

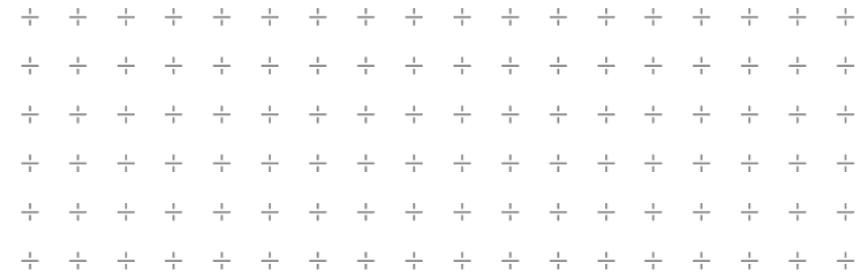


## HOPE: The First 8 Months

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# Our Panel



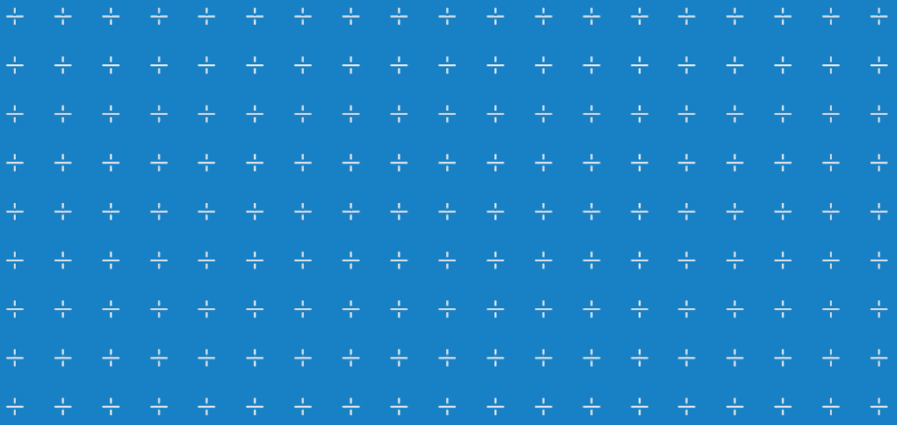
Host

**Jan Milliman, HCS-D,**  
Director, AHCC



Panelist

**Lisa Selman-Holman,**  
JD, BSN, RN, HCS-D,  
HCS-H, HCS-O, COS-C,  
Vice President of Clinical  
Services, McBee



# HOPE: The First 8 Months



# Presenter



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Vice President, Clinical Services

McBee, part of Netsmart

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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).

# 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

# 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



**Compliance Rules**

**Daily Operations**

## 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

# Timing Misalignment

Visits and documentation occur:

Too early

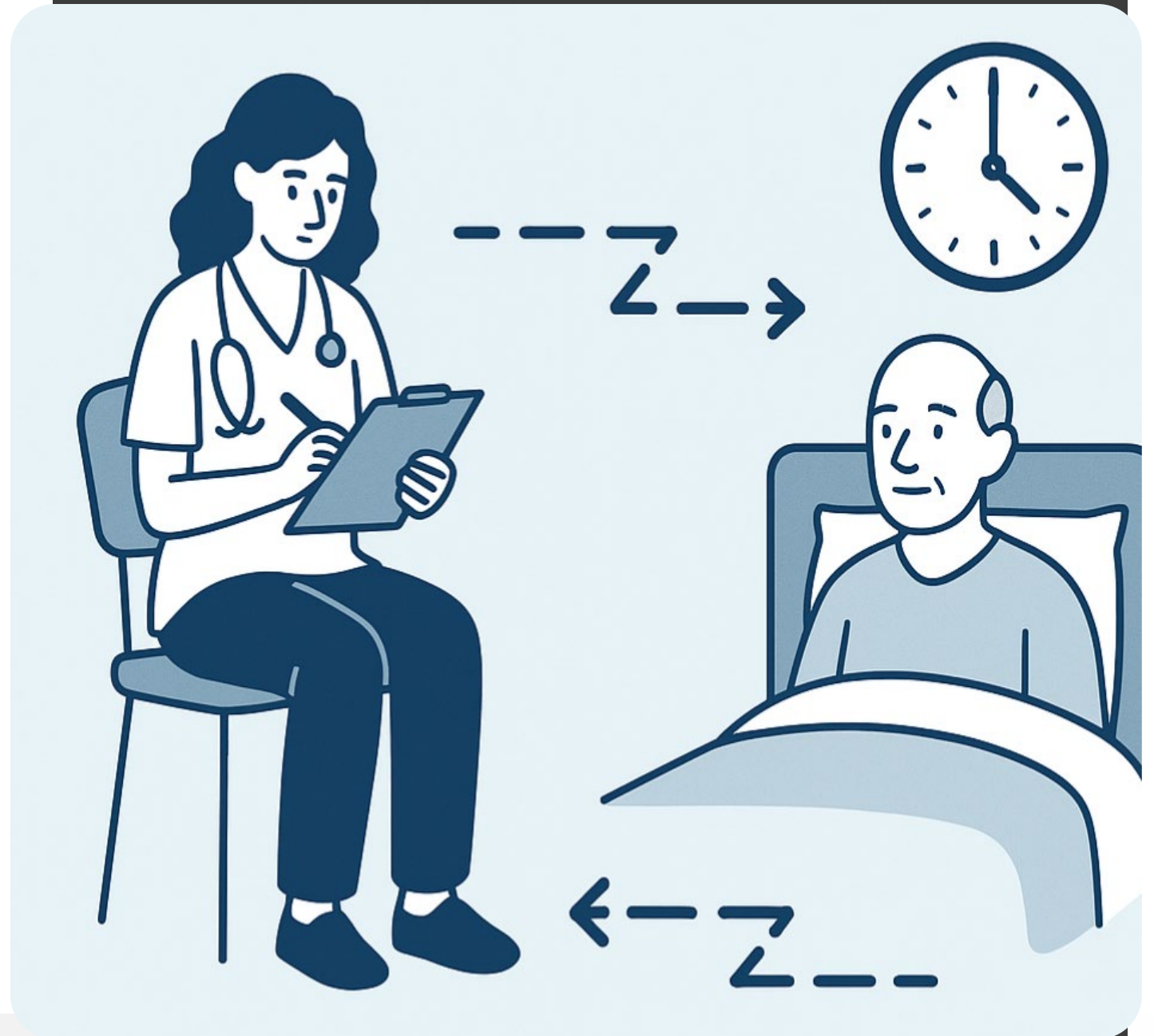
Too late

Not tied to actual symptom  
changes

Result:

HOPE timepoints lose meaning

Trend data becomes unreliable



# Examples—Visit Intensity Misalignment

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Patient declining

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Visits remain flat or decrease

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HOPE signals trajectory mismatch

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Risk: SSVI + medical review

# 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.

# 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”

# 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?

# SFV Trigger Failure

- ⦿ If symptoms actually occur between HUV visits, but no SFV is triggered/documentated 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

# Claims Data Fills the Gap

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

# Stable → Stable → Stable

## No change in utilization

- ⦿ Symptoms are undocumented
- ⦿ No increase in visits

## HOPE sees:

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

# 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”

# Inside the Utilization Score



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

- ⦿ No CHC or GIP provided
- ⦿  $\geq 40\%$  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)

# Let's Talk Transmitting



# 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

# The Most Common Rejections

# Duplicate Assessment Submission

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64% 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

# 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.

# Submission Date Issues

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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.

# 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).

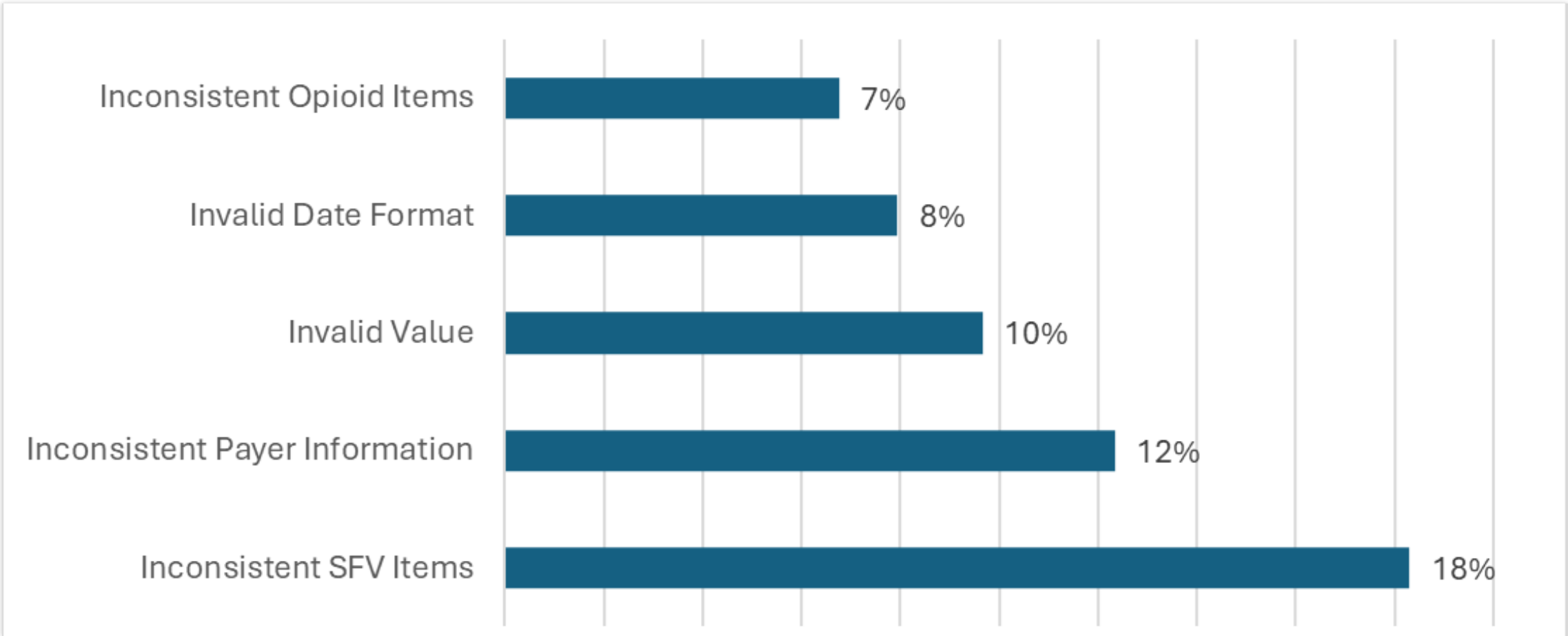
If the rejection is from a batch, be sure when you go back into your EHR to make the correction, that you do **NOT** do a modification. **The assessment was never sent to CMS.** It needs to be completed by unlocking the assessment and making the corrections – it should not be a modification, or you will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

# 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.**

# The Most Common Issues

# What are the most common issues?



# Inconsistent SFV Items

- This one consists of a group of possible issues.
- The most common issue within this group is having 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 “^”/Blank for the date.

## J2052. Symptom Follow-up Visit (SFV)

Complete if any response in section J2051 is '2 or 3'. Otherwise, skip to section M1190

J2052A: Was in-person SFV completed

If '0 - No', skip to question J2052C

1 - Yes

J2052B: Date of in-person SFV

If J2052A is '1 - Yes', complete then skip to section J2053

MM-DD-YYYY



Skip

J2052C: Reason SFV Not Completed

If J2052A is '0 - No', complete then skip to section M1190

^ - Blank (skip pattern)



# J2051

<b>J2051. Symptom Impact</b>	
<p>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.</p> <p>Coding:</p> <ul style="list-style-type: none"><li>0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment</li><li>1. Slight</li><li>2. Moderate</li><li>3. Severe</li><li>9. Not applicable (the patient is not experiencing the symptom)</li></ul>	
	<b>Enter Code</b> ↓
<b>A. Pain</b>	<input type="checkbox"/>
<b>B. Shortness of breath</b>	<input type="checkbox"/>
<b>C. Anxiety</b>	<input type="checkbox"/>
<b>D. Nausea</b>	<input type="checkbox"/>
<b>E. Vomiting</b>	<input type="checkbox"/>
<b>F. Diarrhea</b>	<input type="checkbox"/>
<b>G. Constipation</b>	<input type="checkbox"/>
<b>H. Agitation</b>	<input type="checkbox"/>

# 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 J2052B (Date of in-person SFV) minus J2050B (Date of symptom impact screening) should be less than  
or equal to 2 calendar days.

# Sequencing/Timing Rules

Early HUVs

Just a warning

-3110

Consistency

Warning

or equal to 30 days.

HUV Timing Rules

(a) If A0250 = [2], then A0220 + 6 should be  $\leq$  Z0350.

(b) If A0250 = [2], then A0220 + 15 should be  $\geq$  Z0350.

(c) If A0250 = [3], then A0220 + 16 should be  $\leq$  Z0350.

(d) If A0250 = [3], then A0220 + 30 should be  $\geq$  Z0350.

A0250 is Reason for Record  
A0220 is Admission Date  
Z0350 Date Assessment Completed

# 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

# Checklist

- 90% HOPE Submission Compliance
- Non-compliance means 4% loss of revenue
- CMS proposed an icon to be placed on Care Compare
- FY2026 Non-compliance was >20%



## Found in the Proposed Rule

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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.

# LOS Extremes Create Opposite HOPE Risks

## Short LOS Concentration ( $\leq 7$ or $\leq 14$ days)

- HOPE data becomes
  - Incomplete
  - Rushed
  - Symptom-heavy without intervention trend
- Minimal opportunity to demonstrate:
  - Symptom improvement
  - Goal alignment
  - Care planning progression

HOPE may technically be completed, but lacks clinical narrative credibility

# LOS Extremes Create Opposite HOPE Risks

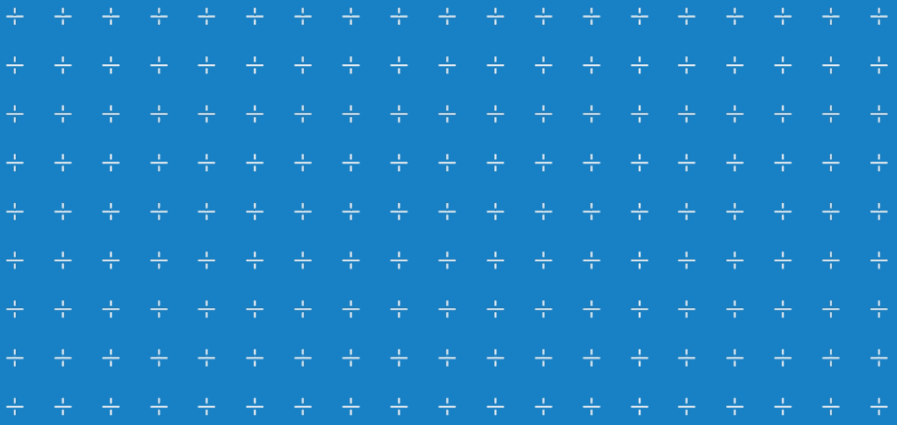
## Long LOS Concentration (>180 days)

- 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



## Resources

- <https://www.federalregister.gov/documents/2026/04/06/2026-06604/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



# Scenario Spotlight



# May Scenario

**Scenario:** A Start of Care clinician completes medication reconciliation using the hospital discharge summary and confirms prescription bottles in the home. During survey, the patient reports taking several supplements and PRN OTC medications not listed in the chart.

**Which statement is most accurate?**

- A. Prescription medications are the only items required for reconciliation.
- B. All items the patient takes should be reviewed and documented.
- C. Supplements are only listed when ordered by a physician.
- D. OTC medications are optional unless side effects occur.

# May Scenario Answer

**Scenario:** A Start of Care clinician completes medication reconciliation using the hospital discharge summary and confirms prescription bottles in the home. During survey, the patient reports taking several supplements and PRN OTC medications not listed in the chart.

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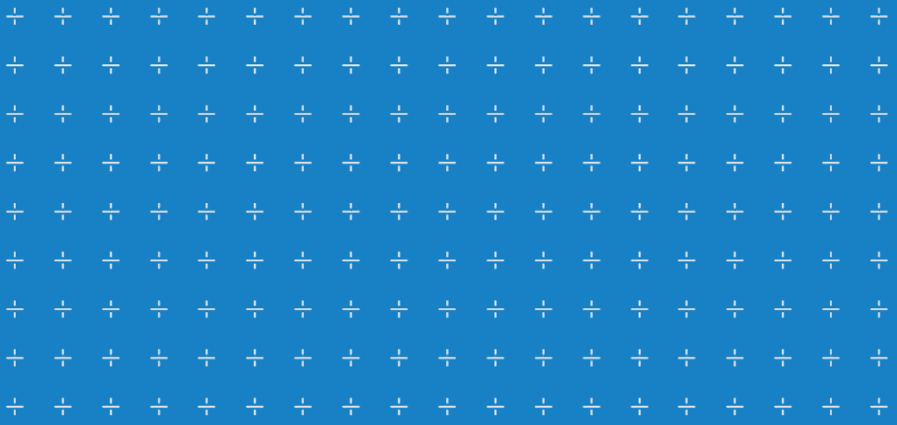
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- C. Supplements are only listed when ordered by a physician.
- D. OTC medications are optional unless side effects occur.

# June Scenario

**Scenario:** A patient was admitted to Hospice and the RN performed a symptom impact assessment at the admission on 6/1/26. The scores for the items were all 0 & 1 for none to mild symptom impact upon admission. The HUV-1 visit was done on 6/10/26 and at this visit, the symptom impact scores for the items were all 0-1 none to mild except that pain was scored as moderate symptom impact. The nurse documents teaching and a change of medication for pain management was ordered during the visit on 6/10/26, but the patient refused to begin taking the medication because he felt the pain, though impactful, was tolerable and he didn't want to just "sleep all the time."

**In regards to the symptom follow up visits for this scenario, which statement is most accurate?**

- A. An SFV was required after the SOC and should have been done on or before 6/3/26.
- B. An SFV is required to be done on or before 48 hours from the 6/10/26 HUV-1 visit.
- C. An SFV is needed, but can be done at the HUV-2 visit due on days 16-30.
- D. The SFV is not required at all for this scenario



# Product Spotlight



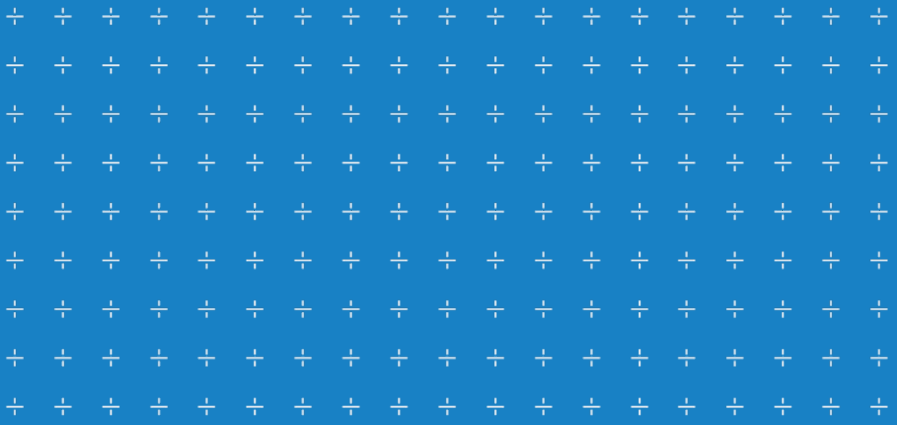
## Product Spotlight

**Credential Your coding & OASIS Team,  
Strengthen Your Agency's Bottom Line**

Stronger coders = stronger compliance.  
Encourage your team to earn AHCC  
credentials and elevate your agency's  
reputation, audit readiness, and financial  
outcomes.

Learn how credentialing pays  
off at [decisionhealth.com/credentials](https://decisionhealth.com/credentials).





# What's New with AHCC



# What's new with AHCC

## AHCC Educational call June 24

- Hospice coding and the HOPE tool.



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Next episode: June 15