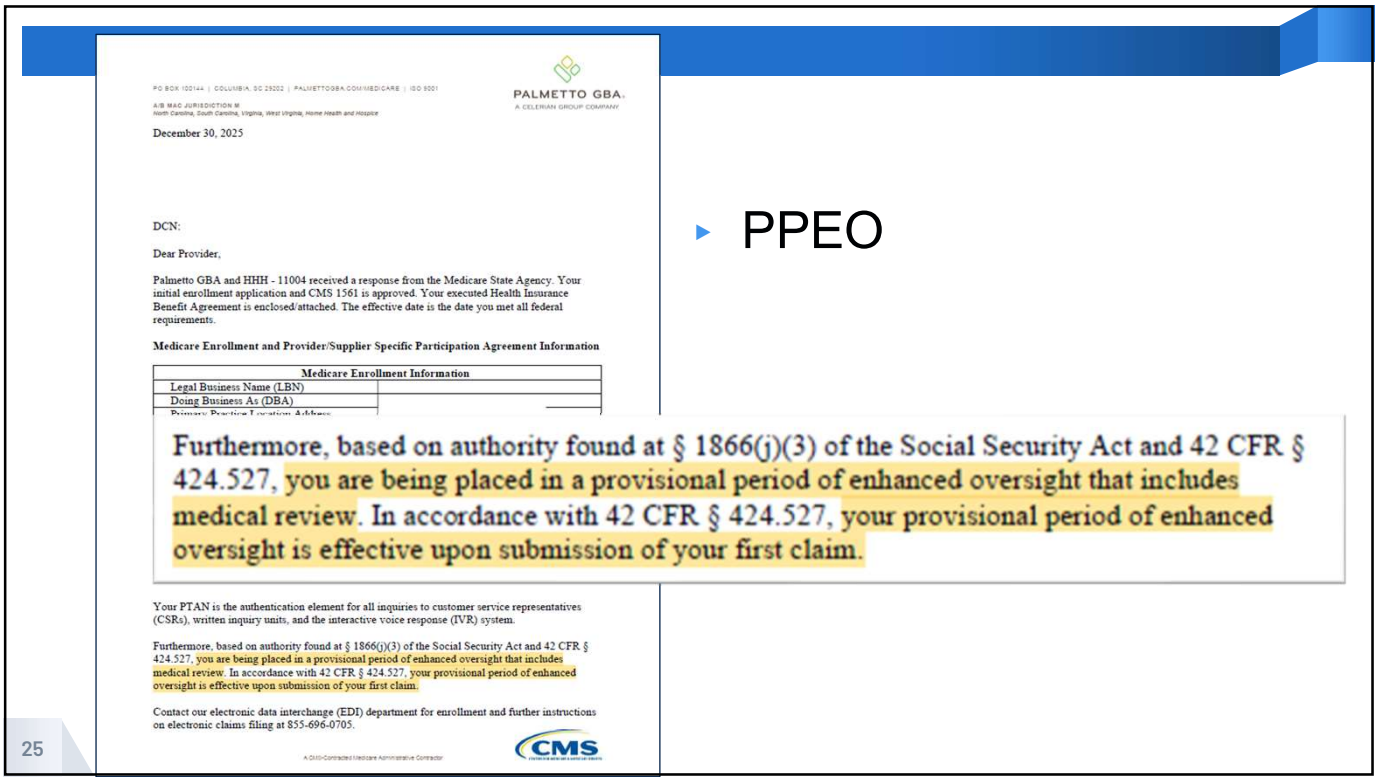
- Newly enrolled in the Medicare Program
- Submitting a change of ownership that meets all the regulatory requirements under 42 CFR 489.18
- Undergoing a 100% ownership change that doesn't fall under 42 CFR 489.18
- Reactivating after being in a deactivated status

On or After 07/13/23

Source: CMS MLN

24

24



PALMETTO GBA
A CELERIAN GROUP COMPANY

December 30, 2025

DCN:

Dear Provider,

Palmetto GBA and HHH - 11004 received a response from the Medicare State Agency. Your initial enrollment application and CMS 1561 is approved. Your executed Health Insurance Benefit Agreement is enclosed/attached. The effective date is the date you met all federal requirements.

Medicare Enrollment and Provider/Supplier Specific Participation Agreement Information

Medicare Enrollment Information	
Legal Business Name (LBN)	
Doing Business As (DBA)	

Furthermore, based on authority found at § 1866(j)(3) of the Social Security Act and 42 CFR § 424.527, you are being placed in a provisional period of enhanced oversight that includes medical review. In accordance with 42 CFR § 424.527, your provisional period of enhanced oversight is effective upon submission of your first claim.

Your PTAN is the authentication element for all inquiries to customer service representatives (CSRs), written inquiry units, and the interactive voice response (IVR) system.

Furthermore, based on authority found at § 1866(j)(3) of the Social Security Act and 42 CFR § 424.527, you are being placed in a provisional period of enhanced oversight that includes medical review. In accordance with 42 CFR § 424.527, your provisional period of enhanced oversight is effective upon submission of your first claim.

Contact our electronic data interchange (EDI) department for enrollment and further instructions on electronic claims filing at 855-696-0705.

CMS

- PPEO

25

25

Pre-Payment Review Results for Hospice Provisional Period of Enhanced Oversight (PPEO) on New Hospices for April through June 2026

The Centers for Medicare & Medicaid Services (CMS) implemented the Probe and Educate process for Hospice PPEO on New Hospices. The reviews with edit effectiveness are presented here for Jurisdiction M.

Average of 8 claims per hospice

Table 1. Cumulative Results.

Number of Providers with Edit Effectiveness	Providers Compliant Completed/Removed	Providers Non-Compliant Progressing to Subsequent Probe
25	21	4

Table 2. Cumulative Results.

Total Number of Claims with Edit Effectiveness	Total Number of Claims Denied	Overall Claim Denial Rate	Total Dollars Reviewed	Total Dollars Denied	Overall Charge Denial Rate
209	23	11%	$742,946.13	$116,330.63	16%

26

Source: Palmetto GBA

26

Compliance Environment

TPE

PPEO

EPPR

SMRC

Data

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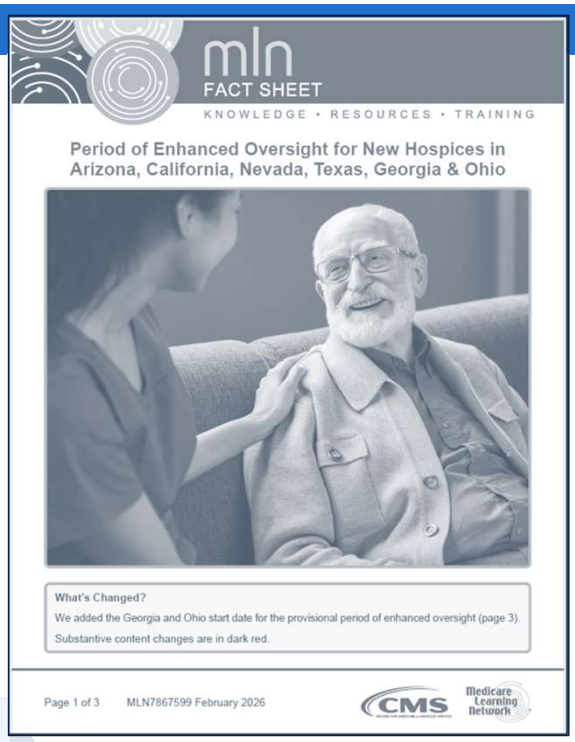

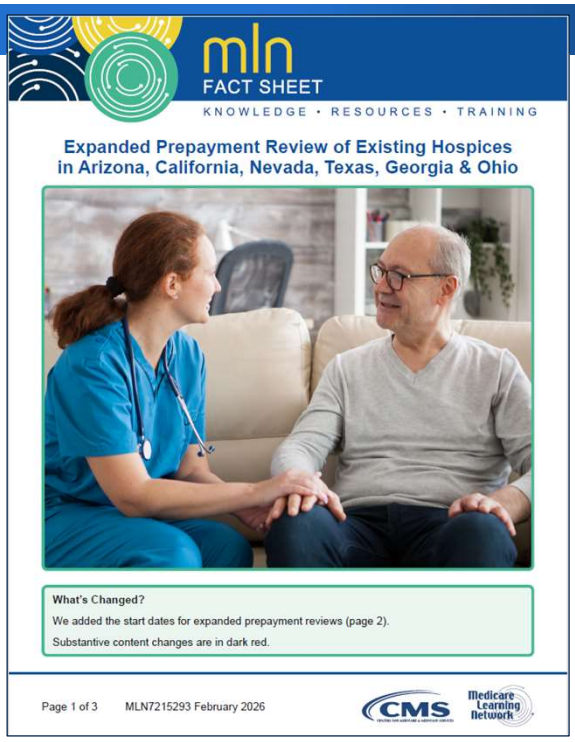

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Compliance Environment – EPPR

- Expanded Pre-Payment Review (EPPR)

CMS conducts expanded prepayment reviews and related activities for existing hospices in Arizona, California, Nevada, Texas, Georgia, and Ohio.

What's the Goal?

The goal is to reduce hospice fraud, waste, and abuse.

Does This Affect Me?

This may affect you if you're an existing hospice provider in the states of Arizona, California, Nevada, Texas, Georgia, or Ohio.

What Type of Expanded Prepayment Review Will You Perform?

To help reduce the burden on compliant providers, we're keeping the initial review volumes low and adjusting them based on the results. If you're noncompliant, we may continue to review or take additional administrative actions.

29

Source: CMS MLN

29

Pre-Payment Review Results for Expanded Pre-Payment Review of Existing Hospices for Targeted Probe and Educate (TPE) for April through June 2026

The Centers for Medicare & Medicaid Services (CMS) implemented the TPE process for Expanded Pre-Payment Review of Existing Hospices in Arizona, California, Nevada and Texas. The reviews with edit effectiveness are presented here for Jurisdiction M.

Average of 9 claims per hospice

Table 1. Cumulative Results.

Number of Providers with Edit Effectiveness	Providers Compliant Completed/Removed	Providers Non-Compliant Progressing to Subsequent Probe
29	22	7

Table 2. Cumulative Results.

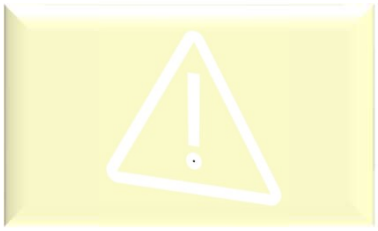
Total Number of Claims with Edit Effectiveness	Total Number of Claims Denied	Overall Claim Denial Rate	Total Dollars Reviewed	Total Dollars Denied	Overall Charge Denial Rate
251	37	15%	$1,035,140.23	$167,282.25	16%

30

Source: Palmetto GBA

30

Compliance Environment



TPE

PPEO

EPPR

SMRC

Data

31

31

Compliance Environment - SMRC

- Supplemental Medical Review Contractor

  Noridian Healthcare Solutions will notify CMS of any identified improper payments and noncompliance with documentation requests.

- Top denial reasons with SMRC audits
  - Lack of medical necessity.
  - No response to the documentation request.
  - Certification deficiencies.

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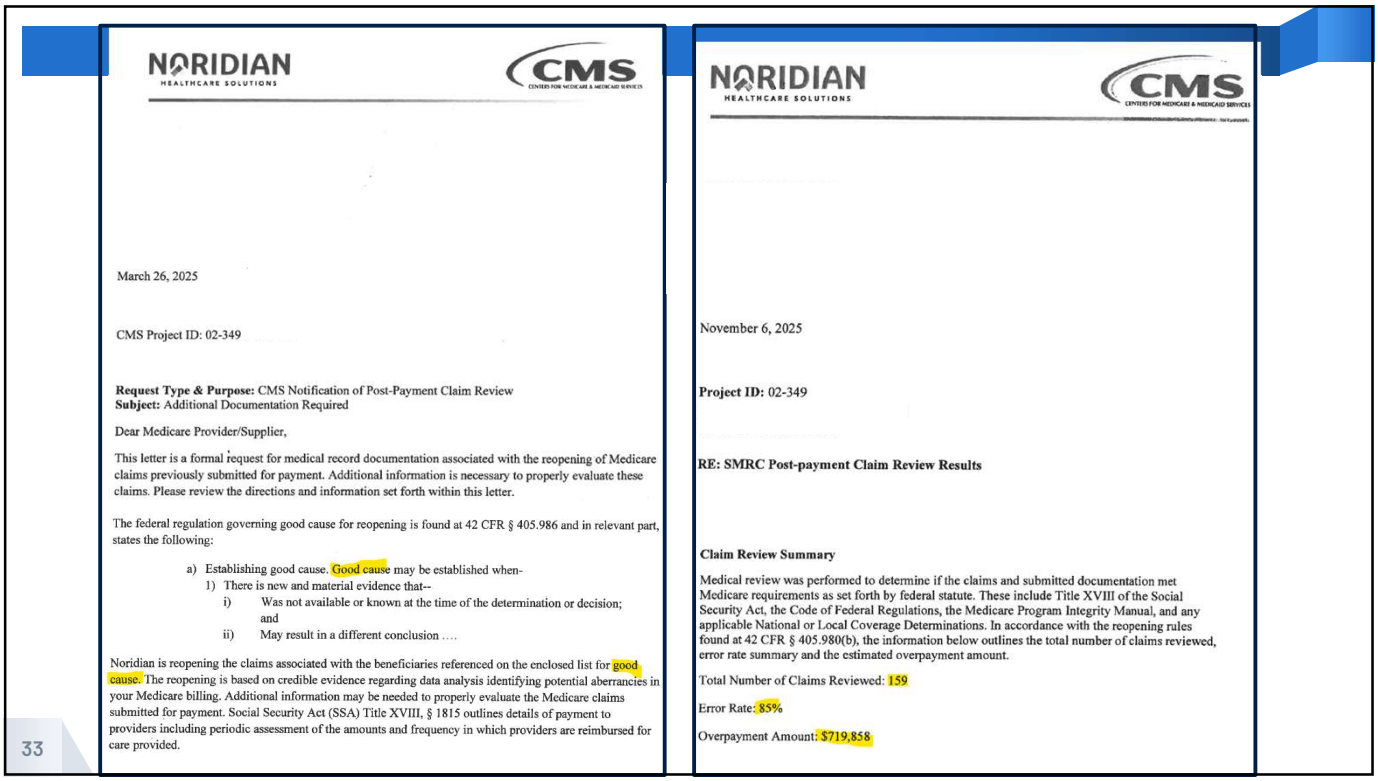

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

March 26, 2025

CMS Project ID: 02-349

Request Type & Purpose: CMS Notification of Post-Payment Claim Review
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

This letter is a formal request for medical record documentation associated with the reopening of Medicare claims previously submitted for payment. Additional information is necessary to properly evaluate these claims. Please review the directions and information set forth within this letter.

The federal regulation governing good cause for reopening is found at 42 CFR § 405.986 and in relevant part, states the following:

a) Establishing good cause. Good cause may be established when-
1) There is new and material evidence that--
i) Was not available or known at the time of the determination or decision; and
ii) May result in a different conclusion ....

Noridian is reopening the claims associated with the beneficiaries referenced on the enclosed list for good cause. The reopening is based on credible evidence regarding data analysis identifying potential aberrancies in your Medicare billing. Additional information may be needed to properly evaluate the Medicare claims submitted for payment. Social Security Act (SSA) Title XVIII, § 1815 outlines details of payment to providers including periodic assessment of the amounts and frequency in which providers are reimbursed for care provided.

33

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

November 6, 2025

Project ID: 02-349

RE: SMRC Post-payment Claim Review Results

Claim Review Summary

Medical review was performed to determine if the claims and submitted documentation met Medicare requirements as set forth by federal statute. These include Title XVIII of the Social Security Act, the Code of Federal Regulations, the Medicare Program Integrity Manual, and any applicable National or Local Coverage Determinations. In accordance with the reopening rules found at 42 CFR § 405.980(b), the information below outlines the total number of claims reviewed, error rate summary and the estimated overpayment amount.

Total Number of Claims Reviewed: 159

Error Rate: 85%

Overpayment Amount: $719,858

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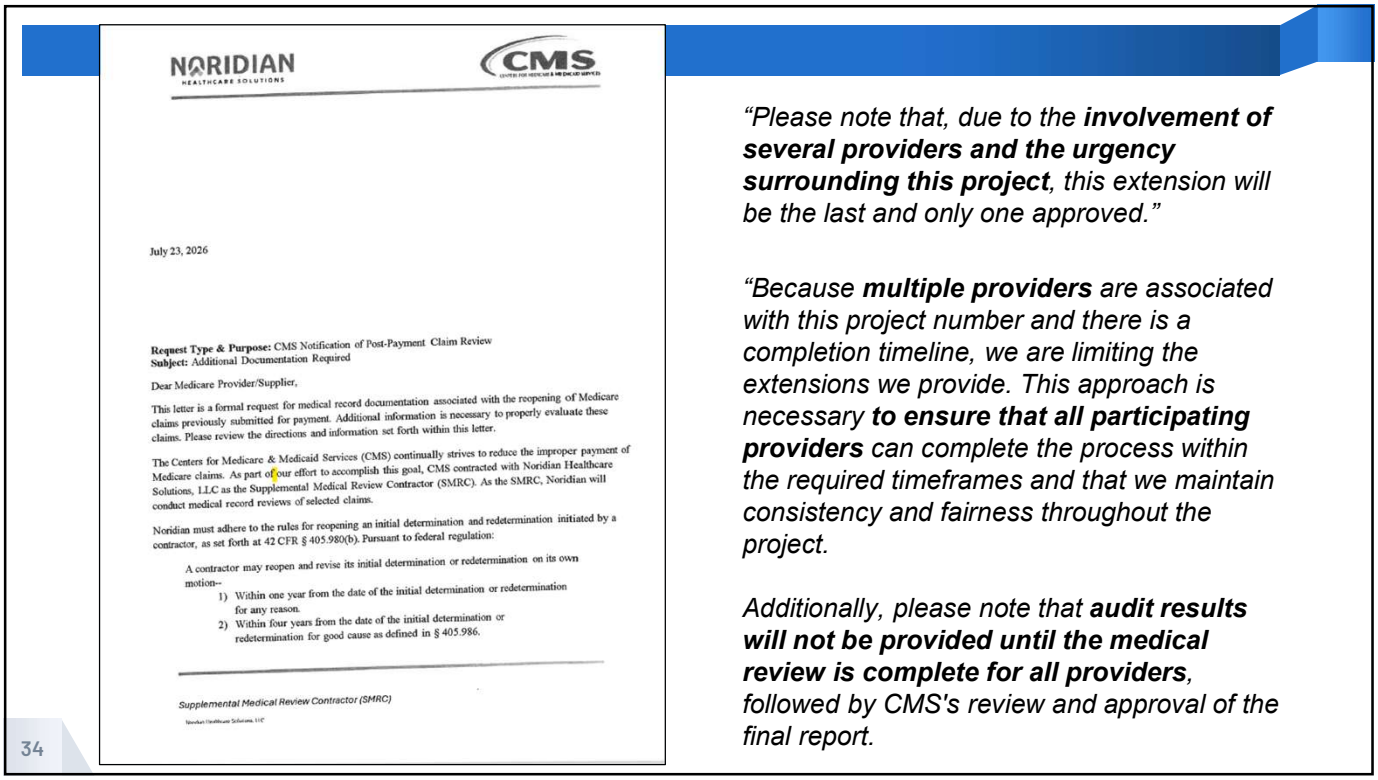


NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

July 23, 2026

Request Type & Purpose: CMS Notification of Post-Payment Claim Review
Subject: Additional Documentation Required

Dear Medicare Provider/Supplier,

This letter is a formal request for medical record documentation associated with the reopening of Medicare claims previously submitted for payment. Additional information is necessary to properly evaluate these claims. Please review the directions and information set forth within this letter.

The Centers for Medicare & Medicaid Services (CMS) continually strives to reduce the improper payment of Medicare claims. As part of our effort to accomplish this goal, CMS contracted with Noridian Healthcare Solutions, LLC as the Supplemental Medical Review Contractor (SMRC). As the SMRC, Noridian will conduct medical record reviews of selected claims.

Noridian must adhere to the rules for reopening an initial determination and redetermination initiated by a contractor, as set forth at 42 CFR § 405.980(b). Pursuant to federal regulation:

A contractor may reopen and revise its initial determination or redetermination on its own motion--
1) Within one year from the date of the initial determination or redetermination for any reason.
2) Within four years from the date of the initial determination or redetermination for good cause as defined in § 405.986.

Supplemental Medical Review Contractor (SMRC)

34

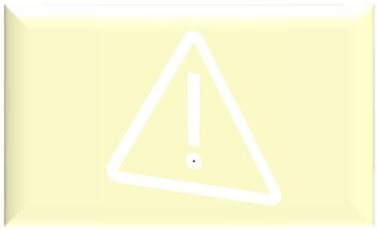
*"Please note that, due to the **involvement of several providers and the urgency surrounding this project**, this extension will be the last and only one approved."*

*"Because **multiple providers** are associated with this project number and there is a completion timeline, we are limiting the extensions we provide. This approach is necessary **to ensure that all participating providers** can complete the process within the required timeframes and that we maintain consistency and fairness throughout the project.*

*Additionally, please note that **audit results will not be provided until the medical review is complete for all providers**, followed by CMS's review and approval of the final report.*

34

Compliance Environment



TPE

PPEO

EPPR

SMRC

Data→

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Latest Data

Available for Monitoring Compliance

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36

Latest Data - SSVI

- Services and Spending Variation Index (SSVI)

  Composite index assessing hospice utilization and non-hospice spending using nine claims-based metrics.

  - Publicly available scoring system
  - Non-hospice spending increases
  - Not an indicator of fraud, waste, or abuse
  - May signal potential program integrity risks or inappropriate utilization

  Scores range from 0 to 16; higher scores indicate greater potential compliance risks and oversight focus.

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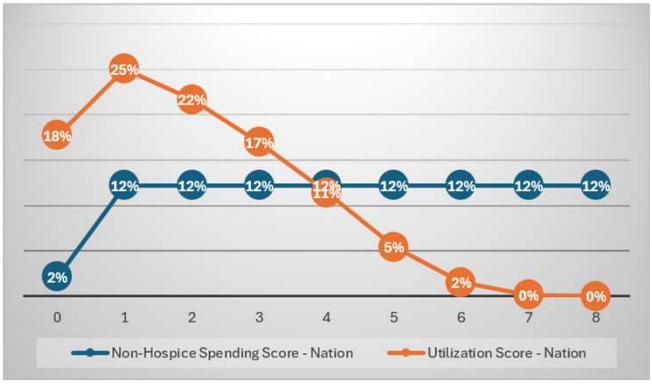
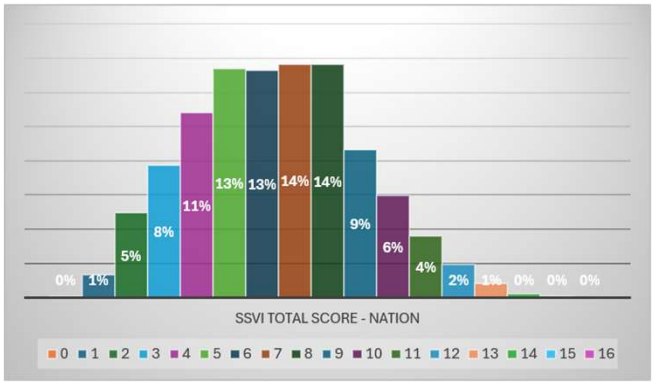
Latest Data - SSVI

- 2025 National Scores – 6,673 Agencies





38 Source: CMS 2027 hospice final Medicare payment rule

38

Latest Data - SSVI

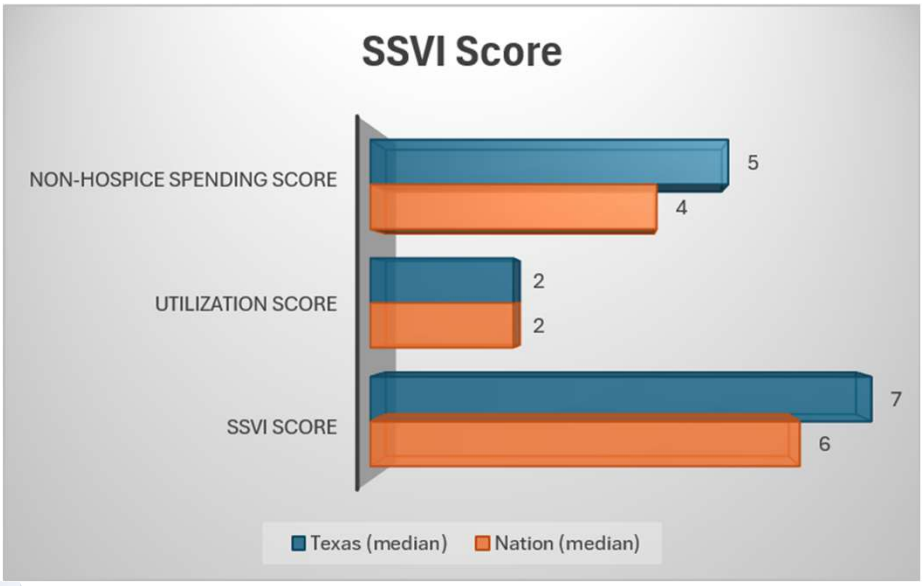
- 2025 Texas scores – 1,005 hospices

  Texas has 1,005 Medicare hospices with a FY2025 SSVI score.

  The Texas median is 7 of 16, and 14% of the Texas hospices landed in the national worst decile (SSVI 11+).

39 Source: CMS 2027 hospice final Medicare payment rule

39



$10.10
Texas (median) non-hospice spending per day (all days in FY 2025)

$5.90
Nation (median) non-hospice spending per day (all days in FY 2025)

40 Source: CMS 2027 hospice final Medicare payment rule

40

Percent of FY 2025 **RHC days** where site of service was a **NF or SNF**

3%
Texas (median)

6%
Nation (median)

41 Source: CMS 2027 hospice final Medicare payment rule

41

Percent of beneficiaries who **died in hospice** in FY 2025, and:

- Last **two days** were **RHC**
- Last **two days** received at least **one SN visit**

97%
Texas (median)

97%
Nation (median)

42 Source: CMS 2027 hospice final Medicare payment rule

42

Average LOS for beneficiaries discharged in FY 2025

- Includes lifetime hospice days
- Excludes transfers

154 days
Texas (average)

133 days
Nation (average)

43 Source: CMS 2027 hospice final Medicare payment rule

43

Median LOS for beneficiaries discharged in FY 2025

- Includes lifetime hospice days
- Excludes transfers

46 days
Texas (median)

40 days
Nation (median)

44 Source: CMS 2027 hospice final Medicare payment rule

44

Percent of beneficiaries discharged in FY 2025 whose **LOS** was **180 days or more**

- Includes lifetime hospice days
- Excludes transfers

25%
Texas (median)

22%
Nation (median)

45 Source: CMS 2027 hospice final Medicare payment rule

45

Percent of FY 2025 discharges that were **live discharges**

- Includes live and dead discharges
- Excludes transfers

28%
Texas (median)

22%
Nation (median)

46 Source: CMS 2027 hospice final Medicare payment rule

46

Percent of FY 2025 **live discharges** where beneficiaries **returned to same hospice in seven days**

0%
Texas (median)

0%
Nation (median)

47 Source: CMS 2027 hospice final Medicare payment rule

47

Percent of FY 2025 **RHC** days on the **weekend** with **at least one skilled visit**

5%
Texas (median)

7%
Nation (median)

48 Source: CMS 2027 hospice final Medicare payment rule

48

Latest Data - PEPPER

- Hospice-specific Medicare statistics for discharges and services vulnerable to improper payment
- Data from 2025 federal fiscal year
- Released on 06.03.2026

Encourages hospices to review data about their billing practices to help ensure they submit accurate claims for payment.

49

49

Live discharges:

- **No longer terminally ill**
- **Revocations**

%
Texas 80th percentile

23%
36%
National 80th percentile

50

Source: FY 2025 hospice PEPPER reports

50

LOS
- **61-179 days**
- **180 days or greater (long)**

%
Texas 80th percentile

40%
28%
National 80th percentile

51 Source: FY 2025 hospice PEPPER reports

51

RHC provided in:
- **ALF**
- **NF**
- **SNF**

%
Texas 80th percentile

44%
36%
21%
National 80th percentile

52 Source: FY 2025 hospice PEPPER reports

52

Claims billed with a **single diagnosis**

%
Texas 80th percentile

5%
National 80th percentile

53 Source: FY 2025 hospice PEPPER reports

53

No GIP or CHC

%
Texas 80th percentile

100%
National 80th percentile

54 Source: FY 2025 hospice PEPPER reports

54

Long GIP LOS (greater than 5 consecutive days)

%
Texas 80th percentile

23%
National 80th percentile

55 Source: FY 2025 hospice PEPPER reports

55

Average number of **Medicare Part D** [*prescription drug*] claims for beneficiaries residing at (3-day minimum):

- **Home**
- **ALF**
- **NF**

%
Texas 80th percentile

8%
14%
10%
National 80th percentile

56 Source: FY 2025 hospice PEPPER reports

56

Average number of **Medicare Part B** [*outpatient services*] claims for beneficiaries residing at (3-day minimum):

- **Home**
- **ALF, NF, or SNF**

%
Texas 80th percentile

4%
10%
National 80th percentile

57 Source: FY 2025 hospice PEPPER reports

57

Implementation

Periodic Compliance Assessment Process

3

58

Revenue Cycle

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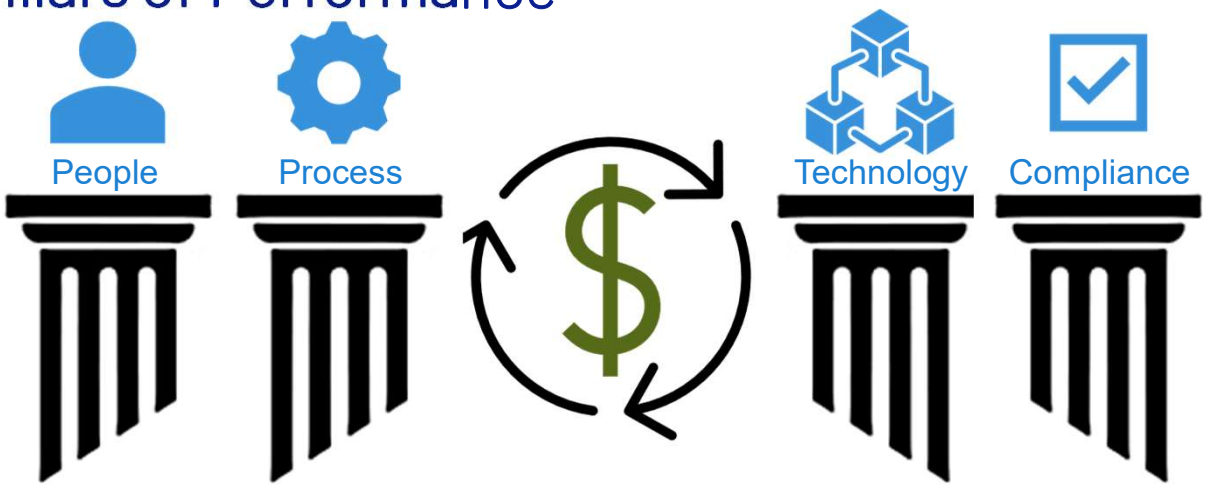
59

Revenue Cycle

Pillars of Performance



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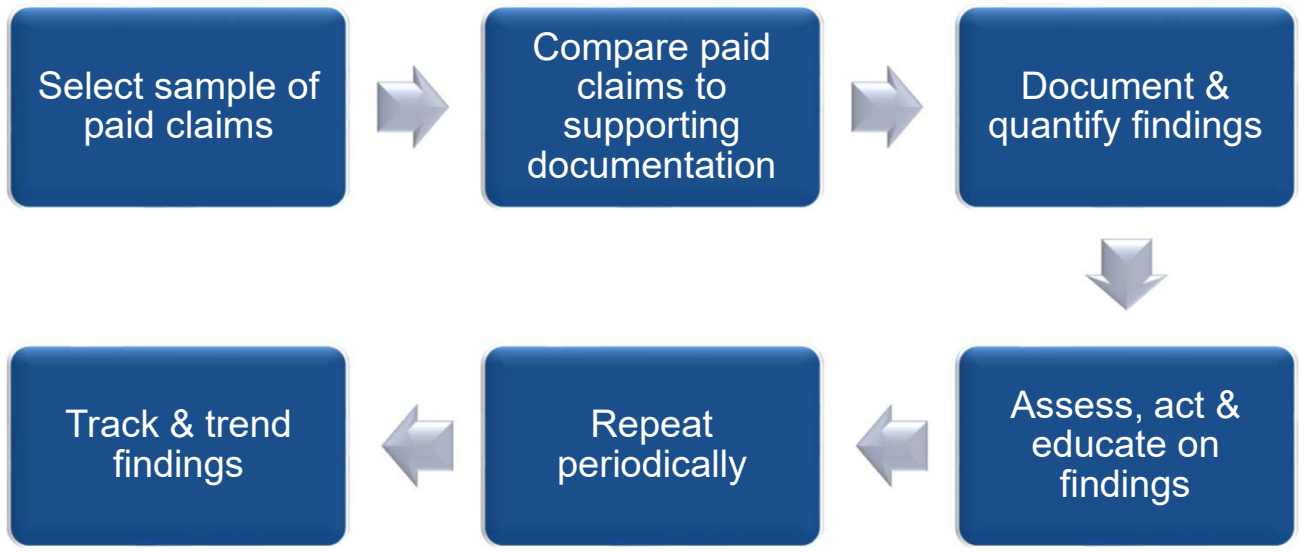
Periodic Compliance Assessment Process



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Summary

Key Takeaways

4

62

Takeaways

1

Keep up on the latest issues impacting the hospice compliance landscape.

2

Review the latest data available for monitoring compliance and compare with your data.

3

Implement a periodic compliance assessment process.

63

63

Revenue Cycle

64

64

Thank You!

Questions?

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- chris.gallarneau@mac-legacy.com

65

65

Acronyms

- **ALF** Assisted living facility
- **CERT** Comprehensive Error Rate Testing
- **CHC** Continuous Home Care
- **EMR** Electronic medical record
- **EPPR** Expanded Prepayment Review
- **GIP** General Inpatient Care
- **IPR** Inpatient Respite
- **LOS** Length of stay
- **MAC** Medicare Administrative Contractor
- **MSS** Medical social services
- **NCLOS** Non-cancer length of stay
- **NF** Nursing facility
- **NOE** Notice of Election
- **PEPPER** Program for Evaluating Payment Patterns Electronic Report
- **PPEO** Provisional Period of Enhanced Oversight
- **R&B** Room and board
- **RAC** Recovery Audit Contractor
- **RHC** Routine Home Care
- **SMRC** Supplemental Medical Review Contractor
- **SN** Skilled nursing
- **SNF** Skilled nursing facility
- **SSVI** Service and Spending Variation Index
- **TPE** Targeted Probe & Educate

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