Hospice Quality Reporting Program (HQRP)

Hospice Item Set (HIS)
Questions and Answers (Q+As)
and Quarterly Updates

July 2017

This document is intended to provide guidance on HIS-related questions that were received by the Hospice Quality Help Desk during the second quarter (April - June) of 2017. This document also contains quarterly updates. Guidance contained in this document may be time-limited, and may be superseded by guidance published by CMS at a later date.

Section 1: Questions and Answers

Section A: Administrative Information

Question 1. **Does CMS have additional guidance for completing Item A1400. Payor Information?**

Answer 1. CMS posted additional guidance for completing A1400 on the HIS portion of the CMS HQRP website. Providers can access the additional guidance on the HQRP website here, under Downloads: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Hospice-Item-Set-HIS.html.

Section J: Pain and associated Quality Measures

Question 2. **Will you please clarify whether the expectation is that the Comprehensive Pain Assessment will be completed if there is NO pain from the Pain Screening (J0900C) but pain is an Active Problem (J0905)?**

Answer 2. CMS is aware that the skip pattern between J0900C and J0910 in the HIS V1.00.0 did not align with current clinical practice (i.e., clinicians will complete a comprehensive pain assessment even if patient does not report current pain at the time of the screening). Based on this, we updated the HIS V2.00.0 to include the pain active problem item (J0905). Now, you respond to J0910 based on whether or not pain is an active problem, not whether the patient has current pain at the time of the screening (J0900C). So now, even if the patient is NOT in pain at the time of the screening, you complete item J0910, provided pain is an active problem. Note that the HIS does not dictate clinical practice; thus, you should still complete care processes you deem clinically appropriate for the patient, even if the HIS skip patterns direct you to skip over an item.

Regarding the relationship between items in Section J and the NQF #1637 Pain Assessment quality measure, currently, J0905 is not used in the calculation of NQF #1637. CMS will analyze HIS V2.00.0 data and use analysis to inform updates to the measure specifications; we will communicate any changes in measure specifications to the public at a future date.

Question 3. **What are the numerator criteria for the Pain Screening (NQF #1634)?**

Answer 3. The Pain Screening NQF #1634 quality measure reports the percentage of hospice patients who were screened for pain within 2 days of admission. Please note there are two ways in which to quality for the numerator of this measure: (1) the patient was screened for pain within 2 days of the admission date and reported that they had no pain OR (2) the patient was screened for pain within 2 days of the admission date and the patient's pain severity was rated mild, moderate, or severe and a standardized pain screening tool was used.

Question 4. **What are the numerator criteria for the Pain Assessment (NQF #1637)?**

Answer 4. The Pain Assessment NQF #1637 quality measure reports the percentage of hospice patients who screened positive for pain, received a comprehensive pain assessment within 1 day of the pain screening, and the pain assessment documentation includes at least 5 characteristics that describe the patient's pain (location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life). Please note that simply responding "1, yes" to J0910A is not sufficient to count towards this measure. A comprehensive pain assessment that does not occur within 1 day of the pain screening, or does not include at least 5 characteristics, does not count toward the numerator, resulting in a hospice not getting credit for this measure.

Section O: Service Utilization and Hospice Visits when Death is Imminent Measure Pair

Question 5. **Sometimes our patients don't want frequent visits from staff. Will our hospice be penalized because of that in the calculation of the Hospice Visits when Death is Imminent Measure pair?**

Answer 5. We recognize that some patients and families may choose to decline certain visits; thus, scores of 100 percent are not the expectation for this measure pair. If no visit was provided from a given discipline on a given day, mark a "0" (zero) in the appropriate cell of O5010 or O5030. Measure 2 of this measure pair addresses whether the patient received at least two visits in the final 7 days of life from a medical social worker, chaplain or spiritual counselor, Licensed Practical Nurse, or aide. Please note that the two visits could both be from the same discipline, or could be from two different disciplines. It is not necessary to receive visits from each of the listed disciplines in order to meet the conditions of the numerator for this measure. Rather, multiple disciplines are grouped together in order to provide flexibility in the visits provided, based on patient and family needs and preferences. Data is collected separately for each date in order to provide enough detail to calculate each of the Visits When Death is Imminent Measures: Measure 1 is calculated using 3 days, while Measure 2 is calculated using 7 days. In addition, this level of detail allows for improved testing of the reliability and validity of this measure pair. Although the two visit items cover different timeframes, both ask about the same types of visits from the same disciplines (Registered Nurse, Physician [or Nurse Practitioner or Physician Assistant], Medical Social Worker, Chaplain or Spiritual Counselor, Licensed Practical

Nurse, and Aide). You can view the draft specifications for the Hospice Visits when Death is Imminent Measure Pair on the CMS HQRP website here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html. Measure 1 of the pair assesses the percentage of patients who received at least one visit from a Registered Nurse, Physician, Nurse Practitioner, or Physician Assistant in the last 3 days of life. Measure 2 includes visits from Medical Social Workers, Chaplains or Spiritual Counselors, Licensed Practical Nurses, or Hospice Aides. The reason that the two measures use different sets of disciplines is that each measure is intended to capture a different aspect of care. Measure 1 addresses case management and clinical care during the active dying phase, while Measure 2 includes a range of other disciplines to give providers flexibility to provide individualized care to each patient, that is in line with the patient and family's preferences and goals of care. The time frame is longer for Measure 2 in order to capture both the active dying phase and the transition period before.

Public Reporting

Question 6. **What do I do if the demographic data on my preview report or in the Hospice Data Directory is incorrect?**

Answer 6. CMS populates the provider demographic information appearing on reports from the CMS Survey Processing Environment (ASPEN) system, which is updated by CMS Regional Offices or State ASPEN Coordinators. If the information you see displayed is inaccurate or has changed, please contact your Regional Office (RO) or State ASPEN Coordinator as identified on the updated Point of Contact (POC) list found on the Hospice Data Directory Datasets webpage. If the information on the Hospice Data Directory is incorrect, contact the RO or State coordinator listed for your area. The RO and State coordinator list can be found at https://data.medicare.gov/Hospice-Data-Directory/Hospice-CASPER-ASPEN-Contacts/qx7x-wipa. Note that the Hospice Agency data file is updated quarterly. Thus, your update may not appear on data.medicare.gov until the next scheduled refresh.

Question 7. **After reviewing our CASPER "Quality Measure Report", our pain assessment measure score being reported is concerningly low, yet it is our policy to perform these assessments on every patient we encounter. Can you explain how the data is pulled and how HIS item completion relates to measure calculation?**

Answer 7. The Pain Assessment NQF #1637 quality measure reports the percentage of hospice patients who screened positive for pain, received a comprehensive pain assessment within 1 day of the pain screening, and the pain assessment documentation includes at least 5 characteristics that describe the patient's pain (location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life). Please note that simply completing a pain assessment is not sufficient to count towards this measure. A comprehensive pain assessment that does not occur within 1 day of the pain screening, or does not include at least 5 characteristics does not count toward the numerator which results in a hospice not getting credit for this measure. As stated in the HIS Manual, completion of HIS items should be based on what has been documented in the patient's clinical record. The HIS is intended to capture whether or not care processes took place – if the clinical record contains no evidence that a care process took place, providers should answer "no" to gateway questions in the HIS, and then follow skip patterns as indicated in the HIS. If the

clinical record indicates at least one characteristics was assessed, providers should answer “yes” to the gateway question (i.e., was comprehensive pain assessment done) and then check the characteristic(s) that were completed.

For more details on the measure specifications, please review the QM User’s Manual. You can find the latest version of the QM User’s Manual here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html in the Download section at the bottom of the page.

Question 8. **Can you explain the legend in the Patient Stay-Level QM Report? If the HIS items were answered/completed, why are patients being excluded? Also, what is the difference between X "triggers" vs b "not triggers"?**

Answer 8. Although you complete HIS records for all patients, not all patients are included in the calculation of all quality measures. Whether a patient is included or excluded from a measure is driven by the denominator criteria and denominator exclusions. As for your question on why records were excluded in the Patient Stay-Level QM report, here is a detailed description of the CASPER Hospice Patient Stay-Level Quality Measure Report Status Legend.

- A “b” means that the patient stay was included in the denominator, but did not meet the numerator criteria. This is a patient stay that the hospice will *not* “get credit” for in the quality measure.
- An “x” means the measure applied to the patient stay (patient stay met denominator criteria) **and** the hospice met the numerator criteria for this measure for this patient stay. This is a patient stay that the hospice will “get credit” for in the quality measure.
- An “e” means that the patient stay meets the exclusion criteria for the measure denominator. This means that the measure does not apply to this patient at all. This patient stay has a “neutral” impact on your hospice’s quality measure score, meaning this patient counts neither “for” or “against” you in your agency’s score.
- A “c” after the Admission Date means that admission date has been extracted from the discharge record because the admission record is missing.

Question 9. **I need to make corrections to HIS records. How do I do that and does it affect my data that is being publicly reported?**

Answer 9. As noted in Section 3.6 in the HIS Manual, hospices should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the patient’s hospice record. Inaccurate information in the QIES ASAP system may affect hospice quality reporting results. A HIS record may be corrected even if subsequent records have been accepted for the patient.

An error identified in a QIES ASAP system HIS record must be corrected. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item response selection errors, or other errors.

The following two processes exist for correcting HIS records that have been accepted into the QIES ASAP system:

- Modification Request
- Inactivation Request

Modifications and inactivations can be made for 36 months from the target date.

Any corrections that need to be made to the underlying measure calculations after the generation of the Hospice Provider Preview Report will be reflected in the next quarterly release of the Hospice Provider Preview Report and Compare refresh.

Question 10. **Can you explain what is meant by the percentile? How can my score be above the national average, but have a low percentile?**

Answer 10. The percentile is largely dependent on the distribution of the QM score. Please note that for several HIS QMs, a large proportion of hospices score 100%. Thus, it is possible for your hospice to have a seemingly high score but a relatively low percentile ranking. CMS's analysis of QM scores suggests that the distribution of HIS QM scores are skewed; the mean (average) scores are affected by a small number of hospices with low scores and are always lower than the median scores. Therefore, it is expected that some hospices with scores higher than the mean yet have a percentile rank below 50. For example, if you have 5 providers in the nation with scores of 50, 90, 100, 100, 100. The national average is 88 and the national median is 100 (50th percentile). The provider with a score of 90 would be above the average but below the median**.** The Hospice Quality Reporting Program: HIS-Based Quality Measures Annual Testing Executive Summary shows the national distribution of the QM scores and can be found on the HQRP website here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html.

Question 11. **When is the last day to submit corrections for January 1, 2016 – December 31 2016 records to ensure they are reflected in August's Preview Report?**

Answer 11. All HIS records, including modifications/corrections and inactivations, need to be submitted and accepted by the ASAP system by 11:59:59 p.m. E.D.T. 8/15/17 to be reflected in the Hospice Provider Preview Report. This report will be available on August 29, 2017.

General Quality Measure Questions

Question 12. **Was the length of stay criterion removed from the "original 7" HIS quality measures (NQF #1617, 1641, 1647, 1634, 1637, 1639, 1638)?**

Answer 12. In 2016, The 7 QMs underwent endorsement maintenance by the NQF. During the endorsement process, analysis of recent HIS data suggested that removing the LOS exclusion criterion increased the average size of the denominator per hospice organization and had little effect on the distribution of the measure scores. The NQF reviewed these analysis results and endorsed the removal of the LOS exclusion. Thus the 7 measures are endorsed by the NQF without any denominator exclusion based on LOS for the hospice population. Please refer to the technical report of the NQF project Palliative and End-of-Life Care 2015-2016. http://www.qualityforum.org/Publications/2016/12/Palliative_and_End-of-Life_Care_2015-2016.aspx.

Section 2: What you may have missed from the 2nd Quarter

Materials from April 25th Data Submission and April 27th Public Reporting Webinars posted on CMS Website

A video recording of the **Hospice Data Submission and Reporting Webinar which took place on Tuesday, April 25, 2017,** is now available. The primary focus of the webinar was CMS data submission requirements for the HQRP, including information on the Hospice Timeliness Compliance Threshold Report, the Hospice-Level Quality Measures Report, and the Patient Stay-Level Quality Measures Report. A brief review of the use of information available in previously released reports was also presented. See the Hospice Quality Reporting Training webpage for details, including copes of the PowerPoint presentation. The video recording can be accessed via YouTube.

The audio recording and written transcript has been added for the **April 27th Hospice Public Reporting Webinar**. During this webinar, CMS discussed Preview Reports, including how to access these reports, how to interpret the contents of these reports, and what to do if they believe their report contains an error.

Preview report period has closed for the Quarter 4 2015 to Quarter 3 2016 reporting period

The 30-day preview window to review quality measure results has ended (June 1, 2017 through June 30, 2017). Hospice providers may continue to submit corrections to their HIS data for up to 36 months beyond the target date on a given assessment, although corrections that are made to any HIS assessment record for which the target dates fall within the applicable reporting period (initially Quarter 4 2015 to Quarter 3 2016), will only be reflected in subsequent quarterly preview reports and Compare refreshes. Hospice providers may request formal CMS review of their preview reports during the preview period, if they believe their quality measure results are inaccurate.

Section 3: What's coming up in the 3rd Quarter

FY 2018 Final Rule to be posted late summer 2017

The annual rulemaking cycle commenced in late spring of 2017 with the release of the proposed rule. The public comment period closed on June 26th, 2017 and the final rule will be posted in late summer 2017.

Providers and other stakeholders should review the final rule carefully as rulemaking is the official vehicle through which new requirements for the HQRP are established and communicated.

The final rule will be published in the Federal Register: https://www.federalregister.gov/ in late summer 2017; its publication will also be announced on the CMS HQRP website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/index.html.

For general information on the rulemaking process, please visit the "Proposed Regulations" portion of the CMS website: http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html?redirect=/QuarterlyProviderUpdates/ or the Office of the Federal Register website: https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf

Hospice Compare to Launch Summer 2017

The Hospice Compare website will launch in Summer 2017. Hospice Compare will report information about hospice programs across the nation. All seven NQF-endorsed HIS measures (NQF #1634, 1637, 1638, 1639, 1641, 1647, 1617) are anticipated to be displayed when we launch Hospice Compare in summer 2017. We anticipate starting public reporting of Hospice CAHPS® Survey data in winter 2018. This public reporting of data will allow patients, family members, and health care providers to get a snapshot of hospices' quality of care. Hospice Compare will present information such as the thoroughness of each hospice's assessment of the patient, including the extent to which the hospice has asked the patient about the severity of his/her pain and the extent to which he/she exhibits shortness of breath. Hospice Compare also measures the extent to which the hospice makes a comprehensive assessment of a patient's treatment preferences. The information on Hospice Compare will:

- Help consumers make more informed decisions about where they get care, and
- Encourage hospices to improve the quality of care that they provide.