March 30, 2026

Shequila Purnell-Saunders
Director, Division of Chronic & Post-Acute Care
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Improvements for the Hospice Outcomes and Patient Evaluation Tool

Dear Director Purnell-Saunders,

On behalf of LeadingAge, the National Alliance for Care at Home, and the National Partnership for Healthcare and Hospice Innovation (NPHI), we again wish to thank CMS and its contractor, Abt Associates, for the recent HQRP Provider Association call and opportunity to share our respective members' experiences with implementation of the HOPE and the following recommendations. These items not only impact the quality of care but also the quality of data CMS receives, provider payment and day-to-day operations. Some of the clarifications have been addressed verbally in the HOPE coding training and/or the HOPE forum held in February. However, we look forward to future opportunities to share member experiences and feedback on HOPE and the HQRP.

Waive Compliance Threshold for First Quarter of HOPE Implementation

First and foremost, we again strongly urge CMS to exclude the first quarter of HOPE submissions from the 2025 HQRP participation and Timeliness Compliance calculation. The Hospice Quality Reporting Program (HQRP) carries uniquely severe financial consequences for hospice providers. It is a "pay-for-reporting" program, which requires hospices to submit a high percentage (90%) of data records within a calendar year or receive an annual payment update penalty of four percent. This penalty is twice that of other providers and has significant impact on hospice providers, as many are small, independent businesses, a great deal of which are not-for-profit. The consequence of adverse outcomes cannot be understated. The risk of negative financial consequences for hospice providers is largely dependent on the last quarter of 2025. This was the first quarter of HOPE submissions and required hospice providers to traverse two transitions – iQIES and HOPE - that were not within their control. This occurred during a uniquely challenging government shutdown. During this time, helpdesks were not open as usual, and hospices were unable to get answers to questions and guidance for situations impacting submissions.

CMS has stated that it does not intend to use the data submitted during the first quarter of HOPE for public reporting purposes because this quarter is considered part of the learning curve and is not reliable for public reporting. It is also not reliable as an indication of a hospice's annual compliance

performance for timely submissions. During the final quarter of 2025, hospices were managing two additional timepoints compared to the previous data reporting tool, the Hospice Item Set (HIS), and simultaneously migrating from QIES to iQIES while navigating inconsistencies in instructions without real-time support to resolve issues. These are extraordinary implementation circumstances.

Clearly Defining Assessment

Throughout the HOPE Manual the term "assessment" is used to describe the tasks that are to occur to gather data for HOPE completion. While we appreciate CMS' attempt to correct this issue in the most recent version of the Manual, published October 1, 2025, more clarification is necessary. The use of the term "assessment" throughout the Manual is viewed by some states and hospice providers as limiting the types of nurses who can complete the HOPE Symptom Follow-up Visit (SFV) to RNs only despite the fact that CMS indicates LPNs/LVNs are able to complete these types of visits. Current healthcare scope of practice and accepted utilization of LPNs/LVNs allows for such credentialed individuals to report observations to RNs but not to "assess", as CMS recognized for the SFV. We believe it is CMS' intent to be consistent with current healthcare practice and allow LPNs/LVNs to perform the HOPE SFV and complete the HOPE tool.

Recommendation: We strongly urge CMS to use the terms "observation or focused clinical assessment" in the description of items J2052 and J2053, as well as in Chapter 1 to describe the HOPE as well as SFV and the types of nurses that may complete this visit.

J2052 Symptom Follow-up Visits (SFV)

Clarifications at J2052-A, J2052-B, and J2052-C are needed. Specifically, the Manual addresses how a missed HUV should be handled, but does not clarify how CMS expects hospices to handle an SFV that is missed. For example, a patient was seen for HUV1 on 10/18 and moderate symptoms were identified. The SFV should have been completed by 10/20 but was missed. The patient is being seen 10/21. Should the nurse complete the SFV late?

Recommendation: Include an example of a "missed" or "late" SFV in this item-specific guidance, include inclement weather as an acceptable reason an SFV is not completed and provide clarifications/examples as delineated below.

- **J2052-A**
  Clarification on whether this item should be completed with "Yes" or "No" in situations where the SFV is completed after the two-day window would be helpful.
- **J2052-C**
  The reasons for the patient being unavailable should be revised and/or clarified with inclement weather being a recognized and allowable reason an SFV is not complete. For example, a hospice patient being at the Emergency Department (ED) or hospital while the HOPE is scheduled to be completed does not necessarily mean the patient is unavailable. Hospices routinely visit patients in the hospital. Hospices are required under Medicare to

have a contract with facilities such as hospitals so that they can continue to serve the patient while in the facility.

Likewise, there should be some guidance/Pro Tips on "travel outside of service area" as a reason for the SFV not being completed. Under the Medicare Hospice Benefit an individual receiving hospice care may travel outside the service area and the hospice may contract with a different hospice to provide care to the patient while traveling. Does CMS intend for the hospice to not require the contracted hospice to perform an SFV on its behalf?

Inclement weather should be an acceptable reason an SFV is not completed. J2052-C should be updated to reflect this allowance. For example, road closures or roads that are impassable due to natural disasters (such as snow, flooding, etc.) prohibit a hospice from completing the SFV. Through no fault of the hospice, the visit cannot be completed. If inclement weather is not an acceptable reason for being unable to complete an SFV, CMS should allow telehealth visits for the SFV. CMS could consider allowing an SFV to be completed via telehealth only in documented extenuating circumstances such as inclement weather.

We appreciate CMS providing clarifications on the recent February 27, 2026 HQRP provider forum on the HOPE items outlined below. We encourage these explanations and CMS' expectations for HOPE completion to be incorporated into the HOPE guidance document.

N0500 Scheduled Opioid, N0510 PRN Opioid, and N0520 Bowel Regimen

Clarification in the Manual on how to complete HOPE items N0500 – N0520 would be helpful as there remains confusion regarding completion of items asking for a date of initiation or continuation. Specifically, hospices are questioning how to complete the items when there is an Opioid/Bowel regimen initiated before the HUV visit - should the date be listed as the date initiated or the date of the visit? CMS responded when this question was submitted to the help desk with the following:

> *N0500 was carried over from the Hospice Item Site (HIS). The item guidance has not changed, and responses can still be abstracted from the clinical record. The purpose of the HOPE Update Visit (HUV) is to collect and confirm information. Item completion should be based on what is determined during the assessment visit. and/or included in the clinical record. The date entered should coincide with the details obtained at that visit (admission, HUVs) regardless of whether it is newly initiated or continued from a previous order. If during the HUV visit an opioid is continued, you would use the date of the HUV visit.*

Recommendation: CMS should revise the existing Manual guidance under N0500, N0510, and N0520 (below) to incorporate the HUV into the guidance.

- *N0500 - Treatment is considered initiated when the hospice has received the order and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment.*
    - *Enter date the scheduled opioid order was received, irrespective of if/when the first dose was given.*
- N0510 - *Treatment is considered initiated when the hospice has received the order and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment.*
    - *Enter date the PRN opioid order (whether hospice initiated or continued from prior care setting) was received, irrespective of if/when the first dose was given (assuming instructions have been provided to initiate).*
- *N0520 - Treatment is considered initiated when the hospice has received the order and there is documentation that the patient/caregiver was instructed to begin use of the medication or treatment.*
    - *Enter date the bowel regimen order (whether hospice initiated or continued from prior care setting) was received, irrespective of if/when the first dose was given (assuming instructions have been provided to initiate).*

A1905 Living Arrangements

The term "Living Arrangements" is causing confusion. Based on CMS' guidance in a written response to a submitted question, CMS is expecting the hospice to complete this item based on the living arrangements at the site of service at the time of admission rather than the patient's permanent living arrangements. Specifically, CMS responded to the question:

> *"Please clarify how to code living arrangements for this example: A patient was living with her daughter at her daughter's home before she was admitted to the hospital. She was discharged from the hospital and admitted to a Hospice IPU GIP LOC. Is the correct code for A1905 2. With others in the home or 4. Inpatient facility?*

with the following response:

> *Per the HOPE Guidance Manual: HOPE items are designed to collect patient-specific data in real-time, based on interactions with the patient and family/caregiver, and with flexibility to accommodate patients with varying clinical needs. The* ***Item-Specific Instructions for A1905 (page 41) specifically state:*** *Enter the code that best describes the patient's current living arrangements* ***at the time of the assessment.*** *These new items are not asking about "prior" living conditions, or the "availability of assistance" before they elected hospice, but what is happening at the time of admission to hospice.*

The confusion is due to the various sites of service where hospice care can be delivered and the temporary nature of some of these sites. This is a situation unique to hospice patients.

For instance, the General Inpatient level of care is a temporary level of care and a temporary site of service. The level of care is intended to be on a short-term, temporary basis. Therefore, the patient is not "living" in a hospital, SNF, or hospice inpatient unit. This is simply a short-term, temporary site of service.

Recommendation: Update the guidance for this item to indicate that it is seeking information for living arrangements for the *site of service* at the time of admission and incorporate the question and response above in the item-specific guidance.

Thank you for your attention to these issues. We look forward to working with you, the team at CMS, and Abt Associates to improve this tool for the future of hospice care.

Sincerely,

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