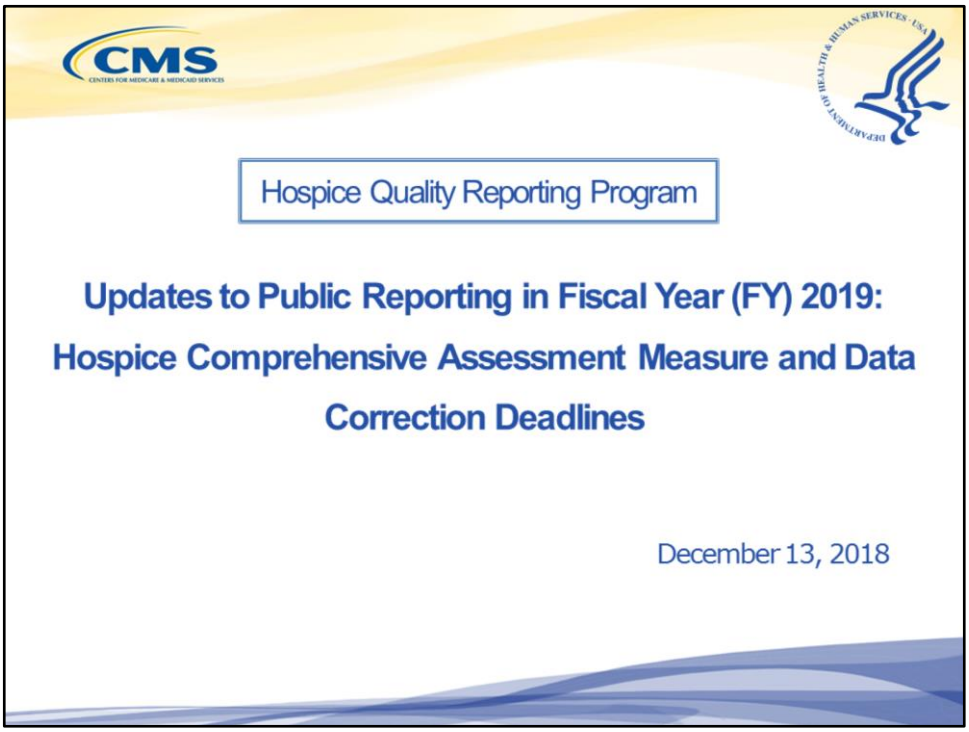
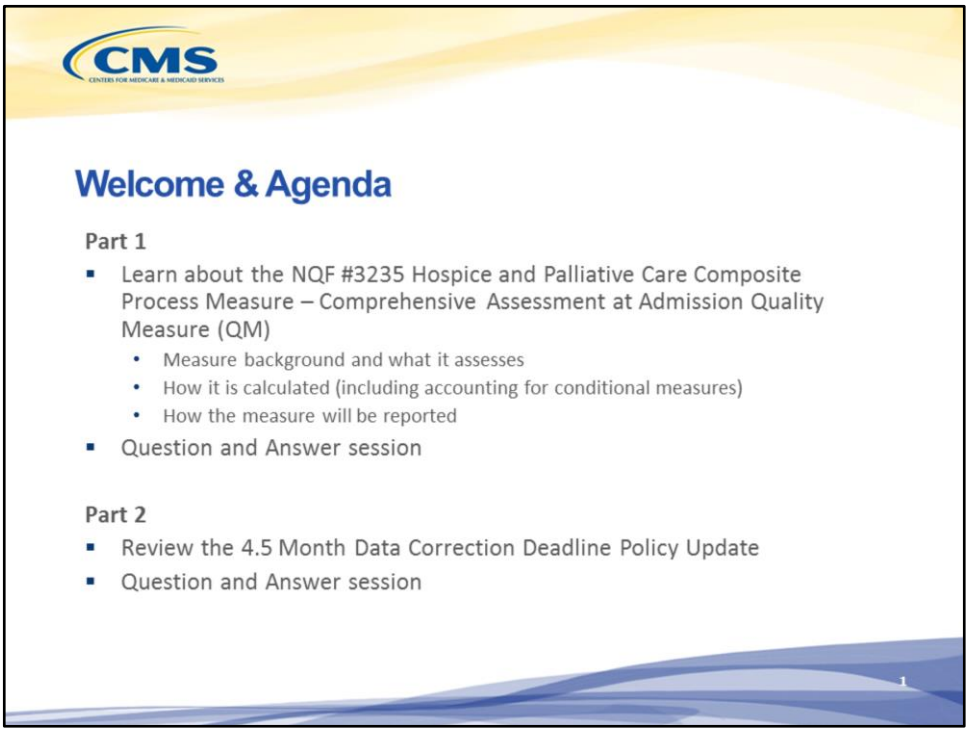


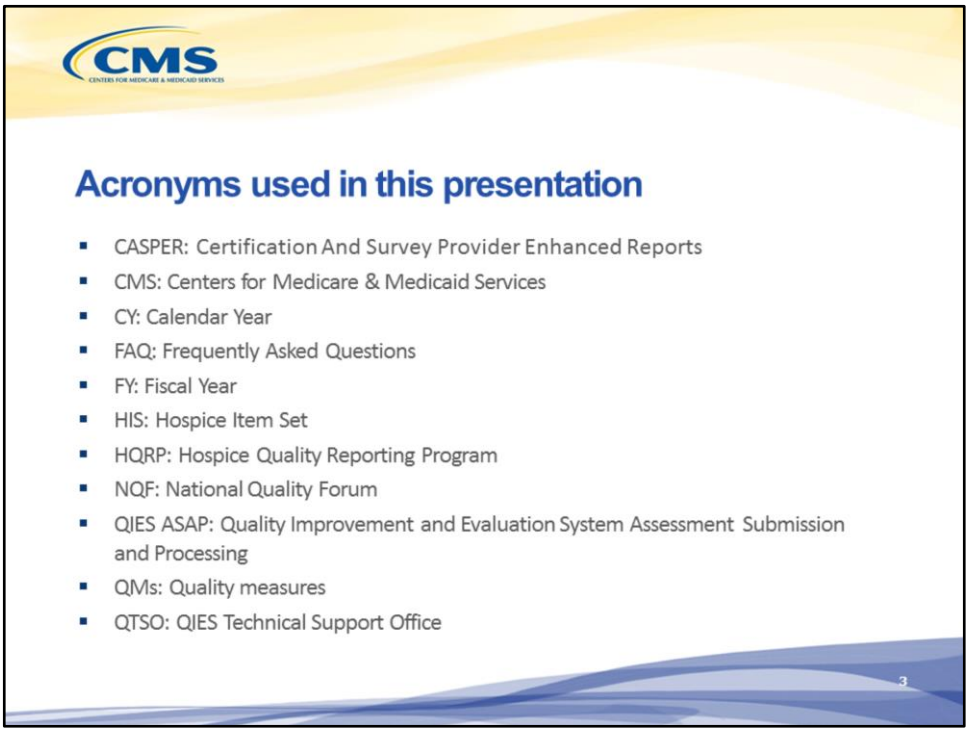
Good afternoon. My name is Cindy Massuda and I'd like to welcome you to the Centers for Medicare & Medicaid Services presentation entitled "Updates to Public Reporting in FY 2019:
Hospice Comprehensive Assessment Measure and Data Correction Deadlines". The goal of this presentation is to inform hospice providers about two different key public reporting updates.



This training will be split into two parts, covering two separate topics.
During Part 1 of the training, we will be going over the Hospice and Palliative Care Composite Process Measure, also known as the Hospice Comprehensive Assessment Measure. Because this measure was added to provider preview reports in September 2018 and is now being publicly reported on Hospice Compare, we wanted to take the opportunity to dive into the details of this measure to be sure that providers understand how this measure is calculated. Following Part 1 of the training, we will have a brief question and answer session.

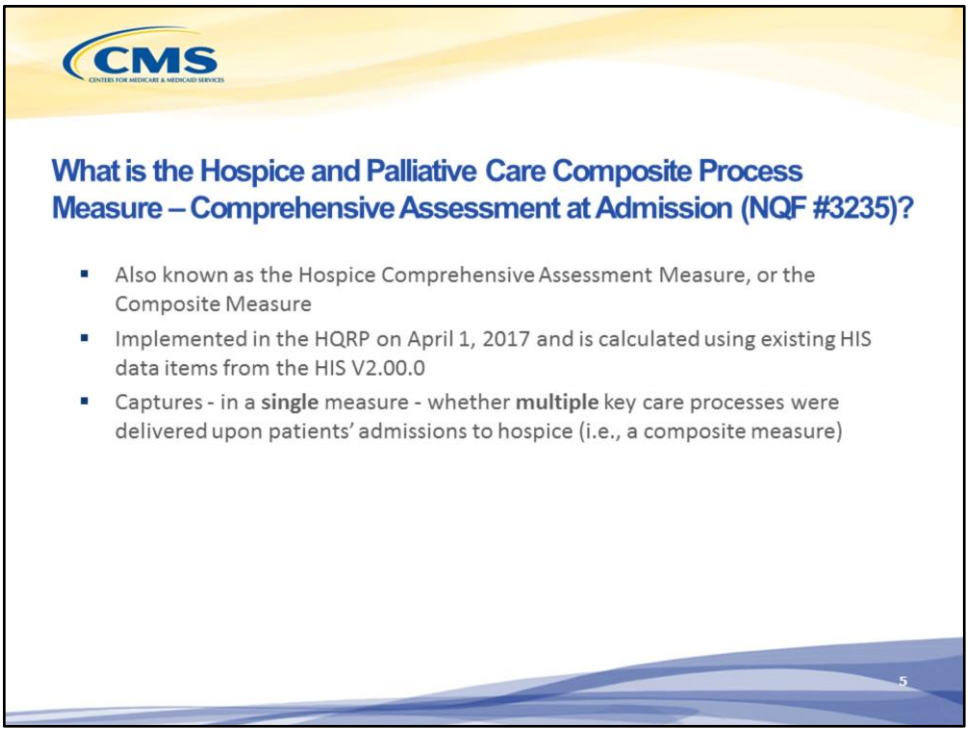
Then, during Part 2 of the training, we will be reviewing the 4.5 Month Data Correction Deadline for Public Reporting policy update that was finalized in the FY 2019 Hospice final rule. Following Part 2 of the presentation, we will host an additional question and answer session.

Our presenters today will be Dorothy Wu and Elizabeth Fehlberg from RTI International. At this point, I'll turn it over to Dorothy who will lead the first portion of today's presentation.

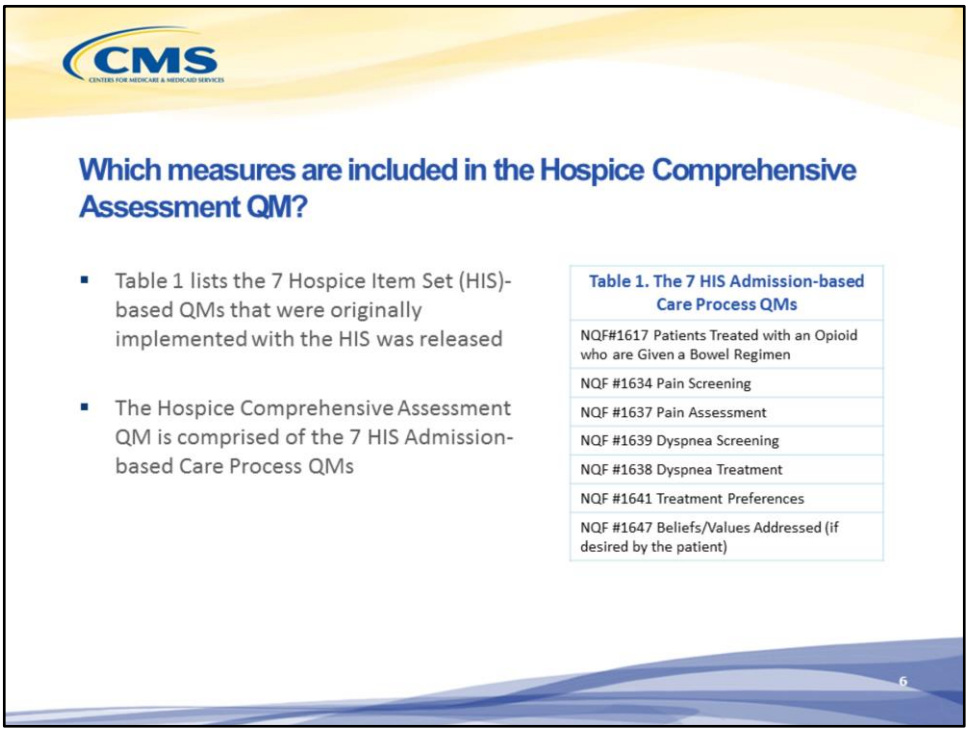


Thank you, Cindy for that introduction. Slide 3 contains a list of acronyms that will be used in this presentation.

As Cindy mentioned, this training has been split into two parts.
Starting with Part 1, we will be reviewing the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission

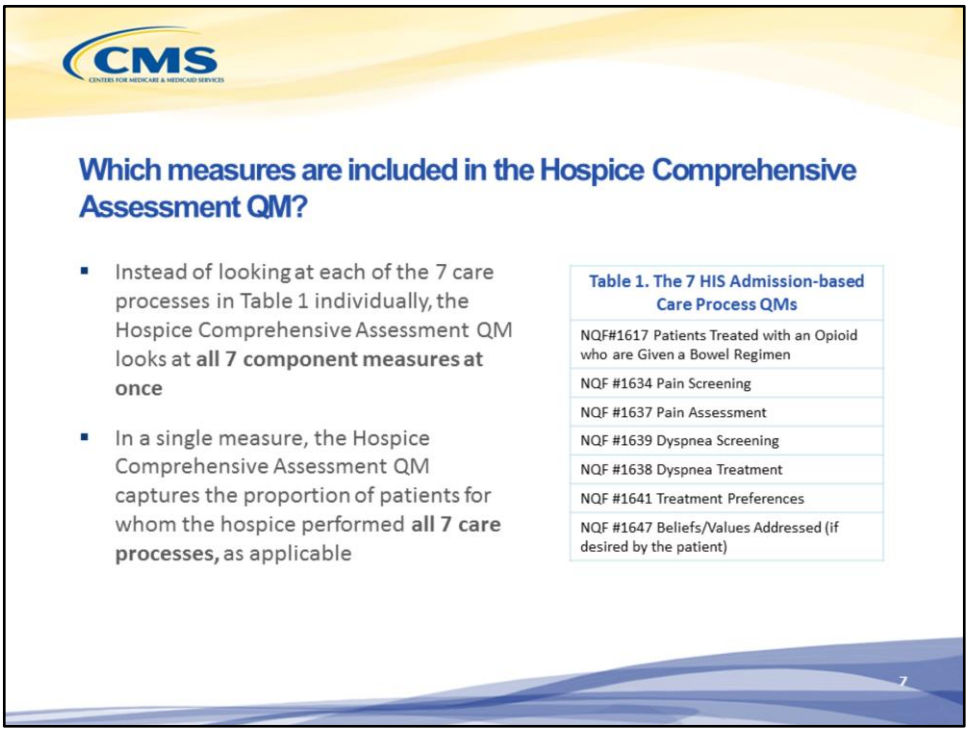


Let's start out with a brief overview. You may be more familiar with this measure by its short measure name which is the Hospice Comprehensive Assessment Measure. This measure was implemented in the HQRP on April 1, 2017 and is calculated using existing HIS data items from the HIS V2.00.0. The motivation behind the Hospice Comprehensive Assessment Measure is to account for the fact that there are many things that a hospice is expected to do when a patient is admitted to hospice in order to provide high quality care. The Hospice Comprehensive Assessment Measure captures, in a **single** measure, whether **multiple** care processes were done when a patient was admitted. I want to pause here for a second and define a term that you are going to hear us use during this training. That term is composite measure. A composite measure is a measure like this one that captures multiple aspects of quality in one measure.

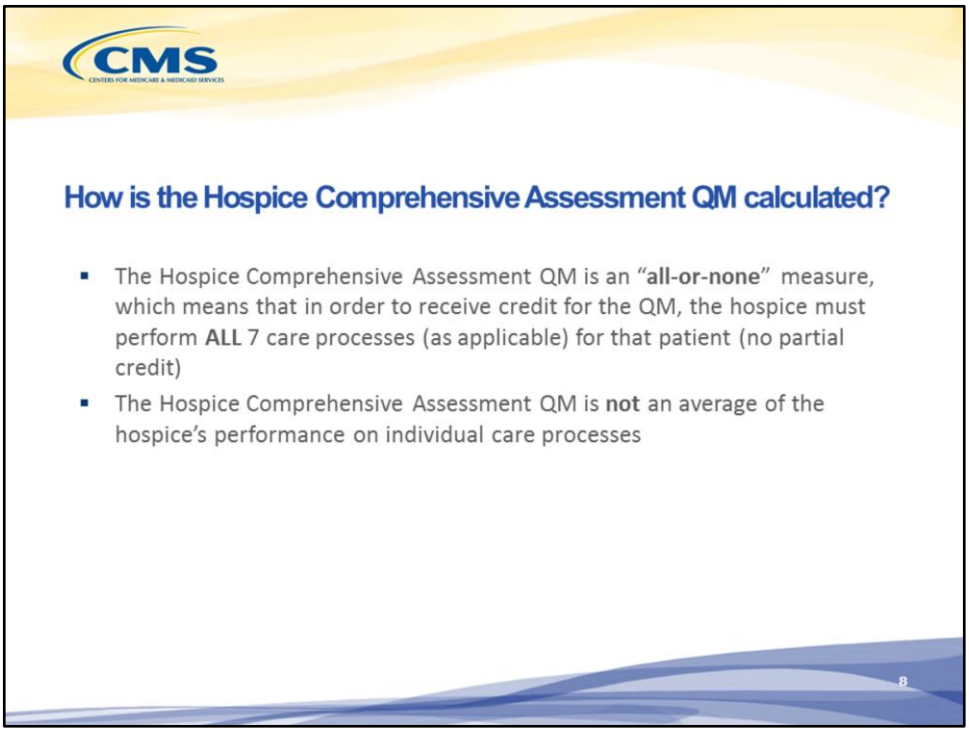


So I mentioned on the prior slide that, as a composite measure, the Hospice Comprehensive Assessment QM looks at multiple care processes at once. I'll now go over which care processes are captured by, or make up, the composite measure.

Historically, hospices have been using the HIS to report data on seven processes of care that should be delivered when patients are admitted to hospice. Those seven measures are listed in Table 1 on this slide. CMS began public reporting of these 7 measures on Hospice Compare last year, and these measures were reported individually, so consumers could look to see how hospices performed on each individual measure.

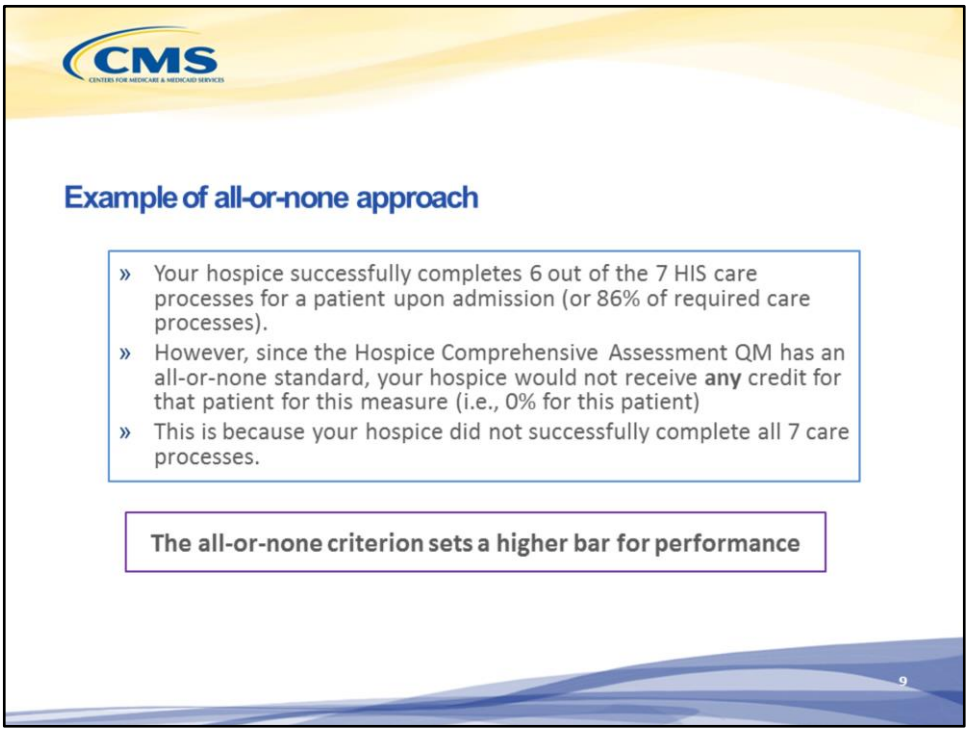


The Hospice Comprehensive Assessment measure takes these 7 individual measures and combines them into a single metric. As such, the Hospice Comprehensive Assessment measure captures, in a single measure, the proportion of hospice patients for whom the hospice performed *all* seven of these care processes, as applicable. This means that in order to get "credit" for this composite measure for a particular patient, the hospice must perform *all* seven of the care processes for which the patient is eligible. We'll talk more about how hospices get credit for this measure on the next slide, but first I want to define one more term that you are going to hear us use during this training. That term is component measure. When we combine multiple individual measures together into a composite measure, we refer to those individual measures that make up the composite as component measures. So we would refer to the 7 individual HIS measures as the component measures that make up the composite measure, the Hospice Comprehensive Assessment measure. You will hear us use the terms component measures and composite measure throughout the rest of this presentation.



There are many different types of composite measures. Two of the most common are "all-or-none" and average-based composite measures. The Hospice Comprehensive Assessment composite measure is calculated as an "all-or-none" measure. This means that in order to receive credit on the hospice composite measure, your hospice must perform all seven care processes -- as applicable -- to receive credit for the measure, for any given patient. In effect, the "all-or-none" requirement means that your hospice does not receive any partial credit for performing *most* of the seven care processes and the score is NOT an average of your individual performance on the seven care process measures.

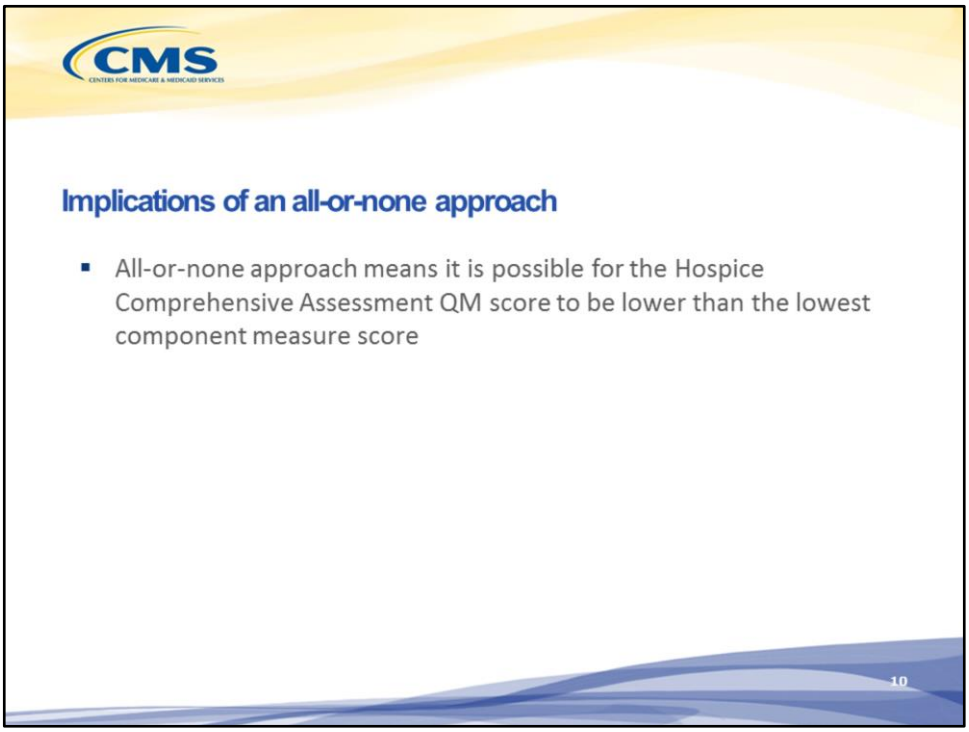
We'll go through an example of this all or none approach next, and what the implications of using an all-or-none approach are.



So on the prior slide, we introduced the concept of an all-or-none approach; I'm now going to go over an example of the all or none approach and the implications that has.

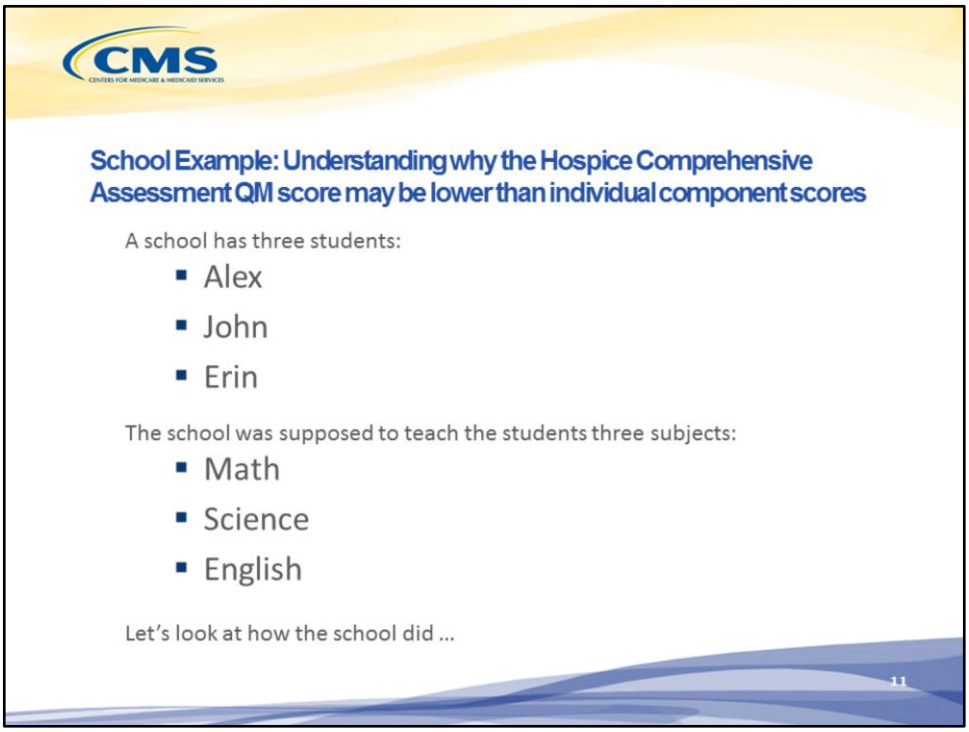
For example, if your hospice completes 6 out of 7 of the care processes for a patient upon admission, then that sounds like a pretty good job – 6 out of 7 means your hospice completed an average of 86% of the 7 required care processes. However, since the composite measure has an all-or-none standard and is not average-based, your hospice would not receive **any** credit for that patient on this composite measure because not all care processes were completed.

As such, the all-or-none approach sets a higher bar for performance as it requires you to do all 7 things (as applicable) and doesn't give partial credit for completing less than 7 care processes.

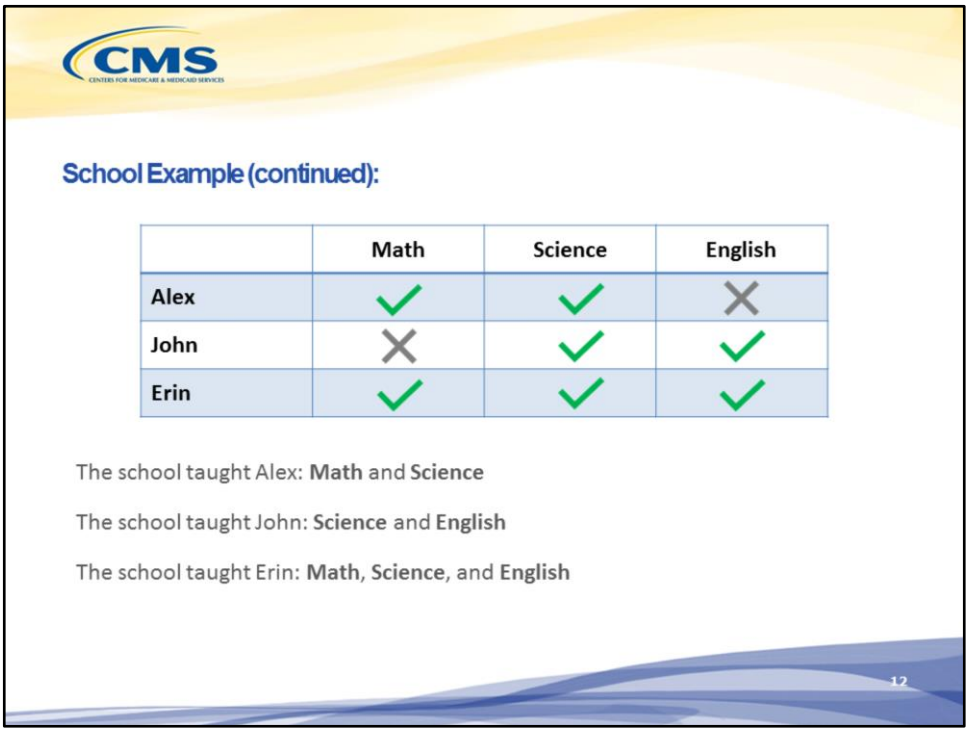


There is an additional implication of the all-or-none criterion that has been a point of confusion for this measure, so I want to call your attention to this important point: this composite measure being an all-or-none measure means that it is possible for your hospice's Comprehensive Assessment Measure score to be lower than your lowest component measure score. A lot of providers find this point confusing because they think of the Comprehensive Assessment Measure as an average-based measure when it is not.

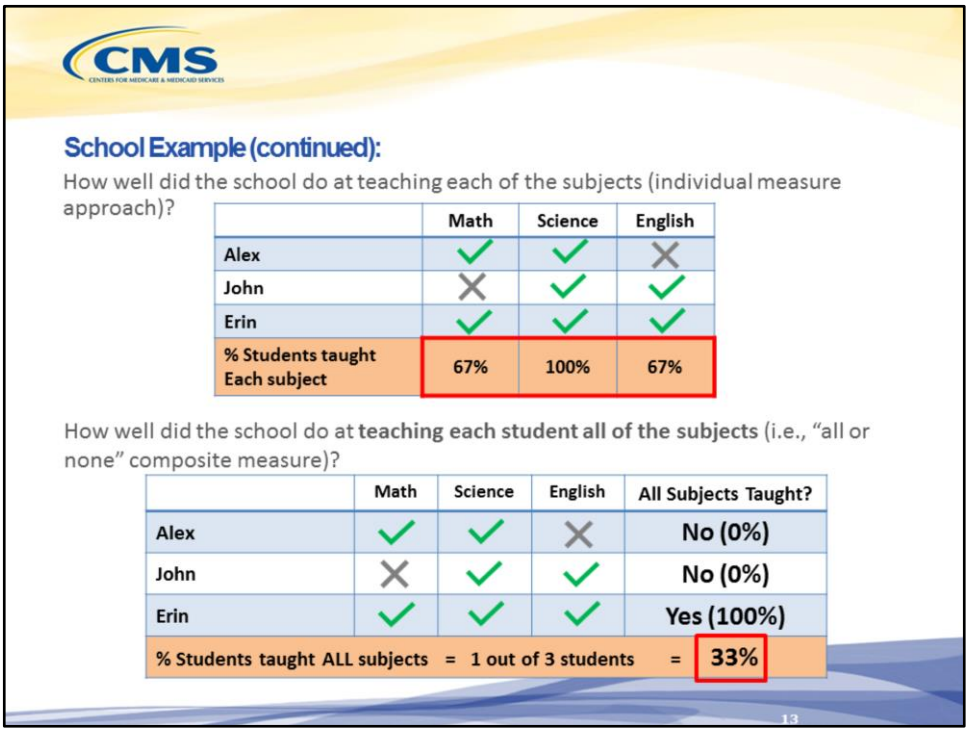
To explain this particular point, we are going to use a simplified example of school performance.



In this simplified example, the school only has three students named Alex, John, and Erin. The school is required to teach its students three subjects which are Math, Science, and English. Next, we are going to take a look to see how well this school performed at teaching Alex, John, and Erin all three subjects.



The school taught Alex two of the three subjects – he learned Math and Science
The school also taught John two of the three subjects – he learned Science and English
And the school taught Erin all three subjects – she learned Math, Science, and English



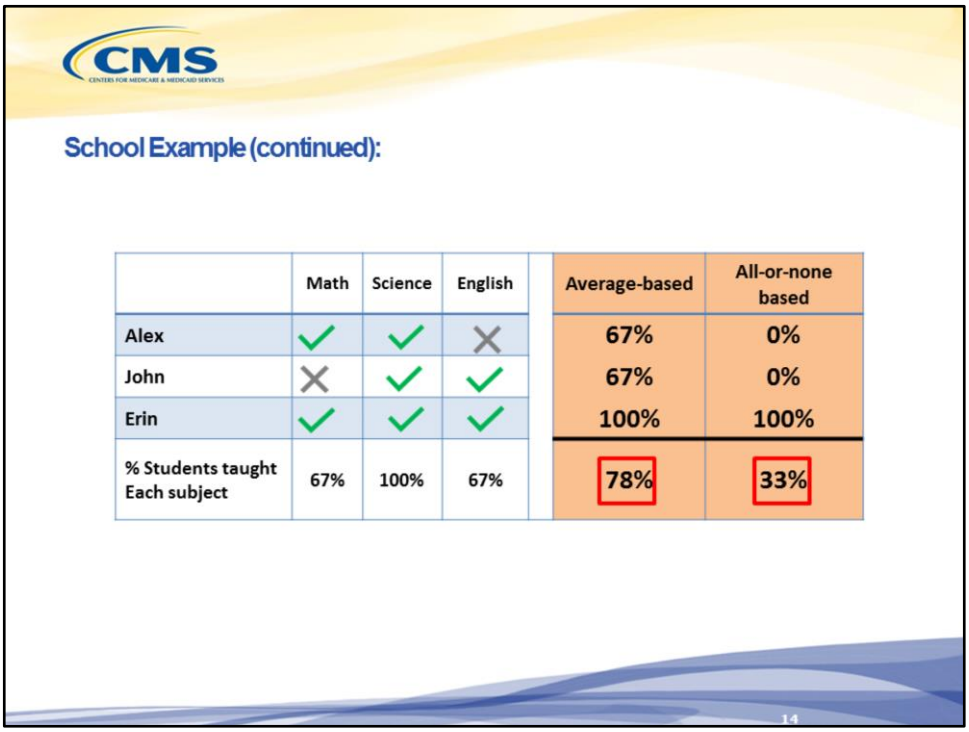
Now we are going to look at the school's performance in two different ways:

The first way is how well the school did at teaching these three students *each* subject. Note that this is the same approach that is used for calculating your scores on the seven HIS component measures.
So how well did the school do at teaching Math? Well, the school taught 2 out of 3 students Math, so that is a 67%
What about Science? The school taught 3 out of 3 students Science, so that is a 100%
And finally English. The school taught 2 out of 3 students English, so that is a 67%.

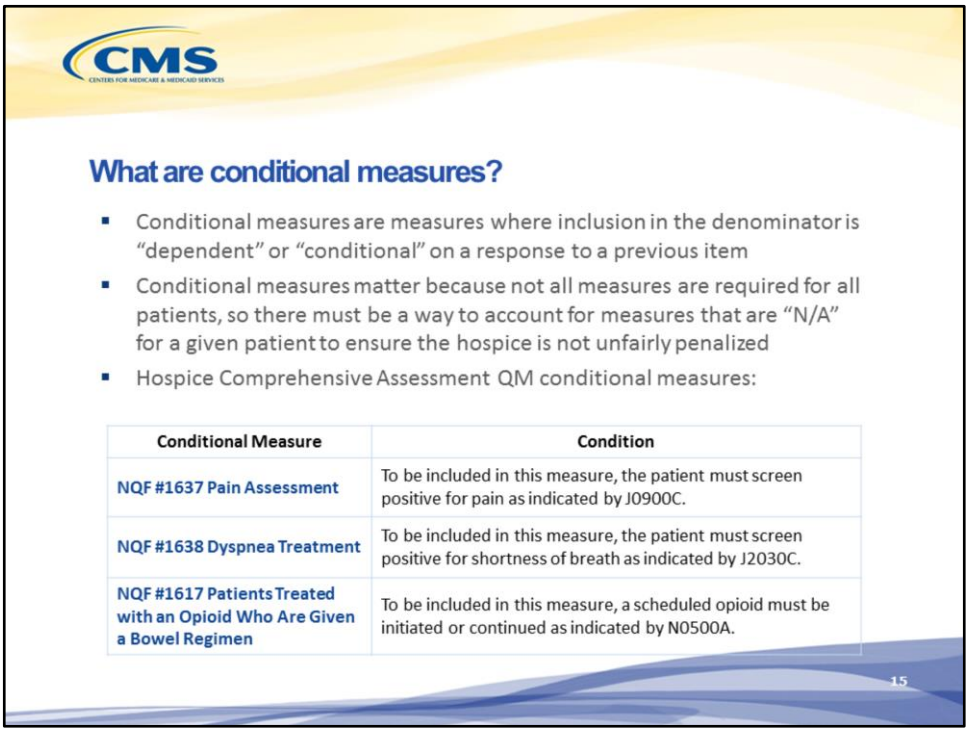
Now, we are going to look at how well the school did at teaching *each* student **all** three subjects. This is where the example is representative of a composite measure because we are looking– in a single measure – at how well the school performed on multiple things. Also, this is an "all or none" composite measure of school performance because we specified that we wanted to know how well the school did at teaching **each** student **all** three subjects.
So how well did the school do? Well, the school only taught one student all three subjects, so that is a 33%.

So the difference is that with the first approach, we are looking at each measure or subject individually and we allow partial credit. The school did not teach math to everyone, but they taught it to 2 out of 3 students, so they get a 67%. In the second table, with an all-or-none approach, there is no partial credit. Instead, we are trying to figure out, for each student, did the school teach all 3 subjects to that student. So, looking at Alex, we see that he was taught 2 out of 3 subjects, but under the all-or-none approach, teaching 2 out of 3 is not enough to receive credit. The school didn't teach all 3, so the school gets 0% for Alex. Each time the school gets a 0% for a student, that brings down the school's overall performance on the measure because we know that 0's quickly bring down overall scores. Thus, we see that the school's final score of 33% is much lower than the school's scores on any one individual subject. The same logic applies to the Hospice composite measure, and if we think about the logic underlying this approach, it makes sense. Although we are holding the school to high bar for performance with this all-or-none approach, the school *should* be responsible for teaching students all three subjects. So taking this back to the HQRP, for the Hospice Comprehensive Assessment measure, the hospice must perform *all* seven care processes as applicable for a patient in order to receive credit for that patient.

Before we move on from this example, lets look at the school's performance in one other way.



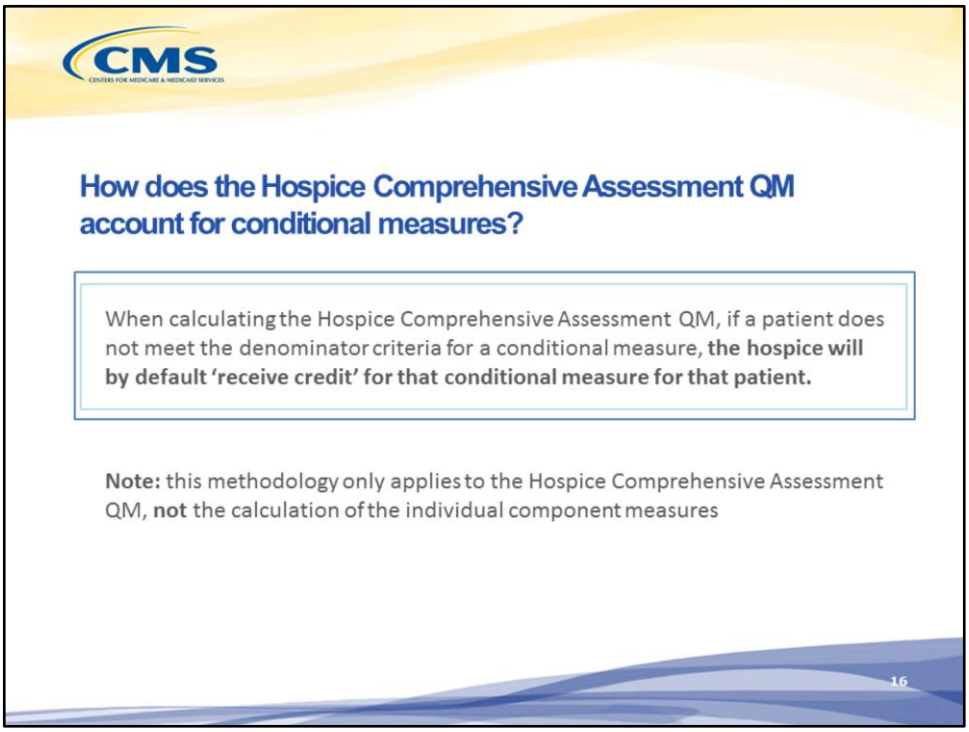
Slide 13 emphasizes what we just went over, but in a slightly different way. Slide 13 compares how you would calculate a composite score under an all-or-none approach versus an average-based approach. The first orange column walks through what would happen under an average-based composite approach. With an average approach, the school would get credit for what they did teach – giving the school 67% for Alex and John and 100% for Erin. If we average across those scores, they school doesn't do great, but they do okay – they get a 78%. The all or none approach is much stricter because it gives no partial credit. Alex was taught 2 out of 3 subjects, but since that wasn't all 3, the school does not get **any** credit for Alex. You can see here that the main difference between the composite and average approach is that for the all-or-none approach, there are only 2 "scores" that the school can get for any one student – either 0% or 100%. And as discussed on the previous slide, 0's quickly bring down your score. Here we see that the school got two 0's and only one 100%. This means that the overall score is 33% which is much lower than if we had used an average-based approach. Similarly, for the Hospice Comprehensive Assessment measure, the hospice must perform *all* seven care processes as applicable for a patient in order to receive credit for that patient. There is no partial credit for performing most of the care processes, but instead the hospice either gets a 0% or a 100% for each patient depending on whether the hospice performed all seven care processes as applicable.



So we've talked a lot thus far about the all or none approach the composite measure takes and the implications of that. I'd like to turn now to discussing another detail of the Hospice Comprehensive Assessment measure methodology: conditional measures. Of the seven component measures that make up the Hospice Comprehensive Assessment measure, three of them are we call conditional measures. You can see the conditional measures listed in the table on this slide. Conditional measures are measures where inclusion in the denominator is dependent, or conditional, on a response to a previous item.

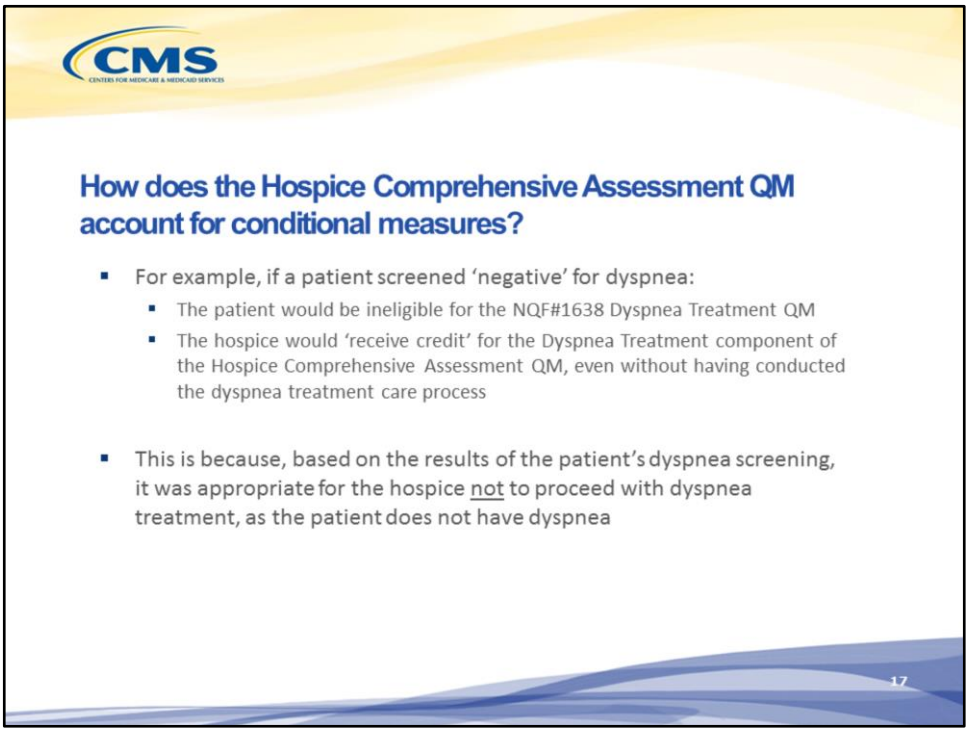
For example, for a patient to be included in the denominator of the Dyspnea Treatment Measure, the patient must have screened positive for dyspnea. This is because the hospice would not initiate treatment for shortness of breath unless the patient was actually short of breath. Along these same lines, for a patient to be included in the Pain Assessment measure, the patient must first screen positive for pain. Finally, for a patient to be included in the denominator of the Patients Treated with an Opioid Who Are Given a Bowel Regimen measure, the patient must be taking a scheduled opioid.

So how do these conditional component measures get treated in the composite measure?

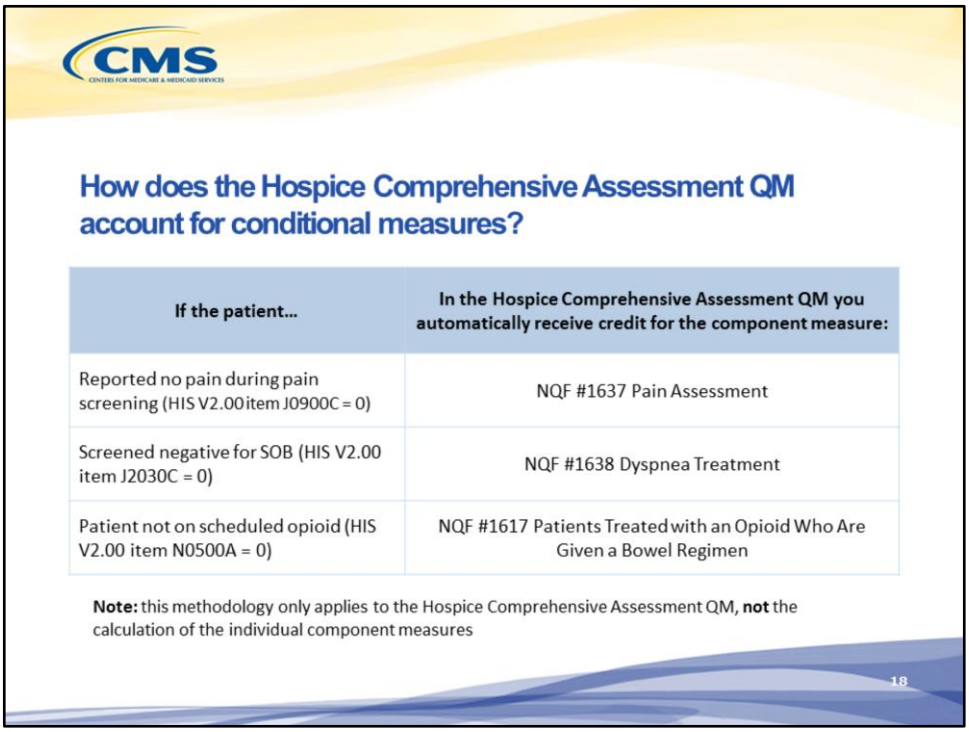


Well the Hospice Comprehensive Assessment measure treats conditional measures differently in that when the composite measure is calculated, the hospice will by default "receive credit" for conditional measures when the patient does not meet the denominator criteria for that conditional measure. Note that this methodology of receiving credit for conditional measures when the patient does not meet the denominator criteria only applies to the calculation of the Hospice Comprehensive Assessment Measure – NOT the calculation of the individual component measures.

This might still sound a bit confusing, so let's talk about what this looks like with a brief example.

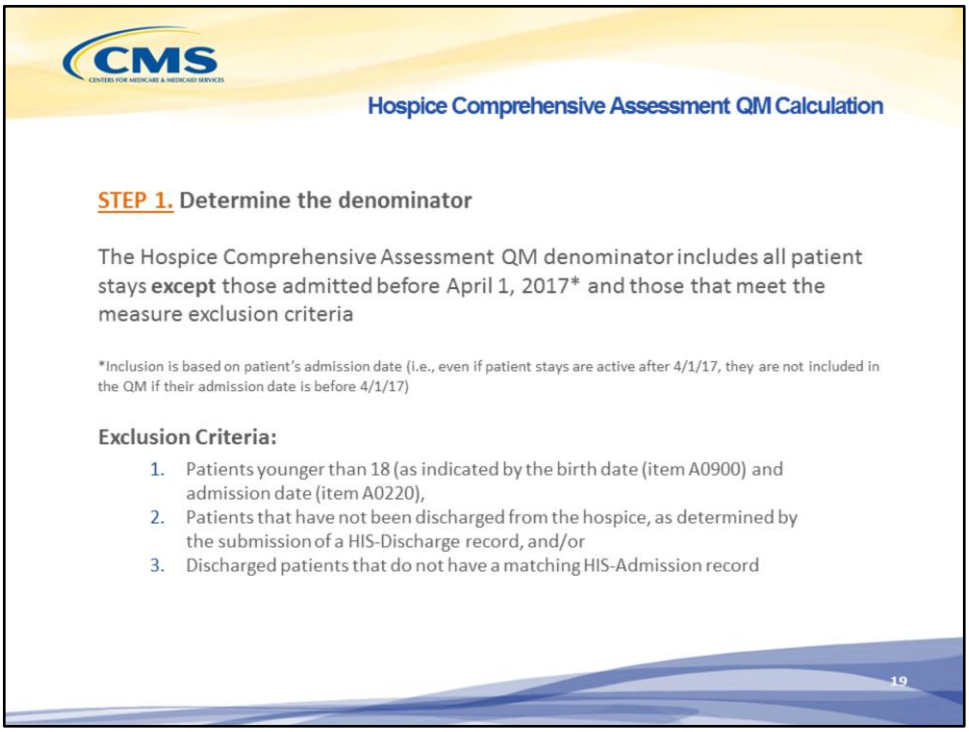


If a patient screened negative for dyspnea, then that patient would be ineligible for the denominator of the Dyspnea Treatment Quality Measure (or in other words that patient would be considered neutral for the dyspnea treatment QM – meaning the hospice would not receive credit for that patient, and the hospice would not be penalized for that patient). Now when it comes to calculating the composite measure, these conditional measures are treated differently. Instead, if a patient screened negative for dyspnea, the hospice would receive credit for the Dyspnea Treatment component of the composite measure. This means that if a patient screens negative for dyspnea, that patient will not count toward the Dyspnea Treatment measure score, but the hospice will receive credit for that patient when calculating the composite score.



Looking across all three conditional measures, if a patient reports that they do not have pain during their pain screening, then when calculating the Hospice Comprehensive Assessment Measure score, your hospice will automatically receive credit for this patient. Similarly, if a patient is not on a scheduled opioid, then your hospice will receive credit for NQF #1617 when calculating the composite measure score.

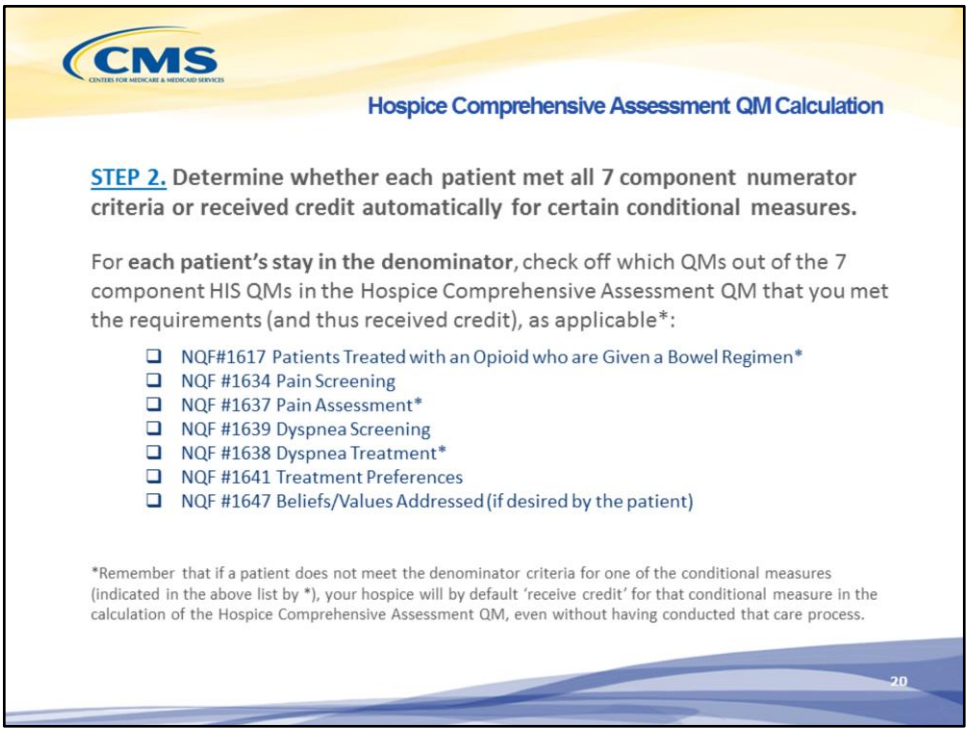
And as a reminder, this methodology of counting patients that do not qualify for conditional measures toward the composite measure score **only** applies to the calculation of the composite measure – so patients will continue to not count toward the individual component QM scores when they do not meet the denominator criteria.



Now we are going to walk through the steps for calculating this composite measure.

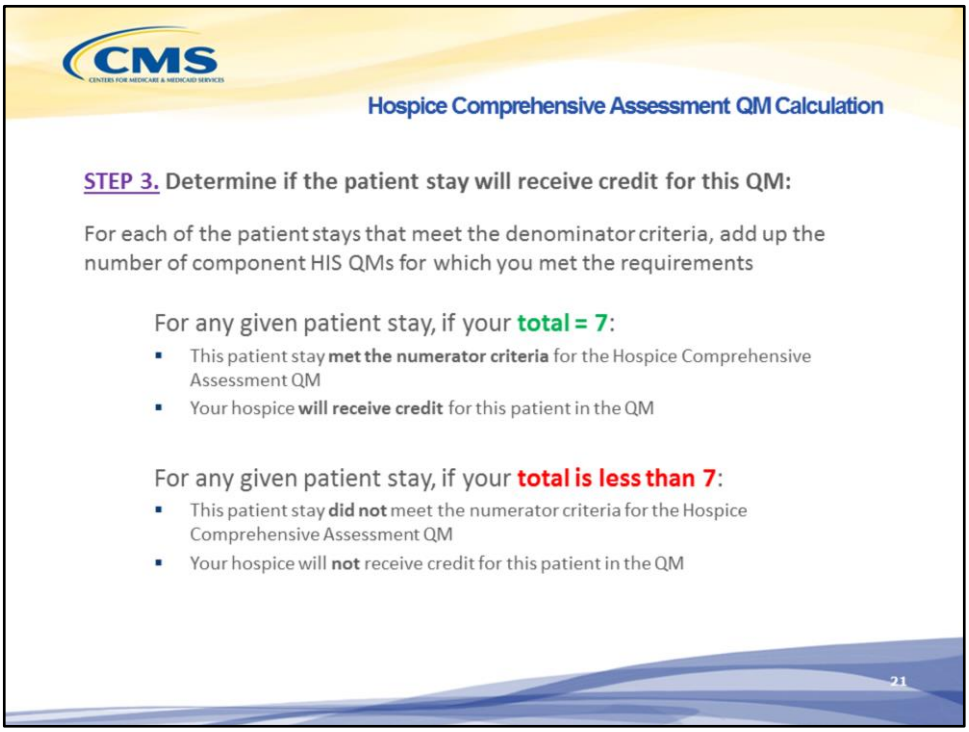
Step 1 is to identify the patients that are eligible for inclusion in the measure denominator. All patients are eligible for inclusion in this measure unless they were admitted before April 1, 2017 or if they meet any of the exclusion criteria. You may be wondering why patients need to be admitted after April 1, 2017 to be included in this measure. Well, you might remember that at the beginning of this training, we mentioned that the composite measure was implemented in the HQRP on April 1, 2017. This is why patients must be admitted after April 1, 2017 to be included in the composite measure. Note that patients admitted prior to April 1, 2017 will continue to be eligible for the seven component HIS measures.

So patients admitted before April 1, 2017 are not eligible and patients that meet any of the exclusion criteria listed at the bottom of the slide are also not eligible. These exclusion criteria are that patients younger than 18, patients that have not been discharged, and patients that are missing their HIS-Admission record are ineligible for inclusion in this measure.

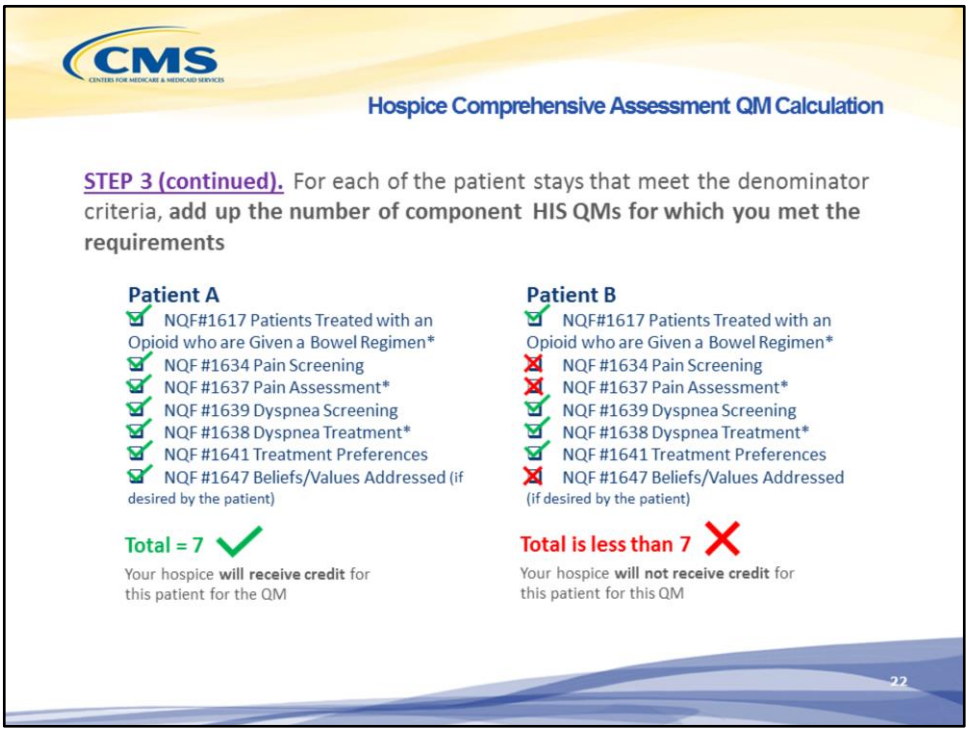


Once you have identified the patients that are eligible for the measure denominator, step 2 is to identify whether your hospice met the requirements for each of the seven HIS component measures for each of these patients as applicable. And the reason that we say "as applicable," is because of the conditional measures that we just went over. Remember, for the purposes of calculating the composite measure, if a patient does not met the denominator criteria for one of the conditional measures, your hospice will by default "receive credit" for that conditional measure.

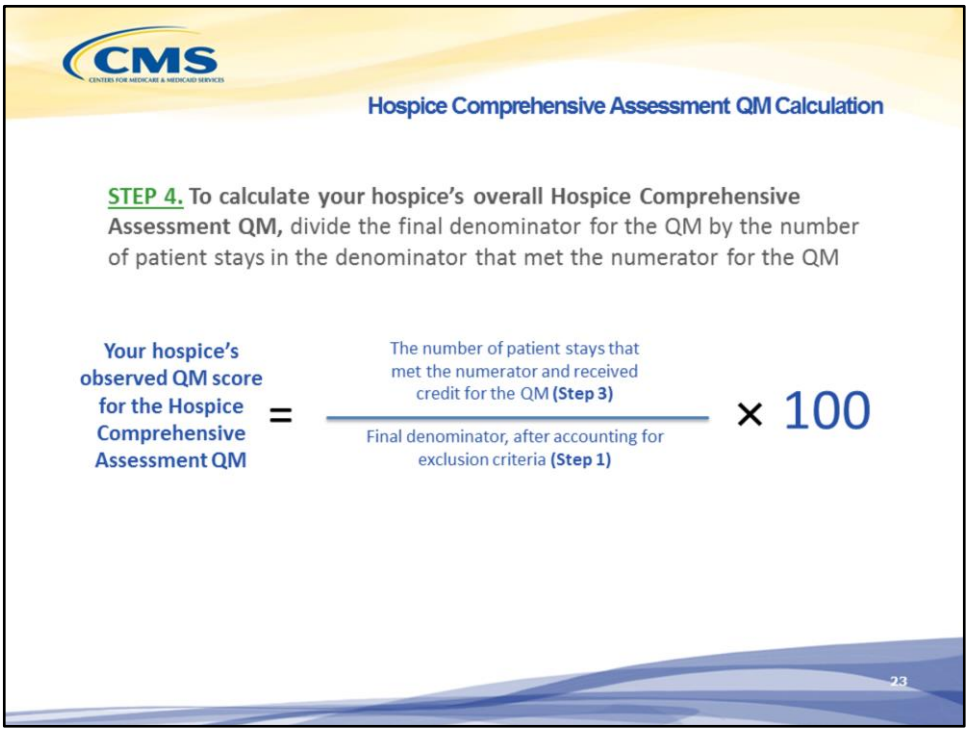
For example, if a patient screened negative for dyspnea and is thus not eligible for the Dyspnea Treatment QM (NQF #1638), for the purposes of calculating the composite measure, mark that your hospice met the requirements for the Dyspnea Treatment QM.



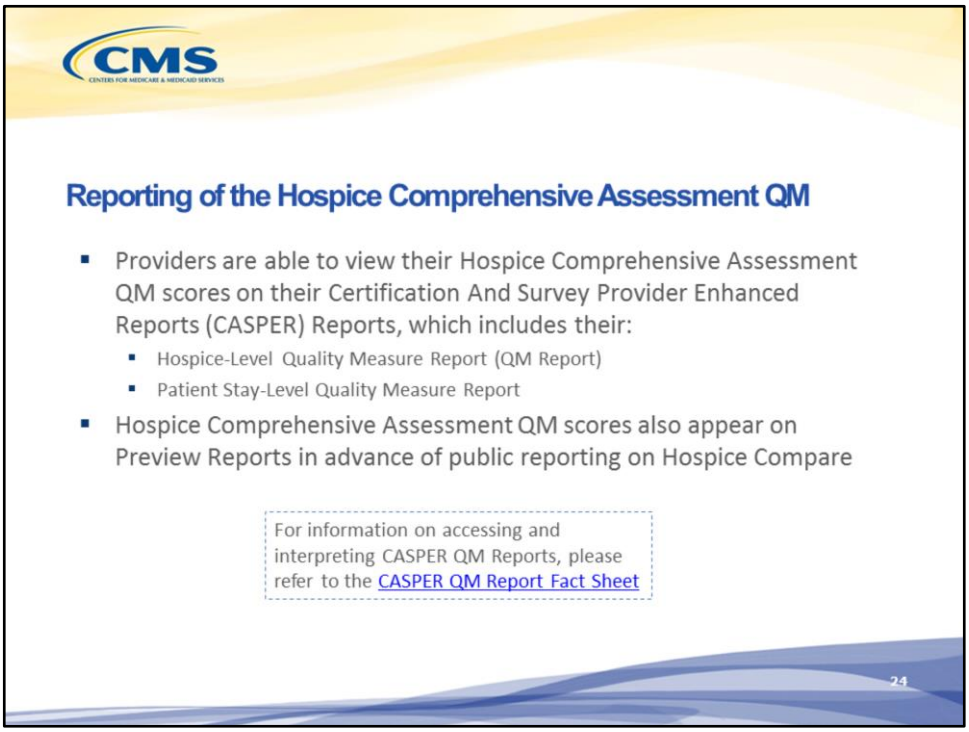
Next, for each patient that qualifies for the denominator, you should add up the number of HIS component measures for which your hospice met the requirements. Remember that this is an all-or-none measure, and this means that you must receive credit for all seven measures, as applicable, to receive credit for this measure.



So once you add up the number of component QMs that you received credit for, if this number equals 7, then that patient qualifies for the numerator for the composite measure and your hospice will receive credit for that patient for this measure. If the number is less than 7, then that patient does not qualify for the numerator for the composite measure, and your hospice will not receive credit for that patient for this measure

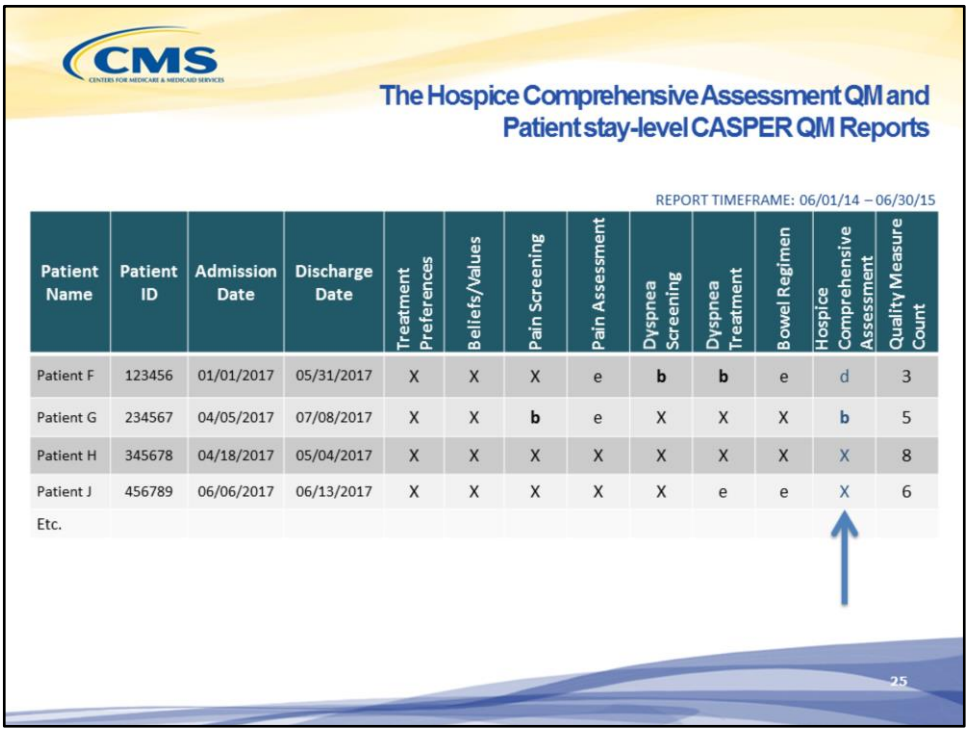


Finally, to calculate your hospice's score on the Hospice Comprehensive Assessment Measure, you need divide the number of patient stays that met the numerator criteria by the number patients that met the denominator criteria and multiply by 100.

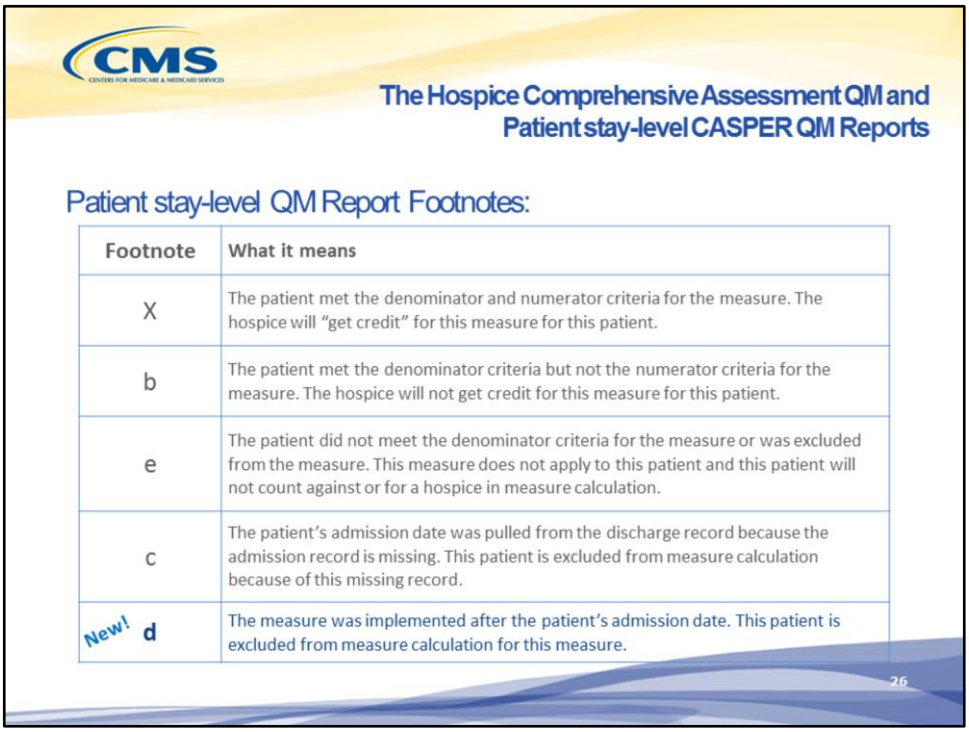


Now that we've talked about how the composite measure is calculated, next we want to talk about the different resources that are available to providers to review and monitor their hospice's scores on the Hospice Comprehensive Assessment measure. Providers can use their CASPER Reports, including the Hospice-Level and Patient-Stay Level QM Reports to monitor their hospice's performance on the composite measure. CASPER Reports can be run on-demand and they enable hospice providers to view and compare their performance to the national average for a reporting period of their choice. For more information on the CASPER QM Reports, we refer readers to the CASPER QM Fact Sheet that is linked at the bottom of this slide. Additionally, providers are able to view their Hospice Comprehensive Assessment Measure scores on their Preview Reports in advance of public reporting on Hospice Compare. Note that this measure was added to Hospice Compare with the November 2018 refresh.

Next, we are going to walk through some examples of how providers can use their CASPER QM reports to understand their hospice's performance on the Hospice Comprehensive Assessment measure.



Let's look at this example of a patient stay-level CASPER QM report. You can see that we have four sample patients listed in the first column. Across the top, you can see each of the seven HIS component measures and the Hospice Comprehensive Assessment Measure. The Hospice Comprehensive Assessment measure is indicated by the arrow. Before we dive into this example, let's go over a quick refresher of what all of these different letters mean.



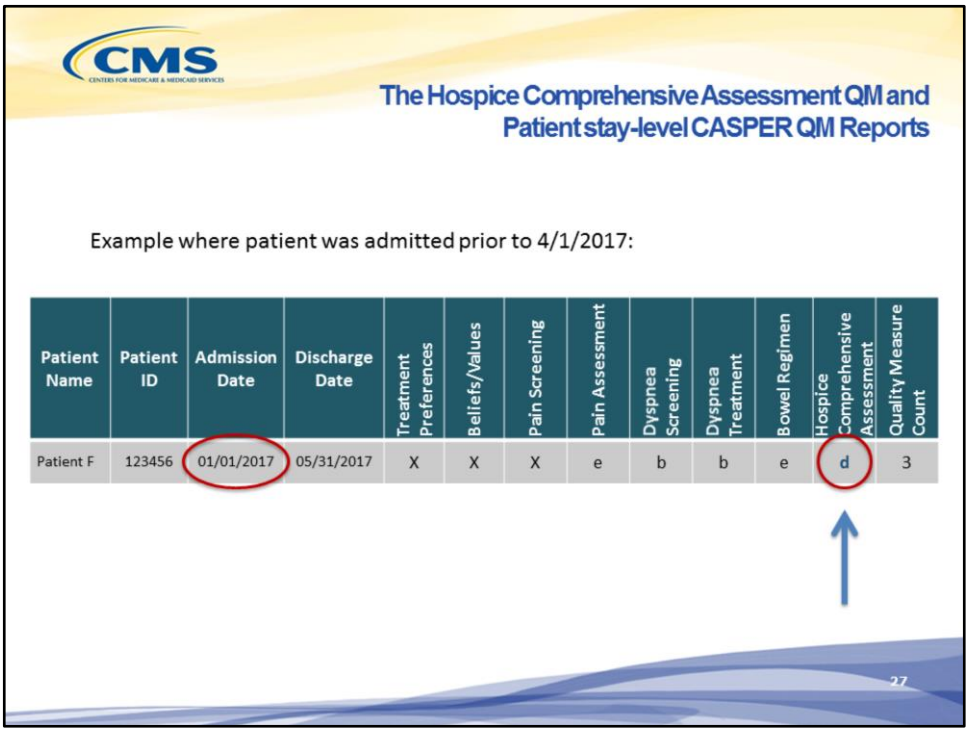
An X means that the hospice has received credit for a patient on a particular quality measure – x's are good things and we like to recommend that you remember them by thinking "x marks the spot"

In contrast, B means the hospice did not receive credit for a patient on a particular quality measure – to remember this, we recommend that you think of "b's" as "bad"

An E means that the patient was excluded from the denominator, which means the patient was not included in the measure – these patients are considered "neutral" from a performance perspective.

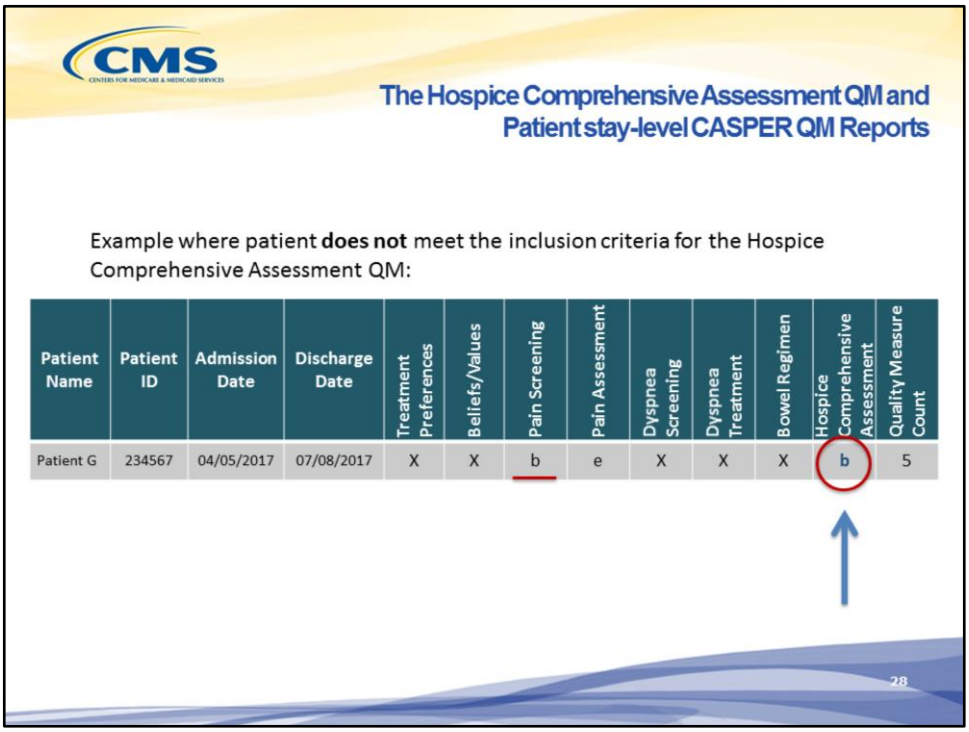
A C in the admission date column means that the HIS-Admission record is missing for that particular patient and that the provider should submit the HIS-Admission record as soon as possible so that the patient can be included in future quality measure calculations.

Finally, a D might be a footnote that providers are not used to seeing. This is a newer footnote in the hospice setting and it means that the measure was implemented after the patient's admission date. You might remember that earlier we said that the Hospice Comprehensive Assessment Measure was implemented in the HQRP on April 1, 2017 and that patients admitted to hospice before this implementation date are not eligible for this composite measure. So this means that if you have a patient that was admitted before April 1, 2017, then you will see a "d" for them under the composite measure on your patient-level CASPER QM report. These patients will still be eligible for the seven component HIS measures.

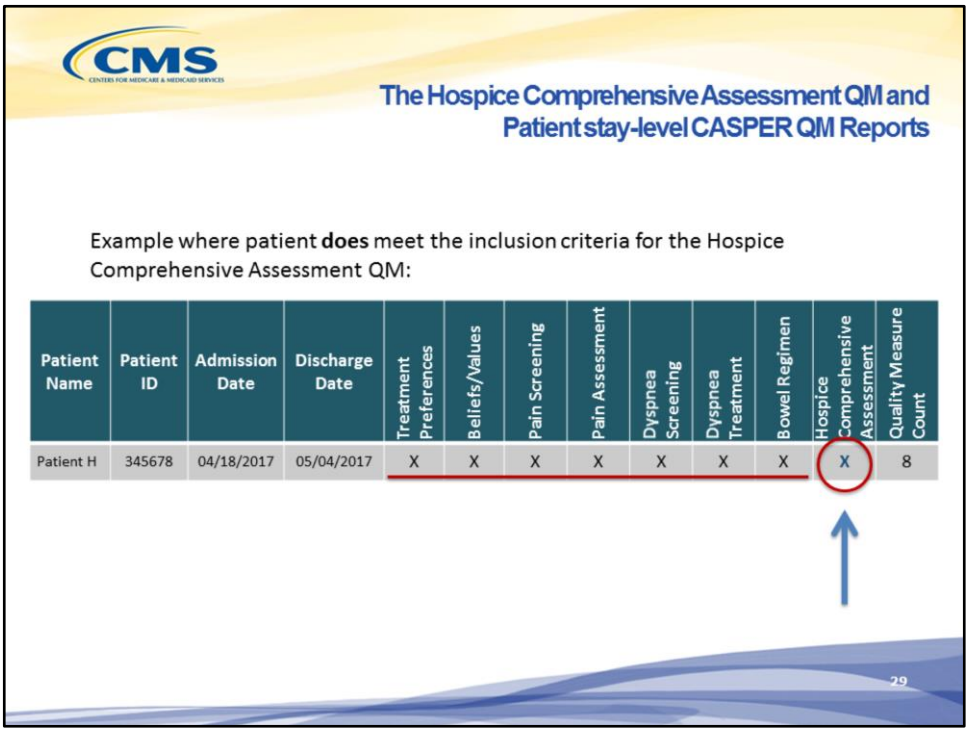


Moving back to our example patient stay-level CASPER QM Report, if you look at the red circle under the patient admission date column, you can see that Patient F was admitted on January 1, 2017. Because this patient was admitted prior to the April 1, 2017, this patient is not included in the measure calculation for the composite measure. This is why there is a "d" under the Hospice Comprehensive Assessment measure column.

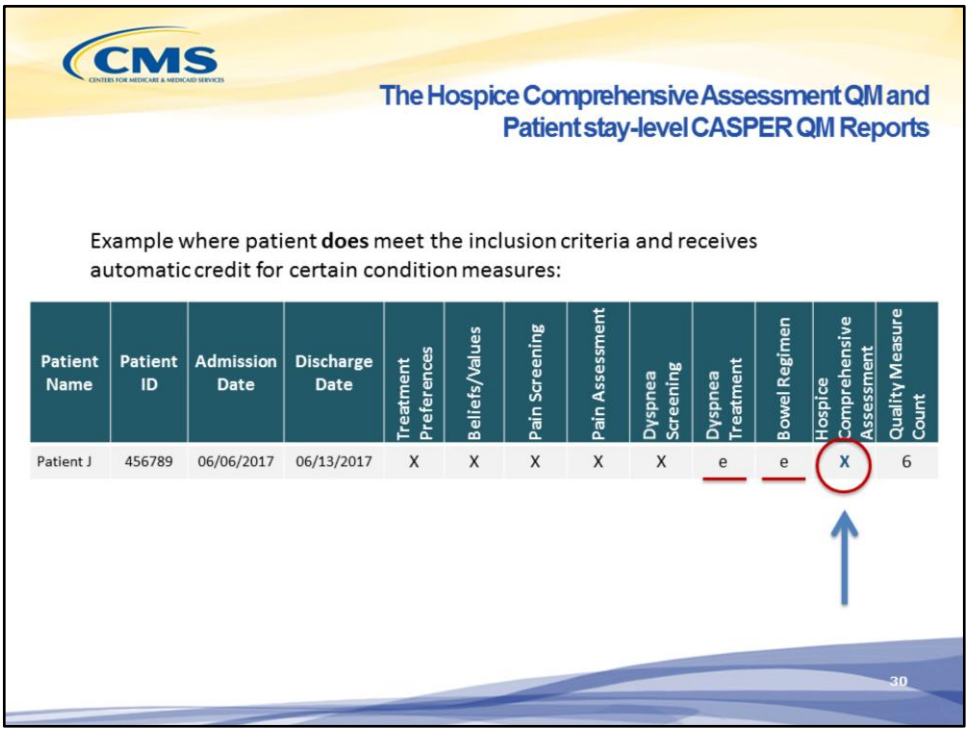
I like to remember what the "d" means by remembering "d means date." This footnote will display when a patient's admission date was prior to the implementation date of the measure.



Let's look at patient G next. You can see that Patient G has a "b" under the composite measure column. Remember, "B means bad", so the hospice did not receive credit for this patient on the composite measure. If we want to know why, then we can look across the row at the hospice's performance on the other seven HIS component measures. For Patient G, we can see that the hospice also has a "B" under the Pain Screening, which means that the hospice did not complete a pain screening for patient G. Since the pain screening is not a conditional measure and the hospice did not complete this care process, this hospice will not receive credit on the composite measure—remember that the way the composite measure is calculated, you must do all seven care processes for the patient as applicable to receive credit.

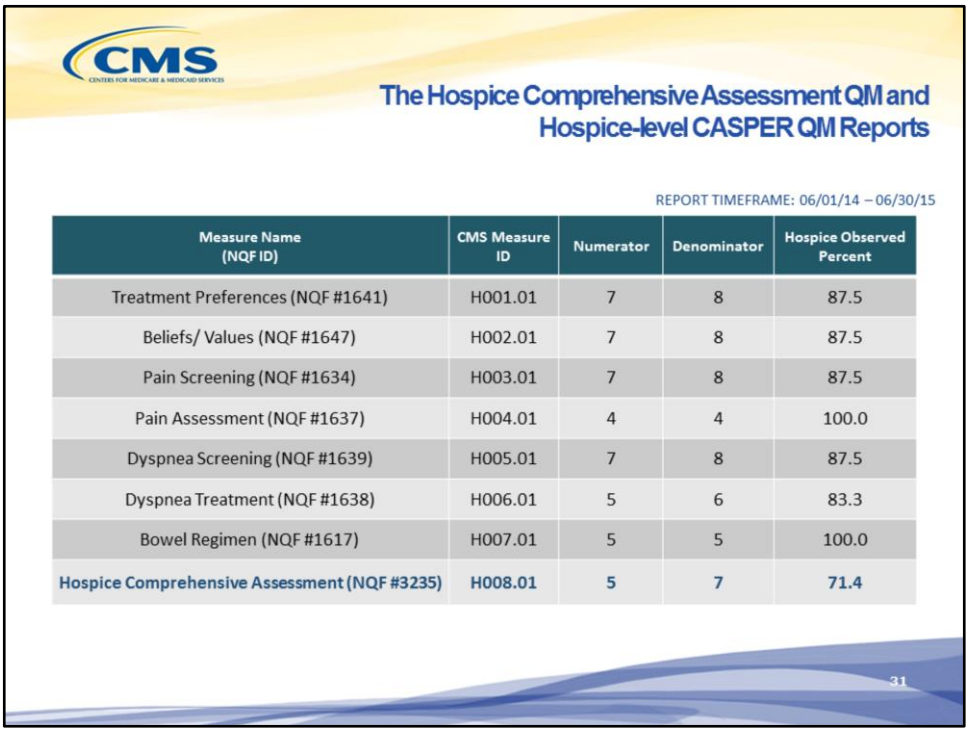


Let's look at the hospice's performance for Patient H. There is an X for all seven HIS component measures for Patient H, and since X marks the spot on treasure maps, this is a good thing – it means the hospice received credit for this patient on these component measures. You can also see that since the hospice successfully completed all seven care processes for Patient X, this hospice received credit for this patient for the composite measure.

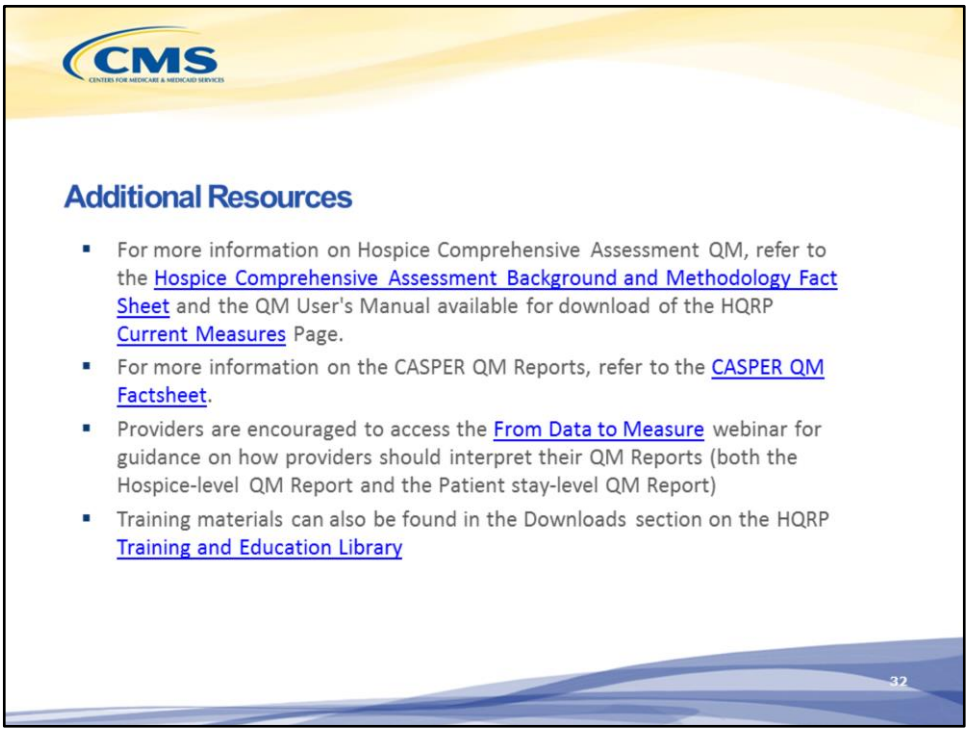


Now we are going to take a look at patient J. In the second to last column, you can see that there is an "x" which indicates that the hospice received credit for Patient J for the composite measure. Looking across at the other seven component measures, you can see that the hospice also received credit for the first five measures. Then, there is an "e" under the dyspnea treatment and bowel regimen columns. The "e" means that the patient was not eligible for inclusion in the measure denominator – probably because the patient screened negative for dyspnea and the patient was not taking a scheduled opioid. However, as we mentioned, to get credit for the composite measure, the hospice must complete all seven HIS care processes **as applicable**. And the reason that we say as applicable is because 3 of the 7 measures are conditional measures – meaning inclusion in the denominator is dependent or conditional on a response to a previous item. Patient J is excluded from the dyspnea treatment and bowel regimen measures and because these are conditional measures, the hospice still receives credit for the Comprehensive Assessment Measure.

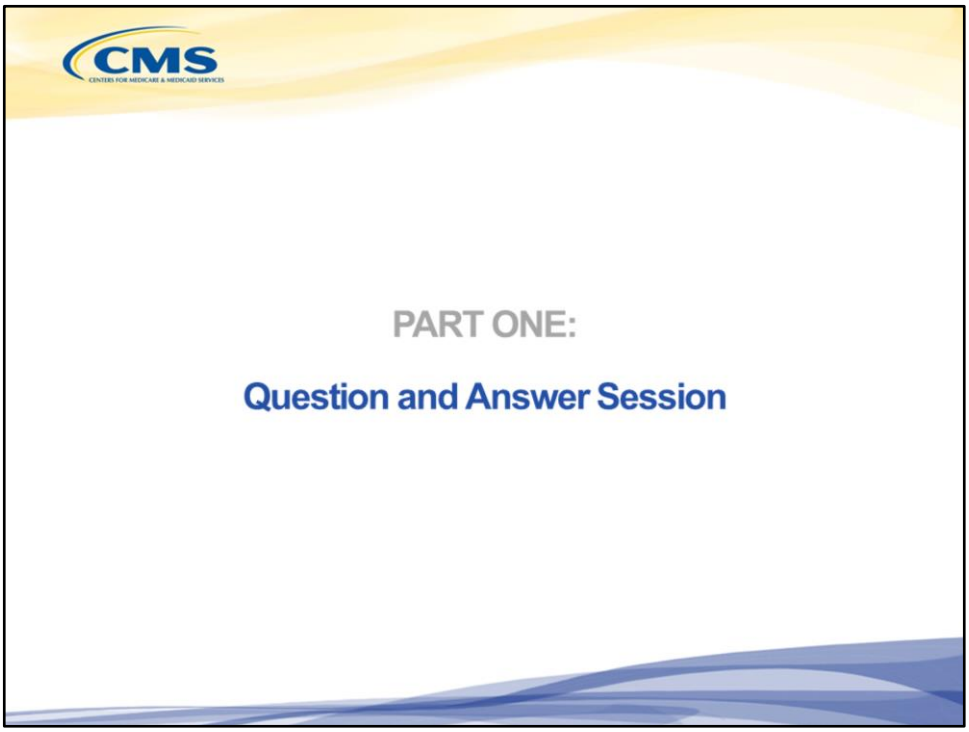
Now that we have reviewed how to interpret the patient stay-level CASPER QM reports, let's take a look at the hospice-level QM report.



Here we are looking at a simplified version of a hospice-level CASPER QM Report. Looking at the bottom row of the table, you can see that for the Hospice Comprehensive Assessment Measure, this sample hospice had 5 patients meet the numerator criteria out of a total 7 patients included in the denominator, leading to a measure score of 71.4%. Looking down the last column of this table, you can see the hospice's performance on each of the 7 component HIS measures. You might notice that out of this column, the Hospice Comprehensive Assessment Measure score is the lowest performance score for this hospice – so the hospice's score on the composite measure is lower than the hospice's lowest component score. Remember that earlier when we went over the school example during slides 10-13, we explained that this is possible because of the higher bar that is set by the "all or none" scoring approach of the measure.



As we are wrapping up Part 1 of this presentation, on slide 33 you can find some additional resources related to the Hospice Comprehensive Assessment Measure.



We will now pause for a brief, 10 minute Q&A session with our CMS experts to cover questions on Part 1 of our presentation – the Hospice Comprehensive Assessment Measure. Note that we will have a second Q&A session at the end of Part 2 of this webinar.

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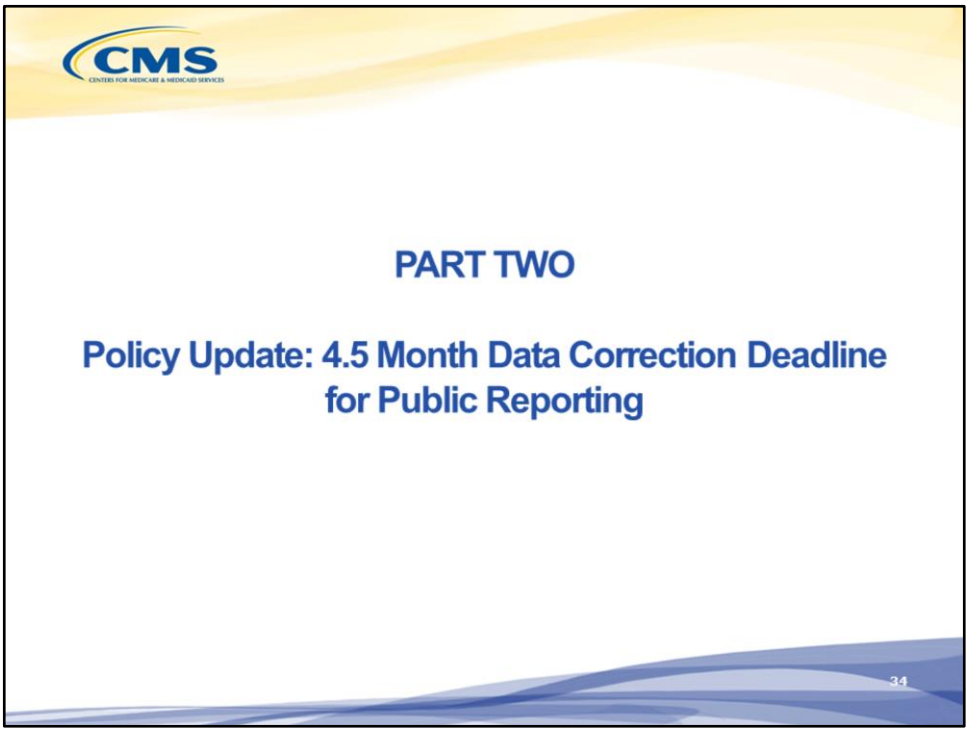
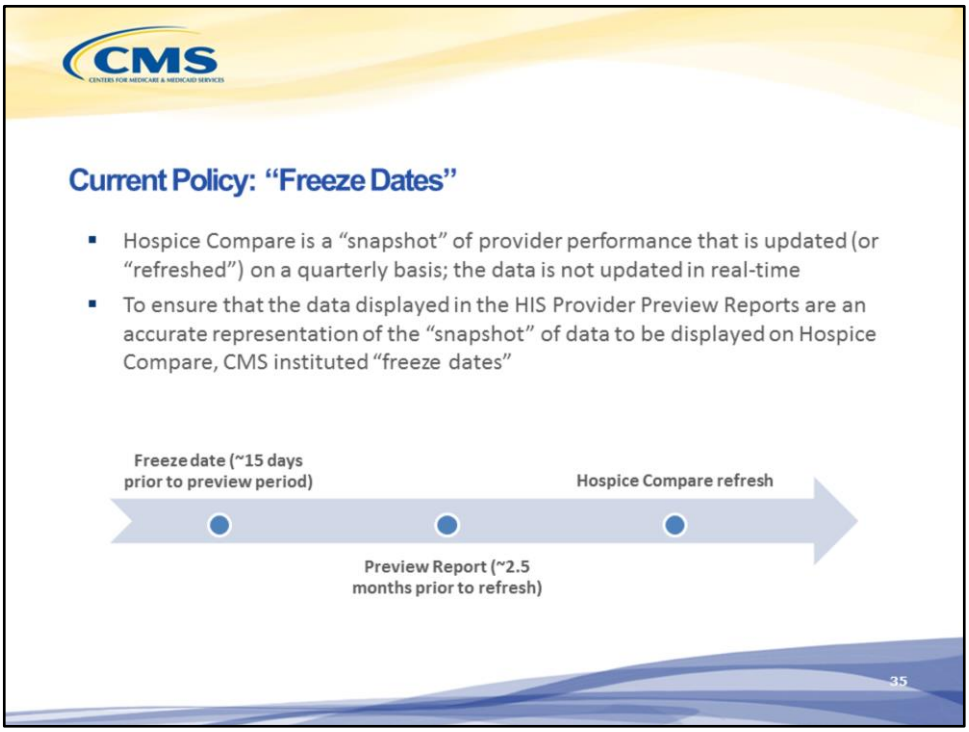
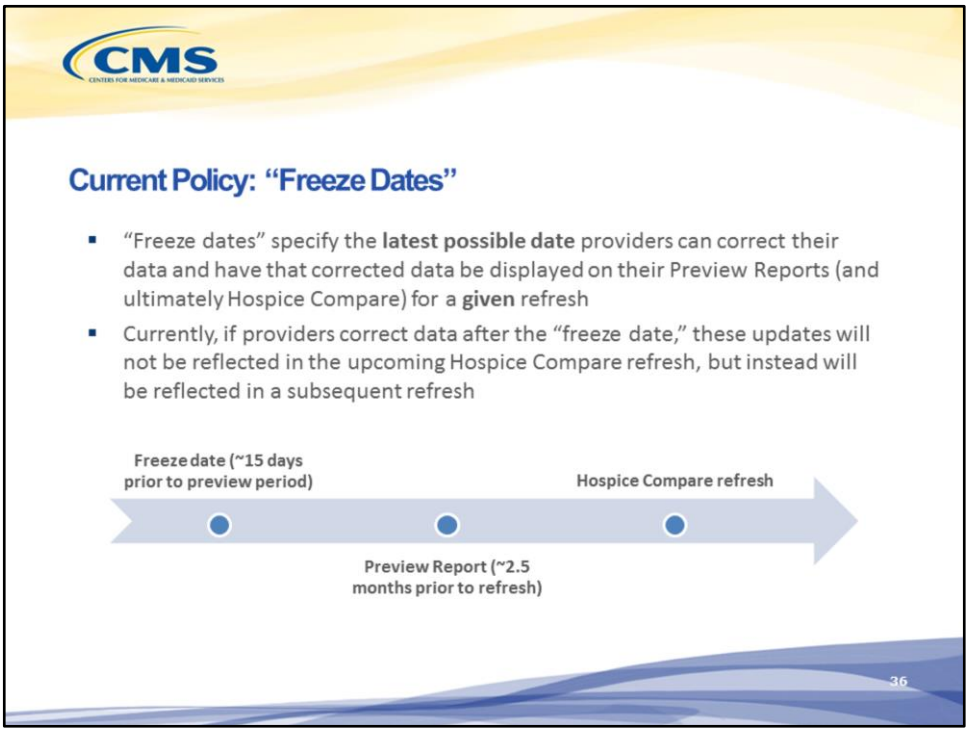
Thank you for your questions regarding the Hospice Comprehensive Assessment Measure. As a reminder, we will have a second Q&A session at the end of Part 2 of this webinar, and if you have any unanswered questions about the Composite measure, you can ask them during this time. Next, I'm going to turn it over to Liz to discuss Part 2 of this training.



Thank you. Next, we are moving into Part 2 of this presentation where we will be reviewing the new 4.5 month data correction deadline for public reporting policy. This policy was finalized in the FY 2019 Hospice Final Rule.

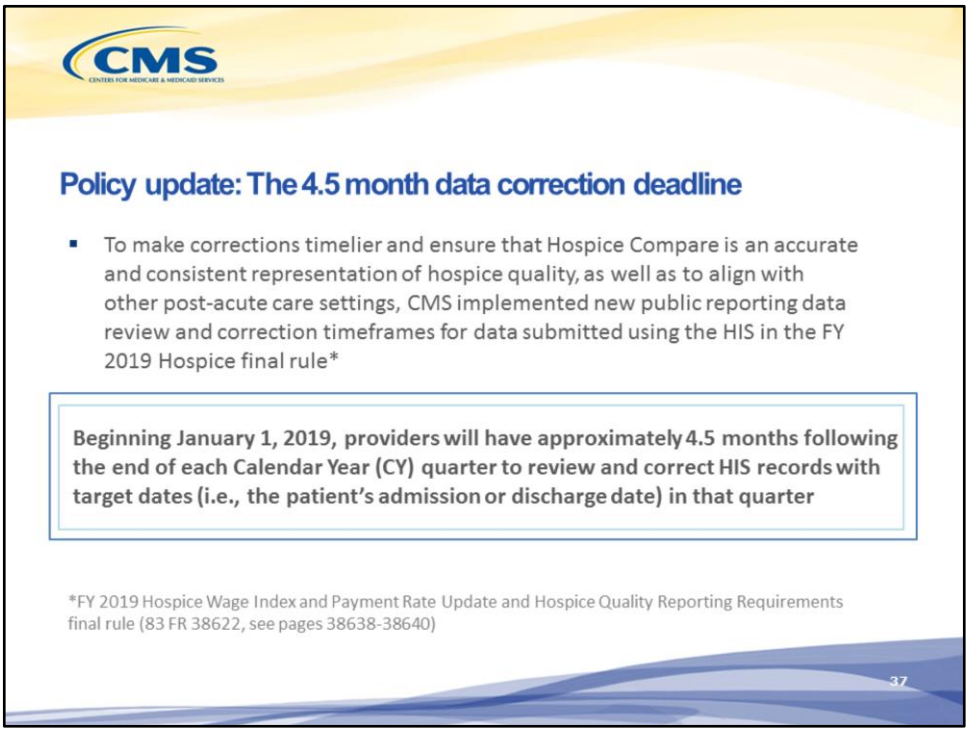


First, lets start out with an overview of the current process for updating data for Hospice Compare as of December 2018. Hospice Compare only shows a snapshot of data, meaning that the data on Hospice Compare is not updated in real-time. Instead, the data on Hospice Compare is updated on a quarterly basis. Prior to the Hospice Compare refresh, providers receive Preview Reports about 2.5 months before the Hospice Compare refresh. These reports allow providers to preview what their QM scores are going to look like on Hospice Compare following the upcoming refresh. However, to ensure that the data that are displayed in the HIS Preview Reports are an accurate representation of the snapshot of data that are going to be displayed on Hospice Compare, CMS instituted "freeze dates" which occur about 15 days before the preview period begins.



As a reminder, freeze dates are the latest possible date that providers can correct their data and have that corrected data display on Hospice Compare for a given refresh. If providers correct their data after the freeze date, then the corrected data will not be displayed on Hospice Compare until the following refresh.

This is how things currently work as of December, 2018. However, starting next month in January, 2019, this process will be changing.

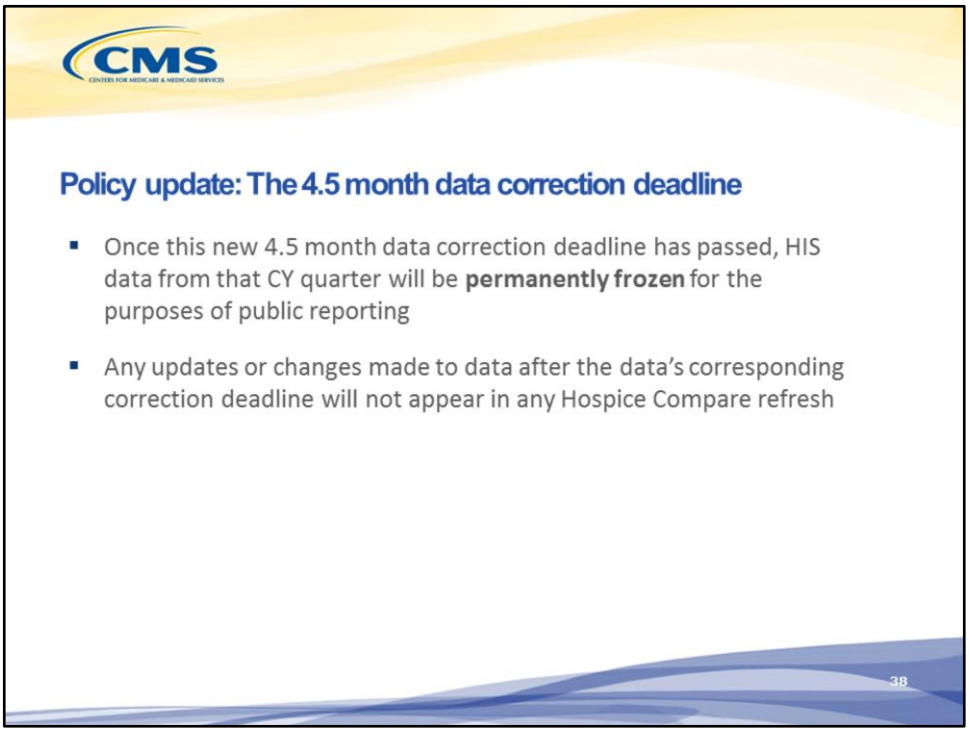


As we mentioned before, with the old policy, providers could correct data after a "freeze date," but those corrections would only influence the data displayed on the following Hospice Compare refresh, not the upcoming refresh. However, to align with other care settings as well as make data corrections more timely and ensure that Hospice Compare is displaying a *consistent* representation of a hospice's quality, CMS finalized the new 4.5 month data correction deadline for public reporting in the FY 2019 Hospice Final Rule.

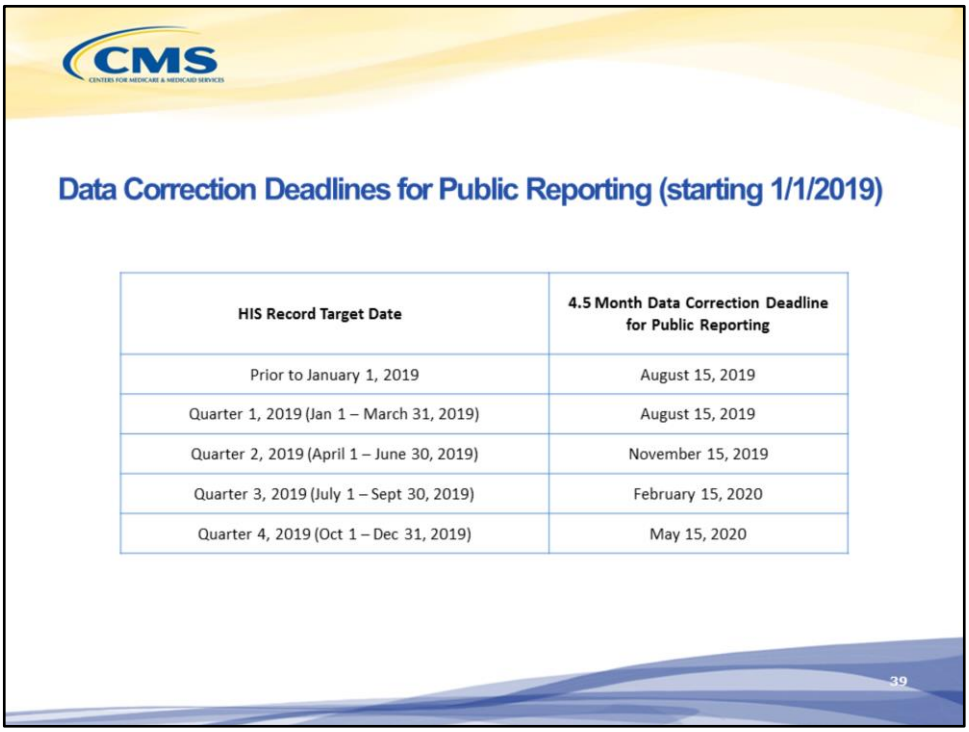
With this new policy, providers will now have approximately 4.5 months after the end of each calendar year quarter to review and correct their HIS data with target dates in that quarter. As a reminder, target dates refer to the patient's admission or discharge date. So this means that if your patient was admitted or discharged in a particular quarter, then your hospice will have approximately 4.5 months after the end of that calendar year quarter to review and correct that data if necessary.

So how does this new policy compare with the old freeze date policy? Well, freeze dates are cyclical and they occur about 3 months before a Hospice Compare refresh. If you missed one freeze date, then you could correct data before the following freeze date and that corrected data would then be displayed with the following Hospice Compare refresh. In comparison, the 4.5 month data correction deadline will create a hard cutoff. Any data corrections that occur after the 4.5 month data correction deadline passes will **not** be reflected on **any** future Hospice Compare refreshes.

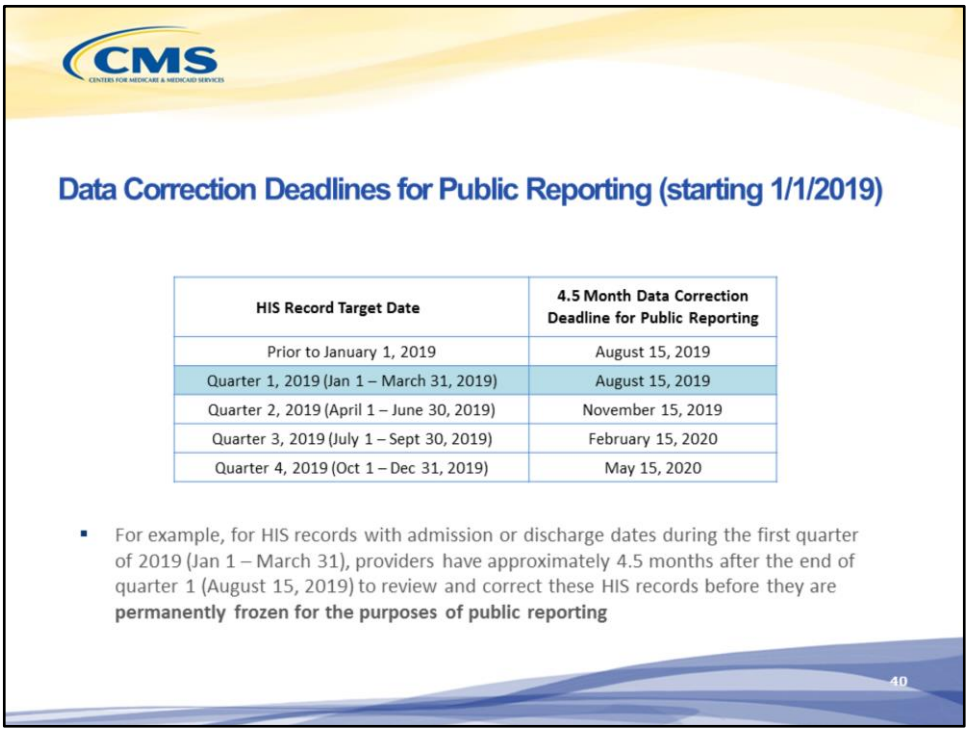
This new data correction deadline for public reporting will go into effect starting January 1, 2019.



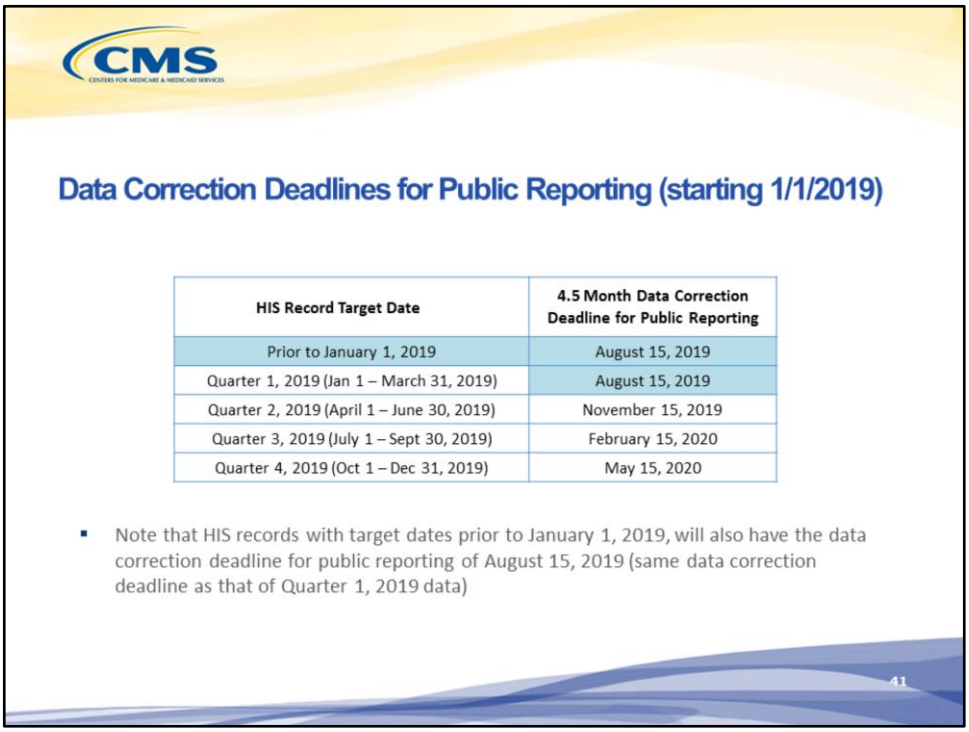
So one of the big differences between the old freeze date policy and the new 4.5 month data correction deadline policy is that with the new policy, any corrections made to data after the 4.5 month deadline will not be reflected on Hospice Compare. Or, in other words, your data will be permanently frozen for the purposes of public reporting after the 4.5 month deadline has passed.



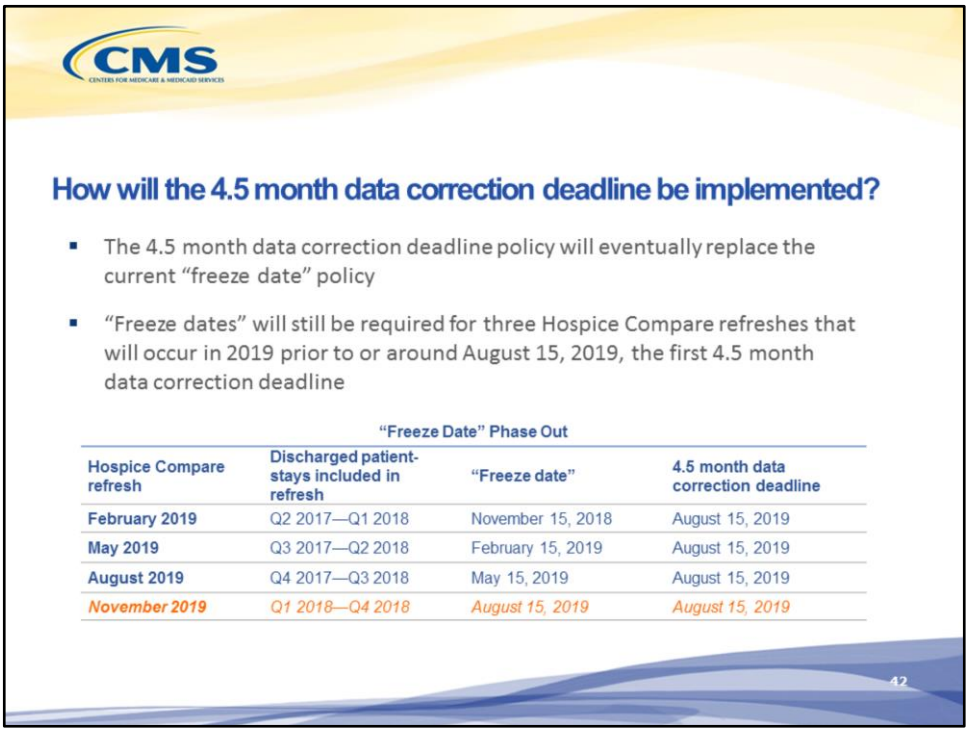
This table displays what the 4.5 month data correction deadlines will look like starting in January 2019. So quarter 1 refers to January through March, Quarter 2 refers to April through June, Quarter 3 refers to July through September, and Quarter 4 refers to October through December. Let's look at an example of how this new deadline is going to work.



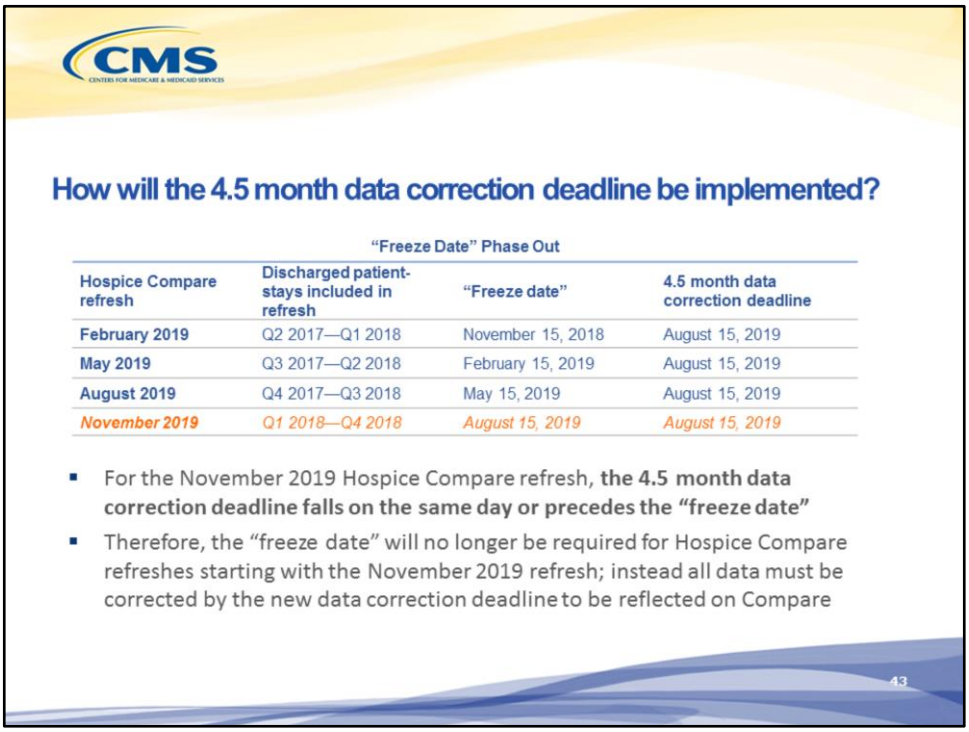
Looking at quarter 1 2019 (which is January through March), you can see that the data correction deadline for public reporting is August 15, 2019 – which is about 4.5 months after the end of March. This means that for HIS records with target dates, or admission and discharge dates, in Q1 of 2019, you will have approximately 4.5 months after the end of March to review the data contained within these HIS records and correct this data if necessary. So this means that you will have until about August 15, 2019 to review and correct HIS records with target dates between January through March 2019. If you correct this data after August 15, 2019, then those changes will **not** be reflected on Hospice Compare because this data will be considered permanently frozen for the purposes of public reporting.



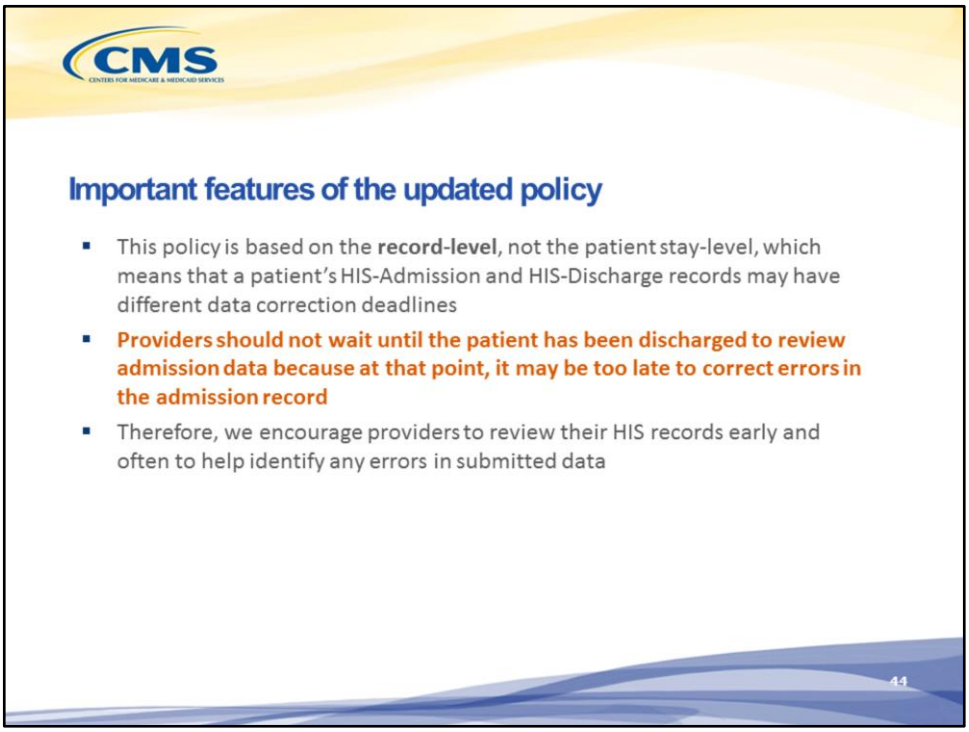
We also want to point out the first row of this table. Please note that HIS records with target dates prior to January 1, 2019 need to be reviewed and corrected, if necessary, before August 15, 2019. This means that HIS records with target dates prior to January 1, 2019 will have the same data correction deadline as HIS records with target dates in quarter 1 of 2019.



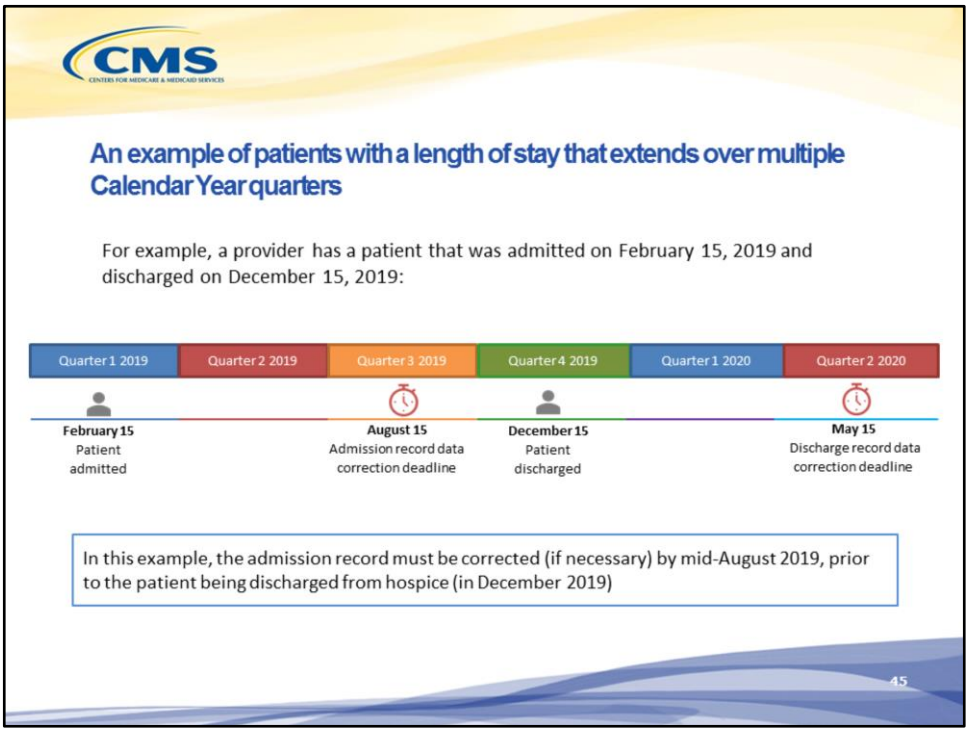
One question that might be running through your head is whether there are still going be freeze dates. Well the 4.5 month data correction deadline policy will *eventually* replace the "freeze date" policy, but as this new policy is being implemented, there will be a couple of Hospice Compare refreshes that will still require a freeze date. Specifically, the first 4.5 month data correction deadline of 2019 will be August 15, 2019, and the February, May, and August Hospice Compare refreshes are going to occur before this deadline. This means that we will still need to have a freeze date for the February, May, and August Hospice Compare refreshes.



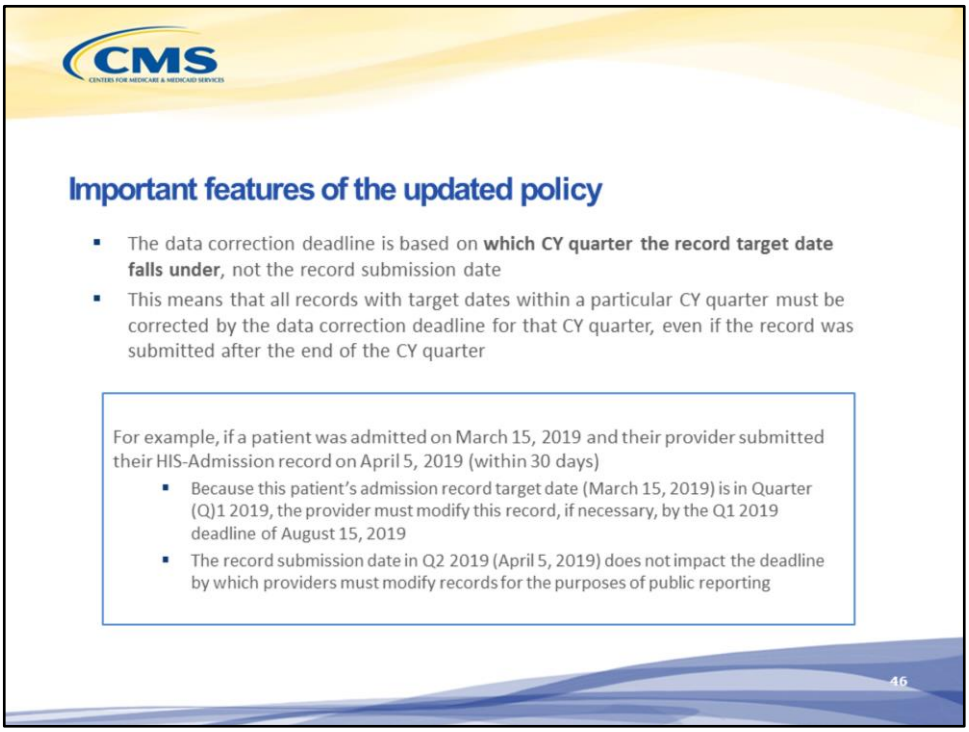
However, for the November 2019 Hospice Compare refresh, the freeze date and the 4.5 month data correction deadline will both be August 15, 2019. So essentially, the freeze date will not be necessary for the November 2019 refresh since we will have the 4.5 month data correction deadline. Then, after the November 2019 Hospice Compare refresh, there will no longer be a freeze date because the 4.5 month data correction deadline will occur prior to the freeze date.



Now that we have given a basic overview of this new policy, there are a couple of key features of this policy that we want to make sure that you understand. First, the 4.5 month data correction deadline policy is based on the record-level, not the patient-level. This means that the data correction deadline is based on each individual record's target date. Therefore, it is possible that one patient's HIS-Admission and HIS-Discharge records may have different data correction deadlines. This could happen if the patient's admission date was in one quarter but their discharge date was in a different quarter. Further, if you had a long-stay patient, it is possible that by the time the patient had been discharged, the data correction deadline for their HIS-Admission record could have already passed. We are going to talk through an example of how this is possible on the next slide, but first we want to emphasize that this means that providers need to be reviewing their HIS records early and often to help identify any errors in submitted data.



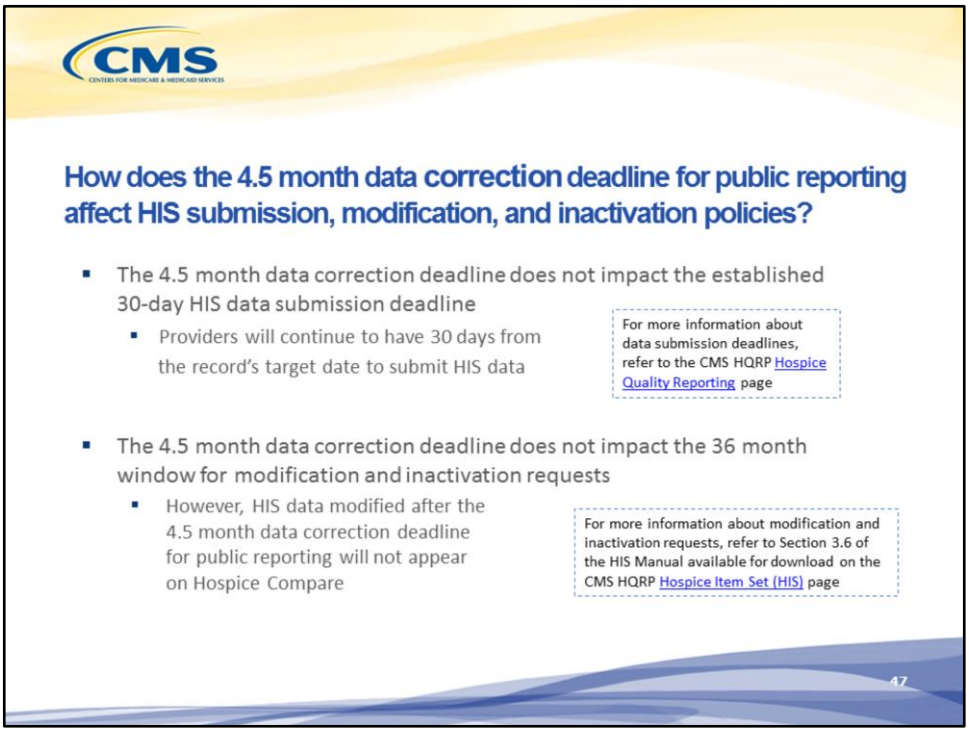
As an example, if a provider had a patient that was admitted on February 15, 2019, then that patient's admission target date would fall in Q1 of 2019. If this patient was not discharged until December 15, 2019, then their discharge target date would fall in Q4 of 2019. This means that the admission record needs to corrected by the Q1 deadline (which occurs in August 2019) and the discharge record needs to be corrected by the Q4 deadline (which occurs in May 2020). What we really want to draw your attention to in this example is that the 2019 Q1 4.5 month data correction deadline is August 15, 2019. This means that the correction deadline for this patient's admission record occurs *before* the patient is discharged from the hospice. This means that providers should **not** wait until the patient has been discharged to review admission data because at that point, it may be too late to correct errors in the admission record



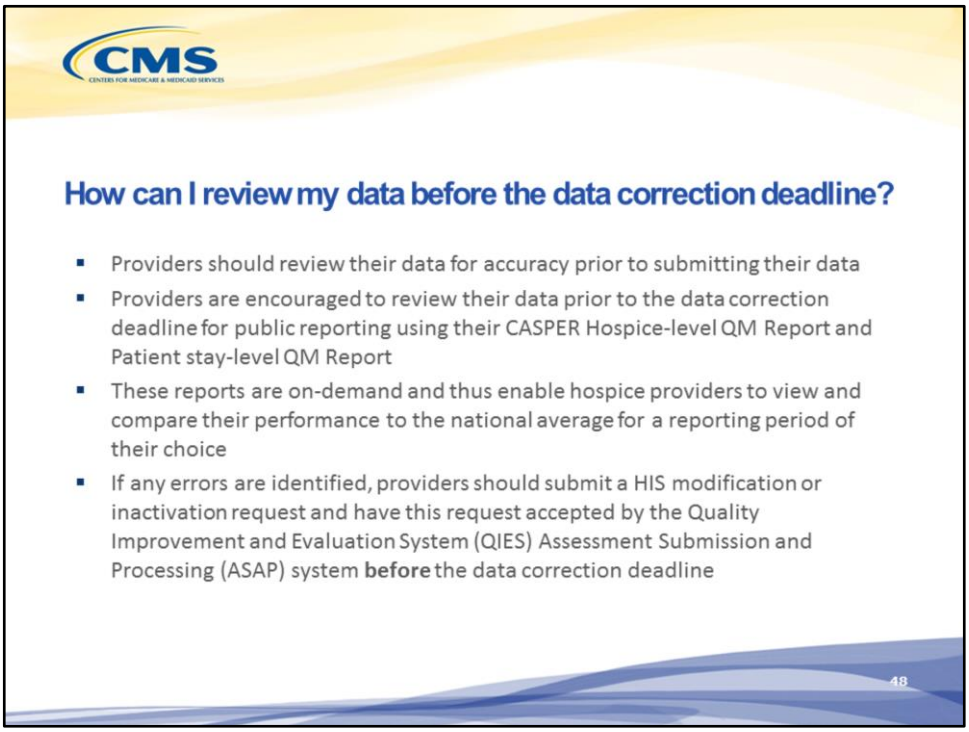
Another key feature of this policy is that it is based on which quarter the record target date falls under, not the record submission date. This is an important feature because hospices have up to 30 days to submit HIS records, and this means that it is possible that a record target date could be in one calendar year quarter, but the submission date could fall in a different calendar year quarter.

Let's walk through an example. If a patient was admitted on March 15, 2019, and their provider submitted their HIS-Admission record on April 5, 2019 (which is within the 30 day submission deadline window), that patient's admission date would be in quarter 1, which means that the correction deadline for that record would be the Q1 2019 deadline of August 15, 2019. It does not matter that the provider did not submit the record until quarter 2.

Therefore, since this policy is based on the target date and not the submission date, the data correction deadline is based on which quarter the target date falls under regardless of when the provider submits the record.



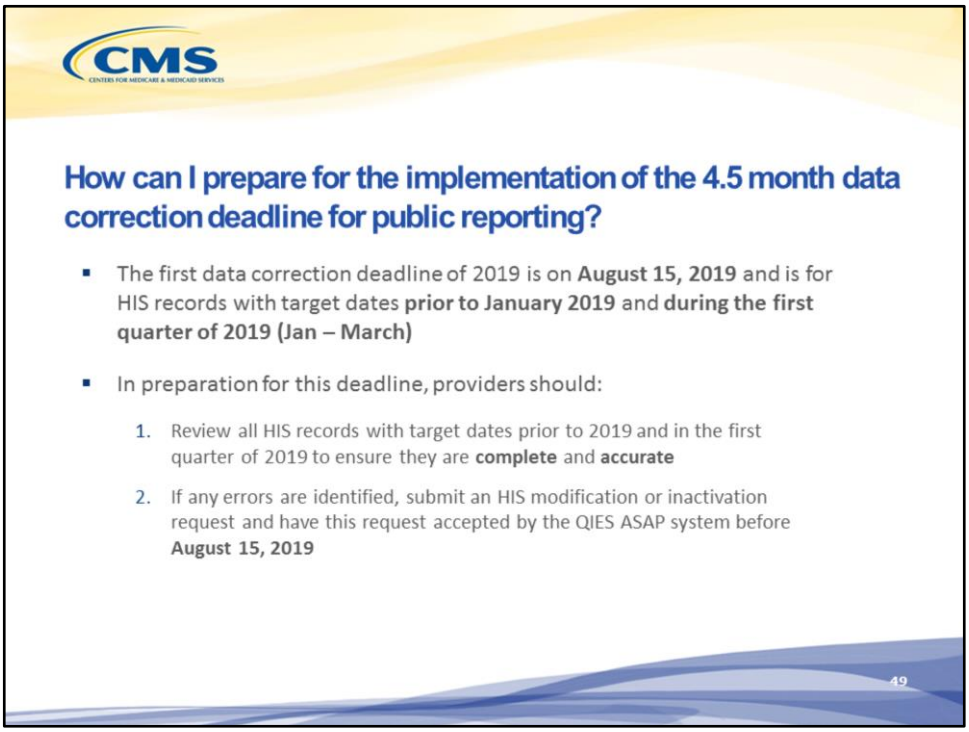
You may be wondering how this new data correction deadline policy is going to impact other HIS submission and data correction policies. Well, this new policy will not affect the established 30-day HIS submission deadline policy. This means that providers will continue to have 30 days from the record's target date to submit HIS data before that record will be considered "late." Additionally, modification and inactivation requests will continue to be permitted for up to 36 months. The change is that even though you have 36 months from the record target date to correct your data, these corrections will only be reflected on Hospice Compare if you make the corrections prior to the 4.5 month deadline. For example, this means that you can still correct an HIS record 1 year after the record target date, but these corrections will not be reflected on Hospice Compare because this would be past the 4.5 month deadline for public reporting.



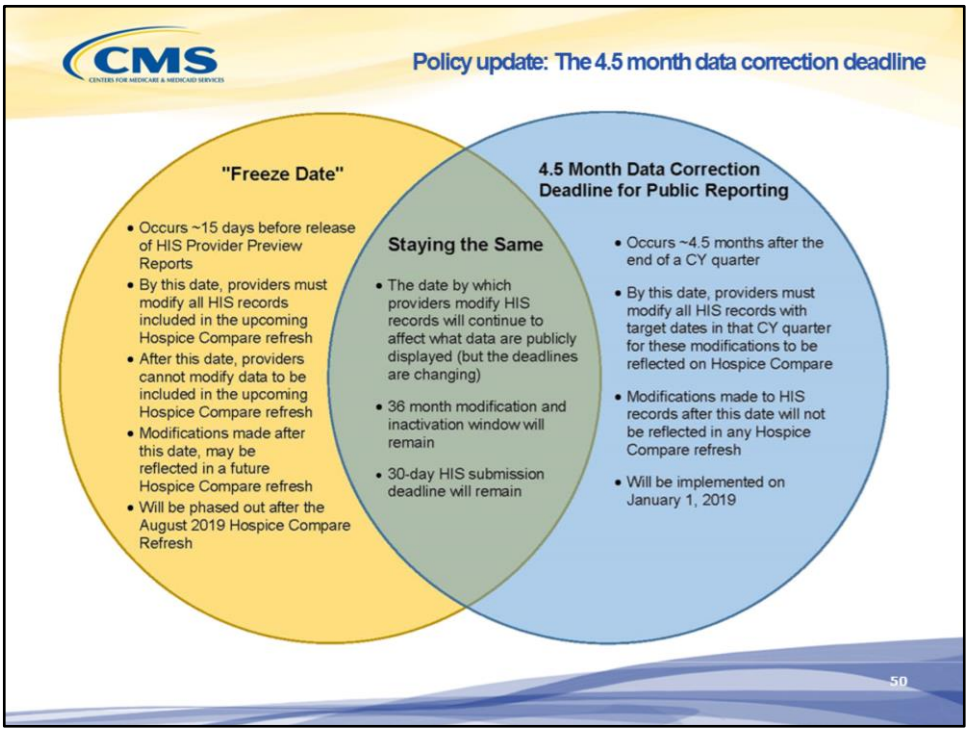
The process for reviewing and submitting corrections for data is not changing -- meaning, providers will continue to have the same resources currently available to review their data and make corrections, if necessary. However, we will go ahead and review these existing processes now.

Providers should review their data for accuracy prior to submitting their HIS data to CMS. Additionally, providers are encouraged to use their CASPER QM reports to review their data prior to the 4.5 month data correction deadline for public reporting. CASPER QM reports are available on-demand, so providers can run these reports at any time to review their data for a reporting period of their choice. As a reminder, CASPER QM Reports only tell you if patients were included in QM calculations once they are discharged.

If providers identify any errors in a patient's data while they are reviewing, then providers should submit either a HIS modification or inactivation request depending on the identified issue. To ensure that any needed updates are reflected on Hospice Compare, be sure to confirm that the modification or inactivation request is accepted by the QIES ASAP system before the data correction deadline.



Next steps for providers to prepare for the implementation of this new policy in January 1, 2019, include that providers should review all HIS records with target dates prior to 2019 and in the first quarter of 2019 to ensure that they are complete and accurate. If you do identify any errors, then you should submit an HIS modification or inactivation request and ensure that the request is accepted by the QIES ASAP system before August 15, 2019, which is the first data correction deadline of 2019.

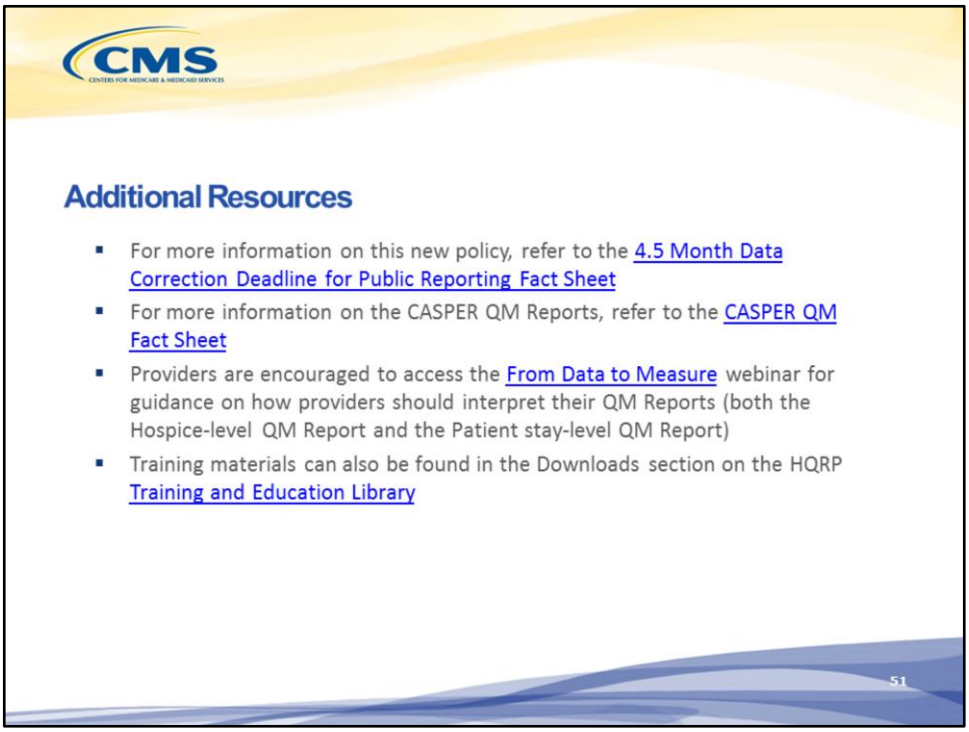


To summarize, let's take a look at how the new 4.5 month data correction deadline for public reporting compares with the "freeze date" policy.

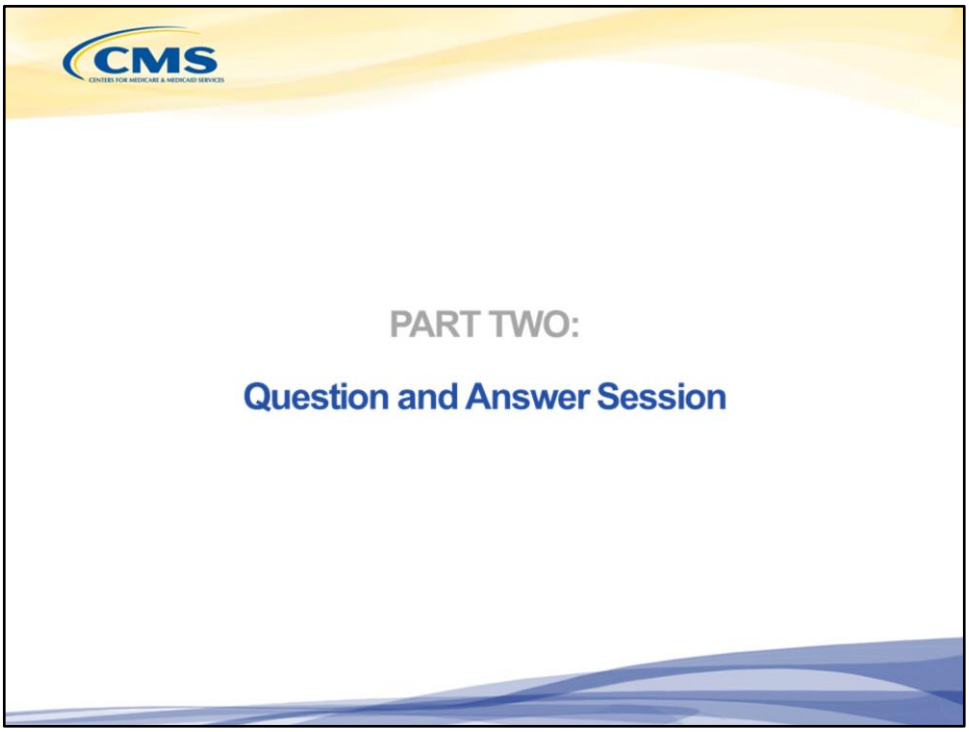
Starting with things that are staying the same, the concept of having a date by which providers must modify HIS records for those modifications to be reflected on Hospice Compare will continue to exist. The thing that is changing is the deadline for correcting data. Other things that are staying the same are that providers will continue to have 36 months to submit modification and inactivation requests and 30 days to submit their HIS data before that data will be considered "late".

Moving into what is different between these policies, whereas the "freeze date" occurs about 15 days before the release of HIS Provider Preview Reports, the 4.5 month data correction deadline for public reporting will occur approximately 4.5 months after the end of each calendar year quarter. With the "freeze date" policy, providers must ensure that all HIS records that are gong to be included in the upcoming Hospice Compare refresh have been corrected by the freeze date for those corrections to be reflected on the upcoming Compare refresh. For the 4.5 month policy, providers must ensure that all HIS records with target dates in that CY quarter are corrected by the 4.5 month deadline for those modifications to be reflected on Hospice Compare. For the "freeze date" policy, if you modify records after the "freeze date," then those modifications will be reflected in future Hospice Compare refreshes, just not the upcoming refresh. With the 4.5 month policy, if you make a modification to an HIS record after the 4.5 month deadline, then those modifications will not be reflected in any Hospice Compare refreshes. Additionally, the "freeze date" policy will be phased out after the August 2019 Hospice Compare refresh. The 4.5 month data correction policy will be implemented on January 1, 2019.

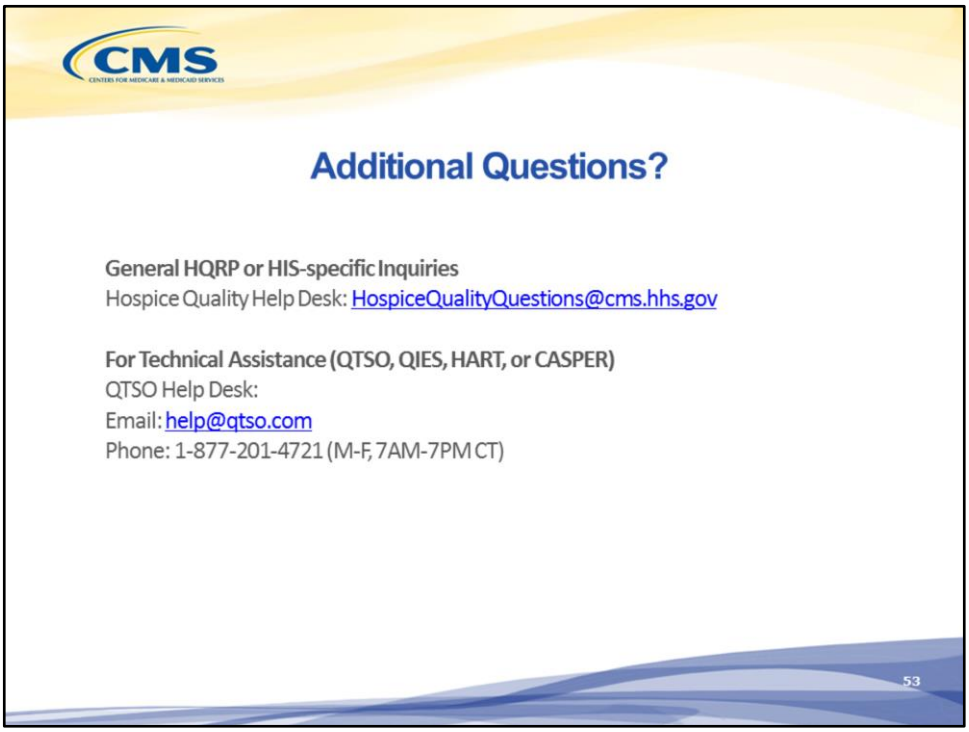
Finally, key features of the new 4.5 month policy that we discussed over slides 44-46 are that the data correction deadline is based on which Calendar Year (CY) quarter the HIS record target date falls under, not the date the HIS record is submitted. Additionally, this policy is based on the record-level, not the patient-stay-level, meaning that a patient's HIS-Admission and HIS-Discharge records may have different data correction deadlines. This means that providers should **not** wait until the patient has been discharged to review admission data because at that point, it may be too late to correct errors in the admission record.



Finally, on slide 49, we have included some additional resources related to the 4.5 month data correction deadline policy for public reporting.



We'll now have a Q&A session with our CMS experts; please ask questions about Part 2 of the presentation (which related to the new 4.5 month data correction deadline for public reporting). Or, if you have any unanswered questions about the Composite measure, you can ask them now as well.



If you have a question that was not answered during the Q&A session, you can submit it to the appropriate Help Desk using the contact info here.