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Presenter



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History

Effective October 1, 2025



Transition from HIS to HOPE

The HIS contained 47 total standardized items (combined across admission and discharge).

The HOPE All Items set contains approximately 196-200 items (Admission, HUV1, HUV2, and Discharge, with the non-timepoint SFV).

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Move Past Theory and Into Operational Reality

HOPE is not just a documentation change – it is a behavior change model CMS can measure.

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Structural Shift

- Organizations underestimated how disruptive HOPE would be.
 - Longitudinal, encounter-based reporting
 - Required RN, in-person visits at defined timepoints (Admission, HUV1, HUV2, Discharge)
 - Introduced condition-triggered requirements
- Early failures were not about learning the tool.
- Workflow misalignment between compliance rules and daily operations

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Misalignment Example

Compliance Rules

- HUV1 must occur between days 6-15
- Must be RN
- Must be in-person
- Must include reassessment items
- If the visit doesn't happen in the window, it doesn't count, even if it was clinically brilliant


Daily Operations Reality

Existing Workflow on Day 6-15

- Case Manager RN visits weekly on a fixed day
- LPNs or aides cover intervening days
- Staffing and routing are optimized for productivity and geography
- Schedulers aim to avoid "extra" visits unless there's a crisis

So, the operational thinking was:
The patient looks stable – RN can wait until next week

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Misalignment

"HOPE didn't break your process – it exposed the gaps that were already there."

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Visit Pattern vs Patient Need

Visits scheduled based on:

- Staff availability
- Routine patterns
- "We've always done it this way."

Instead of:

- Symptom burden
- Decline trajectory

Resulting in:

HOPE flagging inconsistency

Risk in:

- SSVI (future)
- Audit exposure
- Quality perception

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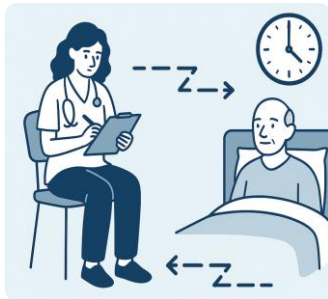
Timing Misalignment

Visits and documentation occur:

- Too early
- Too late
- Not tied to actual symptom changes

Result:

- HOPE timepoints lose meaning
- Trend data becomes unreliable



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Examples – Visit Intensity Misalignment

- _____
Patient declining
- _____
Visits remain flat or decrease
- _____
HOPE signals trajectory mismatch
- _____
Risk: SSVI + medical review

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How does HOPE signal the trajectory mismatch?

- ⦿ Only 2 HUVs are required in the first 30 days.
- ⦿ SFVs are triggered by symptoms at admit, and the two HUVs.
- ⦿ How would HOPE signal a trajectory mismatch if no HUV was required and the symptoms are found between the HOPE visits? Those visits would not be transmitted.

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HOPE isn't visit based – it's signal based

- ⦿ HOPE is not trying to capture every change
- ⦿ It's evaluating consistency between the signals it does receive.
- ⦿ A series of "data snapshots" that should tell a coherent clinical story.

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Trajectory Inconsistency

- ⦿ Admit: Moderate symptom burden
- ⦿ Then shows minimal change at HUVs
- ⦿ Claims show increasing visit intensity (which CMS does see via claims)
- ⦿ Mismatch:
 - Data says "stable"
 - Utilization says "declining"

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Sudden Jumps

- ⦿ If symptoms worsen between visits and are only captured at next HUV:
- ⦿ Admit: Mild pain, no dyspnea
- ⦿ No SFV triggered
- ⦿ HUV1
- ⦿ No SFV triggered
- ⦿ HUV2: Severe pain, significant decline
- ⦿ No intermediate signal of progression
- ⦿ HOPE signals a step-change without trajectory

Data integrity
or
documentation
gap?

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SFV Trigger Failure

- ⦿ If symptoms actually occur between HUV visits, but no SFV is triggered/documented then:
- ⦿ Symptoms didn't exist in HOPE OR
- ⦿ Weren't significant enough to trigger follow-up
- ⦿ Utilization increases so:
 - Care is responding to symptoms, but HOPE data doesn't show a trigger event

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Claims Data Fills the Gap

HOPE Data	Claims Data
Symptom Burden	Visit Frequency
Functional Status	Skilled intensity
SFV Triggers	Response to decline

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Misalignment: Scenario A

No change in utilization

- ⦿ Symptoms are undocumented
- ⦿ No increase in visits

HOPE sees:

- ⦿ Stable → Stable → Stable
- ⦿ No obvious mismatch (but potential under-documentation risk)

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Misalignment: Scenario B

Increased utilization

- ⦿ Symptoms occur between visits
- ⦿ No SFV triggered
- ⦿ But more visits happen

HOPE sees:

- ⦿ Stable patient

Claims show

- ⦿ Increased skilled care

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Misalignment: Scenario C

Symptoms finally captured at next HUV

- Big jump in severity
 - But no prior SFV
- HOPE sees
- Abrupt change without progression

Abrupt decline in patient or data credibility issue?

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Potential Risks

If your care team experiences the decline, but your HOPE data doesn't show how you got there, CMS assumes the story is incomplete.

- ▶ **SSVI**
 - Variation = mismatch between documented severity vs service intensity
- ▶ **HVLDL / LOS scrutiny**
 - Long stays require credible decline trajectory
 - Gaps weaken that credibility
- ▶ **Medical Review**
 - Reviewers look for continuity of decline
 - HOPE becomes the "official story"

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Inside the Utilization Score

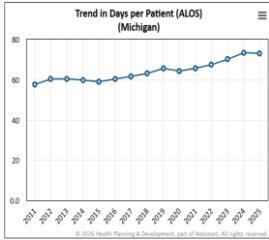


Every hospice starts with a score of zero! Each risk adds 1 point:

- No CHC or GIP provided
- ≥40% of RHC days in SNF/NF
- Low skilled visits at end of life (last 2 days)
- High % live discharge rate
- High % live discharges with LOS >180 days
- Low avg SN minutes on RHC days
- Low weekend skilled visits (SN, SW, Therapy)
- High return after live discharge (within 7 days)

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SSVI Data



- How does that affect HOPE?
- The only HOPE timepoint after day 30 is the discharge.

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Let's Talk Transmitting



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Error vs. Warning

Error

- Critical errors cause rejections
- These **must** be fixed before CMS will accept
- Correct in the EHR and resubmit after corrections are made

Warning

- Warnings do not cause rejections
- They DO flag something to review, but do not require corrective action
- If you do not use SimpleConnect, you will only see these warnings on your detailed Final Validation report after submission

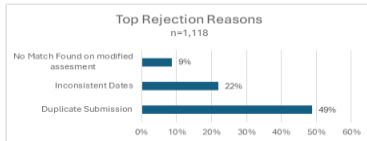
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The Most Common Rejections

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What the Data Shows

- Duplicate Submission = 49% of all rejections
- Date issues = 22% (3032b)
- No match found on modified assessment = 9%



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Duplicate Assessment Submission

49% of all rejections are due to submitting duplicate assessments.

- To try to prevent this, be sure that your assessments are marked as "accepted" or "rejected" within your EHR, so hopefully they cannot be pulled into a batch after they are accepted/rejected.
- Process or technical workflow issue rather than clinicians repeatedly keying in the same assessment

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Possible Causes of Duplicate Assessments

- **Vendor/Automation Retries (same file submitted)**
 - If your EHR or middleware auto-retries failed uploads or a user re-queues a file that was actually accepted, iQIES will see the same XML again. The duplicate shows up on the Provider Final Validation Report (FVR) as warnings/errors, depending on the edit that fires. CMS emphasizes reviewing the FVR for each file and correcting the submission workflow when you see repeats.
- **Batch File Contains the Same Record Twice**
 - It's possible to zip a batch where the same HOPE record appears more than once (e.g. two copies of the same XML). iQIES processes records, not just files; so a single upload can count as multiple duplicates if it includes the same record multiple times. Use the FVR to identify repeated record IDs with the same batch.

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Possible Causes of Duplicate Assessments

- **Out of Sequence Corrections Submitted as New**
 - Teams sometimes fix an issue by generating a fresh assessment instead of correcting/modifying the prior one. iQIES expects a logical sequence and will flag sequencing anomalies with out of sequence trigger warnings.
- **Cross-Over Confusion (HIS vs HOPE)**
- **Multiple Submitters/Vendors for the Same CCN**
- **Incorrect "Record Keys" Generated**
- **Users Don't Check the Final Validation Report (FVR)**
- **Misinterpreting Sequencing Warnings as Failures**

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Submission Date Issues

22% of all rejections are due to date issues – specifically the 3032b errors.

- It is difficult to identify this error manually before submission to avoid the rejection as CMS uses the **submission date** as the point of reference.

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No Match for a Previously Submitted Record

- 9% of all rejections were due to assessments being submitted for records that did not match a previously submitted record in CMS.
- This is often due to submission of an Inactivation or Modification record when the original record was never sent to, or never accepted by, CMS.
- This can be prevented by tracking your submission status through your EHR and ensuring that you reopen/edit assessments that have not been submitted (rather than submitting a Modification of a submitted assessment).

If the rejection is from a batch, be sure when you go back into your EHR to make the correction, that you do **NOT** do a modification. **The assessment was never sent to CMS.** It needs to be completed by unlocking the assessment and making the corrections – it should not be a modification, or you will get a rejection.

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Correcting Errors in HOPE Records That Have Not Yet Been Accepted by CMS

- HOPE records that have not yet been accepted by CMS include records that have been submitted and rejected, or records that have not been submitted at all.
- Records that have been submitted and rejected can usually be corrected and resubmitted without any special correction procedures because they were never accepted by the system.
- **Hospices are responsible for correcting any errors to the record prior to submission or re-submission of the record to CMS.**

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Correcting Errors in HOPE Records That Have Been Accepted by CMS

- Completion of a Modification Request record will archive the inaccurate HOPE record and replace the record with the new, corrected record. **3.7.1**
- Completion of an Inactivation Request will also archive an inaccurate HOPE record but will not replace the record with the new record. **3.7.2**

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The Most Common Issues

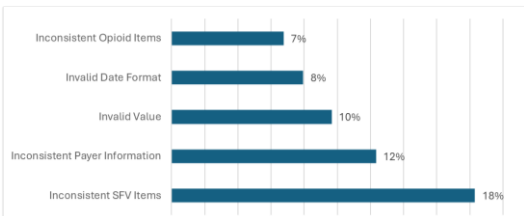
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HOPE Scrubber through December 31, 2025

- Volume: Over 365K assessments scrubbed
- **Assessment Error Rate:** 34% of assessments were flagged with critical warnings in the Simple Scrubber.
→ With such a high error rate, the HOPE scrubber is invaluable to the Hospice submission workflow.
- **Errors Flagged: Over 134K errors caught**
 - Critical = 83% (111,382)
 - Warning = 16% (21,398)
 - Informational = <1% (1,220)

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What are the most common issues?



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Inconsistent SFV Items

- This one consists of a group of possible issues.
- The most common issue within this group is having a "A"/Blank in one of the dates.
 - To help minimize this, double check section J2052A. If your answer is "1", then you cannot have a "A"/Blank for the date.

J2052: Symptom Follow-up Visit (SFV)
Complete if any response in section J2051 in 2 or 3. Otherwise, skip to section M1190

J2052A: Was in-person SFV completed?
If 0 - No, skip to question J2052C

J2052B: Date of in-person SFV
J2052A is 1 - Yes, complete then skip to section J2053

J2052C: Reason SFV Not Completed
J2052A is 0 - No, complete then skip to section M1190

1 - Yes MM-DD-YYYY Skip - Blank (skip pattern)

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J2051

J2051: Symptom Impact
Over the past 2 days, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:

0. Not at all - symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
4. Not applicable (the patient is not experiencing the symptom)

	Enter Code
A. Pain	<input type="checkbox"/>
B. Shortness of breath	<input type="checkbox"/>
C. Anxiety	<input type="checkbox"/>
D. Nausea	<input type="checkbox"/>
E. Vomiting	<input type="checkbox"/>
F. Diarrhea	<input type="checkbox"/>
G. Constipation	<input type="checkbox"/>
H. Agitation	<input type="checkbox"/>

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Other Issues Related to SFVs

Late SFVs

Just a warning

-3105 Consistency Warning IF A0250=(1,2,3) AND (J2051A=(2,3) OR J2051B=(2,3) OR J2051C=(2,3) OR J2051D=(2,3) OR J2051E=(2,3) OR J2051F=(2,3) OR J2051G=(2,3) OR J2051H=(2,3)) THEN J2051B (Date of in-person SFV) minus J2050B (Date of symptom impact screening) should be less than or equal to 2 calendar days.

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Sequencing/Timing Rules

Early HUVs	Just a warning
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-3110	Consistency	Warning	<p>or equal to 30 days. HUV Timing Rules</p> <p>(a) If A0250 = [2], then A0220 + 6 should be <= Z0350. (b) If A0250 = [2], then A0220 + 15 should be >= Z0350. (c) If A0250 = [3], then A0220 + 16 should be <= Z0350. (d) If A0250 = [3], then A0220 + 30 should be >= Z0350.</p> <div style="background-color: #333; color: white; padding: 2px; font-size: 0.8em;"> A0250 is Reason for Record A0220 is Admission Date Z0350 Date Assessment Completed </div>
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How to interpret...

Critical Errors

- Errors that will cause a rejection
- MUST BE CORRECTED in the EHR
 - If assessments are submitted to CMS with critical errors, the batch will be rejected
 - Be sure to resubmit after corrections are made. No special correction procedures are necessary as it was never accepted by the system.

Warnings

- ⦿ Issues that do not cause a rejection
- ⦿ Often do not require any corrective action

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How can my team improve acceptance rate & HOPE accuracy?

- Paying careful attention to any flags or errors you see in the scrubber and making the necessary corrections is the first step to improving the acceptance rate.
- Check every Final Validation report – make sure you’re looking at the full detail version
- Integrate review of scrubber reports as part of the finishing touches on that assessment.
- Scrubber fatigue vs efficiency

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Found in the Proposed Rule

Due to the newness of the HOPE assessment along with the migration to the iQIES platform, CMS has granted a waiver to all HOPE assessments dated October 1, 2025, through December 31, 2025, and as a result, all HOPE assessments with a target date in 2025 will be considered timely.

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What else about HOPE?



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How CMS is Evaluating You

Compliance with HOPE Submission

- 4% Revenue at Risk

HQRP

- Comprehensive Assessment at Admission (HOPE)
- HVLDL (Claims)
- HCI (Claims)
- CAHPS Hospice Survey

SSVI = Service and Spending Variation Index

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LOS Extremes Create Opposite HOPE Risks


Long LOS Concentration (>180 days)

- HOPE exposes:
 - Repetitive symptom scoring without change
 - Flat functional trajectories
 - Weak evidence of terminal decline over time
 - No HOPE transmissions over a length of time with continuing claims
- Patterns that invite:
 - Prognosis skepticism

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Presenter Contact Information

 **Contact us via email** LisaSelman-Holman@McBeeAssociates.com

Home Care & Hospice

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Resources

- <https://www.federalregister.gov/documents/2026/04/06/2028-06604/medicare-program-fy-2027-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting>
- <https://www.cms.gov/files/document/hope-guidance-manual-v1-01.pdf>
- <https://www.cms.gov/medicare/quality/hospice>
- Data on errors in submission from Simple, a part of Netsmart
- Health Pivots data

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