

Hospice Outcomes and Patient Evaluation (HOPE) v1.02 to v1.03 Guidance Manual and Item Set Change Table Effective October 1, 2026

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
1.	Guidance Manual	Cover Page	HOPE v1.02	HOPE – v1.03	Updated version number
2.	All	Footer	HOPE v1.02 Effective October 1, 2025	HOPE Guidance Manual – v1.03 Effective October 1, 2026	Updated footer to correct version number.
3.	All	throughout	N/A	throughout	Minor corrections made for grammar and punctuation.
4.	Guidance Manual Chapter 1	1.2 and throughout	HOPE data sets for each <i>assessment</i> timepoint	HOPE data sets for each timepoint	For clarification: Removed some references to the term “ assessment ” where unnecessary. Not every HOPE item is based on an assessment. Some items include demographic data while others may still be abstracted from the clinical record based on documentation, such as the “Preference” items.
5.	Guidance Manual Chapter 1	1.3 HOPE Timepoints and Definitions	Generally, hospices are required to submit up to four records for each patient admitted to their organization. This includes a minimum of a HOPE-Admission record, a HOPE-Discharge record, and up to two HOPE Update Visits (HUVs). Depending on the patient’s length of stay (LOS), up to two HUV records may be required for every hospice admission, each at specified timeframes. HOPE data are collected during the hospice’s routine clinical assessments and are based on unique patient assessment visits. However, not all HOPE items are completed at every timepoint.	Generally, hospices are required to submit up to four records for each patient admitted to their organization. This includes a minimum of a HOPE-Admission record, a HOPE-Discharge record, and up to two HOPE Update Visits (HUVs). Depending on the patient’s length of stay (LOS), up to two HUV records may be required for every hospice admission, each at specified timeframes. HOPE data are collected during the hospice’s routine clinical visits and are based upon assessment activities, including observations and/or focused clinical assessments during unique patient visits. However, not all HOPE items are completed at every timepoint.	For clarification: Wording was adjusted to include all assessment activities to include observation and/or focused clinical assessments which could be conducted by an LPN/LVN to complete the SFV.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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6.	Guidance Manual Chapter 1	Table 1 and throughout	No later than five calendar days after the effective date of the hospice election.	No later than five calendar days after the effective date of the hospice election, or the date recorded in A0220. Admission Date.	For clarification: Added language here and throughout to clarify that HOPE completion is expected not only for admissions based on the initial hospice election, but also for any admission to the same or a different hospice (different CCN) after the initial hospice election and a subsequent HOPE discharge. “or the date recorded in A0220. Admission Date.”
7.	Guidance Manual Chapter 1	Table 1	The data are collected at Discharge for any reason listed in A2115.	The data are collected at Discharge for any reason listed in A2115. Reason for Discharge.	Added item label for A2115, Reason for Discharge
8.	Guidance Manual Chapter 1	1.3.2. HUV Timepoints	If an HUV is missed or late for any reason (e.g., HUV1 conducted on day 17 or HUV2 conducted on day 33), conduct the visit as appropriate and submit the record once completed, including any SFV if applicable.	If an HUV is missed or late for any reason (e.g., HUV1 conducted on day 17 or HUV2 conducted on day 33), you may still conduct the visit as appropriate and submit the record once it is completed, including any SFV if applicable. Late HUV records will still be accepted. HUV records, if submitted (and accepted) timely, will count positively towards your hospice’s compliance rate.	For clarification: Added language re: handling missed or late HUV records.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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9.	Guidance Manual Chapter 1	1.3.3. Symptom Follow-up Visit (SFV)	During the Admission or HUV, data collected for the Symptom Impact item (J2051) may trigger the need for the Symptom Follow-up Visit (SFV). The SFV is an in-person visit expected within two calendar days as a follow-up for any pain or non-pain symptom impact rated as moderate or severe. The SFV must be a separate visit from the Admission or HUV, and may occur any time within two calendar days, or later on the same day as the assessment where the initial finding of a moderate or severe symptom was determined.	During the Admission or HUV, data collected for the Symptom Impact item (J2051) may trigger the need for the Symptom Follow-up Visit (SFV). The SFV is an in-person visit expected within two calendar days as a follow-up for any pain or non-pain symptom impact rated as moderate or severe. The SFV must be a separate visit (<i>or encounter in an inpatient setting</i>) from the Admission or HUV, and may occur any time within two calendar days, or later on the same day as the assessment where the initial finding of a moderate or severe symptom was determined.	For clarification: Added the phrase <i>“or encounter in an inpatient setting”</i> to describe how the HOPE SFV would be conducted for patients in an inpatient setting.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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10.	Guidance Manual Chapter 1	Examples for SFV	N/A	Situation E During HUV1 on day 10, the RN determines the symptom impact of nausea is resulting in poor nutritional intake. Interventions are initiated to manage the nausea, and the SFV is scheduled within 2 days. Due to a scheduling issue that day, the visit is missed. During a routine nursing visit, the following week, the missed visit is discovered. Instructions for HOPE Timepoint Completion: Since the SFV was not conducted, the reason code for “None of the above” (9) is recorded on J2052C. Symptom Follow-up Visit (SFV), the item Z0350. Date Assessment was Completed is recorded for HUV1, and the record is ready to submit. Coding and Rationale: The only applicable response for this missed SFV would be to code J2052C as 9. None of the above, since the other reasons do not apply. The missed visit was not due to the lack of availability of the patient. HUV records, if submitted timely will count positively towards your hospice’s compliance rate.	A NEW example was added to clarify how to code a missed SFV that was not a result of patient refusal or access.
11.	Chapter 1	Figure 7: Graphic	N/A	Updated graphic colors ONLY	Graphic was updated to improve contrast and clarity – no changes to the text

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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12.	Chapter 1	1.4.1 Applicable Hospices/Agencies	CMS addresses reporting eligibility and requirements for new hospice providers through rulemaking. For more details on requirements for current and new hospices, refer to section 1.7.1 below, and visit the Provider Toolkit documents and those located in the Downloads section on the HQRP Requirements and Best Practices webpage.	CMS addresses reporting eligibility and requirements for new hospice providers through rulemaking. For more details on requirements for current and new hospices, refer to section 1.7.1. Compliance Criteria and visit the Provider Toolkit documents and those located in the Downloads section on the HQRP Requirements and Best Practices webpage.	Added section header name for clarity.
13.	Guidance Manual Chapter 1	Section 1.5 Applicable Patients	For all current patients with discharges occurring through September 30, 2025, completion and submission of both the HIS Admission and Discharge is required. Completion of HOPE records (formerly HIS) applies to all patient admissions to a Medicare-certified hospice program, regardless of the following:	For all current patients with discharges occurring through September 30, 2025, completion and submission of both the HIS Admission and Discharge is required. Completion of HOPE records (formerly HIS) applies to all patient admissions to a Medicare-certified hospice program, regardless of the following:	Deleted text as it is no longer applicable.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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14.	Guidance Manual Chapter 1	1.5.1. Special Circumstances Affecting HOPE	Patient transfers from one hospice to another provider with a different CMS Certification Number (CCN): - Hospice quality reporting is at the CCN level. - If a hospice patient's care transfers or changes from one hospice to another and the two hospices have different CCNs, each hospice should complete a HOPE- Admission, HOPE Update Visit records (as applicable), and a HOPE-Discharge record for the care provided to the patient by their organization (based on the length of stay in each hospice). - When the transferring hospice completes its HOPE-Discharge, response 05, "transferred to another hospice," should be selected for Item A2115—Reason for Discharge.	Transfers - Patient transfers from one hospice to another provider with a different CMS Certification Number (CCN): - Hospice quality reporting is at the CCN level. - If a hospice patient's care transfers or changes from one hospice to another (including a GIP setting), and the two hospices have different CCNs, each hospice should complete a HOPE- Admission, HUV(s) (as applicable), and a HOPE-Discharge record for the care provided to the patient by their organization (based on the length of stay in each hospice). - When the transferring hospice completes its HOPE-Discharge, response 05, "transferred to another hospice," should be selected for Item A2115. Reason for Discharge. As noted in section 1.3, the date of the hospice election (or the date recorded in A0220. Admission Date for your hospice) would be considered "Day 0."	Added text for clarity based on questions CMS received via the HQRP Help Desk

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

15.	Guidance Manual Chapter 1	1.5.1. Special Circumstances Affecting HOPE	In some circumstances, a hospice's policy may be to discharge a patient administratively and re-admit them. Such circumstances might include the following: • Change in patient's payer source: a private pay patient becomes eligible for Medicare during the hospice stay; the hospice completes an "administrative" discharge and re-admits the patient for billing purposes. • Hospice fails to meet the face-to-face requirement: if a hospice fails to meet the face-to-face requirement, the hospice must "administratively" discharge the patient, but the patient remains on service. This means that Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required (face-to-face) encounter occurs, enabling the hospice to re-establish Medicare eligibility. • In general, if the patient remains under hospice care with no interruption in hospice service, completion of a HOPE-Discharge record is not required. In both situations listed above, the patient remained under the hospice's care without interruption in service. The hospice would not be required to submit a HOPE-Discharge. Hospices should submit a HOPE-Discharge record once the patient is no longer receiving hospice services or there is an interruption in care	Administrative Discharges - In some circumstances, a hospice's policy may be to discharge a patient administratively and re-admit them. Such circumstances might include the following: • Change in patient's payer source: Example: A private pay patient becomes eligible for Medicare during the hospice stay; ○ Any hospice days prior to the Medicare hospice election do not factor into the benefit periods. ○ Although the hospice may choose to complete an "administrative" discharge and re-admit the patient for billing purposes, the completion of HOPE is unrelated to the benefit periods for Medicare. • Hospice fails to meet the face-to-face requirement: if a hospice fails to meet the face-to-face requirement, the hospice may choose to "administratively" discharge the patient, but the patient remains on service. An actual "HOPE-Discharge" is not required. This means that Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required (face-to-face) encounter occurs, enabling the hospice to re-establish Medicare eligibility. • In general, if the patient remains under hospice care with no interruption in hospice service, completion of a HOPE-	For clarification: Added language to differentiate Medicare benefit periods from HOPE data collections and submission to comply with the HQR. Removed the word "must" from administrative discharges to the words "may choose to" since administrative discharges are unrelated to HOPE completion.
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HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
			related to one of the reasons for discharge listed in Item A2115.	Discharge record is not required. In both situations listed above, the patient remained under the hospice's care without interruption in service. The hospice would not be required to submit a HOPE-Discharge. Hospices should submit a HOPE-Discharge record once the patient is no longer receiving hospice services or there is an interruption in care related to one of the reasons for discharge listed in Item A2115. Reason for Discharge.	
16.	Guidance Manual Chapter 1	1.5.1. Special Circumstances Affecting HOPE	Traveling Patients In rare circumstances where a newly admitted hospice patient travels during the first month of hospice service, the home hospice may request the host hospice to conduct and provide the documentation for HUV1 and/or HUV2.	Traveling Patients In rare circumstances where a newly admitted hospice patient travels during the first month of hospice service, the home hospice may request the host hospice to conduct and provide the documentation for HUV1 and/or HUV2, including any SFVs, as applicable.	For clarification since the HUVs may include SFVs.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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17.	Guidance Manual Chapter 1	1.6. General Conventions for Completing HOPE	1. To accurately and fully complete HOPE data, hospice staff should understand what information each item requires and complete the item based only on what is being requested. Responses to items in HOPE can be selected by the assessing clinician as part of the routine assessment during a patient visit or, for select items, can be based on information documented in the clinical record and abstracted on or before the Completion Date (Item Z0500B).	1. To accurately and fully complete HOPE data, hospice staff should understand what information each item requires and complete the item based only on what is being requested. Clinicians may select responses to HOPE items during routine patient assessment activities, including observation and/or focused clinical assessment during unique patient visits. Responses for select items, (such as those from the original HIS), may be abstracted from information documented in the clinical record. 2. Responses to items in HOPE can be selected by the assessing clinician as part of the routine assessment during a patient visit or, for select items, can be based on information documented in the clinical record and abstracted on or before the Completion Date (Item Z0500B).	For clarification: wording was adjusted to include observation and/or focused clinical assessments which could be conducted by an LPN/LVN to complete the SFV. Clarified language to identify that items, such as those from the original HIS may be abstracted from the clinical record. Removed the “Completion Date (Item Z0500B)” since this only refers to the HUV.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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18.	Guidance Manual Chapter 1	1.6.1 Who May Complete HOPE	HOPE contains a combination of existing HIS items and new items. Some of the data elements are to be collected during routine clinical assessment visits, while other data may be extracted from the clinical record by hospice staff, including volunteers, contractors, and affiliates. For example, staff could collect data from the quality division of the health system to which a hospice belongs. HOPE may be completed by any appropriate hospice staff member, based on the data being collected, such as the registered nurse (RN) for HOPE items requiring a skilled nursing assessment. The hospice is responsible for the accuracy and completeness of information in HOPE. Per the hospice CoPs, (See 418.114 Conditions of Participation), it is at the discretion of the hospice to determine who can accurately complete HOPE. Each person completing any portion of HOPE should provide a signature in Section Z, Record Administration, per the instructions provided in Section Z of Chapter 2.	HOPE includes both a combination of legacy HIS items and new items. Some of the data elements are to be collected during routine patient assessment activities, including observation and/or focused clinical assessments during unique patient visits. Select data (such as those from the original HIS) may be abstracted from the clinical record by hospice staff, including volunteers, contractors, and affiliates. HOPE may be completed by any appropriate hospice staff member, based on the data being collected, such as the registered nurse (RN) for HOPE items requiring a skilled nursing assessment. The hospice is responsible for the accuracy and completeness of information in HOPE. Per the hospice CoPs, (See 418.114 Conditions of Participation), it is at the discretion of the hospice to determine who can accurately complete HOPE. Each person completing any portion of HOPE should provide a signature in Section Z, Record Administration, per the instructions provided in Section Z of Chapter 2.	Revised reference to HIS, since it no longer exists. Added language to clarify that assessment activities may also include observations and or focused clinical assessments to accommodate the inclusion of LPN/LVN staff for the SFV.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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19.	Guidance Manual Chapter 1	1.7 Compliance with HQRPs Requirements and Annual Payment Update (APU) Determinations	HQRPs activities operate on a cycle of data collection and submission, compliance determinations, and payment impact. Referred to as the HQRPs FY reporting cycle, the data collected will impact hospice payments two years later. HOPE data collection consists of selecting responses to standardized items in conjunction with patient assessment activities and reporting the data to CMS. For example, HOPE data collected, submitted, and accepted on time during calendar year (CY) 2026 will be processed for compliance determinations in CY 2027. The impact on hospice payment will occur in FY 2028, which starts on October 1, 2027. See Figure 8 for an example:	HQRPs activities operate on a cycle of data collection and submission, compliance determinations, and payment impact. Referred to as the HQRPs FY reporting cycle, the data collected will impact hospice payments two years later. HOPE data collection consists of selecting responses to standardized items in conjunction with patient assessment activities, including observation and/or focused clinical assessments during unique patient visits, and reporting the data to CMS. For example, HOPE data collected, submitted, and accepted on time during calendar year (CY) 2026 will be processed for compliance determinations in CY 2027. The impact on hospice payment will occur in FY 2028, which starts on October 1, 2027. See Figure 8 for an example:	Added language to clarify that assessment activities may also include observations and/or focused clinical assessments to accommodate the inclusion of LPN/LVN staff for the SFV.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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20.	Guidance Manual Chapter 2, Section A	A0215. Site of Service at Admission	Item Code 01. Patient's Home/Residence Code 02. Assisted Living Facility (ALF) Code 03. Nursing Long-Term Care (LTC) or Non-Skilled Nursing Facility (NF) Code 04. Skilled Nursing Facility (SNF) Code 05. Inpatient Hospital Code 06. Inpatient Hospice Facility (General Inpatient [GIP]) Code 07. Long Term Care Hospital (LTCH) Code 08. Inpatient Psychiatric Facility Code 09,.Hospice Home Care (Routine Home Care [RHC]) Provided in a Hospice Facility Code 99. Not listed	Item Code 01. Patient's Home/Residence Code 02. Assisted Living Facility (ALF) Code 03. Nursing Long-Term Care (LTC) or Non-Skilled Nursing Facility (NF) Code 04. Skilled Nursing Facility (SNF) Code 05. Inpatient Hospital Code 06. Inpatient Hospice Facility (General Inpatient [GIP]) Code 07. Long Term Care Hospital (LTCH) Code 08. Inpatient Psychiatric Facility Code 09,.Hospice Home Care (Routine Home Care [RHC]) Provided in a Hospice Facility Code 99. Not listed	Added the acronym ALF for clarity in the Item and the guidance.
21.	Guidance Manual Chapter 2, Section A	A0215. Site of Service at Admission	Item Specific Instructions Code 02, Assisted Living Facility, if the patient received hospice care in an ALF at the time of admission.	Item Specific Instructions Code 02, Assisted Living Facility (ALF), if the patient received hospice care in an ALF at the time of admission.	Added the acronym ALF for clarity in the Item and the guidance.
22.	Guidance Manual Chapter 2, Section A	A1905. Living Arrangements	Item Specific Instructions Enter the code that best describes the patient's current living arrangements at the time of the assessment.	Item Specific Instructions - Enter the code that best describes the patient's current living arrangements at the time of the visit based on the site of service. This item is not asking about the living situation prior to the hospice election, or prior to the time of the HOPE-Admission assessment visit.	For clarification: Added language to describe how the completion of this item should be based on the site of service at admission and the location at the time of the HOPE Admission assessment visit.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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23.	Guidance Manual Chapter 2, Section A	A1910. Availability of Assistance	Item Specific Instructions • Patient and/or caregiver interview can be used to code this item. • In the event the patient cannot respond, and no caregiver is present, facility staff, clinical record, and referral information can be used to code the item.	Item Specific Instructions • Patient and/or caregiver interview can be used to code this item. • In the event the patient cannot respond, and no caregiver is present, facility staff, clinical record, and referral information can be used to code the item. • This question is asking about the availability of assistance at the time of the HOPE-Admission assessment visit, or admission to the hospice.	For clarification: Added language to describe how the completion of this item should be based on the information gathered at the time of the HOPE Admission assessment visit (excluding hospice or facility staff).
24.	Guidance Manual Chapter 2, Section A	A2115. Reason for Discharge	Item Specific Instructions • Review the clinical record, including the discharge plan and discharge order, for documentation of discharge reason. • Code the response that corresponds to the patient's reason for discharge.	Item Specific Instructions • Review the clinical record, including the discharge plan and discharge order, for documentation of discharge reason. • Code the response that corresponds to the patient's reason for discharge. • When there is no interruption in care (such as in an administrative discharge) no HOPE-Discharge is required. • Hospices should submit a HOPE-Discharge record once the patient is no longer receiving hospice services or there is an interruption in care related to one of the reasons for discharge listed here.	Added language to clarify when hospices should submit a HOPE-Discharge. To confirm that a HOPE-Discharge occurs when the patient is no longer receiving hospice services or there is an interruption in care related to one of the reasons for discharge listed in A2115.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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25.	Guidance Manual Chapter 2, Section I	I0010. Principle Diagnosis	Item Specific Instructions The principal diagnosis is defined as the condition established after reviewing all available information to be chiefly responsible for the patient's admission.	Item Specific Instructions - The principal diagnosis is defined as the condition chiefly responsible for the patient's admission to hospice. The principal diagnosis is determined after reviewing all available information and in consultation with the hospice medical director (or physician designee), with input from the patient's attending physician, if any.	For clarification: Added language for more detail and to clarify how the principle diagnosis is determined.
26.	Guidance Manual Chapter 2, Section I	I0010. Principle Diagnosis	Coding Tips Code 02 includes all types of dementia, e.g., Lewy body dementia and Pick's disease.	Coding Tips Code 02 includes all types of dementia; (e.g., Alzheimer's Disease; Pick's disease; other frontotemporal dementia; senile degeneration of brain; dementia with Lewy bodies).	For clarification: Added language with more examples that had been included in the former HIS Manual.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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27.	Guidance Manual Chapter 2, Section I	I0010. Principle Diagnosis	Comorbidities and Coexisting Conditions - Review the medical record for comorbidities and/or coexisting conditions at the time of admission to hospice. - Check all comorbid and/or coexisting diseases or medical conditions that are addressed in the plan of care or that have the potential to impact the plan of care. - Do not include the principal diagnosis, except if the patient has a secondary cancer.	Comorbidities and Coexisting Conditions Review the medical record for comorbidities and/or coexisting conditions at the time of admission to hospice. - Check all comorbid and/or coexisting diseases or medical conditions. that are addressed in the plan of care or that have the potential to impact the plan of care. Include other health conditions, whether related or unrelated to the terminal condition. - Do not include the principal diagnosis, except if the patient has a secondary cancer. If there are no comorbidities or co-existing conditions, leave blank.	For clarification: In response to questions received, removed reference focused on the plan of care and updated language to include all health conditions whether related or unrelated to the terminal condition. Additional update to clarify that if there are no coexisting conditions or comorbidities, this section can be left blank.
28.	Guidance Manual Chapter 2, Section I	I0010. Principle Diagnosis	Example Rationale: Based upon the clinician's assessment and patient report, the nurse records Cancer for both the Principal Diagnosis and the Comorbidities and Coexisting Conditions category.	Example Rationale expanded Rationale: Based upon the clinician's assessment and patient report, the nurse records Cancer for both the Principal Diagnosis and the Comorbidities and Coexisting Conditions category. Although the original cancer diagnosis was many years ago, this significant history warrants inclusion.	For clarification

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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29.	Guidance Manual Chapter 2, Section J	Section Intent	Items in this section are intended to document the physical symptoms and the impact of pain and non-pain symptoms for hospice patients. The items in this section include an assessment of imminent death, screening for pain, a comprehensive pain assessment if warranted, and screening for dyspnea. The items are intended to incorporate information from the interview with the patient and family/caregiver, as well as the clinical assessment and judgment of the assessing nurse if the patient is unable to participate.	Items in this section are intended to document the physical symptoms and the impact of pain and non-pain symptoms for hospice patients. The items in this section include an assessment of imminent death, screening for pain, a comprehensive pain assessment if warranted, and screening for dyspnea. These items are designed to incorporate information from interviews with the patient and family/caregiver during assessment activities, including observations and/or focused clinical assessment, and judgment of the nurse.	Slight revisions for clarification and added language regarding assessment activities that may also include observations and/or focused clinical assessment to accommodate the inclusion of LPN/LVN staff for the SFV.
30.	Guidance Manual Chapter 2, Section J	J0905. Pain Active Problem	Coding Tips Code 1, Yes, includes situations where the patient is not in pain at the time of screening, but pain is an active problem for the patient.	Coding Tips - Code 1, Yes, includes situations where the patient is not in pain at the time of screening, but pain is an active problem for the patient. Code 1, Yes, if pain is noted as 1. Mild, 2. Moderate, or 3. Severe in J0900.	For clarification regarding when pain should be coded as an “active” problem.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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31.	Guidance Manual Chapter 2, Section J	J2051. Symptom Impact	Coding Tips Symptom impact is coded based on the clinician's observations and/or clinical judgment after considering all the information provided by the patient, family/caregiver, and/or facility staff, in addition to their own observations and/or clinical assessment.	Coding Tips - Symptom impact is coded based on the clinician's observations and/or clinical judgment after considering all the information provided by the patient, family/caregiver, and/or facility staff, in addition to their own observations and/or clinical assessment. Considering all of the information: Code 0, for Symptom Impact if the patient has or has had the symptom but is not impacted by it (including when symptoms are well-controlled via treatment). Code 9, for Symptom Impact if the patient is neither experiencing, being treated for, nor impacted by the symptom	For clarification: Added language to help providers distinguish between Code 0 and Code 9.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

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32.	Guidance Manual Chapter 2, Section J	J2051. Symptom Impact	Example N/A	New Example 3. During the patient's admission to the hospice, they reported constipation that was caused by the initiation of pain medication, which started three days earlier while still in the hospital. A bowel regimen was initiated immediately, resulting in one bowel movement at the hospital, and two since they returned home. Constipation remains the only symptom the patient has experienced, but it is well controlled by the current bowel regimen. The patient stated that they have neither experienced, been impacted by, nor been treated for any of the other symptoms listed. Coding: Item J2051. Symptom Impact: g. Constipation, 0. Not at all – if the patient has or has had the symptom but is not impacted by it (including symptoms well-controlled with current treatment). Code all other symptoms, 9, Not applicable. Rationale: Based on assessment, observation, and interviewing the patient, the assessing nurse determined that the patient experienced constipation due to the initiation of their pain medication, but it is well-controlled by the prescribed bowel regimen. The patient denies experiencing, being impacted by, or being treated for any of the other symptoms listed.	For clarification: A new example was added to demonstrate when to Code 0 . Not at all for symptoms that may have been an issue for the patient, but are now well controlled.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
33.	Guidance Manual Chapter 2, Section J	J2052. Symptom Follow-up Visit (SFV)	Item Specific Instructions Unlike the assessments, the SFV item for symptom follow-up may be conducted by either an RN or LPN/LVN.	Item Specific Instructions Unlike the assessment visits, the SFV item for symptom follow-up may be conducted by either an RN or LPN/LVN.	For added clarity and specificity
34.	Guidance Manual Chapter 2, Section J	J2052. Symptom Follow-up Visit (SFV)	Item Specific Instructions C. Reason SFV not completed Code 1, if the patient and/or caregiver declined an in-person visit. Code 2, if the patient was unavailable. (e.g., in emergency department, hospital, traveled outside of the service area, expired). Code 3, if attempts to contact the patient and/or caregiver were unsuccessful. Code 9, None of the above, if none of the above reasons apply.	Item Specific Instructions C. Reason SFV not completed Code 1, if the patient and/or caregiver declined an in-person visit. Code 2, if the patient was unavailable. (e.g., in emergency department, hospital, traveled outside of the service area, expired). Code 3, if attempts to contact the patient and/or caregiver were unsuccessful. Code 9, None of the above, if none of the above reasons apply.	Removed the examples for Code 2 to avoid confusion caused by the wide variety of existing examples.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
35.	Guidance Manual Chapter 2, Section J	J2053. SFV Symptom Impact	Coding Tips - Symptom impact is coded based on the clinician's observations and/or clinical judgment after considering all the information provided by the patient, family/caregiver, and/or facility staff, in addition to their own observations and/or clinical assessment. - Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day- to-day activities, or ability to interact with others.	Coding Tips - Symptom impact is coded based on the clinician's observations and/or clinical judgment after considering all the information provided by the patient, family/caregiver, and/or facility staff, in addition to their own observations and/or focused clinical assessment. - Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day- to-day activities, or ability to interact with others. Considering all of the information: Code 0, for Symptom Impact if the patient has or has had the symptom but is not impacted by it (including when symptoms are well-controlled via treatment). Code 9, for Symptom Impact if the patient is neither experiencing, being treated for, nor impacted by the symptom	For clarification: Added language to refer to "observations and focused" clinical assessments to include LPN/LVN visits for the SFV and additional coding tip to help providers distinguish between Code 0 and Code 9.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
36.	Guidance Manual Chapter 2, Section J	J2053. SFV Symptom Impact	Example Rationale Rationale: Based on assessment and/or observation, and interviewing the patient and caregiver, the nurse determined at the SFV that the nausea was now well-controlled with the current medication and had no further effect on the patient. However, based on observation and/or clinical judgment, the nurse determined that constipation was moderately affecting the patient. There were no other symptoms/treatments reported by the patient or caregiver at the SFV. Although no further SFV is required, the nurse obtained orders to address the constipation and to revisit the patient in one day.	Example Rationale Rationale: Based on a focused clinical assessment and/or observation, and interviewing the patient and caregiver, the nurse determined at the SFV that the nausea was now well-controlled with the current medication and had no further effect on the patient. However, based on observation and/or clinical judgment, the nurse determined that constipation was moderately affecting the patient. There were no other symptoms/treatments reported by the patient or caregiver at the SFV. Although no further SFV is required, the nurse obtained orders to address the constipation and to revisit the patient in one day.	For clarification: Added language to refer to “a focused” clinical assessment to include LPN/LVN visits for the SFV.
37.	Guidance Manual Chapter 2, Section M	M 1195. Types of Skin Conditions	Coding Instructions Check all that apply at the time of assessment.	Coding Instructions - Check all that apply at the time of assessment. Response should be based on the patient/caregiver interview, observation, clinical assessment, medical records, and clinical judgment.	For clarification: Added language to include information obtained from the patient, caregiver, and/or family and not only that which the nurse is able to view or assess directly.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
38.	Guidance Manual Chapter 2, Section N	N0500. Scheduled Opioid	Item Specific Instructions B. Date scheduled opioid initiated or continued Note: In order to continue regularly scheduled opioids from a previous care setting, the hospice must receive a new order to continue the treatment. Once this order is received, the date the hospice received the order is entered in N0500B.	Item Specific Instructions B. Date scheduled opioid initiated or continued • Notes: ○ On Admission: In order to continue regularly scheduled opioids from a previous care setting, the hospice must receive a new order to continue the treatment. Once this order is received, the date the hospice received the order is entered in N0500B. ○ For HOPE Update Visits (HUV): The date entered should coincide with the details obtained at the HUV, regardless of whether the opioid is newly initiated or continued from a previous order. ▪ If an opioid order is continued, or initiated during the HUV visit, enter the date of the HUV visit—not the original order date.	For clarification: Added language to differentiate how this item is completed during a HOPE-Admission vs a HOPE-HUV.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
39.	Guidance Manual Chapter 2, Section N	N0500. Scheduled Opioid	Coding Tips Code response 1, Yes if the clinical record indicates that a regularly scheduled opioid was initiated for any reason, regardless of symptom.	Coding Tips - Code response 1, Yes if the clinical record indicates that a regularly scheduled opioid was initiated for any reason, regardless of symptom. Code response 1, Yes when completing a HOPE-HUV if a regularly scheduled opioid is initiated or identified as continued from a previous order. For HUVs, the date should coincide with the date the HUV was conducted and the information is confirmed.	For clarification: Added language to describe how this item is coded for a HOPE-HUV.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

40.	Guidance Manual Chapter 2, Section N	N0510. PRN Opioid	Item Specific Instructions B. Date PRN opioid initiated or continued Treatment is considered initiated when the hospice has received the order, and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment. An order may be verbal (when permitted) or written. Responses should be based on whichever was used to determine the start of treatment. Enter date the PRN opioid order (whether hospice initiated or continued from prior care setting) was received, irrespective of if/when the first dose was given (assuming instructions have been provided to initiate). If the patient received instructions for different types of PRN opioids in sequence over time, enter the date that the order for the first type of opioid treatment was received. Note: In order to continue PRN opioids from a previous care setting, the hospice must receive a new order to continue the treatment. Once this order is received, the	Item Specific Instructions B. Date PRN opioid initiated or continued - Treatment is considered initiated when the hospice has received the order, and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment. - An order may be verbal (when permitted) or written. - Responses should be based on whichever was used to determine the start of treatment. - Notes: On Admission: Enter date the PRN opioid order (whether hospice initiated or continued from prior care setting) was received, irrespective of if/when the first dose was given (assuming instructions have been provided to initiate). - If the patient received instructions for different types of PRN opioids in sequence over time, enter the date that the order for the first type of opioid treatment was received. - Note: In order to continue PRN opioids from a previous care setting, the hospice must receive a new order to continue the treatment. Once this order is received, the date	For clarification: Added language to differentiate how this item is completed during a HOPE-Admission vs a HOPE-HUV.
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HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
			date the hospice received the order is entered in N0510B.	the hospice received the order is entered in N0510B. • For HOPE Update Visits (HUV): The date entered should coincide with the details obtained at the HUV, regardless of whether the opioid is newly initiated or continued from a previous order. ○ If an opioid order is continued, or initiated during the HUV visit, enter the date of the HUV visit – not the original order date.	
41.	Guidance Manual Chapter 2, Section N	N0510. PRN Opioid	Coding Tips • Code 1, Yes, if the clinical record indicates that a PRN opioid was initiated for any reason, regardless of symptom • For the purposes of completing Item N0510, an “opioid” includes Schedule II–Schedule IV opioids, including hydrocodone and tramadol, because of the side effect profile, which includes constipation.	Coding Tips • Code 1, Yes, if the clinical record indicates that a PRN opioid was initiated for any reason, regardless of symptom. • Code response 1, Yes when completing a HOPE-HUV if a regularly scheduled opioid is initiated or identified as continued from a previous order. • For HUVs, the date should coincide with the date the HUV was conducted and the information is confirmed. • For the purposes of completing Item N0510, an “opioid” includes Schedule II–Schedule IV opioids, including hydrocodone and tramadol, because of the side effect profile, which includes constipation.	For clarification: Added language to differentiate how this item is completed during a HOPE-Admission vs a HOPE-HUV.

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

42.	Guidance Manual Chapter 2, Section N	N0520. Bowel Regimen	Item Specific Instructions A. Was a bowel regimen initiated or continued? - Code 0, No, if a bowel regimen was neither initiated nor continued, and/or the clinical record does not include documentation that a bowel regimen was initiated or continued from the previous care setting. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record. - Code 1, No, but there is documentation of why a bowel regimen was not initiated or continued, if the clinical record indicates that a bowel regimen was not initiated or continued and includes a reason why it was not initiated or continued. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record. The documented reason why a bowel regimen was not initiated could include clinical contraindications to a bowel regimen or patient was offered a bowel regimen but refused treatment. - Code 2, Yes, if a bowel regimen was initiated or continued and/or the clinical record includes documentation that a bowel regimen was initiated or continued from the previous care setting.	Item Specific Instructions A. Was a bowel regimen initiated or continued? - Code 0, No, if a bowel regimen was neither initiated nor continued, and/or the clinical record does not include documentation that a bowel regimen was initiated or continued from the previous care setting, or for the HUV, prior to the visit. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record. - Code 1, No, but there is documentation of why a bowel regimen was not initiated or continued, if the clinical record indicates that a bowel regimen was not initiated or continued and includes a reason why it was not initiated or continued. Skip to Item Z0400: Signature(s) of Person(s) Completing the Record. The documented reason why a bowel regimen was not initiated could include clinical contraindications to a bowel regimen or the patient was offered a bowel regimen but refused treatment. - Code 2, Yes, if a bowel regimen was initiated or continued and/or the clinical record includes documentation that a bowel regimen was initiated or continued from the previous care setting (at the time of Admission).	For clarification: Added language to differentiate how this item is completed during a HOPE-Admission vs a HOPE-HUV.
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HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
				• Code 2, Yes when completing a HOPE-HUV if a new bowel regimen was initiated or identified as continued from a previous order. • For HUVs, the date should coincide with the date the HUV was conducted and the information is confirmed.	

HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

43.	Chapter 3	Section 3.8	Special Manual Record Deletion Request A special Manual Record Deletion Request is only necessary when there has been an error in a record that has been accepted by CMS that cannot be corrected with a Modification or Inactivation Request record. There are only two items to which this applies. A Manual Record Deletion Request must be performed when the record has the wrong state code (STATE_CD) and/or facility ID (FAC_ID) in the control items. Control items are items created by the HOPE software. These errors most likely occurred at the time of software installation when initializing the software, and not during the routine entry of the patient's administrative or clinical data. If a HOPE record has the wrong state code and/or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in the system. The record must be resubmitted with the correct STATE_CD and FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record. In the event that this error has occurred, the provider must contact the iQIES Service Center by email (iQIES@cms.hhs.gov) or telephone (1-877-201-4721).	Record Deletion Request A Record Deletion Request is only necessary when there has been an error in a record that has been accepted by CMS that cannot be corrected with a Modification or Inactivation Request record. There are only two items to which this applies. A Record Deletion Request must be performed when the record has the wrong state code (STATE_CD) and/or facility ID (FAC_ID) in the control items. Control items are items created by the HOPE software. These errors most likely occurred at the time of software installation when initializing the software, and not during the routine entry of the patient's administrative or clinical data. If a HOPE record has the wrong state code and/or facility ID (control items STATE_CD and FAC_ID), then the record must be removed without leaving any trace in the system. The record must be resubmitted with the correct STATE_CD and FAC_ID value, when indicated. All data items must be complete and correct on the newly submitted record. "In the event that this error has occurred, the provider will need to create and submit a change request within iQIES. Directions on how to submit a Record Deletion Request can be found in the HOPE Assessment Management Manual for Assessment Submitter available on the following website: hospice-providers	Updated to remove the words Special Manual and added a link to the resource that includes instruction for the newer automated process in iQIES.
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HOPE v1.02 to HOPE v1.03 Guidance Manual and Item Set Change Table

#	Section or Item Set(s) Affected	Section or Item / Text Affected	HOPE v1.02	HOPE v1.03	Rationale for Change / Comments
				Reference & Manuals QIES Technical Support Office.	
44.	Appendix A	APPENDIX A	ACRONYMS AND GLOSSARY N/A	ACRONYMS AND GLOSSARY ALF—Assisted Living Facility LOS—Length of Stay	Added two new Acronyms.
45.	Listservs	Listservs	Listserv Open Door Forum (ODF) listserv CMS regularly holds Open Door Forums in which it makes announcements pertinent to various programs/care settings. Open Door Forums are also an opportunity for live dialogue between CMS and the provider Medical Equipment Open Door Forum. Use the link to sign up: CMS listserv sign-up page .	Listserv Post-Acute Care (PAC) QRP listserv For the latest Hospice quality reporting information including, but not limited to, training, stakeholder engagement opportunities, and general updates about reporting requirements, quality measures, and reporting deadlines. Use this link to subscribe: Post-Acute Care QRP listserv sign-up page	Deleted the reference to the Open Door Forum Listserv. Added the PAC QRP listserv.