Hospice Quality Reporting Program Quality Measure Specifications User's Manual

Version 1.04

Effective February 25, 2026

Table of Contents

Chapter 1: Background and Manual Organization

Quality measures (QMs) are tools that help measure or quantify healthcare processes, outcomes, patient or resident perceptions and organizational structure/systems that are associated with the ability to provide high-quality services related to one or more quality goals.[1] The purpose of this manual is to present the methods used to calculate quality measures in the Centers for Medicare & Medicaid Services (CMS) Hospice Quality Reporting Program (HQRP). An overview of the HQRP and additional information pertaining to public reporting are available on the HQRP website.[2]

To view your provider's HQRP reports, please visit the CMS iQIES Systems for Providers webpage. Data submission deadlines and other important dates can be found on the key dates webpage: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Public-Reporting-Key-Dates-for-Providers.

This manual reflects the measures currently in the HQRP. Starting in Fiscal Year (FY)2022, the HQRP includes four measures that capture quality throughout the hospice stay. Endorsed measures include a Consensus-Based Entity (CBE) identifier number and non-endorsed measures include a CMS Inventory Tool (CMIT) identifier. These measures are the Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission, CBE #3235 (hereinafter referred to as the "Comprehensive Assessment at Admission (CBE #3235)", Hospice Visits in Last Days of Life or "HVLDL", (CBE #3645), the Hospice Care Index or "HCI" (CMIT #328), and the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey. The Comprehensive Assessment at Admission (CBE #3235) measures care processes at admission. The HVLDL measures care received during the last three days of life before death. The HCI measures care processes throughout the hospice stay. The CAHPS® Hospice Survey measures (CBE #2651) caregivers' experience of hospice care.

This manual also provides detailed information for future measures that will use data from the Hospice Outcome & Patient Evaluation (HOPE): Timely Follow-up for Pain Impact (CMIT #01795-02-C-HQR) and Timely Follow-up for Non-Pain Symptom Impact (CMIT #01796-01-C-HQR).

The CAHPS® Hospice Survey is not covered in this manual. For information on CBE #2651, please visit the CAHPS® Hospice Survey website.[3]

Outlined below are the organization of this manual and an overview of the information found in each section. Chapter 1 provides an overview of the manual, and the remaining chapters are organized by quality measure and provide detailed information about measure specifications and reporting components.

---

[1] Centers for Medicare & Medicaid Services. Hospice Quality Reporting Program. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting
[2] HQRP website. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting
[3] Centers for Medicare & Medicaid Services. CAHPS® Hospice Survey. Available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/CAHPS%C2%AE-Hospice-Survey.

- **Chapter 1** explains the purpose and structure of this manual.

- **Chapter 2** details the Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission, CBE #3235 (hereinafter referred to as the "Comprehensive Assessment at Admission (CBE #3235)", or just "CBE #3235". This will now be calculated from the Hospice Outcome & Patient Evaluation (HOPE).

- **Chapter 3** details Hospice Visits in the Last Days of Life (CBE #3645), a claims-based measure based on 8 quarters of Medicare hospice claims data.

- **Chapter 4** details the Hospice Care Index (HCI), a claims-based measure based on 8 quarters of Medicare hospice claims data.

- **Chapter 5** details the new process measures to be calculated from HOPE at some time after data collection begins on October 1, 2025: Timely Follow-up for Pain Impact (CMIT #01795-02-C-HQR) and Timely Follow-up for Non-Pain Symptom Impact (CMIT #01796-01-C-HQR).

- **Chapter 6** provides the specifications for the measures described in Chapters 2 through 5.

Chapter 2: Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission (CBE #3235)

Section 1: Measure Description

The purpose of this chapter is to describe the **Comprehensive Assessment at Admission** (CBE #3235), captures whether multiple key care processes were completed upon patients' admissions to hospice. It is a single "all or none" composite process measure that requires hospices to perform 7 care processes to receive credit. The care processes are:

1. Preferences
2. Beliefs/Values Addressed if desired by the patient
3. Pain Screening
4. Pain Assessment
5. Dyspnea Treatment
6. Dyspnea Screening
7. Patients Treated with an Opioid who are Given a Bowel Regimen

Since FY2022, the seven care processes are no longer individually publicly-reported. The composite measure is the only measure reported; hospices must perform all seven care processes to receive credit. Section 2 below describes the method in which eligible records are selected for calculating CBE #3235.

Section 2: Data Sources

Record Selection

An admission-anchored QM is designed to measure the quality of care surrounding the hospice admission.

The eligible records for the Comprehensive Assessment at Admission (CBE #3235) are selected as follows (note that **bold italic** text indicates terms defined in Appendix 1: Definitions):

1. Determine the **reporting** period.

2. Create **patient stays** and calculate **length of stay**.
   a. Sort the records in all **patient data streams** according to the **sort order**.
   b. Identify **stay(s)** for each patient. For each **stay**, identify **stay start date** and the admission record (when available); identify **stay end date** and the discharge record (when available).
   c. Calculate **length of stay**

3. Identify **Comprehensive Assessment at Admission (CBE #3235) sample**:
   a. Select stays to be included in the **Comprehensive Assessment at Admission (CBE #3235) sample** if the patient stays have a discharge record with the **target date**

within the *reporting period*. All eligible stays for a patient are included; thus, a patient can have multiple stays included in the Comprehensive Assessment at Admission (CBE #3235) sample.

4. Select each admission record (A0250 Reason for Record = [01]) associated with each patient stay for the *Comprehensive Assessment at Admission (CBE #3235) sample*.

5. Apply the Comprehensive Assessment at Admission (CBE #3235) specifications (see Section 3 below) to the selected admission records. Round all Comprehensive Assessment at Admission (CBE #3235) scores using the *rounding rule*.

Section 3: Measure Calculation

CBE #3235: Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission

Below are the steps to calculate Comprehensive Assessment at Admission (CBE #3235) using the individual component measures, i.e. the care processes, which comprise it.

1. Identify excluded stays:
    a. Patient stay is excluded if the patient is under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**).
    b. *Type 2 and 3* patient stays* (*see Appendix 1: Definitions).

    OR

2. Calculate the denominator count:
    a. Calculate the total number of *Type 1* stays* that do not meet the exclusion criteria. (*see Appendix 1: Definitions).

3. Calculate the hospice's overall numerator:
    Calculate the total number of stays in the denominator that meet the following criteria:

    a. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (**F2000A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date (**−7 ≤ F2000B − A0220 ≤ 5 and F2000B ≠ [−,^]**);
    OR
    The patient/responsible party was asked about preferences regarding life-sustaining treatments other than CPR (F2100A = [1,2]) no more than 7 days prior to admission or within 5 days of the admission date (−7 ≤ F2100B − A0220 ≤ 5 and F2100B ≠ [−,^]);
    OR
    The patient/responsible party was asked about preferences regarding hospitalization (**F2200A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date (**−7 ≤ F2200B − A0220 ≤ 5 and F2200B ≠ [−,^]**).

AND

b. The patient and/or caregiver was asked about spiritual/existential concerns (**F3000A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date (**−7 ≤ F3000B − A0220 ≤ 5 and F3000B ≠ [−,^]**).

AND

c. The patient was screened for pain within 2 days of the admission date (**J0900B - A0220 ≤ 2 and J0900B ≠ [−,^]**) and reported that they had no pain (**J0900C = [0]**);
    OR
    The patient was screened for pain within 2 days of the admission date (**J0900B − A0220 ≤ 2 and J0900B ≠ [−,^]**), the patient's pain severity was rated mild, moderate, or severe (**J0900C = [1,2,3]**), **AND** a standardized pain tool was used (**J0900D = [1,2,3,4]**).

AND[4]

d. For a patient whose pain severity was rated mild, moderate, or severe (**J0900C = [1,2,3]**) during the pain screening, a comprehensive pain assessment was completed within 1 day of the pain screening during which the patient screened positive for pain (**J0910B − J0900B ≤ 1 and J0910B and J0900B ≠ [−,^]**) **AND** included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (**5 or more items in J0910C1 − J0910C7 checked and not all J0910C boxes = [−,^]**);
    OR
    The patient reported that they had no pain during the pain screening (**J0900C = [0]**).
    AND

e. The patient was screened for shortness of breath within 2 days of the admission date (**J2030B − A0220 ≤ 2 and J2030B ≠ [−,^]**).

AND

f. For a patient that screened positive for shortness of breath (**J2030C = [1]**), the patient declined treatment (**J2040A = [1]**);

---

[4] Denotes paired measures. For paired measures, some patients may not qualify for the second component of the paired measure. In this instance, in the calculation of the composite measure, the patient will be eligible for the numerator as if hospices completed both care processes for the patient. For example, if a patient screened negative for pain, they are not eligible for the component pain assessment measure, however, in the composite measure, the patient would be considered to have had both processes completed (screening and assessment) and thus counted toward the numerator of the composite measure, provided all other composite measure numerator requirements are met.

OR

Treatment for shortness of breath was initiated prior to the screening for shortness of breath or within 1 day of the screening for shortness of breath during which the patient screened positive for shortness of breath (**J2040B − J2030B ≤ 1 and J2040B and J2030B ≠ [−,^]**);
OR
The patient screened negative for shortness of breath (**J2030C = [0]**).

AND[5]

g. For a patient who had a scheduled opioid initiated or continued (**N0500A= [1]**), there is documentation of why a bowel regimen was not initiated or continued (**N0520A = [1]**);
OR
For a patient who had a scheduled opioid initiated or continued (**N0500A= [1]**) a bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (**N0520B − N0500B ≤ [1] and N0520B and N0500B ≠ [−,^]**);
OR
The patient did not have a scheduled opioid initiated or continued (**N0500A = [0]**).

4. Calculate the hospice's overall observed score:
   a. Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the ***rounding rule***, as defined in Appendix 1.

Section 4: Public Reporting Threshold

Hospices must have at least 20 patients in the denominator (i.e., 20 hospice admissions by patients at least 18 years of age) during the reporting period for measure scores to be publicly reported. Hospices that do not meet this threshold will have measure scores suppressed.

Section 5: National and State Average Calculation

To calculate the national average for the Comprehensive Assessment at Admission QM, take the national sum of all the hospices' individual numerators and divide by the total summation of nationwide hospices' individual denominators. Statewide averages are calculated by dividing the statewide summations of numerators by statewide summation of denominators among all hospices located in that state. Round the national and state averages using the ***rounding rule***, as

---

[5] The Bowel Regimen item (**N0520**) is only completed if a scheduled opioid was initiated or continued (**N0500A = [1]**). If a scheduled opioid was not initiated or continued (**N0500A = [0]**), the patient will still be eligible for the composite measure numerator. For example, if a patient did not have a scheduled opioid initiated or continued, the patient would be counted toward the numerator of the composite measure, provided all other composite measure numerator requirements are met.

defined in Appendix 1. Note that both state and national averages include the scores of hospices that are suppressed on the compare tool on Medicare.gov and the Provider Data Catalog because the numbers of claims, stays, etc. did not meet the minimum threshold for public reporting.

Section 6: Component Measure Specifications

The seven component measures, i.e., care processes, used to calculate the Comprehensive Assessment at Admission (CBE #3235) measure are described in Table 2-1 followed by their specifications. Each of these components measures a hospice care process using the HOPE tool. The Comprehensive Assessment at Admission (CBE #3235) measure captures all seven component measures into a single QM.

Table 2-1. Comprehensive Assessment at Admission (CBE #3235) Component Measures

CBE Number	Measure Name
3235	Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission (CBE #3235) Includes the following components, care processes: 1. Preferences 2. Beliefs/Values Addressed (if desired by the patient) 3. Pain Screening 4. Pain Assessment 5. Dyspnea Screening 6. Dyspnea Treatment 7. Patients Treated with an Opioid Who Are Given a Bowel Regimen

Component Measure 1 of Comprehensive Assessment at Admission (CBE #3235): Preferences

Below are the steps to calculate the Preferences care process:

1. Identify excluded stays:
   a. Patient stay is excluded if the patient is under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
      OR
   b. *Type 2 and 3* patient stays.

2. Calculate the denominator count:
   a. Calculate the total number of *Type 1* stays that do not meet the exclusion criteria.

3. Calculate the hospice's overall numerator:
   Calculate the total number of stays in the denominator that meet any of the following criteria:
   a. The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation **(F2000A = [1,2])** no more than 7 days prior to

admission or within 5 days of the admission date **(-7 ≤ F2000B − A0220 ≤ 5 and F2000B ≠ [-,^])**;
OR

b. The patient/responsible party was asked about preferences regarding life-sustaining treatments other than CPR **(F2100A = [1,2])** no more than 7 days prior to admission or within 5 days of the admission date **(-7 ≤ F2100B − A0220 ≤ 5 and F2100B ≠ [-,^])**;
OR

c. The patient/responsible party was asked about preference regarding hospitalization **(F2200A = [1,2])** no more than 7 days prior to admission or within 5 days of the admission date **(-7 ≤ F2200B − A0220 ≤ 5 and F2200B ≠ [-,^])**.

4. Calculate the hospice's overall observed score:
   a. Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2.
   b. The score is converted to a percent value by multiplying by 100.
   c. Round the score using the ***rounding rule.***

Component Measure 2 of Comprehensive Assessment at Admission (CBE #3235): Beliefs & Values Addressed (if desired by the patient)

Below are the steps to calculate the Beliefs & Values Addressed (if desired by the patient) care process:

1. Identify excluded stays:

   a. Patient stay is excluded if patient is under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
      OR
   b. ***Type 2 and 3*** patient stays.

2. Calculate the denominator count:

   a. Calculate the total number of ***Type 1*** stays that do not meet the exclusion criteria.

3. Calculate the numerator count:

   a. Calculate the total number of stays in the denominator that the patient and/or caregiver was asked about spiritual/existential concerns **(F3000A = [1,2])** no more than 7 days prior to admission or within 5 days of the admission date **(-7 ≤ F3000B − A0220 ≤ 5 and F3000B ≠ [-,^])**.

4. Calculate the hospice's overall observed score:

   a. Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the ***rounding rule***.

Component Measure 3 of CBE #3235: Pain Screening

Below are the steps to calculate Pain Screening:

1. Identify excluded stays:

   a. Patient stay is excluded if patient is under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
      OR
   b. *Type 2 and 3* patient stays.

2. Calculate the denominator count:

   a. Calculate the total number of *Type 1* stays that do not meet the exclusion criteria.

3. Calculate the hospice's overall numerator:

   a. Calculate the total number of stays in the denominator that meet any of the following criteria:

      i. The patient was screened for pain within 2 days of the admission date **(J0900B − A0220 ≤ 2 and J0900B ≠ [-,^])** and reported that they had no pain **(J0900C = [0])**;
      OR
      ii. The patient was screened for pain within 2 days of the admission date **(J0900B − A0220 ≤ 2 and J0900B ≠ [-,^])**, the patient's pain severity was rated mild, moderate, or severe **(J0900C = [1,2,3]), AND** a standardized pain tool was used **(J0900D = [1,2,3,4])**.

4. Calculate the hospice's overall observed score:

   a. Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the *rounding rule.*

Component Measure 4 of Comprehensive Assessment at Admission (CBE #3235): Pain Assessment

Below are the steps to calculate the Pain Assessment care process:

1. Identify excluded stays:

   a. Patient stay is excluded if patient is under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
      OR
   b. *Type 2 and 3* patient stays.

2. Calculate the denominator count:

a. Calculate the total number of *Type 1* stays in the denominator where the patient's pain severity was rated mild, moderate, or severe **(J0900C = [1,2,3])** that do not meet the exclusion criteria.

3. Calculate the numerator count:
    a. Calculate the total number of stays where a comprehensive pain assessment was completed 1 day of the pain screening during which the patient was screened positive for pain **(J0910B − J0900B ≤ 1 and J0910B and J0900B ≠ [-,^]) AND** included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life **(5 or more items in J0910C1 − J0910C7 checked and not all J0910C boxes = [-,^])**.

4. Calculate the hospice's overall observed score:
    a. Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the *rounding rule.*

Component Measure 5 of Comprehensive Assessment at Admission (CBE #3235): Dyspnea Screening

Below are the steps to calculate the Dyspnea Screening care process:

1. Identify excluded stays:

    a. Patient stay is excluded if patient is under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
        OR
    b. *Type 2 and 3* patient stays.

2. Calculate the denominator count:

    a. Calculate the total number of *Type 1* stays that do not meet the exclusion criteria.

3. Calculate the numerator count:

    a. Calculate the total number of stays in the denominator where the patient was screened for shortness of breath within 2 days of the admission date **(J2030B − A0220 ≤ 2 and J2030B ≠ [-,^])**.

4. Calculate the hospice's overall observed score:

    a. Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the *rounding rule.*

Component Measure 6 of Comprehensive Assessment at Admission (CBE #3235): Dyspnea Treatment

Below are the steps to calculate the Dyspnea Treatment care process:

1. Identify excluded stays:

    a. Patient stay is excluded if patient is under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
        OR
    b. *Type 2 and 3* patient stays.

2. Calculate the denominator count:

    a. Calculate the total number of *Type 1* stays where the screening indicated the patient had shortness of breath **(J2030C = [1])**, that do not meet the exclusion criteria.

3. Calculate the hospice's overall numerator:

    a. Calculate the total number of stays in the denominator that meet any of the following criteria:

    b. The patient declined treatment **(J2040A = [1])**;
        OR
    c. Treatment for shortness of breath was initiated prior to the screening for shortness of breath or within 1 day of the screening for shortness of breath during which the patient screened positive for shortness of breath **(J2040B − J2030B ≤ 1 and J2040B and J2030B ≠ [-,^])**.

4. Calculate the hospice's overall observed score:

    a. Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the *rounding rule*.

Component Measure 7 of Comprehensive Assessment at Admission (CBE #3235): Patients Treated with an Opioid Who Are Given a Bowel Regimen

Below are the steps to calculate the Patients Treated with an Opioid Who Are Given a Bowel Regimen care process:

1. Identify Excluded Records (excluded stays):

    a. Patient stay is excluded if patient is under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
        OR
    b. *Type 2 and 3* patient stays.

2. Calculate the denominator count:

a. Calculate the total number of *Type 1* stays where a scheduled opioid was initiated or continued **(N0500A = [1])**, that do not meet the exclusion criteria.

3. Calculate the hospice's overall numerator:

   a. Calculate the total number of stays in the denominator that meet any of the following criteria:

   b. There is documentation of why a bowel regimen was not initiated or continued **(N0520A = [1])**;
   OR
   c. A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued **(N0520B − N0500B ≤ [1] and N0520B and N0500B ≠ [-,^])**.

4. Calculate the hospice's overall observed score:

   a. Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the *rounding rule.*

Chapter 3: Hospice Visits in the Last Days of Life (CBE #3645)

Section 1: Measure Description

Hospice Visits in the Last Days of Life or "HVLDL" (CBE #3645) measures the hospice provider's proportion of Medicare Fee-for-Service patients who received in-person visits from a registered nurse (RN) or medical social worker (MSW) on at least two out of the final three days of the patient's life.

HVLDL aims to capture the provision of services at the end-of-life. The last few days before death are typically the period in the terminal illness trajectory with the highest symptom burden.[6] During this time, patients experience many physical and emotional symptoms, necessitating close monitoring and drawing increasingly on hospice team resources.[7,8,9] Although Medicare-certified hospices are not given minimum visit mandates at the end-of-life, hospices should be equipped to meet the higher symptom and caregiving burdens of patients and their caregivers during this critical period.[10]

In 2022, HVLDL replaced a previously implemented QM, Hospice Visits when Death is Imminent. The major change for HVLDL was the data source, using claims data instead of records from the original Hospice Item Set. The original specifications were changed after reviewing the results from performance testing.[11]

Section 2: Data Sources

Data Sources

The measure is constructed from 8 quarters of Medicare Fee-for-Service hospice claims records, which are already collected by CMS.

---

[6] Hui D et al. (2014). Clinical Signs of Impending Death in Cancer Patients. The Oncologist. 19(6):681-687. doi:10.1634/theoncologist.2013-0457.

[7] de la Cruz, M., et al. (2014). Delirium, agitation, and symptom distress within the final seven days of life among cancer patients receiving hospice care. Palliative & Supportive Care, 13(2): 211-216. doi: 10.1017/S1478951513001144

[8] Dellon, E. P., et al. (2010). Family caregiver perspectives on symptoms and treatments for patients dying from complications of cystic fibrosis. Journal of Pain & Symptom Management, 40(6): 829-837. doi: 10.1016/j.jpainsymman.2010.03.024

[9] Kehl, K. A., et al. (2013). A systematic review of the prevalence of signs of impending death and symptoms in the last 2 weeks of life. American Journal of Hospice & Palliative Care, 30(6): 601-616. doi: 10.1177/1049909112468222

[10] Teno, J. M., et al. (2016). Examining Variation in Hospice Visits by Professional Staff in the Last 2 Days of Life. JAMA Internal Medicine, 176(3): 364-370. doi: 10.1001/jamainternmed.2015.7479

[11] For more information, *see Hospice Visits When Death is Imminent: Measure Validity Testing Summary and Re-Specifications* (2020); accessible via: https://www.cms.gov/files/document/hqrphospice-visits-when-death-imminent-testing-re-specification-reportoctober-2020.pdf.

Target Population

The target population is Medicare Part A enrolled beneficiaries discharged due to death from hospice services during the reporting period. Note that once the hospice benefit starts, Original Medicare covers everything related to the terminal illness. Original Medicare covers these services even for those in a Medicare Advantage Plan or other Medicare health plan.

Measure Reporting Period

The measure is calculated using 8 quarters of pooled Medicare Fee-for-Service claims data. That is, all data from across the 8 quarters are combined. All hospice claims that were eligible are assigned to the reporting period based upon the beneficiary's date of discharge from hospice.[12]

Section 3: Measure Calculation

Hospice Visits in the Last Days of Life (HVLDL) (CBE #3645)

Below are the steps to calculate the HVLDL measure:

1. The data are all Medicare hospice claims within the relevant time period (covering 8 quarters of data).

2. Calculate the denominator:
   a. Identify all Medicare hospice decedents discharged due to death within the reporting period.
      i. Identify the denominator: all Medicare hospice patient stays with the patient discharged to death within the measurement period as identified by the claims discharge status code, ***PTNT_DSCHRG_STUS_CD* equals [40, 41, or 42].**
   b. The exclusion criteria are that the:
      i. Patient received any continuous home care, respite care or general inpatient care in the final three days of life (exclude if **revenue codes[13] = [0652, 0655, or 0656]**).
      ii. Patient was enrolled with the hospice fewer than three calendar days.

3. Calculate the numerator:

   a. Cases meeting the target process are identified as the number of patient stays in the denominator for which registered nurses (RN) or medical social workers provided visits on at least two days of the final three days of life:
      i. Registered nurse visits are identified by revenue code **055x** with the presence of HCPCS code **G0299**. For HVLDL, only RN visits are included.
      ii. In-person visits from medical social workers are identified by revenue code **056x** (other than **0569**); HCPCS code **G0155.**
      iii. The last three days are defined as: the day of death, the day prior to death, and two days prior to death.

---

[12] Note at the time of development, a single year of data, Federal Fiscal Year 2018 (10/1/2017 – 9/30/18) was used for initial performance testing and calculations).

[13] Refer to Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf.

iv. Post-mortem visits (signified by the "**PM**" modifier" are *not* counted towards the numerator.

4. Calculate the measure score as the rates of patients meeting the target process.
   a. For each hospice, divide the total number of patients in the numerator (Step 3) by the total number of patients in the denominator (Step 2) and multiply by 100.
   b. The measure is not calculated for hospices with fewer than 20 patients in the denominator.

5. For any process measure, there are no risk adjustments to the measure score.

Section 4: Public Reporting Threshold

Hospices must have at least 20 patients in the denominator during the reporting period for measure scores to be publicly reported. This means 20 hospice discharges to death with enrollment of at least three days, and without any continuous home care, respite care or general inpatient care in the final three days of life. Hospices that do not meet this threshold will have measure scores suppressed.

Section 5: National and State Average Calculation

To calculate the national average for the Hospice Visits in the Last Days of Life, take the national sum of all the hospices' individual numerators and divide by the total summation of nationwide hospices' individual denominators.

Statewide averages are calculated by dividing the statewide summations of numerators by statewide summation of denominators among all hospices whose offices are located in that state.

Round the national and state averages using the *rounding rule*, as defined in Appendix 1.

Note that both state and national averages include the scores of hospices that are suppressed on the compare tool on Medicare.gov and the Provider Data Catalog because the numbers of claims, stays, etc. did not meet the minimum threshold for public reporting.

Chapter 4: Hospice Care Index (CMIT #328)

Section 1: Measure Description

The **Hospice Care Index** or "HCI" (CMIT #328) captures care processes occurring throughout the hospice stay, between admission and discharge. The HCI is a single measure comprised of ten indicators calculated from Medicare claims data. The indicators are:

1. Continuous Home Care (CHC) or General Inpatient (GIP) Provided,
2. Gaps in Skilled Nursing Visits,
3. Early Live Discharges,
4. Late Live Discharges,
5. Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission,
6. Burdensome Transitions (Type 2) - Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital,
7. Per-beneficiary Medicare Spending,
8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day,
9. Skilled Nursing Minutes on Weekends, and
10. Visits Near Death.

The index design of the HCI simultaneously monitors all ten indicators. Collectively these indicators represent different aspects of hospice service and thereby characterize hospices comprehensively, rather than on just a single care dimension. Each indicator equally affects the single HCI score, reflecting the equal importance of each aspect of care delivered from admission to discharge.

Section 2: Data Sources

Data Sources

The measure is constructed from 8 quarters of Medicare hospice claims records, which are already collected by CMS. Claims data are used for provider payments and subject to audit and therefore considered accurate and reliable for measure development. Claims data are used to calculate publicly reported quality measures in other CMS quality reporting programs. Claims are readily available and require no additional data submission beyond what is already collected in the normal course of business. Therefore, this measure poses no additional data collection burden to providers, patients, or caregivers.

Target Population

The target population is Medicare Part A enrolled beneficiaries utilizing hospice services (with claim through dates ending) during the measure time window. Note that once the hospice benefit starts, Original Medicare covers everything related to the terminal illness. Original Medicare covers these services even for those in a Medicare Advantage Plan or other Medicare health plan.

Measure Reporting Period

The measure is calculated using 8 quarters of pooled Medicare Fee-for-Service claims data.[14] That is, all data from across the 8 quarters are combined. All hospice stays that were eligible are assigned to the reporting period where (claim through dates end) during the measure time window.

Section 3: Measure Calculation

A hospice's HCI score is the sum of indicators for which a hospice has met the earned point criteria. Each HCI indicator is assigned a criterion that determines whether a point is earned toward the total index score. The criteria reflect either normative performance standards (such as providing certain kinds of services) or reference criteria relative to national hospice performance (such as performing higher or lower than a certain percentage of all hospices). Hospices will score worse if they meet fewer indicators' criteria and will score better if they meet more indicators' criteria.

A hospice is awarded a point for meeting each criterion for each of the 10 HCI indicators. A hospice's HCI score is the sum of the points earned from meeting the criterion of each indicator, with 10 as the highest score a hospice can attain for the HCI quality measure. Section 6 of this Chapter describes the process used to calculate each HCI indicator from the relevant data sources (see also Table 5-3).

Section 4: Public Reporting Threshold

Hospices must have at least 20 discharges with dates ending during the reporting period for the HCI overall measure score to be publicly reported. Hospices that do not meet this threshold will have the HCI overall measure score suppressed. The individual 10 HCI indicators do not have a minimum threshold, and these will be reported in the Provider Data Catalog as long as the hospice has at least 20 discharges overall.

Section 5: National and State Average Calculation

To calculate the national average for the Hospice Care Index, take the sum of all the hospices' total HCI scores and divide by the number of hospices. To calculate the state averages, take the sum of all the hospices' total HCI scores within each state and divide by the number of hospices located in that state. Round the national and state averages using the *rounding rule*, as defined in Appendix 1.

National averages for the individual indicators are similarly calculated by taking the sum of all the indicators numerator scores divided by the denominator sum nationwide (for a particular indicator). Similarly, state indicator averages are calculated by dividing the sum of numerator values by the sum of denominator values for all hospices located within that state. The national and state indicator averages are also rounded using the *rounding rule* from Appendix 1.

---

[14] Data from Federal Fiscal Years 2017-2019 (10/1/16 – 9/30/19) were used to develop this measure.

Note that both state and national averages include the scores of hospices that are suppressed on the compare tool on Medicare.gov and the Provider Data Catalog because the numbers of discharges, stays, etc. did not meet the minimum threshold for public reporting.

Section 6: Indicator Specifications

Each indicator is a key component of the HCI measure. The ten indicators are described in Table 4-1 followed by indicator specifications.

Table 4-1: Hospice Care Index Indicators

HCI Indicator	Description	Index Earned Point Criteria
Continuous Home Care (CHC) or General Inpatient (GIP) Provided	The percentage of hospice service days that were provided at the Continuous Home Care (CHC) or General Inpatient (GIP) level of care.	Hospice Score Above 0%
Gaps in Skilled Nursing Visits	The percentage of hospice stays, of at least 30 days, where the patient experienced at least one gap between nursing visits exceeding 7 days.	Below 90th Percentile Rank
Early Live Discharges	The percentage of all live discharges from hospice occurring within the first 7 days after hospice admission.	Below 90th Percentile Rank
Late Live Discharges	The percentage of all live discharges from hospice occurring on or after 180 days after hospice admission.	Below 90th Percentile Rank
Burdensome Transitions (Type 1) Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission	The percentage of all live discharges from hospice that were followed by hospitalization within two days and followed by hospital readmission within two days of hospital discharge.	Below 90th Percentile Rank
Burdensome Transitions (Type 2) Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital	The percentage of all live discharges from hospice that were followed by hospitalization within two days, and where the patient also died during the inpatient hospitalization stay.	Below 90th Percentile Rank
Per-beneficiary Medicare Spending	Average per-beneficiary Medicare payments (in U.S. dollars): the total number of payments Medicare paid to hospice providers divided by	Below 90th Percentile Rank

	the total number of hospice beneficiaries served.	
Skilled Nursing Care Minutes per Routine Home Care (RHC) Day	Average total skilled nurse minutes provided by hospices on all Routine Home Care (RHC) service days: the total number of skilled nurse minutes provided by the hospice on all RHC service days divided by the total number of RHC days the hospice serviced.	Above 10th Percentile Rank
Skilled Nursing Minutes on Weekends	The percentage of skilled nurse visits minutes that occurred on Saturdays or Sundays out of all skilled nurse visits provided by the hospice during RHC service days.	Above 10th Percentile Rank
Visits Near Death	The percentage of beneficiaries receiving at least one visit by a skilled nurse or social worker during the last three days of the patient's life (a visit on the date of death, the date prior to the date of death, or two days prior to the date of death).	Above 10th Percentile Rank

1. **Continuous Home Care (CHC) or General Inpatient (GIP) Provided**
   1. Calculate the denominator: The total number of hospice service days provided at any level of care within a reporting period.

   2. Calculate the numerator: The total number of CHC or GIP service days provided by the hospice within a reporting period.
      a. The provision of CHC and GIP are identified on hospice claims by the presence of hospice revenue center codes **0652** (CHC) and **0656** (GIP).

   3. Index Earned Point Criterion: Hospices earn a point towards the HCI if they provided at least one CHC or GIP service day within a reporting period.

2. **Gaps in Skilled Nursing Visits**
   1. Calculate the denominator: The total number of stays with the hospice, excluding hospice stays where the patient elected hospice for less than 30 days within a reporting period.

   2. Calculate the numerator: The number of stays with the hospice where the patient experienced at least one gap between skilled nursing visits (i.e., those from a RN or LPN) exceeding seven days, excluding hospice stays where the patient elected hospice for less than 30 days within a reporting period.
      a. Days of hospice service are identified based on the presence of revenue center codes **0651** (RHC), **0652** (CHC), **0655** (IRC), and **0656** (GIP) on hospice claims.
      b. Identify the dates billed for RHC, IRC, and GIP by examining the corresponding revenue center date (which identifies the first day in the sequence of days by level of care) and the revenue center units (which identify the number of days (including the first day) in the sequence of days by level of care).

    c.   Identify the dates billed for CHC by examining the revenue center date.[15]

    d.   A hospice stay is defined as a sequence of consecutive days for a particular beneficiary that are billed under the hospice benefit. A gap of at least one day without hospice ends the sequence. Hospice stays that include less than 30 consecutive days of hospice are excluded.

    e.   Nursing visits are identified if any of the following criteria are met:

        i.   The presence of revenue center code **055x** (Skilled Nursing) on the hospice claim. The date of the visit is recorded in the corresponding revenue center date. This code includes both RN and LPN visits.

        ii.   The presence of revenue code **0652** (CHC) on the hospice claim. Therefore, we assume any day with CHC care also includes nursing visits, even if not explicitly recorded.

        iii.   The presence of revenue code **0656** (GIP) on the hospice claim. Because Medicare does not require hospices to record all visits on the claim for the GIP level of care, we assume that days billed as GIP will include nursing visits even if not explicitly recorded.

3.   Based on the above information, if within a hospice stay, there are eight or more consecutive days where no nursing visits are provided, no CHC is provided, and no GIP is provided, then the hospice stay is identified as having a gap in nursing visits greater than seven days.

4.   For each hospice, the number of stays with at least one gap of eight or more days without a nursing visit (for stays of 30 or more days) is divided by the number of stays of 30 or more days.

5.   Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for gaps in nursing visits greater than seven days falls below the 90th percentile ranking among hospices nationally.

3. Early Live Discharges

1.   Calculate the denominator: The total number of all live discharges from the hospice within a reporting period.

    a.   Live discharges are assigned to a particular reporting period based on the date of the live discharge (which corresponds to the through date on the claim indicating the live discharge).

    b.   Live discharges occur when the patient discharge status code on a hospice claim *does not* equal a value from the following list: "30", "40", "41", "42", "50", "51".

2.   Calculate the numerator: The total number of live discharges from the hospice occurring within the first seven days of hospice within a reporting period.

    a.   Whether a live discharge occurs during the first seven days of hospice is assessed by looking at a patient's lifetime length of stay in hospice.[16]

---

[15] Hospices bill each day of CHC on a separate line item on the hospice claim.

[16] That is, measure the first seven days of hospice over a patient's lifetime and potentially across multiple hospice stays and fiscal years.

3. For each hospice, divide the number of live discharges in the first seven days of hospice by the number of live discharges.

4. Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual percentage of live discharges on or before the seventh day of hospice falls below the 90th percentile ranking among hospices nationally.

4. **Late Live Discharges**
   1. Calculate the denominator: The total number of all live discharges from the hospice within a reporting period.
      a. Live discharges are assigned to a particular reporting period based on the date of the live discharge (which corresponds to the through date on the claim indicating the live discharge).
      b. Live discharges occur when the patient discharge status code on a hospice claim _does not_ equal a value from the following list: "30", "40", "41", "42", "50", "51".

   2. Calculate the numerator: The total number of live discharges from the hospice occurring on or after 180 days of enrollment in hospice within a reporting period. Measure whether a live discharge occurs on or after the 180th day of hospice by looking at a patient's lifetime length of stay in hospice.

   3. For each hospice, divide the number of live discharges that occur on or after the 180th day of hospice by the number of live discharges.

   4. Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for live discharges on or after the 180th day of hospice falls below the 90th percentile ranking among hospices nationally.

5. **Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission**
   1. Calculate the denominator: The total number of all live discharges from the hospice within a reporting period.
      a. Live discharges occur when the patient discharge status code does not equal a value from the following list: "30", "40", "41", "42", "50", "51".

   2. Calculate the numerator: The total number of live discharges from the hospice followed by hospital admission within two days, then hospice readmission within two days of hospital discharge within a reporting period.
      a. Hospitalizations are found by looking at all Fee-for-Service Medicare inpatient claims.
      b. Consecutive and overlapping inpatient claims are combined to determine the full length of a single inpatient hospital stay (looking at the earliest from date and latest through date from a series of combined inpatient claims for a beneficiary).
      c. To be counted, the "from" date of the hospitalization had to occur no more than two days after the date of hospice live discharge. From there, identify all beneficiaries that

ended their hospitalization and were readmitted back to hospice no more than two days after the last date of the hospitalization.

3. For each hospice, divide the number of live discharges that are followed by a hospitalization (within two days of hospice discharge) and then followed by a hospice readmission (within two days of hospitalization) in a reporting period by the number of live discharges in that same fiscal year.

4. Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for Type 1 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

6. **Burdensome Transitions (Type 2) - Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital**
   1. Calculate the denominator: The total number of all live discharges from the hospice within a reporting year.
      a. Live discharges occur when the patient discharge status code does not equal a value from the following list: "30", "40", "41", "42", "50", "51".

   2. Calculate the numerator: The total number of live discharges from the hospice followed by a hospitalization within two days of live discharge with death in the hospital within a reporting year.
      a. Hospitalizations are found by looking at all Fee-for-Service Medicare inpatient claims.
      b. Consecutive and overlapping inpatient claims are combined to determine the full length of a single inpatient hospital stay (looking at the earliest from date and latest through date from a series of combined inpatient claims for a beneficiary).
      c. To be counted, the "from" date of the hospitalization had to occur no more than two days after the date of hospice live discharge. From there, identify all beneficiaries whose date of death is listed as occurring during the dates of the hospitalization.

   3. For each hospice, divide the number of live discharges that are followed by a hospitalization (within two days of hospice discharge) and then the patient dies in the hospital in a reporting period year by the number of live discharges in that same fiscal year.

   4. Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for Type 2 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

7. **Per-beneficiary Medicare Spending**
   1. Calculate the denominator: Total number of beneficiaries electing to receive care from the hospice provider within a reporting period.
      a. Count the number of unique beneficiaries on all hospice claims in the same period for a particular hospice.

2. Calculate the numerator: Total Medicare hospice payments received by a hospice within a reporting period.
   a. Sum all payments on hospice claims for a particular reporting year for a particular hospice.

3. Medicare spending per beneficiary is calculated by dividing the total payments by the total number of unique beneficiaries.

4. Index Earned Point Criterion: Hospices earn a point towards the HCI if their average Medicare spending per beneficiary falls below the 90th percentile ranking among hospices nationally.

8. Skilled Nursing Care Minutes per Routine Home Care (RHC) Day
   1. Calculate the denominator: The total number of RHC days provided by a hospice within a reporting period.
      a. Identify RHC days by the presence of revenue code **0651** on the hospice claim.
      b. Identify the dates of RHC service by the corresponding revenue center date (which identifies the first day of RHC) and the revenue center units (which identifies the number of days of RHC (including the first day of RHC).

   2. Calculate the numerator: Total skilled nursing minutes provided by a hospice on all RHC service days within a reporting period.
      a. Identify nursing visits by the presence of revenue code **055x** (Skilled Nursing) on the claim. This indicator includes both RN and LPN visits to recognize the frequency of skilled nursing visits and to maintain consistency in HCI when using revenue center code 055x.
      b. Count skilled nursing visits where the corresponding revenue center date overlaps with one of the days of RHC previously identified.
      c. Calculate the minutes of skilled nursing visits by taking the corresponding revenue center units and multiplying by 15.

   3. For each hospice, sum together all skilled nursing minutes provided on RHC days and divide by the sum of RHC days.

   4. Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for Nursing Minutes per RHC day falls above the 10th percentile ranking among hospices nationally.

9. Skilled Nursing Minutes on Weekends
   1. Calculate the denominator: Total skilled nursing minutes provided by the hospice during RHC service days within a reporting period.
      a. Identify RHC days by the presence of revenue code **0651** on the hospice claim.
      b. Identify the dates of RHC service by the corresponding revenue center date (which identifies the first day of RHC) and the revenue center units (which identifies the number of days of RHC (including the first day of RHC)).

    c.   Identify nursing visits by the presence of revenue code **055x** (Skilled Nursing) on the claim. This indicator includes both RN and LPN visits to recognize the frequency of skilled nursing visits and to maintain consistency in HCI when using revenue center code 055x.

    d.   Count skilled nursing visits where the corresponding revenue center date overlaps with one of the days of RHC previously identified.

    e.   Calculate the minutes of skilled nursing visits by taking the corresponding revenue center units and multiplying by 15.

2. Calculate the numerator: Total sum of minutes provided by the hospice during skilled nursing visits during RHC service days occurring on Saturdays or Sundays within a reporting period.

3. For each hospice, sum together all skilled nursing minutes provided on RHC days that occur on a Saturday or Sunday and divide by the sum of all skilled nursing minutes provided on all RHC days.

4. Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for percentage of skilled nursing minutes provided during the weekend is above the 10th percentile ranking among hospices nationally.

10. Visits Near Death

1. Calculate the denominator: The number of decedent beneficiaries with at least one day of hospice during the last three days of life.

2. Calculate the numerator: The number of decedent beneficiaries receiving a visit by a skilled nurse or social worker for the hospice in the last three days of the beneficiary's life within a reporting period.

    a.   Determine if a beneficiary was in hospice for at least one day during their last three days of life by comparing days of hospice enrollment from hospice claims to their date of death.

    b.   Identify skilled nursing visits and medical social service visits by the presence of revenue codes **055x** (Skilled Nursing) and **056x** (Medical Social Services) on the claim. (Assume that days billed as GIP (revenue code **0656**) include skilled nursing (i.e., RNs and LPNs) visits.)

        i.   Identify the dates of those visits by the revenue center date for those revenue codes.

       ii.   Post-mortem visits (signified by the "**PM**" modifier" are *not* counted towards the numerator

3. For each hospice, divide the number of beneficiaries with a skilled nursing or medical social services visit on a hospice claim during the last three days of life by the number of beneficiaries with at least one day of hospice during the last three days of life.

4. Index Earned Point Criterion: Hospices earn a point towards the HCI if their individual hospice score for percentage of decedents receiving a visit by a skilled nurse or social

worker in the last three days of life falls above the 10th percentile ranking among hospices nationally.

Chapter 5: Symptom Impact Process Measures Calculated from the Hospice Outcome & Patient Evaluation (HOPE): Timely Follow-up for Pain Impact (CMIT #01795-02-C-HQR) and Timely Follow-up for Non-Pain Symptom Impact (CMIT #01796- 01-C-HQR)

Section 1: Measure Description

This chapter describes **Timely Follow-up for Pain Impact** (CMIT #01795-02-C-HQR) and **Timely Follow-up for Non-Pain Symptom Impact** (CMIT #01796-01-C-HQR). These quality measures are calculated from data collected through the Hospice Outcomes & Patient Evaluation (HOPE) and submitted to CMS under the Hospice Quality Reporting Program (HQRP). Both measures track the percent of hospice patient assessments that have a symptom follow-up within two (2) calendar days when the symptom impact was initially assessed as moderate or severe. Specifically:

- *Timely Follow-up for Pain Impact* measures the percent of hospice patient assessments that have a symptom follow-up visit within two calendar days after pain impact was initially assessed as moderate or severe; and
- *Timely Follow-up for Non-Pain Symptom Impact* measures the percent of hospice patient assessments that have a symptom follow-up visit within two calendar days after non-pain symptom impact was initially assessed as moderate or severe.

Hospice clinicians collect data for these measures using HOPE. Symptom impact assessments are conducted at fixed timepoints during a hospice election:

- At admission (ADM) and
- Two HOPE Update Visits (HUVs).

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 moderate or severe pain or non-pain symptom impact identified during an Admission or HUV. For these measures, the measurement time window is defined as the date of the symptom impact screening (J2050B) where the impact is assessed as moderate or severe to two calendar days thereafter.

- Depending upon responses to the Symptom Impact item (J2051) at ADM and the two HUVs (each at specified timeframes), up to three SFVs may be required over the course of the hospice stay.
- If there is evidence of ongoing moderate or severe symptom impact during an SFV, no additional SFV is required for HOPE. However, the hospice staff are expected to continue following up with the patient based on their clinical and symptom management needs.

Section 2 below describes the method in which eligible records are selected. **Section 3** describes the steps for calculating the measure. **Section 4** and **Section 5** discuss considerations for public reporting, the minimum quality denominator threshold count for a hospice to have publicly reported data, and methods for calculating state and national measure scores, respectively.

Section 2: Data Sources

Record Selection

The eligible records for both hospice process measures are selected as follows (note that bold italic text indicates terms defined in **Appendix 1: Definitions**):

1. Determine the one-year/four-quarter *reporting period.*
2. Identify ADM records (A0250. = 01) and HUV records (A0250. = 02 or 03).
3. Select ADM and HUV records to be included in the *measure sample* where:
   a. The record is an ADM assessment and the admission date (A0220) falls within the *reporting period*.
      OR
   b. The record is an HUV assessment and the completion date (Z0350) falls within the *reporting period.*
4. Note that a patient can have multiple records included in the sample (up to three records per hospice election).
5. Apply the measure specifications (see Section 3 below) to the ADM and HUV records selected for the *measure sample*. Round all measure scores using the rounding rule.

Section 3: Measure Calculation

Steps to calculate each measure and data elements used in each step are as follows. Note that in the notation, numbers in brackets index a data element located on the ADM or HUV record (initial assessments) [1] or on the SFV record [2].

Step	Calculation of *Timely Follow-up for Pain Impact*	Calculation of *Timely Follow-up for Non-Pain Symptom Impact*
Step 1: Calculate the denominator	Total number of HOPE ADM or HUV assessments where pain impact was assessed as moderate or severe. • At ADM or HUV (A0250. = 1. Admission, 2. HUV #1, or 3. HUV #2) [1], ○ Symptom Impact - Pain (J2051.A.) [1] = 2. Moderate or 3. Severe	Total number of HOPE ADM or HUV assessments where any non-pain symptom impact was assessed as moderate or severe. • At ADM or HUV (A0250. = 1. Admission, 2. HUV #1, or 3. HUV #2) [1], ○ Symptom Impact - Shortness of Breath (J2051.B.) [1] = 2. Moderate or 3. Severe, or ○ Symptom Impact - Anxiety (J2051.C.) [1] = 2. Moderate or 3. Severe, or ○ Symptom Impact - Nausea (J2051.D.) [1] = 2. Moderate or 3. Severe, or ○ Symptom Impact - Vomiting (J2051.E.) [1] = 2. Moderate or 3. Severe, or

		o Symptom Impact - Diarrhea (J2051.F.) [1] = 2. Moderate or 3. Severe, or o Symptom Impact - Constipation (J2051.G.) [1] = 2. Moderate or 3. Severe, or o Symptom Impact - Agitation (J2051.H.) [1] = 2. Moderate or 3. Severe
Step 2: Remove any denominator exclusions	Remove if: • Patient was discharged from hospice for any reason before an SFV could be completed → **exclude** o Symptom Follow-up in-person visit was not completed (Symptom Follow-up Visit (J2052.A.) [2] = 0, and o Discharge Date (A0270.) [2] ≤ Date of Symptom Impact Screening (J2050.B.) [1] + two days • Hospice was unable to complete the SFV → **exclude** o Symptom Follow-up in-person visit was not completed (Symptom Follow-up Visit (J2052.A.) [2] = 0, and o Hospice Unable to Visit (J2052.C.) [2] = 1. Patient and/or caregiver declined an in-person visit, 2. Patient unavailable (e.g., in ED, hospital, travel outside of service area), or 3. Attempts to contact patient and/or caregiver were unsuccessful.	Remove if: • Patient was discharged from hospice for any reason before an SFV could be completed → **exclude** o Symptom Follow-up in-person visit was not completed (Symptom Follow-up Visit (J2052.A.) [2] = 0, and o Discharge Date (A0270.) [2] ≤ Date of Symptom Impact Screening (J2050.B.) [1] + two days • Hospice was unable to complete the SFV → **exclude** o Symptom Follow-up in-person visit was not completed (Symptom Follow-up Visit (J2052.A.) [2] = 0, and o Hospice Unable to Visit (J2052.C.) [2] = 1. Patient and/or caregiver declined an in-person visit, 2. Patient unavailable (e.g., in ED, hospital, travel outside of service area), or 3. Attempts to contact patient and/or caregiver were unsuccessful.
Step 3: Calculate the numerator	Number of HOPE ADM or HUV assessments for which a symptom follow-up visit date was within two days of the initial/triggering assessment date. • Date of in-person SFV (J2052.B.) [2] - Date of Symptom Impact Screening (J2050.B.) [1] ≤ Two	Number of HOPE ADM or HUV assessments for which a symptom follow-up visit date was within two days of the initial/triggering assessment date. • Date of in-person SFV (J2052.B.) [2] - Date of Symptom Impact Screening (J2050.B.) [1] ≤ Two (2)

	days when a Symptom Impact Screening occurred (J2050.A. = 1. yes) [1]	days when a Symptom Impact Screening occurred (J2050.A. = 1. yes) [1]
Step 4: Express the measure score as a proportion	Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the rounding rule, as defined in **Appendix 1**.	Divide the hospice's numerator count by its denominator count to obtain the hospice's observed score; that is, divide the result of step 3 by the result of step 2. The score is converted to a percent value by multiplying by 100. Round the score using the rounding rule, as defined in **Appendix 1**.

Section 4: Public Reporting Threshold

Hospices must have at least 20 qualifying denominator cases (i.e., 20 ADM or HUV assessments where symptom impact was assessed as moderate or severe) during the reporting period in each respective measure for scores to be publicly reported on the compare tool on Medicare.gov and Provider Data Catalog. Hospices that do not meet this threshold will have measure scores suppressed. If there are 20 qualifying denominator cases for one measure but not the other, then the measure above the threshold will be reported but the other with below 20 qualifying denominator cases will be suppressed.

Section 5: National and Average State Calculation

To calculate the national average for each measure, take the national sum of all the hospices' individual numerators and divide by the total summation of nationwide hospices' individual denominators. Statewide averages are calculated by dividing the statewide summations of numerators by statewide summation of denominators among all hospices located in that state. Round the national and state averages using the *rounding rule*, as defined in **Appendix 1**. Note that both state and national averages include the numerators and denominators of hospices that are publicly suppressed individually because the denominator size did not meet the minimum threshold for public reporting.

Chapter 6: Measure Logic Specifications

This chapter provides the logic specifications for each measure described in the preceding chapters calculated from HOPE or Medicare claims and administrative records. For information on the CAHPS® Hospice Survey, please visit the CAHPS® Hospice Survey website: https://www.cms.gov/medicare/quality/hospice/cahpsr-hospice-survey.

CMS implemented HOPE in the FY2025 Hospice Final Rule (CMS-1801-F). HOPE is a standardized set of items intended to capture patient-level data on each hospice stay. HOPE contains some original HIS items, and HOPE data will now replace the items on the admission record used to calculate the Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission (CBE #3235).

Table 5-1.   Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission (CBE #3235)

Measure Description
Percentage of patient stays during which the patient received all seven care processes: Preferences, Pain Screening, Pain Assessment, Dyspnea Treatment, Dyspnea Screening, Beliefs/Values Addressed if desired by the patient, and Patients Treated with an Opioid who are Given a Bowel Regimen, as applicable.
Measure Specifications
Numerator   **Type 1** patient stays from the denominator are included in the numerator if they meet the following criteria: • The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation (**F2000A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date (**−7 ≤ F2000B − A0220 ≤ 5 and F2000B ≠ [–,^]**) **OR** preferences regarding life-sustaining treatments other than CPR (**F2100A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date **(−7 ≤F2100B − A0220 ≤ 5 and F2100B ≠ [–,^]**) **OR** preference regarding hospitalization (**F2200A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date (**−7 ≤ F2200B − A0220 ≤ 5 and F2200B ≠ [–,^]**)   *AND*   • The patient and/or caregiver was asked about spiritual/existential concerns (**F3000A = [1,2]**) no more than 7 days prior to admission or within 5 days of the admission date **(−7 ≤ F3000B − A0220 ≤ 5 and F3000B ≠ [–,^]**)   *AND*   • The patient was screened for pain within 2 days of the admission date (**J0900B − A0220 ≤ 2 and J0900B ≠ [–,^]**) and reported that they had no pain (**J0900C = [0]**) **OR** The patient was screened for pain within 2 days of the admission date (**J0900B − A0220 ≤ 2 and J0900B ≠ [–,^]**), the patient's pain severity was rated mild, moderate, or severe (**J0900C = [1,2,3]**), and a standardized pain tool was used (**J0900D = [1,2,3,4]**)   *AND**

- For a patient whose pain severity was rated mild, moderate, or severe (**J0900C = [1,2,3]**), a comprehensive pain assessment was completed within 1 day of the pain screening during which the patient screened positive for pain (**J0910B − J0900B ≤ 1 and J0910B and J0900B ≠ [−,^]**) and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life (**5 or more items in J0910C1 − J0910C7 checked and not all J0910C boxes = [−,^]**) **OR** the patient reported that they had no pain during the pain screening (**J0900C = [0]**)

  AND

- The patient was screened for shortness of breath within 2 days of the admission date (**J2030B − A0220 ≤ 2 and J2030B ≠ [−,^]**)

  AND*

- For a patient that screened positive for shortness of breath (**J2030C = [1]**), the patient declined treatment (**J2040A = [1]**) **OR** Treatment for shortness of breath was initiated prior to the screening for shortness of breath or within 1 day of the screening for shortness of breath during which the patient screened positive for shortness of breath (**J2040B − J2030B ≤ 1 and J2040B and J2030B ≠ [−,^]**) OR the patient screened negative for shortness of breath (**J2030C = [0]**)

  AND†

- For a patient who had a scheduled opioid initiated or continued (**N0500A= [1]**), there is documentation of why a bowel regimen was not initiated or continued (**N0520A = [1]**) **OR** A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued (**N0520B − N0500B ≤ [1] and N0520B and N0500B ≠ [−,^]**) **OR** the patient did not have a scheduled opioid initiated or continued (**N0500A = [0]**).

Denominator

Patient stays, except for those with exclusions, are included in the denominator.

Exclusions

Patient stays are excluded if the patient is:

- Under 18 years of age as indicated by the birth date (**A0900**) and admission date (**A0220**);

  OR

- *Type 2 or 3* patient stays.

The following specifications describe the calculation of the seven components of the Comprehensive Assessment at Admission (CBE #3235). Meeting the requirements for all seven components is the algorithmic equivalent of the requirements for the overall composite. The components are calculated separately to inform the area(s) by which there was a failure to receive measure credit.

1. Preferences

The percentage of hospice patient stays with chart documentation that the hospice discussed (or attempted to discuss) preferences for life-sustaining treatments.

Numerator

Type 1 patient stays from the denominator are included in the numerator if they meet the following criteria:

- The patient/responsible party was asked about preference regarding the use of cardiopulmonary resuscitation **(F2000A = [1,2])** no more than 7 days prior to admission or within 5 days of the admission date **(-7 ≤ F2000B − A0220 ≤ 5 and F2000B ≠ [-,^])**;
    OR
- The patient/responsible party was asked about preferences regarding life-sustaining treatments other than CPR **(F2100A = [1,2])** no more than 7 days prior to admission or within 5 days of the admission date **(-7 ≤ F2100B − A0220 ≤ 5 and F2100B ≠ [-,^])**;
    OR
- The patient/responsible party was asked about preference regarding hospitalization **(F2200A = [1,2])** no more than 7 days prior to admission or within 5 days of the admission date **(-7 ≤ F2200B − A0220 ≤ 5 and F2200B ≠ [-,^])**.

Denominator

All patient stays except for those with exclusions.

Exclusions

Patient stays are excluded if the patient is:

- Under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
    OR
- *Type 2 or 3* patient stays.

2. Beliefs/Values Addressed (if desired by the patient)

The percentage of hospice patient stays with documentation of a discussion of spiritual/existential concerns or documentation that the patient and/or caregiver did not want to discuss.

Numerator

Type 1 patient stays from the denominator are included in the numerator if they meet the following criteria:

- The patient and/or caregiver was asked about spiritual/existential concerns **(F3000A = [1,2])** no more than 7 days prior to admission or within 5 days of the admission date **(-7 ≤ F3000B − A0220 ≤ 5 and F3000B ≠ [-,^])**

Denominator

All patient stays except for those with exclusions.

Exclusions

Patient stays are excluded if the patient is:

- Under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
    OR
- *Type 2 or 3* patient stays.

3. Pain Screening

The percentage of hospice patient stays during which the patient was screened for pain during the initial nursing assessment.

Numerator
Type 1 patient stays from the denominator are included in the numerator if they meet the following criteria:

- The patient was screened for pain within 2 days of the admission date **(J0900B − A0220 ≤ 2 and J0900B ≠ [-,^])** and reported that they had no pain **(J0900C = [0])**;
    OR
- The patient was screened for pain within 2 days of the admission date **(J0900B − A0220 ≤ 2 and J0900B ≠ [-,^])**, the patient's pain severity was rated mild, moderate, or severe **(J0900C = [1,2,3])**, and a standardized pain tool was used **(J0900D = [1,2,3,4])**.

Denominator
All patient stays except for those with exclusions.

Exclusions

Patient stays are excluded if the patient is:

- Under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
    OR
- *Type 2 or 3* patient stays.

4. Pain Assessment

The percentage of hospice patient stays during which the patient screened positive for pain and received a comprehensive assessment of pain within 1 day of screening.

Numerator
Type 1 patient stays from the denominator are included in the numerator if they meet the following criteria:

- A comprehensive pain assessment was completed within 1 day of the pain screening during which the patient was screened positive for pain **(J0910B − J0900B ≤ 1 and J0910B and J0900B ≠ [-,^])** and included at least 5 of the following characteristics: location, severity, character, duration, frequency, what relieves or worsens the pain, and

the effect on function or quality of life **(5 or more items in J0910C1 − J0910C7 checked and not all J0910C boxes = [-,^])**.

Denominator
Patient stays, except for those with exclusions, are included in the denominator if they meet the following criteria:
- The patient's pain severity was rated mild, moderate, or severe **(J0900C = [1,2,3])**.

Exclusions
Patient stays are excluded if the patient is:
- Under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
     OR
- *Type 2 or 3* patient stays.

5. Dyspnea Screening

The percentage of hospice patient stays during which the patient was screened for dyspnea during the initial nursing assessment.

Numerator
Type 1 patient stays from the denominator, except for those with exclusions, are included in the numerator if they meet the following criteria:
- The patient was screened for shortness of breath within 2 days of the admission date **(J2030B − A0220 ≤ 2 and J2030B ≠ [-,^])**.

Denominator
All patient stays except for those with exclusions.

Exclusions
Patient stays are excluded if the patient is:
- Under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
     OR
- *Type 2 or 3* patient stays.

6. Dyspnea Treatment

The percentage of hospice patient stays during which the patient screened positive for dyspnea and received treatment within 1 day of the screening.

Numerator
Type 1 patient stays from the denominator are included in the numerator if they meet the following criteria:
- The patient declined treatment **(J2040A = [1])**;
     OR

- Treatment for shortness of breath was initiated prior to the screening for shortness of breath or within 1 day of the screening for shortness of breath during which the patient screened positive for shortness of breath **(J2040B − J2030B ≤ 1 and J2040B and J2030B ≠ [-,^])**.

Denominator
Patient stays, except for those with exclusions, are included in the denominator if they meet the following criteria:
- The screening indicated the patient had shortness of breath **(J2030C = [1])**.

Exclusions
Patient stays are excluded if the patient is:
- Under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
    OR
- *Type 2 or 3* patient stays.

7. Patients Treated with an Opioid who are Given a Bowel Regimen

The percentage of patient stays with vulnerable adults treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed.

Numerator
Type 1 patient stays from the denominator are included in the numerator if they meet the following criteria:
- There is documentation of why a bowel regimen was not initiated or continued **(N0520A = [1])**;
    OR
- A bowel regimen was initiated or continued within 1 day of a scheduled opioid being initiated or continued **(N0520B − N0500B ≤ [1] and N0520B and N0500B ≠ [-,^])**.

Denominator
Patient stays, except for those with exclusions, are included in the denominator if they meet the following criteria:
- A scheduled opioid was initiated or continued **(N0500A = [1])**.

Exclusions
Patient stays are excluded if the patient is:
- Under 18 years of age as indicated by the birth date **(A0900)** and admission date **(A0220)**;
    OR
- *Type 2 or 3* patient stays.

[*]Denotes paired measures. For paired measures, some patients may not qualify for the second component of the paired measure. In this instance, in the calculation of the composite measure, the patient will be eligible for the numerator as if hospices completed both care processes for the

patients. For example, if a patient screened negative for pain, they are not eligible for the component pain assessment measure, however, in the composite measure, the patient would be considered to have had both processes completed (screening and assessment) and thus counted toward the numerator of the composite measure, provided all other composite measure numerator requirements are met.

†The Bowel Regimen item (**N0520**) is only completed if a scheduled opioid was initiated or continued (**N0500A = [1]**). If a scheduled opioid was not initiated or continued (**N0500A = [0]**), the patient will still be eligible for the composite measure numerator. For example, if a patient did not have a scheduled opioid initiated or continued, the patient would be counted toward the numerator of the composite measure, provided all other composite measure numerator requirements are met.

Table 5-2.   Hospice Visits in the Last Days of Life (CBE #3645)

Measure Description
The proportion of hospice patients who have received in-person visits from a Registered Nurse or Medical Social Worker (non-telephonically) on at least two out of the final three days of the patient's life.

Measure Specifications
Numerator
The number of patient stays in the denominator in which the patient and/or caregiver received in-person visits from registered nurses or medical social workers on at least two of the final three days of the patient's life, as captured by hospice claims records.
Registered nurse visits are identified by revenue code **055x** with the presence of Healthcare Common Procedure Coding System (HCPCS) code **G0299** (Note that the numerator *does NOT* include G0300 - LPN visits). Non-telephonic visits by medical social workers are identified by revenue code **056x** (other than 0569); HCPCS code **G0155**.
The last three days are defined as: the day of death (the same as the date provided in **A0270**, Discharge Date), the day prior to death (calculated as **A0270** minus 1), and two days prior to death (calculated as **A0270** minus 2).
Denominator
All Medicare hospice patient stays with the patient discharged to death within the measurement period as identified by the claims discharge status code, *PTNT_DSCHRG_STUS_**CD equals [40, 41, or 42].** All hospice patient stays except those meeting exclusion criteria as identified below.
Exclusions
Patient stays are excluded if the patient:
• Received any continuous home care, respite care or general inpatient care in the final three days of life (exclude if **revenue codes = [0652, 0655, or 0656]**).
OR
• Was enrolled in hospice for less than three days.

Table 5-3.   Hospice Care Index (CMIT #328)

Measure Description
The Hospice Care Index monitors a broad set of claims-based indicators of hospice care processes. The ten indicators reflect care throughout the hospice stay.
Measure Specifications

Total Index Score

The sum out of a possible 10 indicators for which a hospice achieved the Index Earned Point Criterion as identified below.

1. **Continuous Home Care (CHC) or General Inpatient (GIP) Provided**

   Numerator

   The total number of CHC or GIP service days provided by the hospice within a reporting period. The provision of CHC and GIP are identified on hospice claims by the presence of revenue center codes **0652** (CHC) and **0656** (GIP).

   Denominator

   The total number of hospice service days provided by the hospice at any level of care within a reporting period.

   Index Earned Point Criterion

   Hospices earn a point towards the HCI if they provided at least one CHC or GIP service day within a reporting period.

2. **Gaps in Skilled Nursing Visits**

   Numerator

   The number of stays with the hospice where the patient experienced at least one gap between nursing visits exceeding seven days, excluding hospice stays where the patient elected hospice for less than 30 days within a reporting period.

   Days of hospice service are identified based on the presence of revenue center codes **0651** (RHC), **0652** (CHC), **0655** (IRC), and **0656** (GIP) on hospice claims.

   Dates billed for RHC, IRC, and GIP are identified by examining the corresponding revenue center date (which identifies the first day in the sequence of days by level of care) and the revenue center units (which identify the number of days (including the first day) in the sequence of days by level of care). Dates billed for CHC are identified by examining the revenue center date.[17]

   A hospice stay is defined as a sequence of consecutive days for a particular beneficiary that are billed under the hospice benefit. A gap of at least one day without hospice ends the sequence. Hospice stays that include less than 30 consecutive days of hospice are excluded. Examine the timing of the provision of nursing visits within those stays.

---

[17] Hospices bill each day of CHC on a separate line item on the hospice claim.

Measure Description

Skilled nursing visits are identified if any of the following criteria are met:

- The presence of revenue center code **055x** (Skilled Nursing) on the hospice claim. The date of the visit is recorded in the corresponding revenue center date. This code includes both RN and LPN visits.

- The presence of revenue code **0652** (CHC) on the hospice claim.

- The presence of revenue code **0656** (GIP) on the hospice claim.

Based on the above information, if within a hospice stay, there are eight or more consecutive days where no nursing visits are provided, no CHC is provided, and no GIP is provided, then the hospice stay is identified as having a gap in nursing visits greater than seven days.

Denominator

The total number of stays with the hospice, excluding hospice stays where the patient elected hospice for less than 30 days within a reporting period.

Index Earned Point Criterion

Hospices earn a point towards the HCI if their individual hospice score for gaps in nursing visits greater than seven days falls below the 90th percentile ranking among hospices nationally.

3. **Early Live Discharges**

Numerator

The total number of live discharges from the hospice occurring within the first seven days of hospice within a reporting period.

Live discharges are assigned to a particular year based on the date of the live discharge (which corresponds to the through date on the claim indicating the live discharge).

Live discharges occur when the patient discharge status code on a hospice claim does not equal a value from the following list: "30", "40", "41", "42", "50", "51".

Whether a live discharge occurs during the first seven days of hospice is assessed by looking at a patient's lifetime length of stay in hospice.[18]

Denominator

The total number of all live discharges from the hospice within a reporting period.

Index Earned Point Criterion

---

[18] That is, measure the first seven days of hospice over a patient's lifetime and potentially across multiple hospice stays and fiscal years.

Measure Description

Hospices earn a point towards the HCI if their individual percentage of live discharges on or before the seventh day of hospice falls below the 90th percentile ranking among hospices nationally.

4. **Late Live Discharges**

Numerator

The total number of live discharges from the hospice occurring on or after 180 days of enrollment in hospice within a reporting period.

Live discharges are assigned to a particular year based on the date of the live discharge (which corresponds to the through date on the claim indicating the live discharge).

Live discharges occur when the patient discharge status code on a hospice claim does not equal a value from the following list: "30", "40", "41", "42", "50", "51".

Whether a live discharge occurs on or after the 180th day of hospice is assessed by looking at a patient's lifetime length of stay in hospice.

Denominator

The total number of all live discharges from the hospice within a reporting period.

Index Earned Point Criterion

Hospices earn a point towards the HCI if their individual hospice score for live discharges on or after the 180th day of hospice falls below the 90th percentile ranking among hospices nationally.

5. **Burdensome Transitions (Type 1) - Live Discharges from Hospice Followed by Hospitalization and Subsequent Hospice Readmission**

Numerator

The total number of live discharges from the hospice followed by hospital admission within two days, then hospice readmission within two days of hospital discharge within a reporting period.

Live discharges occur when the patient discharge status code does not equal a value from the following list: "30", "40", "41", "42", "50", "51".

Hospitalizations are found by looking at all Fee-for-Service Medicare inpatient claims.

Consecutive and overlapping inpatient claims are combined to determine the full length of a single inpatient hospital stay (looking at the earliest from date and latest through date from a series of combined inpatient claims for a beneficiary).

To be counted, from date of the hospitalization had to occur no more than two days after the date of hospice live discharge. From there, identify all beneficiaries that ended their hospitalization and were readmitted back to hospice no more than two days after the last date of the hospitalization.

Denominator

The total number of all live discharges from the hospice within a reporting period.

Index Earned Point Criterion

Hospices earn a point towards the HCI if their individual hospice score for Type 1 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

6. **Burdensome Transitions (Type 2) - Live Discharges from Hospice Followed by Hospitalization with the Patient Dying in the Hospital**

Numerator

The total number of live discharges from the hospice followed by a hospitalization within two days of live discharge with death in the hospital within a reporting period.

Live discharges occur when the patient discharge status code does not equal a value from the following list: "30", "40", "41", "42", "50", "51".

Hospitalizations are found by looking at all Fee-for-Service Medicare inpatient claims.

Consecutive and overlapping inpatient claims are combined to determine the full length of a single inpatient hospital stay (looking at the earliest from date and latest through date from a series of combined inpatient claims for a beneficiary).

To be counted, from date of the hospitalization had to occur no more than two days after the date of hospice live discharge. From there, identify all beneficiaries whose date of death is listed as occurring during the dates of the hospitalization.

Denominator

The total number of all live discharges from the hospice within a reporting period.

Index Earned Point Criterion

Hospices earn a point towards the HCI if their individual hospice score for Type 2 burdensome transitions falls below the 90th percentile ranking among hospices nationally.

7. **Per-beneficiary Medicare Spending**

Numerator

Total Medicare hospice payments received by a hospice within a reporting period.

The sum of all payments on hospice claims for a particular fiscal year for a particular hospice.

Denominator

Total number of beneficiaries electing hospice within a reporting period.

Measure Description

The number of unique beneficiaries on all hospice claims in the same year for a particular hospice.

Index Earned Point Criterion

Hospices earn a point towards the HCI if their average Medicare spending per beneficiary falls below the 90th percentile ranking among hospices nationally.

8. **Skilled Nursing Care Minutes per Routine Home Care (RHC) Day**

   Numerator

   Total skilled nursing minutes provided by a hospice on all RHC service days within a reporting period.

   RHC days are identified by the presence of revenue code **0651** on the hospice claim. Dates of RHC service are identified by the corresponding revenue center date (which identifies the first day of RHC) and the revenue center units (which identifies the number of days of RHC (including the first day of RHC)).

   Skilled nursing visits are identified by the presence of revenue code **055x** (Skilled Nursing) on the claim. This code includes both RN and LPN visits.

   Skilled nursing visits are counted where the corresponding revenue center date overlaps with one of the days of RHC previously identified.

   Minutes of skilled nursing visits are calculated by taking the corresponding revenue center units and multiplying by 15.

   Denominator

   The total number of RHC days provided by a hospice within a reporting period.

   Index Earned Point Criterion

   Hospices earn a point towards the HCI if their individual hospice score for Nursing Minutes per RHC day falls above the 10th percentile ranking among hospices nationally.

9. **Skilled Nursing Minutes on Weekends**

   Numerator

   Total sum of minutes provided by the hospice during skilled nursing visits during RHC service days occurring on Saturdays or Sundays within a reporting period.

   RHC days are identified by the presence of revenue code **0651** on the hospice claim. Dates of RHC service are identified by the corresponding revenue center date (which identifies the first day of RHC) and the revenue center units (which identifies the number of days of RHC (including the first day of RHC)).

   Skilled nursing visits are identified by the presence of revenue code **055x** (Skilled Nursing) on the claim. This code includes both RN and LPN visits.

Measure Description

Skilled nursing visits are counted where the corresponding revenue center date overlaps with one of the days of RHC previously identified.

Minutes of skilled nursing visits are calculated by taking the corresponding revenue center units and multiplying by 15.

Denominator

Total skilled nursing minutes provided by the hospice during RHC service days within a reporting period.

Index Earned Point Criterion

Hospices earn a point towards the HCI if their individual hospice score for percentage of skilled nursing minutes provided during the weekend is above the 10th percentile ranking among hospices nationally.

10. **Visits Near Death**

Numerator

The number of decedent beneficiaries receiving a visit by a skilled nurse or social worker staff for the hospice in the last three days of the beneficiary's life within a reporting period.

Whether a beneficiary was in hospice for at least one day during their last three days of life is determined by comparing days of hospice enrollment from hospice claims to their date of death.

Nursing visits and medical social service visits are identified by the presence of revenue codes **055x** (Skilled Nursing) and **056x** (Medical Social Services) on the claim. Dates of those visits are identified by the revenue center date for those revenue codes. The 055x revenue code includes both RN and LPN visits.

Days billed as GIP (revenue code **0656**) are assumed to include nursing visits.

Denominator

The number of decedent beneficiaries with at least one day of hospice during their last three days of life.

Index Earned Point Criterion

Hospices earn a point towards the HCI if their individual hospice score for percentage of decedents receiving a visit by a skilled nurse or social worker in the last three days of life falls above the 10th percentile ranking among hospices nationally.

Table 5-4. Timely Follow-up for Pain Impact

Measure Description
The percent of hospice patient assessments that have a symptom follow-up visit within two calendar days after pain impact was initially assessed as moderate or severe.

Measure Specifications
Numerator
Number of HOPE ADM or HUV assessments for which a symptom follow-up visit date was within two days of the initial/triggering assessment date.
• Date of in-person SFV (J2052.B.) [2] - Date of Symptom Impact Screening (J2050.B.) [1] ≤ Two days when a Symptom Impact Screening occurred (J2050.A. = 1. yes) [1]
Denominator
Total number of HOPE ADM or HUV assessments where pain impact was assessed as moderate or severe.
• At ADM or HUV (A0250. = 1. Admission, 2. HUV #1, or 3. HUV #2) [1], Symptom Impact - Pain (J2051.A.) [1] = 2. Moderate or 3. Severe
Exclusions
Remove if:
• Patient was discharged from hospice for any reason before an SFV could be completed → **exclude**
o Symptom Follow-up in-person visit was not completed (Symptom Follow-up Visit (J2052.A.) [2] = 0, and
o Discharge Date (A0270.) [2] ≤ Date of Symptom Impact Screening (J2050.B.) [1] + two days
• Hospice was unable to complete the SFV → **exclude**
o Symptom Follow-up in-person visit was not completed (Symptom Follow-up Visit (J2052.A.) [2] = 0, and
o Hospice Unable to Visit (J2052.C.) [2] = 1. Patient and/or caregiver declined an in-person visit, 2. Patient unavailable (e.g., in ED, hospital, travel outside of service area), or 3. Attempts to contact patient and/or caregiver were unsuccessful.

Table 5-5.   Timely Follow-up for Non-Pain Impact

Measure Description
The percent of hospice patient assessments that have a symptom follow-up visit within two calendar days after non-pain symptom impact was initially assessed as moderate or severe.
Measure Specifications
Numerator
Number of HOPE ADM or HUV assessments for which a symptom follow-up visit date was within two days of the initial/triggering assessment date.
• Date of in-person SFV (J2052.B.) [2] - Date of Symptom Impact Screening (J2050.B.) [1] ≤ Two days when a Symptom Impact Screening occurred (J2050.A. = 1. yes) [1]
Denominator
Total number of HOPE ADM or HUV assessments where any non-pain symptom impact was assessed as moderate or severe.
• At ADM or HUV (A0250. = 1. Admission, 2. HUV #1, or 3. HUV #2) [1],
o Symptom Impact - Shortness of Breath (J2051.B.) [1] = 2. Moderate or 3. Severe, or
o Symptom Impact - Anxiety (J2051.C.) [1] = 2. Moderate or 3. Severe, or
o Symptom Impact - Nausea (J2051.D.) [1] = 2. Moderate or 3. Severe, or

- Symptom Impact - Vomiting (J2051.E.) [1] = 2. Moderate or 3. Severe, or
- Symptom Impact - Diarrhea (J2051.F.) [1] = 2. Moderate or 3. Severe, or
- Symptom Impact - Constipation (J2051.G.) [1] = 2. Moderate or 3. Severe, or
- Symptom Impact - Agitation (J2051.H.) [1] = 2. Moderate or 3. Severe

Exclusions

Remove if:

- Patient was discharged from hospice for any reason before an SFV could be completed → **exclude**
  - Symptom Follow-up in-person visit was not completed (Symptom Follow-up Visit (J2052.A.) [2] = 0, and
  - Discharge Date (A0270.) [2] ≤ Date of Symptom Impact Screening (J2050.B.) [1] + two days
- Hospice was unable to complete the SFV → **exclude**
  - Symptom Follow-up in-person visit was not completed (Symptom Follow-up Visit (J2052.A.) [2] = 0, and
  - Hospice Unable to Visit (J2052.C.) [2] = 1. Patient and/or caregiver declined an in-person visit, 2. Patient unavailable (e.g., in ED, hospital, travel outside of service area), or 3. Attempts to contact patient and/or caregiver were unsuccessful.

Appendix 1: Definitions

The following definitions are used in the manual and may assist in understanding the calculation of the measures.

Index Earned Point Criterion
Each of the ten HCI indicators has a defined threshold for determining whether a hospice receives a point towards its cumulative HCI score. If a hospice meets the criterion for an indicator, it earns a point towards the full index score.

Indicator
The HCI component indicators reflect various elements and outcomes of care provided between admission and discharge. The HCI uses information from all ten indicators to collectively represent a hospice's ability to address patients' needs, best practices hospices should observe, and/or care outcomes that matter to consumers. Each indicator is a key component of the HCI measure, and all ten are necessary to derive the HCI score.

Measure Sample
Records that are included in the *reporting period*.

Patient data stream
Consists of all records for a specific patient at a specific hospice in a particular *reporting period*.

Patient Stay
(For the Comprehensive Assessment at Admission (CBE #3235) measure sample): A *Type 1* patient stay is eligible to be included in the Comprehensive Assessment at Admission (CBE #3235) sample if the patient stay has a discharge record (A0250 = [09]) with the discharge date (A0270) within the reporting period. A patient can have multiple stays included in the measure sample. All eligible stays for a patient are included.

- For Comprehensive Assessment at Admission (CBE #3235) calculation purposes, both the admission and the discharge records are assigned to a reporting period based on the discharge date.

- The patient stays included in a Comprehensive Assessment at Admission (CBE #3235) sample could span across quarters, which means the admission record could have a target date outside the reporting period.

Reporting period
The span of time that defines the period of data that will be publicly reported.

Rounding Rule
Generally, quality measure scores, (where applicable), including national and state averages, are rounded to one decimal.

- This is accomplished using the following method: *If the digit after the first decimal (in second place), is greater than or equal to 5, add 1 to the first digit after the decimal, otherwise, the first digit will remain unchanged. All digits following the first digit after the decimal will be dropped. (e.g., 9.52% would be rounded down to 9.5%; and 8.76% would be rounded up to 8.8%).*

Sort order

For the Comprehensive Assessment at Admission (CBE #3235) measure, the records in a patient's data stream must be sorted by the following variables:

- Provider Internal ID

- Resident Internal ID

- Target date (descending): This will cause records to appear in reverse chronological order so that the most recent records appear first in the data stream. This will also ensure that the discharge record appears prior to the admission record in the data stream, when a discharge record for a patient stay is available (i.e., the patient was discharged).

- Item A0250 Reason for Record (descending): If more than one record shares a target date (e.g., the patient was admitted and discharged on the same day), this will cause the discharge record to appear first in the data stream, followed by the admission record.

Stay

The period of time between a patient's admission to a hospice and either (a) a discharge or (b) the end of the reporting period, whichever comes first. Because a patient can leave and return to hospice as many times as they wish, a single patient can have multiple stays in a reporting period.

Specifically for the Comprehensive Assessment at Admission (CBE #3235):

- A patient stay starts with an admission record (A0250 = [01]). The stay start date is the admission date (A0220) on the admission record.

  - When the admission record that starts a stay is missing (i.e., when a discharge record has no matching admission record for the same patient with the same admission date and in the same hospice), the stay start date is the admission date (A0220) on the discharge record.

- A patient stay ends with either (a) a discharge record (A0250 = [09]) or (b) the end of the reporting period, whichever comes first.

  - When a patient stay ends with a discharge record (A0250 = [09]), the ***stay end date*** is the discharge date (A0270) on the discharge record.

- The stay end date must be the same as or later than the stay start date.

- Both the admission and the discharge records associated with the patient stay must have identical admission dates (A0220).

  - When a patient stay ends with the end of the reporting period (this typically indicates that the patient is still enrolled with the hospice at the end of the reporting period), the ***stay end date*** is the end of the reporting period.

- The admission and discharge records that define the start and the end of patient stays are paired by matching the patient identifier (State Code and Resident Internal ID), hospice identifier (Provider Internal Number), and admission date (A0220). If multiple admission records (or multiple discharge records) share the same information in these matching criteria,

the most recent chronological submission is kept and used. The submission time is first determined by submission date (SUBMSN_DT) and then, if multiple records are submitted on the same day, by the highest-numbered Hospice Assessment ID (HOSPC_ASMT_ID).

- The definitions above generate three types of stays for a reporting period:

    - *Type 1*: stays with both the admission and the discharge records (i.e., discharged stays).

    - *Type 2*: stays with the discharge record but no admission record (i.e., discharged stays but missing the admission records).

    - *Type 3*: stays with the admission record but no discharge record (i.e., active stays as of the end of the reporting period).

Target date

For the Comprehensive Assessment at Admission (CBE #3235) measure, the record's target date is defined as follows:

- For an admission record (A0250 Reason for Record = [01]), the admission target date is equal to the admission date (A0220).

- For a discharge record (A0250 Reason for Record = [09]), the discharge target date is equal to the discharge date (A0270).

Appendix 2: Help Desk Contact List

HOSPICE RESOURCES AND HELP DESKS

Hospice Quality Reporting Program (HQRP)

CMS' HQRP website and links to topic specific webpages.

https://www.cms.gov/medicare/quality/hospice

HospiceQualityQuestions@cms.hhs.gov

HQRP Public Reporting

Key Dates for Providers:
https://www.cms.gov/medicare/quality/hospice/public-reporting-key-dates-providers

Provider Preview Reports & Requests for CMS Review:
https://www.cms.gov/medicare/quality/hospice/public-reporting-provider-preview-report-and-requests-cms-review-data

HospicePRQuestions@cms.hhs.gov

CAHPS® Hospice Survey

CAHPS Hospice Survey and Star Ratings.

https://www.cms.gov/medicare/quality/hospice/cahpsr-hospice-survey

HospiceCAHPSSurvey@hsag.com
(844) 472-4621

iQIES

Data submission, processing, technical questions, error messages, or reports.

https://qtso.cms.gov/providers/hospice-providers

iQIES@cms.hhs.gov
(877) 201-4721

HQRP Reconsideration Process

Extensions & Exemptions:
https://www.cms.gov/medicare/quality/hospice/hqrp-extensions-and-exemption-requests

Reconsideration Requests:
https://www.cms.gov/medicare/quality/hospice/hqrp-reconsideration-requests

HospiceQRPReconsiderations@cms.hhs.gov