

QUARTERLY OASIS UPDATE

January 22, 2025

January 2025



PRESENTED BY: OASIS ANSWERS, INC.



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1

Presenters

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2


2

SESSION HANDOUTS:

OAI Quarterly OASIS Update Slides 

CMS OASIS All-Payer Q&As 

CMS January 2025 OASIS Quarterly Q&As 

Application Scenarios 



3

AGENDA:

OASIS Answers Updates

CMS Updates

- Measure Updates
- OASIS-E1 & All-Payer Resources
- Coding Update
- HHVBP Updates

Highlights

- The Buzz on Home Health Reports

Feature Presentation

- Review of All-Payer Q&As
- Review of NEW January 2025 CMS Quarterly OASIS Q&As
- Application Scenarios – January 2025 CMS Quarterly OASIS Q&As and All-Payer Q&As

Participant Questions and Answers



4

Measure Updates

CMS Updates



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5

New Measures on Care Compare and Provider Data Catalog

Measure Reference Name	Publicly Reported Quality Measure Description	Publicly Reported Measure Domain
Transfer of Health Information to the Patient	How often the home health team reviewed and provided a medication list to the patient, family, and/or caregiver at final discharge	Preventing Harm
Transfer of Health Information to the Provider	How often the home health team reviewed and provided a medication list to the next healthcare setting	Preventing Harm
Discharge Function Score	How often patients were at or above an expected ability to care for themselves and move around at discharge	Managing Daily Activities



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6

6

OASIS Update

CMS Updates



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7

OASIS-E1 Guidance Manual

- December 12th: Final Version of the OASIS-E1 Manual posted on the Home Health Quality Reporting Program OASIS User Manuals webpage
 - Available in the download section:
<https://www.cms.gov/files/document/oasis-e1-manualfinal12-9-2024.pdf-0>
 - Change table highlighting key changes between the draft and final version also posted:
<https://www.cms.gov/files/document/oasis-e1-changes-may-2024-draft-dec-2024-final-manual.pdf-0>



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8

8

OASIS-E1 Guidance Manual

Only changes are in Chapter 1 related to all-payer OASIS data collection and existing guidance relocated from the CMS OASIS Q&As (Static Q&As)

1.5.1 Who does OASIS data collection apply to?

The comprehensive assessment and OASIS data collection requirements apply to home health agencies (HHAs) that must meet the Medicare home health (HH) Conditions of Participation (CoPs), that is **Medicare-certified HHAs and Medicaid home health providers** (including HHAs operating under a Medicaid waiver) in states where that state's laws require those agencies to meet the Medicare HH CoPs.

Relocated from Category 1 of CMS OASIS Q&As (Q1 now retired)

❖ Example: Medicaid home health provider

A Medicaid-certified pediatric home care agency, that is not Medicare certified, is only required to collect and submit OASIS data if:

- The home care agency's state requires Medicaid home care agencies to meet the Medicare HH CoPs, **AND**
- The patient is not excluded from OASIS data collection, that is, a patient under the age of 18, a patient receiving maternity services, a patient receiving only personal care, housekeeping services or chore services

Relocated from Category 1 of CMS OASIS Q&As (Q1.1 & Q3 now retired)

OASIS-E1 Guidance Manual

Only changes are in Chapter 1 related to all-payer OASIS data collection and existing guidance relocated from the CMS OASIS Q&As (Static Q&As)

1.5.1.1 How to Transition to All-Payer OASIS Data Collection and Submission

In the Calendar Year (CY) 2023 HH Prospective Payment System (PPS) final rule, CMS finalized:

- The end of the temporary suspension of OASIS data collection on non-Medicare/non-Medicaid HHA patients.
- The requirement for HHAs to submit all-payer OASIS data for the purposes of the HH Quality Reporting Program (QRP), beginning with the CY 2027 Program Year (87 FR 66862 through 66865).

Prior to January 1, 2025, OASIS data collection and submission are required for:

- All skilled Medicare and/or Medicaid patients with some exceptions.
 - Patients under the age of 18, patients receiving maternity services, and patients receiving only personal care, housekeeping services, or chore services are excluded from the requirement for OASIS data collection and submission.
 - NOTE: Some payers may require OASIS data for patients who are otherwise excluded from the requirement for OASIS data collection and submission. OASIS data for these patients should not be submitted to IQIES.

Effective January 1, 2025, through June 30, 2025:

- Continue OASIS data collection and submission for all skilled Medicare and/or Medicaid patients
- OASIS data collection and submission are **voluntary** for:
 - Non-Medicare/non-Medicaid patients who are not exempt from OASIS data collection, and who begin receiving home health care services with an OASIS start of care (SOC) M0090 date from January 1, 2025 through June 30, 2025.
 - When OASIS data collection and submission is started for a non-Medicare/non-Medicaid patient with the SOC OASIS assessment HHAs may, but are not required, to complete all subsequent OASIS time point assessments related to the patient's home health stay (that is, resumption of care, recertification, other follow-up, transfer, discharge, and death at home). This includes assessments

Effective July 1, 2025:

- OASIS data collection and submission are **required** for patients with any pay source who are not exempt from OASIS data collection, and who begin receiving home health care services with an OASIS SOC M0090 date on or after July 1, 2025. The requirement includes the SOC OASIS and any subsequent OASIS time point assessments relevant to the patient's home health stay (that is, resumption of care, recertification, other follow-up, transfer, discharge, and death at home).
 - Patients under the age of 18, patients receiving maternity services, and patients receiving only personal care, housekeeping and/or chore services continue to be **excluded** from OASIS data collection and submission requirements.

Language from CY 2025 Home Health Final Rule

OASIS-E1 Guidance Manual

Only changes are in Chapter 1 related to all-payer OASIS data collection and existing guidance relocated from the CMS OASIS Q&As (Static Q&As)

1.5.1.2 When a pediatric patient turns 18 years of age while receiving skilled home health care services

- For a pediatric patient who turns 18 years of age while receiving skilled home health care services, OASIS data collection and submission begins with the next OASIS time point. That is, when one of the following takes place:
 - The patient returns home from a qualifying inpatient stay (Complete the Resumption of Care, M0100 reason for assessment (RFA) 3).
 - The patient is transferred to an inpatient facility for 24 hours or longer for a reason other than diagnostic testing (Complete the Transfer to inpatient facility, M0100 RFA 6 if not discharged from the HHA, or M0100 RFA 7 if discharged from the HHA).
 - The 60-day recertification is due – i.e., the last five days of the certification period. (Complete the Follow-up, M0100 RFA 4).
 - There is a major decline or improvement in the patient's condition (Complete Other Follow-up, M0100 RFA 5).
 - The patient dies at home (Complete Death at Home, M0100 RFA 8).
 - The patient is discharged from the agency, not to an inpatient facility (Complete Discharge, M0100 RFA 9).

Relocated from Category 1 of CMS OASIS Q&As (Q1.2 now retired)

11

CMS OASIS Q&As

OASIS-E-1 Q & A's

Dec 06, 2024

- 📄 Category 1: Applicability (PDF 150 KB) [Posted 11/20/2024]
- 📄 Category 2: Comprehensive Assessment (PDF 600 KB) [Posted 11/20/2024]
- 📄 Category 3: Follow-up Assessments (PDF 225 KB) [Posted 11/20/2024]
- 📄 Category 4: OASIS Data Set - Forms and Items (PDF 1.75 MB) [Posted 11/20/2024]

- December 6th: Updated version of the CMS OASIS Q&As posted on QTSO
 - Available under the OASIS-E-1 Q&As header:
<https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals>
 - Effective date of 11/20/24

12

CMS OASIS Q&As – Highlights from Category 2

2023 Version

Q35. The patient's payer source changes from Medicare to Medicaid or private pay (or vice versa). The initial Start of Care (SOC) including OASIS data collection was completed. Does a new SOC need to be completed at the time of the change in payer source? [Q&A EDITED 10/23; EDITED 05/22; EDITED 10/16]

A35. Different States, different payers, and different agencies have varying responses to payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually can work their way through what they need to do if they answer this question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and reassessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails). When transitioning from a skilled Medicare or Medicaid patient to a payer not requiring OASIS, CMS encourages HHAs to complete a discharge OASIS assessment at the last visit under the Medicare or Medicaid pay source. While this is not a requirement, conducting a discharge OASIS assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's quality episode for purposes of the agency's quality initiatives.

Updated 2024 Version

Q35.

The patient's payer source changes from Medicare to Medicaid or private pay (or vice versa). The initial Start of Care (SOC) including OASIS data collection was completed. Does a new SOC need to be completed at the time of this change in payer source? [Q&A EDITED 11/24; EDITED 10/23; EDITED 05/22; EDITED 10/16]

A35. Different States, different payers, and different agencies have varying responses to payer change situations, so we usually find it most effective to ask, "Does the new payer require a new SOC?" HHAs usually can work their way through what they need to do if they answer this question. If the new payer source requires a new SOC (Medicare is one that DOES require a new SOC), then it is recommended that the patient be discharged from the previous pay source and reassessed under the new pay source, i.e., a new SOC comprehensive assessment. The agency does not have to re-admit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails). When transitioning from a skilled Medicare or Medicaid patient to a situation not requiring OASIS (e.g., moving from skilled Medicare to personal care only), CMS encourages HHAs to complete a discharge OASIS assessment at the last visit under the Medicare or Medicaid pay source. While this is not a requirement, conducting a discharge OASIS assessment at the point where the patient's skilled need has ended provides a clear endpoint to the patient's quality episode for purposes of the agency's quality initiatives.



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13

13

CMS OASIS Q&As – Highlights from Category 2

2023 Version

Q42.1.1. If nursing performs a non-billable admit for a PT only case, the PT goes the same day completing an evaluation only, and there is no further need for therapy, are we required to complete the RFA 9 - Discharge from agency? [Q&A EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q2]

A42.1.1. For skilled Medicare and Medicaid patients, OASIS data collection is required if more than one visit was made in a quality episode. In your scenario, the nurse made one visit and the PT made one visit. Therefore, the comprehensive assessment including OASIS is required for both the SOC (RFA 1) and DC (RFA 9). This is true even if one of the visits was non-billable.

Updated 2024 Version

Q42.1.1. If nursing performs a non-billable admit for a PT only case, the PT goes the same day completing an evaluation only, and there is no further need for therapy, are we required to complete the RFA 9 - Discharge from agency? [Q&A EDITED 11/24; EDITED 05/22; ADDED 01/12; Previously CMS OCCB Q&A 10/11 Q2]

A42.1.1. OASIS data collection is required if more than one visit was made in a quality episode. In your scenario, the nurse made one visit and the PT made one visit. Therefore, the comprehensive assessment including OASIS is required for both the SOC (RFA 1) and DC (RFA 9). This is true even if one of the visits was non-billable.



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14

14

CMS OASIS Q&As – Highlights from Category 2

2023 Version

Q53.2. Please provide guidance on the following scenario: A patient was recertified between days 56-60 and then in the new 60-day certification period, prior to any home health visits being made, the patient is admitted to the hospital for a qualifying inpatient stay. Should the agency complete the RFA 6 - Transferred to an inpatient facility, patient not discharge from agency and a Resumption of Care when the patient returns? Or should an RFA 7 - Transferred to an inpatient facility, patient discharged from agency be completed and a new Start of Care be completed? [Q&A ADDED 10/23; Previously CMS Qtrly Q&A 10/22 Q1]

A53.2. If the Medicare PPS (PDGM) patient had a recertification assessment visit during the last five days of the episode, and then experiences a qualifying hospitalization in the new 60-day certification period, the agency should complete a Transfer assessment. This is true whether or not any home care visits have been made in the new episode. The agency selects RFA 6 or RFA 7, depending on whether the agency anticipates the patient will be returning to service or not.

When an RFA 6 Transfer OASIS is submitted, the next expected submission would be a Resumption of Care (ROC) - RFA 3. If the patient did not resume services at your agency, then your internal agency discharge process would occur (with no OASIS collection).

Updated 2024 Version

Q53.2. Please provide guidance on the following scenario: A patient was recertified between days 56-60 and then in the new 60-day certification period, prior to any home health visits being made, the patient is admitted to the hospital for a qualifying inpatient stay. Should the agency complete the RFA 6 - Transferred to an inpatient facility, patient not discharge from agency and a Resumption of Care when the patient returns? Or should an RFA 7 - Transferred to an inpatient facility, patient discharged from agency be completed and a new Start of Care be completed? [Q&A EDITED 11/24; ADDED 10/23; Previously CMS Qtrly Q&A 10/22 Q1]

A53.2. If the patient had a recertification assessment visit during the last five days of the episode, and then experiences a qualifying hospitalization in the new 60-day certification period, the agency should complete a Transfer assessment. This is true whether or not any home care visits have been made in the new episode. The agency selects RFA 6 or RFA 7, depending on whether the agency anticipates the patient will be returning to service or not.

When an RFA 6 Transfer OASIS is submitted, the next expected submission would be a Resumption of Care (ROC) - RFA 3. If the patient did not resume services at your agency, then your internal agency discharge process would occur (with no OASIS collection).



CMS OASIS Q&As – Highlights from Category 3

2023 Version

Q2. What are the requirements for follow-up comprehensive assessment for pediatric and maternity patients where the payer is Medicaid? [Q&A EDITED 05/22; EDITED 08/07]

A2. Pediatric and maternity patients are exempt from the OASIS data collection requirements; however, the agency must still perform a follow-up comprehensive assessment at any time up to and including day 60. The timetable for the subsequent 60-day period would then be measured from the completion date of the most recently completed assessment. The agency may develop its own comprehensive assessment form for these clients. For patients exempt from OASIS data collection, clinicians may perform the follow-up comprehensive assessment more frequently than the last 5 days of the 60-day certification period, without conducting another comprehensive assessment on day 56-60, and remain in compliance with CoP §484.55(d).

Updated 2024 Version

Q2. What are the requirements for recertification(follow-up) comprehensive assessments for pediatric and maternity patients where the payer is Medicaid? [Q&A EDITED 11/24; EDITED 05/22; EDITED 08/07]

A2. Pediatric and maternity patients are exempt from the OASIS data collection requirements; however, the agency must still perform a follow-up comprehensive assessment during the last 5 days of every 60-days beginning with the start of care date.



CMS OASIS Q&As – Highlights from Category 3

2023 Version

Q1. When is a recertification (follow-up) assessment due for a skilled Medicare or Medicaid patient? [Q&A EDITED 05/22; EDITED 08/07]

A1. A skilled Medicare or Medicaid adult patient who remains on service into a subsequent certification period requires a follow-up comprehensive assessment (including OASIS items) during the last 5 days of each 60-day period (days 56-60, counting from the start of care date) until discharged.

Updated 2024 Version

Q1. When is a follow-up comprehensive assessment (including OASIS) due? ? [Q&A EDITED 11/24; EDITED 05/22; EDITED 08/07]

A1. All patients who remain on service into a subsequent certification period require a follow-up comprehensive assessment (including OASIS) during the last 5 days of each 60-day period (days 56-60, counting from the start of care date) until discharged.



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17

17

CMS OASIS Q&As – Highlights from Category 4

2023 Version

Q21. M0100. For a one-visit Medicare PPS (PDGM) patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it transmitted? Is a discharge OASIS required? [Q&A EDITED 10/23; EDITED 05/22; EDITED 06/14]

A21. Based on CMS policy, OASIS data collection and submission is not required when only one visit is made in a quality episode (SOC/ROC date to TRF/DC). However, to bill Medicare PPS (PDGM) for a single visit quality episode, OASIS data must be collected and submitted, and used to calculate a HIPPS code for inclusion on the Medicare claim. If you choose NOT TO BILL Medicare for the single visit provided, there is no requirement to collect and transmit OASIS data for the single visit quality episode.

If OASIS is collected, RFA 1 - SOC is the appropriate response on M0100 for a one-visit Medicare PPS (PDGM) patient. When a patient is discharged after only one visit (a single visit quality episode), a Discharge OASIS should NOT be collected or submitted.

Updated 2024 Version

Q21. M0100. When only one visit is provided to a patient, is Reason for Assessment (RFA) 1 the appropriate response for M0100? Is it transmitted? Is a discharge OASIS required? [Q&A EDITED 11/24; EDITED 10/23; EDITED 05/22; EDITED 06/14]

A21. OASIS data collection and submission is not required when only one visit is made in a quality episode. This is a single visit quality episode (SOC/ROC to TRF/DC). When a patient is discharged after only one visit, a Discharge OASIS should NOT be collected or submitted. However, to bill Medicare PPS (PDGM) for a single visit quality episode, OASIS data must be collected and submitted. If OASIS is collected for a Medicare PPS patient's single visit quality episode M0100 RFA 1 - SOC is the appropriate response.

Some payers may require OASIS data for a single visit quality episode. In such cases, the HHA will be expected to work with the payer to deliver any required OASIS data. When OASIS data is only required by the payer, submission to iQIES is not expected.



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18

18

CMS OASIS Q&As – Highlights from Category 4

2023 Version

Q29.5. M0150. CMS Q&A Cat 4b Q24 says that "when a Medicare patient has a private insurance pay source, Medicare may be considered a secondary payer", therefore whenever we have a private insurance patient who also has Medicare, for M0150 we routinely mark both "1 - Medicare" and "8 - Private Insurance" (for health) and/or "11 - Other" (for auto, etc.), just in case Medicare ends up getting billed for a portion of the home care services. Are we interpreting this guidance accurately? And, for those cases where Medicare never ends up getting billed for services, can we retroactively correct M0150, eliminating response "1" or inactivate the assessments altogether, since OASIS data collection/submission is not required for Private Pay patients only? [Q&A EDITED 10/23; EDITED 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 01/08 Q14]

A29.5. M0150 - Current Payment Sources for Home Care, is asking for identification and reporting of any payers the agency plans to bill for services during this episode of care. When a Medicare patient is admitted for home care services under a private insurer and the Medicare is considered to be a secondary payer then Medicare would be included in M0150. This action will ensure that OASIS data is collected in the event Medicare is a payer. If at the end of the episode, the agency did not bill Medicare for services, (and assuming there were no other Medicare or Medicaid payers for home health services), then the agency should take action to delete any and all assessments (e.g., SOC, Transfer, ROC, Discharge), clarifying in the clinical chart why the assessment is being deleted. Simply correcting M0150 and resubmitting to the OASIS system or inactivating affected assessments will not adequately remove the patient from the database. If the assessment is not deleted, the patient identifiable data will remain in the database and may inappropriately impact quality initiatives.

Updated 2024 Version

Q29.5. M0150. CMS Q&A Cat 4b Q24 says that "when a Medicare patient has a private insurance pay source, Medicare may be considered a secondary payer", therefore whenever we have a private insurance patient who also has Medicare, for M0150 we routinely mark both "1 - Medicare" and "8 - Private Insurance" (for health) and/or "11 - Other" (for auto, etc.), just in case Medicare ends up getting billed for a portion of the home care services. Are we interpreting this guidance accurately? And, for those cases where Medicare never ends up getting billed for services, can we retroactively correct M0150, eliminating response "1" or inactivate the assessments altogether? [Q&A EDITED 11/24; EDITED 10/23; EDITED 05/22; EDITED 06/14; ADDED 09/09; Previously CMS OCCB Q&A 01/08 Q14]

A29.5. M0150 - Current Payment Sources for Home Care, is asking for identification and reporting of any payers the agency plans to bill for services during this episode of care. When a Medicare patient is admitted for home care services under a private insurer and the Medicare is considered to be a secondary payer then Medicare would be included in M0150. This action will ensure that OASIS data is collected in the event Medicare is a payer. If at the end of the episode, the agency did not bill Medicare for services, (and assuming there were no other Medicare or Medicaid payers for home health services), then the agency should take action to correct M0150 in any and all assessments (e.g., SOC, Transfer, ROC, Discharge) when the assessment reports Medicare as a payer in M0150 for an episode where Medicare is not billed, if M0150 is not corrected, the patient data may inappropriately impact quality initiatives.



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19

19

CMS Home Health All-Payer Resources

- November 27th: CMS Home Health All-Payer OASIS Q&As were posted on the HHQR P OASIS User Manuals webpage
 - Available in the download section: <https://www.cms.gov/medicare/quality/home-health/oasis-user-manuals>
- December 20th: Transition to All-Payer OASIS Data Collection and Submission Fact Sheet was posted on the HHQR Home Health Quality Reporting Training webpage
 - Available in the download section: <https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-training>

The image shows two overlapping documents. The top document is titled "CMS Home Health OASIS All Payer Q&As" dated November 2024. It contains several questions and answers regarding OASIS data collection for all payers. The bottom document is titled "Transition to All-Payer OASIS Data Collection and Submission" and includes sections for Purpose, Changes, and Impact. It details the requirements for all-payer OASIS data collection starting in 2025.



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20

20

OASIS Privacy Statement

<https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/home-health-agency-center>

Outcome and Assessment Information Set (OASIS)

- [Outcome and Assessment Information Set \(OASIS\) Data Sets](#)
- [OASIS User Manuals](#)
- [Statement of Patient Privacy Rights in English and Spanish \(Zip, 1.5 MB\) \(ZIP\)](#)

Attachment A

Home Health Agency (HHA) Outcome and Assessment Information Set (OASIS) Statement of Patient Privacy Rights

As a Home Health patient, you have these privacy rights:

- You have the right to know why we need to ask you questions. We are required by law to collect health information to make sure you get quality health care, and that payments for Medicare and Medicaid agencies is correct.
- You have the right to have your personal health care information kept confidential. We may ask you for information about yourself so that we know which home health services will be best for you. We keep anything we learn about you confidential. This means only those legally authorized or with a medical need to know will see your personal health information.
- You have the right to refuse to answer questions. We may need your help to collect your health information. If you choose not to answer, we'll fill in the information as best we can. You don't have to answer any question to get services.
- You have the right to look at your personal health information. It's important that the information we collect about you is correct. If you think we made a mistake, ask us to correct it. If you're not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services the Federal Medicare and Medicaid agency to see, review, copy or correct your personal health information. See the Privacy Act Statement for more details about your privacy rights.

Need to correct your personal information?
To see, review, copy or correct your personal health information in OASIS records call 1-800-MEDICARE (1-800-431-4227) for help contacting the HHA, CMS System Manager. TTY users call 1-877-486-2049.

This is a Medicare & Medicaid Approved Notice.

Privacy Act Statement

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW ON THE PRIVACY ACT OF 1974. THE PURPOSE OF THIS STATEMENT IS TO HELP YOU UNDERSTAND HOW YOUR INFORMATION IS USED.

WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS STATEMENT

PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

- identify and help assess the health of persons provided by home health agencies (HHA)
- and administration of services and collection of Medicare/Medicaid payments
- support operations of the public government's behavioral, medical and social welfare effectiveness and quality of risk

ROUTINE USES

IN DIRECT OR YOU IF YOU DO NOT PROVIDE INFORMATION

NOTE: This statement may be included in the electronic patient file for all Home Health Agency admissions. Home health agencies may request you to provide information to use the information to improve their services. Home health agencies may request you to provide information to use the information to improve their services. Home health agencies may request you to provide information to use the information to improve their services.

Attachment C

Home Health Agency (HHA) Outcome and Assessment Information Set (OASIS) Notice About Privacy for Patients Who Don't Have Medicare or Medicaid

As a Home Health patient, there are a few things to know about how and why we collect your personal health care information:

- Federal and State governments oversee home health care to be sure we furnish quality home health care services, and to be sure you get quality home health care services.
- We need to ask you questions because we're required by law to collect health information, and to make sure you get quality home health care services.
- The information we collect is anonymous. The Centers for Medicare & Medicaid Services (the federal agency that oversees this home health agency) won't know the information about you.
- We keep anything we learn about you confidential.

COVID-19 Vaccination "Up to Date" Definition

For most home health patients go to: https://www.cdc.gov/covid/vaccines/stay-up-to-date.html#cdc_vaccine_recommendations_section_2-recommended-covid-19-vaccines (last updated October 3rd, 2024)

- "Up to Date" definition is broken out by age groups:
 - Children 6 months – 4 years
 - Children 5-11 years
 - People ages 12-64 years
 - People ages 65 years and older

People ages 65 years and older

You are up to date when you have received:

- 2 doses of any 2024–2025 COVID-19 vaccine 6 months apart.
 - While it is the *recommended* to get 2024-2025 COVID-19 vaccine doses 6 months apart, the *minimum* time is 2 months apart, which allows flexibility to get the second dose prior to typical COVID-19 surges, travel, life events, and healthcare visits

Exceptions:

- If you are receiving a COVID-19 vaccine for the first time and getting Novavax, you need:
 - 2 doses of 2024–2025 Novavax COVID-19 vaccine 3–8 weeks apart
 - A 3rd dose of any COVID-19 vaccine 6 months later
- If you received 1 dose of Novavax vaccine before the 2024–2025 vaccine, you need:
 - A 2nd dose of 2024–2025 Novavax vaccine **AND**
 - A 3rd dose of any 2024–2025 COVID-19 vaccine 6 months later

COVID-19 Vaccination “Up to Date” Definition

For **moderately or severely immunocompromised patients** go to: <https://www.cdc.gov/covid/vaccines/immunocompromised-people.html> (last updated December 6th, 2024)

- Vaccination recommendations will be dependent on:
 - Age
 - Prior vaccination status
 - Vaccine brand

Patients may be immunocompromised (have a weakened immune system) because of a medical condition or if they received medications or treatments that suppress their immune system.

Already completed initial series

- **Children ages 6 months–4 years:** Get 2 doses of 2024–2025 COVID-19 vaccine from the same brand (either Moderna or Pfizer-BioNTech, depending on what they received for their initial series) spaced 6 months apart.*
- **Children ages 5–11 years:** Get 2 doses of 2024–2025 COVID-19 vaccine from either brand (Moderna or Pfizer-BioNTech) spaced 6 months apart.*
- **People ages 12 years and older:** Get 2 doses of 2024–2025 COVID-19 vaccine from any brand (Moderna, Pfizer-BioNTech, or Novavax) spaced 6 months apart.*

Coding Update

CMS Updates

ICD-10 Coding Updates

- April 1, 2025 code updated files are now available and can be found here: <https://www.cms.gov/medicare/coding-billing/icd-10-codes>
 - 50 new procedure codes
 - Correction of typographical errors
 - No new diagnosis codes
- Grouper software: <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software>
- Upcoming ICD-10 C&M Committee Meeting will take place on **March 18-19, 2025**.

ICD-10 MS-DRG Version 42.1 Effective April 01, 2025

The Centers for Medicare & Medicaid Services (CMS) is implementing 50 new procedure codes into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS), effective April 01, 2025.

The ICD-10 MS-DRG Grouper assigns each case into an MS-DRG based on the reported diagnosis and procedure codes and demographic information (age, sex, and discharge status).

The ICD-10 Medicare Code Editor (MCE) Version 42.1 software uses edits to detect and report errors in the claims data for the ICD-10 codes reported to ensure correct coding on claims for discharges on or after April 01, 2025.

The ICD-10 MS-DRG Grouper software package to accommodate these 50 new codes, Version 42.1, is effective for discharges on or after April 01, 2025.

Assignment of the 50 new ICD-10-PCS procedure codes is as follows:

Procedure Code	Description	DRG	MCC	MS-DRG
01292C1	Supernovular other vision (emergency of conduct)	9	05	117
01292C4	Supernovular to assist with internal device, via	9	05	117
01292C5	Supernovular to assist with internal device, via	9	05	117
01292C6	Supernovular to assist with internal device, via	9	05	117
01292C7	Supernovular to assist with internal device, via	9	05	117
01292C8	Supernovular to assist with internal device, via	9	05	117
01292C9	Supernovular to assist with internal device, via	9	05	117
01292D1	Supernovular to assist with internal device, via	9	05	117
01292D2	Supernovular to assist with internal device, via	9	05	117
01292D3	Supernovular to assist with internal device, via	9	05	117
01292D4	Supernovular to assist with internal device, via	9	05	117
01292D5	Supernovular to assist with internal device, via	9	05	117
01292D6	Supernovular to assist with internal device, via	9	05	117
01292D7	Supernovular to assist with internal device, via	9	05	117
01292D8	Supernovular to assist with internal device, via	9	05	117
01292D9	Supernovular to assist with internal device, via	9	05	117
01292E1	Supernovular to assist with internal device, via	9	05	117
01292E2	Supernovular to assist with internal device, via	9	05	117
01292E3	Supernovular to assist with internal device, via	9	05	117
01292E4	Supernovular to assist with internal device, via	9	05	117
01292E5	Supernovular to assist with internal device, via	9	05	117
01292E6	Supernovular to assist with internal device, via	9	05	117
01292E7	Supernovular to assist with internal device, via	9	05	117
01292E8	Supernovular to assist with internal device, via	9	05	117
01292E9	Supernovular to assist with internal device, via	9	05	117



Home Health Value-Based Purchasing (HHVBP) Updates

CMS Updates



HHVBP CY 2025 Performance Year Applicable Measure Set

- OASIS-based measures
 - Improvement in Dyspnea/Dyspnea
 - Improvement in Management of Oral Medications/Oral Medications
 - **New:** Discharge Function Score
- Claims-based measures
 - **New:** Discharge to Community
 - **New:** Potentially Preventable Hospitalizations
- HCAHPS Survey-based
 - Care of Patients/Professional Care
 - Communications between Providers and Patients/Communication
 - Specific Care Issues/Team Discussion
 - Overall rating of home health care/Overall Rating
 - Willingness to recommend the agency/Willing to Recommend

NEW as of January 1, 2025



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27

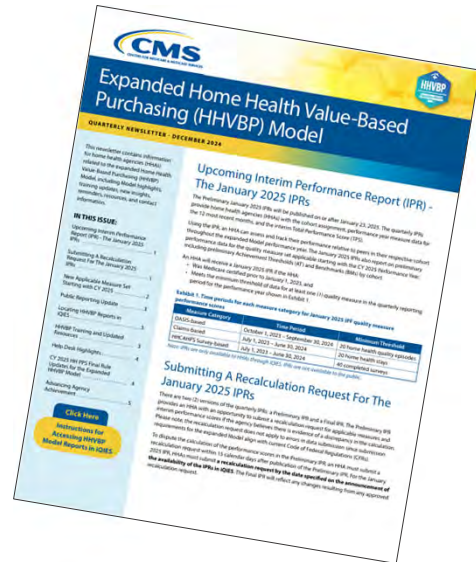
27

December Newsletter

HHVBP Model Newsletter

- December 2024
- Highlights:
 - Information regarding the January 2025 Interim Performance Report (IPR)
 - Steps for submitting a recalculation request for the January 2025 IPRs
 - The New Applicable Measure Set for CY 2025
 - HHVBP Training Updates
 - Expanded HHVBP Model Web-based Training: Changes to the Applicable Measure Set Beginning in CY 2025
 - Help Desk Highlights
 - CY 2025 Final Rule Updates for the Expanded HHVBP Model
 - Advancing Agency Achievement

Available under: Newsletters



*Expanded HHVBP Model webpage:

<https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model>

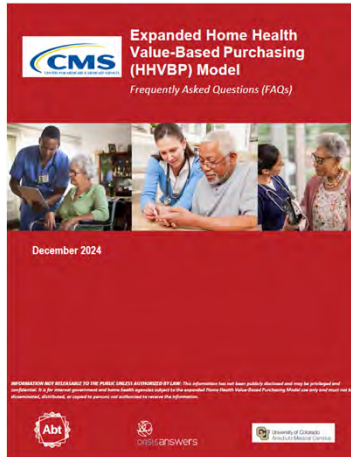


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28

December FAQs

- 2 New FAQs



New FAQs

Q 6029. On our agency's Annual Performance Report (APR), the Annual Payment Adjustment tab, Step 6 (C7) *TPS-Adjusted Payment Percentage* has a value greater than five (5) percent. However, in Step 8 (C8), the *Final TPS-Adjusted Payment Percentage* is a much lower value. Why do we have two (2) different TPS-Adjusted Payment Percentages on this report?

CMS will apply a payment adjustment that ranges from minus five (5) percent to plus five (5) percent in payment year CY 2025 based on an IHA's performance in CY 2023. Step 7 (C8) *Final TPS-Adjusted Payment Percentage* is a result of normalizing the TPS-Adjusted Payment Percentage by subtracting the maximum payment adjust of five (5) percent and redistributing the excess that is above five (5) percent across all eligible HHAs in the cohort. The percentage in Step 7 (C8) *Final TPS-Adjusted Payment Percentage* indicates the adjustment that will be applied to that agency's Medicare fee-for-service claims with a "through date" in the HHVBP payment year.

Q6030. Our agency did not receive an Annual Performance Report (APR). We have received Interim Performance Reports this year and do not understand why our agency did not receive an APR.

Home Health Agencies (HHAs) were eligible to receive the CY 2024 APR and an annual payment percentage if the agency was Medicare certified prior to January 1, 2022, and had sufficient data for at least five (5) quality measures to calculate a TPS. If an agency does not have sufficient data for at least five (5) quality measures, they will not receive an APR even if they received IPRs previously. HHAs that were Medicare certified prior to January 1, 2022, and meet the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year will receive an IPR.

Public Reporting of HHVBP Data

- Care Compare Announcement regarding new HHVBP Data

New data are now available for home health services

- CMS updated HH ORP OASIS-based measures for January 2025.
- CMS added these measures:
 - How often the home health team reviewed and provided a medication list to the patient, family, and/or caregiver at final discharge
 - How often the home health team reviewed and provided a medication list to the next healthcare setting
 - How often patients were at or above an expected ability to care for themselves and move around at discharge
- CMS removed this measure:
 - How often a patient's functional abilities were assessed at admission and discharge and functional goals were included in their care plan

[Learn about the home health quality measures](#)

- CMS updated the expanded Home Health Value-Based Purchasing (HHVBP) Model data.
 - [Learn about the expanded HHVBP Model quality measures](#)

January 2025

New

New data are now available for home health services

- CMS updated the HH ORP OASIS-based quality measures for January 2025
- CMS added these OASIS-based measures:
 - Transfer of Health Information to the Patient
 - Transfer of Health Information to the Provider
 - Discharge Function Score
- CMS removed this OASIS-based measure:
 - Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function Process Measure

[CMS posted results from the calendar year \(CY\) 2023 performance year for the expanded Home Health Value-Based Purchasing \(HHVBP\) Model. View data.](#)

January 2025

<https://www.medicare.gov/care-compare/>

Public Reporting of HHVBP Data

- Provider Data Catalog (PDC) Announcement regarding new HHVBP Data

Announcements

- CMS posted calendar year (CY) 2023 performance data for the expanded Home Health Value-Based Purchasing (HHVBP) Model.
- CMS updated the HH QRP OASIS-based and CAHPS quality measures for January 2025.
- The functional status process measure has been removed.
- Three OASIS-based measures have been added:
 - Transfer of Health Information to the Patient
 - Transfer of Health Information to the Provider
 - Discharge Function Score

<https://data.cms.gov/provider-data/topics/home-health-services>



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31

31

Public Reporting of HHVBP Data

- New PDC Topic: Expanded Home Health Value-Based Purchasing (HHVBP) Model

The screenshot shows a sidebar menu with the following items:

- About the data (selected)
- Expanded Home Health Value-Based Purchasing (HHVBP) Model
- Patient care star ratings
- What is the patient experience of care survey?
- Patient survey star ratings
- About using government data
- Current data collection periods
- Measuring agency performance
- Process of care and outcome of care quality measures
- Quality measures

<https://data.cms.gov/provider-data/topics/home-health-services/about-the-data>



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32

32

Public Reporting of HHVBP Data

- New PDC Topic: Expanded Home Health Value-Based Purchasing (HHVBP) Model

About the data

Expanded Home Health Value-Based Purchasing (HHVBP) Model

The Centers for Medicare & Medicaid Services (CMS) awards incentive payments to home health agencies (HHAs) through the [Expanded Home Health Value-Based Purchasing \(HHVBP\) Model](#) to encourage HHAs to improve the quality of care they provide to patients. For the calendar year (CY) 2023 performance year, performance in the expanded HHVBP Model is based on twelve quality measures.

As authorized by the CY 2022 Home Health Prospective Payment System (HH PPS) final rule (86 FR 62240), CMS expanded the HHVBP Model to all Medicare certified HHAs in the 50 States, territories, and District of Columbia beginning January 1, 2022, with 2022 designated as a pre-implementation year.

CMS requires all Medicare-certified HHAs that provide services in the 50 States, District of Columbia, and U.S. territories to compete in the expanded Model. A competing HHA has a current Medicare certification, identified by a CMS Certification Number (CCN), and receives payment from CMS for home health care services. All HHAs that were certified for participation in Medicare at least one full year prior to the beginning of the performance year have their performance assessed and are eligible for a payment adjustment.

For HHAs that provide services to a small number of patients, the number of patients they serve may affect the number of applicable measures with sufficient data to create a baseline year score or performance score. HHAs must have sufficient data to allow calculation of at least five of the 12 measures to receive a Total Performance Score (TPS). Therefore, some small HHAs may not receive a TPS and a corresponding payment adjustment.

Expanded HHVBP Model annual performance data were first published on the PDC in January 2025 and are planned to be updated annually.

For more information about the expanded HHVBP Model, including the expanded HHVBP Model measures, visit the [Expanded Home Health Value-Based Purchasing Model](#) webpage.

<https://data.cms.gov/provider-data/topics/home-health-services/about-the-data#expanded-home-health-value-based-purchasing-model>



Public Reporting of HHVBP Data

- PDC reference to Expanded HHVBP Model Current Data Collection Periods

Current data collection periods

Quality measures and patient survey results

Expanded Home Health Value-Based Purchasing (HHVBP) Model

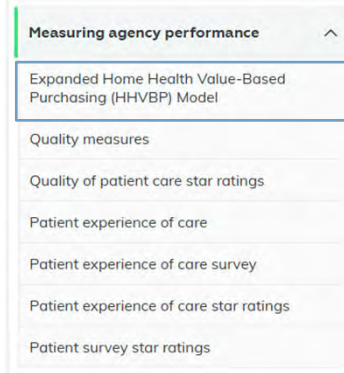
All expanded HHVBP Model applicable measures (OASIS-based, claims-based, HHCAHPS Survey-based) are based on calendar year (CY) 2023 performance and the reporting period of January 1, 2023 - December 31, 2023. These measure dates do not necessarily align with the HHQR measure results reported on Care Compare.

<https://data.cms.gov/provider-data/topics/home-health-services/current-data>



Public Reporting of HHVBP Data

- CDC reference to Expanded HHVBP Measuring Agency Performance



<https://data.cms.gov/provider-data/topics/home-health-services/measuring-agency-performance>



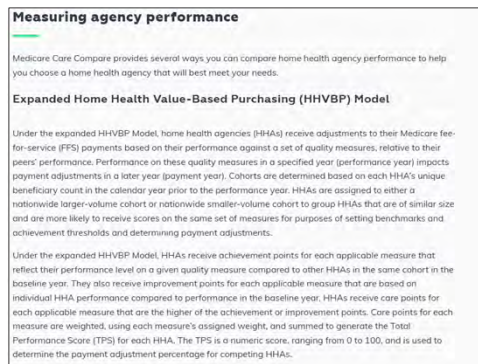
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35

35

Public Reporting of HHVBP Data

- CDC reference to Expanded HHVBP Measuring Agency Performance



<https://data.cms.gov/provider-data/topics/home-health-services/measuring-agency-performance#expanded-home-health-value-based-purchasing>



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36

36

Public Reporting of HHVBP Data

- New PDC Datasets for the Expanded HHVBP Model



The screenshot shows a 'Datasets' section with a dropdown arrow. Under the 'Home health services' filter, two datasets are listed:

- Expanded Home Health Value-Based Purchasing (HHVBP) Model - Cohort Data**
Cohort data on the HHVBP performance metrics.
Last Modified: January 3, 2025 • Released: January 15, 2025
Overview • Data Table • API • Download CSV
- Expanded Home Health Value-Based Purchasing (HHVBP) Model - Agency Data**
A list of active home health care agencies with data on the HHVBP performance metrics.
Last Modified: January 3, 2025 • Released: January 15, 2025
Overview • Data Table • API • Download CSV

<https://data.cms.gov/provider-data/search?theme=Home%20health%20services>

37

The Buzz on Home Health Reports

Highlights from HH QRP and HHVBP Reports

38



The BUZZ on Home Health Reports

Building a Critical Foundation

2025 Edition

Learn the basics of home health reports used in the Home Health Quality Reporting Program (HHQRP) and expanded Home Health Value-Based Purchasing (HHVBP) Model.


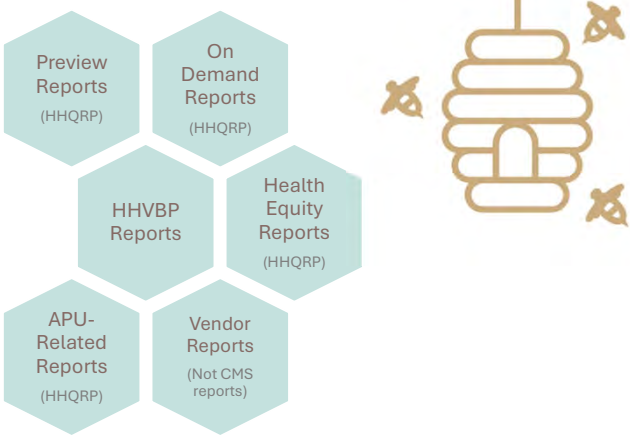


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39

Back to Basics: Report Categories

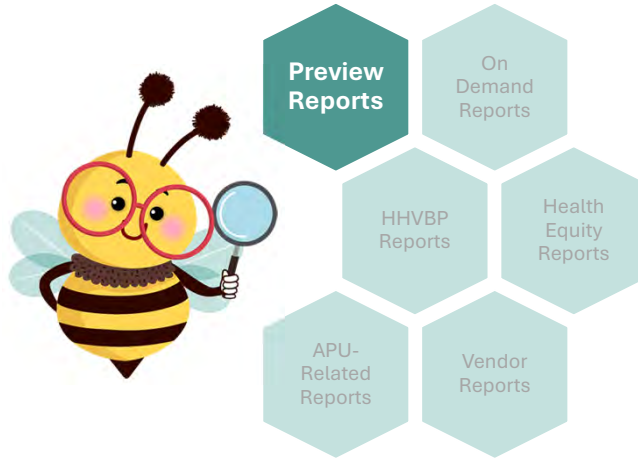
Bee in the know

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40

Today's Focus: HHQRP Preview Reports



41

41

Definition

TERM	DEFINITION	EXAMPLE
<p>Public Reporting</p>	<p>Reporting data on a Centers for Medicare & Medicaid Services (CMS) website that is accessible to the public</p>	<p>Care Compare</p> <ul style="list-style-type: none"> • For patients, families, caregivers • Uses "plain language" <p>Provider Data Catalog</p> <ul style="list-style-type: none"> • For professionals and researchers • Uses more technical language



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42

42

Preview Reports

Purpose

Allows HHAs to preview their data before the public sees the data on Care Compare and/or on the Provider Data Catalog

Report Names

- 1) Quality of Patient Care (QoPC) Star Rating Provider Preview
- 2) Survey (HHCAHPS) Star Rating Preview Report
- 3) Care Compare Preview Report

Frequency

A new report is provided quarterly

QoPC Star and Care Compare are generally available one quarter before the data is publicly reported in January, April, July, October

Survey (HH CAHPS) Sar Rating Preview is available a few weeks before the data is publicly reported

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43

43

Quality of Patient Care Star Rating Preview Report

Preview Report #1

44

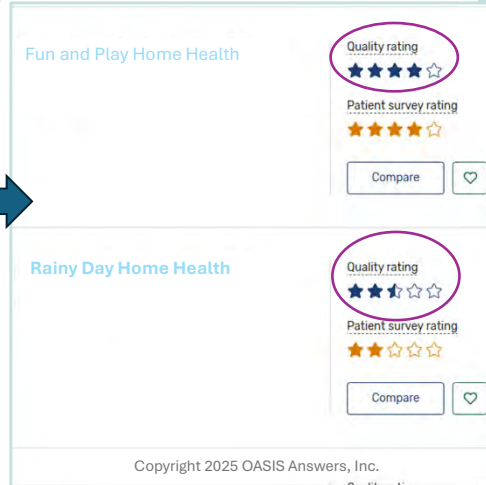
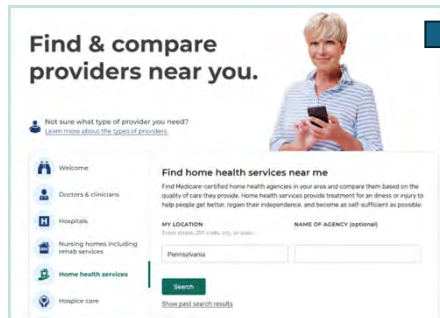
44

Quality of Patient Care Star Rating Provider Preview Report

Purpose: Provides agencies with a preview of data that will go on the CMS Care Compare website (www.medicare.gov) to assist consumers in finding a home health agency.

Data Included: OASIS and Medicare fee-for-service claims

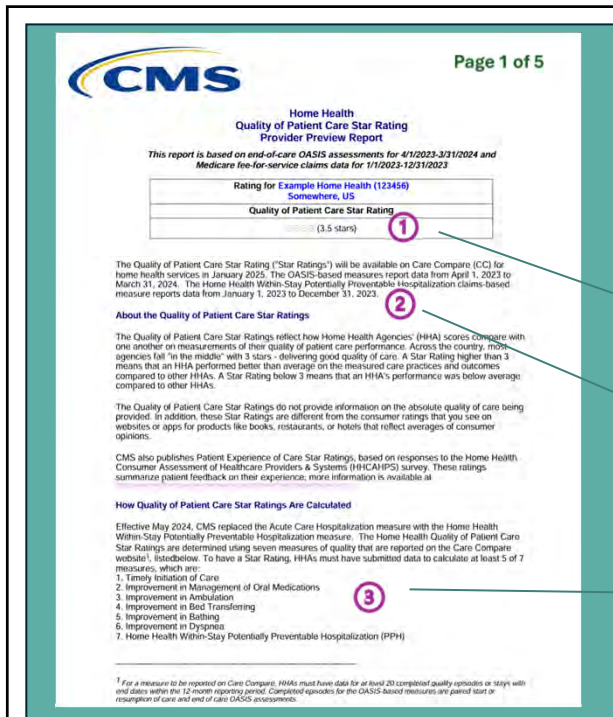
Care Compare



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45

45



Quality of Patient Care Star Rating Provider Preview Report (page 1)

Star Ratings on this report can be 1.0, 1.5, 2.0, 2.5, 3.0, 3.5, 4.0, 4.5, or 5.0



Let's take a closer look!

The actual star rating to be publicly reported

Dates of the data included in the report and the month and year when it will be published on Care Compare

The list of quality measures included in the calculation of this star rating

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46

46

Quality of Patient Care Star Rating Provider Preview Report (page 2-4)

Pages 2-4 provide information and references as to how the QoPC Star Rating is calculated.

Page 2 of 5

For all measures, except PPI, a higher measure value means a better score. For PPI, a lower measure value means a better score.

On the scorecard below, the ranges for each measure are shown at Rows 7-8. The ranges are calculated using all HHA's with available information. They are also updated each quarter. These measures are used to calculate the HHA's Star Rating using the steps below.

The Scorecard at the end of this report has your information.

Measures:

- Star Groupings:** For each of the 7 quality measures, all HHA's scores are sorted from high (best) to low (worst) into 10 groups that are generally equally sized.
- Average Group Rating:** Your HHA's score on each measure is then assigned a group (shown on a 10-point scale). Each group is assigned an average rating from 1.0 to 5.0 in 0.5 increments.
- Adjust Ratings:** Ratings may need to be adjusted if your HHA's score is not statistically different from other HHA's in the same group (1.0 to 5.0). This is done by comparing your HHA's score to the average score of all HHA's in each group. If the two scores are statistically different, your HHA's score is adjusted to the average score of all HHA's in that group. If the two scores are not statistically different, your HHA's score is adjusted to the average score of all HHA's in that group. The rating is rounded up 0.1 if your score is within 0.1 of the average score of all HHA's in that group. The rating is rounded up 0.1 if your score is within 0.1 of the average score of all HHA's in that group.
- Get Average Adjusted Rating:** To obtain an overall score for your HHA's care plan system, measures (by weight), the adjusted ratings are averaged across all 7 measures and rounded to the nearest 0.5.
- Star Rating:** Your HHA's Star Rating is then determined by comparing your HHA's average adjusted rating to the average adjusted ratings of all HHA's in your state. There are 9 star categories, with 1.0 being the lowest category.

Average Adjusted Rating	Final Quality of Patient Care Star Rating
4.5 to 5.0	5.0
4.0 to 4.5	4.5
3.5 to 4.0	4.0
3.0 to 3.5	3.5
2.5 to 3.0	3.0
2.0 to 2.5	2.5
1.5 to 2.0	2.0
1.0 to 1.5	1.5
0.5 to 1.0	1.0
0.0 to 0.5	0.5

The calculation is done using the following formula: $\text{Star Rating} = \text{Average Adjusted Rating} \times 10 \div 5$

Page 3 of 5

More information on how the Quality of Patient Care Star Rating is calculated can be found at: [https://www.oasisanswers.com/quality-of-patient-care-star-rating](#)

If Your Quality of Patient Care Star Rating is Not Available

If your provider report data did not include the report that there were not enough episodes of care to calculate your QoPC Star Rating, you may request a review of your rating by submitting that report. Requests must be submitted by November 1, 2024 to [https://www.oasisanswers.com/quality-of-patient-care-star-rating](#). As the Conditions of Participation require accurate OASIS data collection, inaccurate OASIS data may result in a calculation error or a request for review of an agency's Quality of Patient Care Star Rating.

Requests for a Review of Your Star Rating

If you have proof that there are errors in calculating your Quality of Patient Care Star Rating, you may request a review of your rating by submitting that proof. Requests must be submitted by November 1, 2024 to [https://www.oasisanswers.com/quality-of-patient-care-star-rating](#). As the Conditions of Participation require accurate OASIS data collection, inaccurate OASIS data may result in a calculation error or a request for review of an agency's Quality of Patient Care Star Rating.

Your request should include the following information:

- Provider name and CCR
- Provider contact person - Name, telephone #, email address
- Measure(s) affected, if any
- Detailed reason for the request with supporting documentation (do not send identifiable patient information through email)
- Any other information to assist CMS in identifying the calculation error and determining if the error(s) have affected your Star Rating

PLEASE DO NOT SEND ANY IDENTIFIABLE PATIENT INFORMATION THROUGH EMAIL. This includes medical record numbers, dates of birth, service dates (including end dates), addresses, or discharge dates, or any other data that is considered identifiable as Protected Health Information (PHI) under HIPAA.

You should receive a response of your request within 3 business days. You do not designate point of contact(s) may be asked to provide more information to assist CMS in fully review your request.

If the review of your documentation against the data in the national data system confirms that a calculation error was observed for the Quality of Patient Care Star Rating, you may be granted suspension of your Star Rating and any measure measures for one quarter. You (or your designated point of contact) will receive a final decision on your request by November 15, 2024. Please note that this is a one-time suspension for the measure.

Please note that this report allows that Review and Correct Reports to determine and remedy errors in OASIS data submission in a timely manner. Review and Correct Reports, concerning quality measure information in the agency's report for the OASIS Report data by quarter, are available on the OASIS website and allow home health providers to view aggregate performance for the prior four full quarters before data is available. These reports only contain data submitted prior to the applicable quarter plus submission deadline and display whether the data correction period for a given "Q" quarter is "open" or "closed." Note that the Review and Correct Reports provide a data correction deadline for each reporting quarter. Only corrections that are made on or before the data correction deadline will be used in the calculation of the measure(s) reported on the Care Compare and in the Quality of Patient Care Star Rating.

Page 4 of 5

Providers can access their reports in the HHA Provider Preview Reports table by selecting "My Reports" in QDS.

For More Information

Any comments, questions, and suggestions about the Quality of Patient Care Star Ratings can be submitted to [https://www.oasisanswers.com/quality-of-patient-care-star-rating](#).

Contacting the Quality of Patient Care Star Rating

Home Health Quality Measures

Home health agencies can review the OASIS Guidance Manual, Appendix F - OASIS and Quality Improvement for further information related to the steps toward improving their quality measures. The OASIS Guidance Manual is available at [https://www.oasisanswers.com/quality-of-patient-care-star-rating](#).

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Quality of Patient Care Star Rating Provider Preview Report (page 5)



Quality of Patient Care Star Rating Scorecard¹ Example Home Health (123456) Somewhere, US

	Measure Score Cut Points by Initial Decile Rating							
	Measure 1. Timely Initiation of Care	Measure 2. Improvement in Management of Oral Medications	Measure 3. Improvement in Ambulation	Measure 4. Improvement in Bed Transferring	Measure 5. Improvement in Bathing	Measure 6. Improvement in Dyspnea	Measure 7. Home Health Within-Stay Potentially Preventable Hospitalization (PHH)	
1	0.5	0.0-82.5	0.0-54.1	0.0-61.7	0.0-59.1	0.0-65.8	0.0-61.6	
2	1.0	82.6-90.2	54.2-67.5	61.8-73.6	59.2-72.5	65.9-77.5	61.7-75.4	
3	1.5	90.3-94.0	67.6-75.7	73.7-79.9	72.6-80.3	77.6-83.2	75.5-82.6	
4	2.0	94.1-96.3	75.8-81.0	80.0-83.6	80.4-84.6	83.3-86.7	82.7-86.6	
5	2.5	96.4-97.7	81.1-84.4	83.7-86.5	84.7-87.3	86.8-89.0	86.7-89.2	
6	3.0	97.8-98.7	84.5-87.0	86.6-88.7	87.4-89.4	89.1-91.0	89.3-91.2	
7	3.5	98.8-99.3	87.1-89.4	88.8-90.7	89.5-91.1	91.1-92.7	91.3-92.9	
8	4.0	99.4-99.7	89.5-91.8	90.8-92.8	91.2-92.8	92.8-94.5	93.0-94.6	
9	4.5	99.8-99.9	91.9-95.4	92.9-95.7	92.9-95.2	94.6-97.2	94.7-97.7	
10	5.0	100.0-100.0	95.5-100.0	95.8-100.0	95.3-100.0	97.3-100.0	97.8-100.0	
11	Your HHA Score	99.4	84.9	88.0	89.9	87.0	90.3	
12	Your Initial Group Rating	4.0	3.0	3.0	3.0	2.5	3.0	
13	Your Episodes in the Numerator	1,686	1,141	1,154	1,131	1,161	916	
14	Your Episodes in the Denominator	1,696	1,238	1,252	1,250	1,253	993	
15	National (All HHA) Middle Score	97.8	84.4	86.5	87.4	89.0	89.3	
16	Your Statistical Test Probability Value (p-value)	0.000	0.332	0.061	0.051	0.127	0.158	
17	Your Statistical Test Results (Is the p-value < 0.05?)	Yes	No	No	No	No	No	
18	Your HHA Adjusted Group Rating	4.0	3.0	3.0	3.0	2.5	3.0	
19	Your Average Adjusted Rating							3.0
20	Your Average Adjusted Rating Rounded							3.0
21	Your Quality of Patient Care Star Rating (1.0 to 5.0)							3.5 stars

¹OASIS data from April 1, 2023 to March 31, 2024; claims data from January 1, 2023 to December 31, 2023.

Known as the "Scorecard"

Row 12 - Displays results for each measure for your agency

Row 13 - Uses the result for result for each measure (row) 12 and assigns it a star rating based upon the range of scores in rows 2-11

Row 22 - Displays the final star rating by averaging the rating of all measures, rounding and adjusting the average results.

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Survey (HHCAHPS) Star Rating Preview Report

Preview Report #2

49

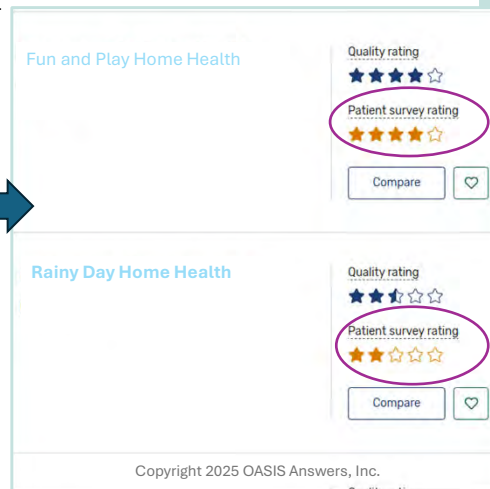
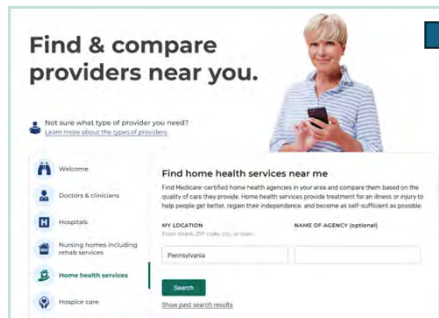
49

Survey (HHCAHPS) Star Rating Preview Report

Purpose: Provides agencies with a preview of data that will go on the CMS Care Compare website (www.medicare.gov) to assist consumers in finding a home health agency.

Data Included: HH CAHPS Surveys

Care Compare



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50

50

Care Compare Preview Report

Preview Report #3

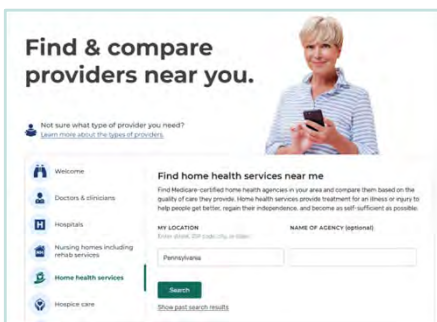
51

Care Compare Preview Report

Purpose: Provides agencies with a preview of data that will go on the CMS Care Compare website (www.medicare.gov) to assist consumers in finding a home health agency.

Data Included: OASIS and Medicare fee-for-service claims

Care Compare



Managing daily activities

<p>How often patients got better at walking or moving around</p> <p>↑ Higher percentages are better</p> <p><small>This measure was included in the quality star rating calculation.</small></p>	<p>85%</p> <p>National average: 88%</p> <p>Pennsylvania average: 88%</p>	<p>∨</p>
<p>How often patients got better at getting in and out of bed</p> <p>↑ Higher percentages are better</p> <p><small>This measure was included in the quality star rating calculation.</small></p>	<p>89%</p> <p>National average: 88%</p> <p>Pennsylvania average: 89%</p>	<p>∨</p>
<p>How often patients got better at bathing</p> <p>↑ Higher percentages are better</p> <p><small>This measure was included in the quality star rating calculation.</small></p>	<p>86%</p> <p>National average: 89%</p> <p>Pennsylvania average: 89%</p>	<p>∨</p>
<p>How often patients were at or above an expected ability to care for themselves and move around at discharge</p> <p>↑ Higher percentages are better</p>	<p>69.49%</p> <p>National average: 67.15%</p> <p>Pennsylvania average: 71.75%</p>	<p>∨</p>

Treating symptoms

<p>How often patients' breathing improved</p> <p>↑ Higher percentages are better</p> <p><small>This measure was included in the quality star rating calculation.</small></p>	<p>93.1%</p> <p>National average: 89.7%</p> <p>Pennsylvania average: 89.3%</p>	<p>∨</p>
<p>How often patients have pressure ulcers/pressure injuries that are new or worsened</p> <p>↓ Lower percentages are better</p>	<p>0.5%</p> <p>National average: 0.2%</p> <p>Pennsylvania average: 0.4%</p>	<p>∨</p>

This screenshot does not include all measures on Care Compare.

52

Preview of Home Health Agency Quality Measure Scores To Be Posted on Care Compare (April 2025) iQIES Report

Care Compare Preview Report

(page 2 of 4)

OASIS-BASED Measures [1] (REPORTING PERIOD: 07/01/2023 - 06/30/2024)

Process Measures

Measure Name	Number of HHA Episodes Included in the Numerator	Number of HHA Episodes Included in the Denominator	Agency Average % [2]	State Average % [2]	National Average %
Timely Initiation of Care	1,191	1,194	99.75	97.75	96.23
Influenza Immunization Rec'd For Current Flu Season	502	815	61.60	65.13	67.47
Drug Regimen Review Conducted with Follow-up for Identified Issues	1,165	1,194	97.57	94.62	94.41
Transfer of Health Information to the Provider	92	93	98.92	87.81	80.97
Transfer of Health Information to the Patient	631	658	95.90	86.00	90.19

End Result Outcome Measures (REPORTING PERIOD: 07/01/2023 - 06/30/2024)

Measure Name	Number of HHA Episodes Included in the Numerator	Number of HHA Episodes Included in the Denominator	Agency Average % [2]	State Average % [2]	National Average %
Improvement in Bathing	720	724	95.55	91.48	89.55
Improvement in Bed Transfer	710	724	96.23	91.24	88.66
Improvement in Ambulation/Locomotion	711	724	96.08	89.58	87.74
Discharge Function Score	379	717	52.86	70.30	67.26
Improvement in Management of Oral Medications	715	723	95.07	88.40	86.41
Improvement in Dyspnea	723	731	93.37	91.15	90.03
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	2	751	0.07	0.17	0.24
Percent of Patients Experiencing One or More Falls with Major Injury	13	1,193	1.09	0.86	0.94

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53

Preview of Home Health Agency Quality Measure Scores To Be Posted on Care Compare (April 2025) iQIES Report

Care Compare Preview Report

(page 3 of 4)

Claims Based Outcomes Post-Discharge [1] (REPORTING PERIOD: 01/01/2021 - 12/31/2023)

Potentially Preventable 30-Day Post-Discharge Readmission Measure For Home Health Quality Reporting Program

Number of Readmissions	Number of Eligible Stays	Observed Readmission Rate	Risk-Standardized Readmission Rate*	National Observed Rate	Agency Performance Category	Number of HHAs that Performed Better than the National Rate	Number of HHAs that Performed No Different than the National Rate	Number of HHAs that Performed Worse than the National Rate	Number of HHAs that Have Too Few Cases for Public Reporting
23	475	4.84%	3.99% (3.14%, 5.15%)	3.86%	Same As National Rate	58	6,209	140	3,143

Discharge To Community - Post Acute Care (PAC) Home Health Quality Reporting Program (REPORTING PERIOD: 01/01/2022 - 12/31/2023)

Number of Discharges to Community	Number of Eligible Stays	Observed Discharge to Community Rate	Risk-Standardized Discharge to Community Rate**	National Observed Rate	Agency Performance Category	Number of HHAs that Performed Better than the National Rate	Number of HHAs that Performed No Different than the National Rate	Number of HHAs that Performed Worse than the National Rate	Number of HHAs that Have Too Few Cases for Public Reporting
617	861	71.66%	80.47% (77.24%, 83.18%)	76.06%	Better Than National Rate	3,545	2,988	1,802	1,744

Claims Based Outcome Within-Stay [1] (REPORTING PERIOD: 01/01/2023 - 12/31/2023)

Home Health Within-Stay Potentially Preventable Hospitalization Measure

Number of Within Stay Hospitalizations	Number of Eligible Stays	Observed Within Stay Hospitalization Rate	Risk-Standardized Within Stay Hospitalization Rate***	National Observed Rate	Agency Performance Category	Number of HHAs that Performed Better than the National Rate	Number of HHAs that Performed No Different than the National Rate	Number of HHAs that Performed Worse than the National Rate	Number of HHAs that Have Too Few Cases for Public Reporting
51	358	14.25%	11.03% (8.68%, 14.17%)	9.90%	Same As National Rate	751	5,792	818	2,113

Claims Based Cost Measures (REPORTING PERIOD: 01/01/2022 - 12/31/2023)

Medicare Spending Per Beneficiary - Post Acute Care (PAC) Home Health

Measure Name	Eligible Episodes [2]	Agency Score [2]	National Avg Score
Medicare Spending Per Beneficiary - Post Acute Care (PAC) Home Health	1,450	0.99	1.00

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54

Table Legend

* RSRR	Risk-Standardized Readmission Rate, reported as RSRR (Lower Limit, Upper Limit of 95% Confidence Interval Estimate)
**	Risk-Standardized Discharge to Community Rate is displayed as Rate (Lower Limit, Upper Limit of 95% Confidence Interval Estimate)
***	Risk-Standardized Within Stay Hospitalization Rate is displayed as Rate (Lower Limit, Upper Limit of 95% Confidence Interval Estimate)

Footnote Legend

①

- (1) A value of (4) means the number of episodes is too small to report; (5) means the measure currently does not have data or has less than 6 months of data; (13) means data suppressed by CMS for one or more quarters; (2) will also be indicated if the HHA provides services to a special needs population (see https://rodas.health.ny.gov/home_care/special_needs). The Care Compare website will display the footnote with an associated descriptive tooltip.
- (2) Each state average is the aggregate rate for all patients served by providers in that state. The national average is the aggregate rate for all patients served by providers in the nation.

Important Notes

- Please review the data about your agency. Details about how to update information about your home health agency's characteristics/administrative data (name, address, phone number, services or type of ownership) and who to contact for questions are available on the Home Health Quality Reporting Program website at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits>. Select How to Update Home Health Demographic Data at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/How-to-Update-Home-Health-Demographic-Data>.
- The order of the measures in the table above may not represent the order displayed on Care Compare.
- The titles of the measures in the table above are not the Consumer Language titles that appear on Care Compare. The crosswalk between these titles can be found on the Care Compare website at <https://data.cms.gov/provider-data/topics/home-health-services/progress-care-outcome-care-quality-measures#list-of-quality-measures>.
- For questions about quality measure reports, definitions and calculations, contact the Home Health Quality Measures Help Desk at HomeHealthQualityQuestions@cms.hhs.gov

②

Where can I find the Preview Reports?

Report Name	Location	Directions to Find Reports
QoPC Star Rating Provider Preview Report	iQIES https://iqies.cms.gov/	<ul style="list-style-type: none"> Select the My Reports option from the Reports menu From the My Reports page, select the HHA Provider Preview Reports folder
Care Compare Provider Preview Report		
Survey Star Rating Preview Report	HHCAHPS https://homehealthcahps.org	<ul style="list-style-type: none"> Select the "Preview Reports" link under the "For HHAs" tab

Note: Only authorized users at the home health agency can access these reports.

Next Sessions



Quarterly OASIS Update Webinar	Topic
April	On Demand Reports (HHQRP)
July	HHVBP Reports
October	APU-Related Reports (HHQRP) Health Equity Reports (HHQRP) Vendor Reports (Not supported by CMS)

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57

57

All-Payer Q&As

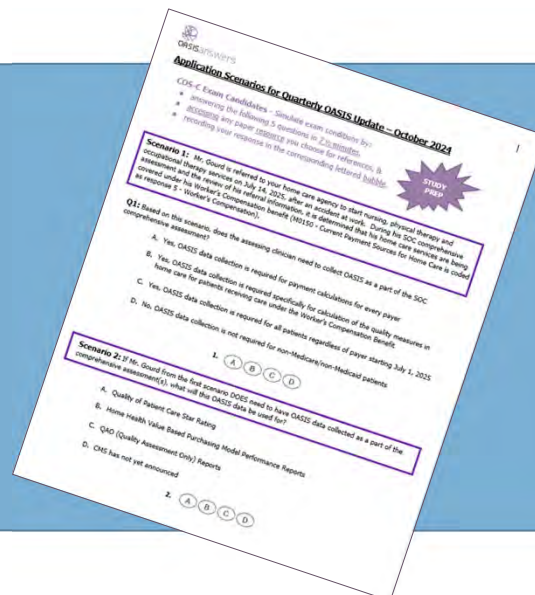


58

January 2025 CMS Quarterly OASIS Q&As



Application Scenarios



All-Payer Scenarios



Questions???

OASIS Questions that relate to existing OASIS guidance or issues otherwise not presented on today's call may be forwarded to your state's OASIS Education Coordinator:
OASIS Education Coordinators (by state) posted at:
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/OASIS-Coordinators>

Questions related to quality measures or OASIS data collection may be forwarded to
homehealthqualityquestions@cms.hhs.gov (for OASIS and claims-based measures)
and hhcahps@rti.org (for HH CAHPS measures).

To register for future OASIS Answers Quarterly OASIS Updates, visit www.oasisanswers.com or call 425-868-2304

WORKSHOP

OASIS E1

2-DAY OASIS DATA COLLECTION WORKSHOP

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EXAM

COS-C EXAM

The Certificate for OASIS Specialist – Clinical (COS-C) Exam is a voluntary certificate examination that evaluates an individual's knowledge of CMS' OASIS data collection guidance.

TESTING OPTIONS AVAILABLE:

- Paper & Pencil Test @ a Workshop Location
- Computer Based Test @ a Computer Based Testing Center

City	State	Blueprint for OASIS Accuracy Workshop	COS-C Exam Administration
Atlanta	GA	March 5-6, 2025	March 7, 2025
Chicago	IL	April 9-10, 2025	April 11, 2025
Nashville	TN	May 14-15, 2025	May 16, 2025
Portland	OR	June 18-19, 2025	June 20, 2025
Baltimore	MD	September 17-18, 2025	September 19, 2025
Dallas	TX	October 8-9, 2025	October 10, 2025
Las Vegas	NV	December 3-4, 2025	December 5, 2025

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85

RECORDED RESOURCE

COS-C EXAM CRAM

OASIS ANSWERS

Updated for OASIS-E1 and 2025

A virtual exam refresher session with interactive test questions. The webinar is organized to mimic the breakdown of the COS-C exam, with education modeled to demonstrate use of test taking strategies using CMS references. All domains of the COS-C Exam will be represented in the mock exam questions and training.

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86

Updated for 2025, the **OASIS Now** three-part webinar series is designed to provide important core foundational OASIS guidance to support an agency's OASIS orientation and competency program. This streamlined training is based on current OASIS guidance.

Updated January 2025

OASIS Now



RECORDED



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87

Upcoming Teleconference Schedule

Wednesday – April 16, 2025

1:00-2:30 Eastern

12:00-1:30 Central

11:00-12:30 Mountain

10:00-11:30 Pacific



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88

88

Nursing Contact Hours Disclosure

This nursing continuing professional development activity was approved by Montana Nurses Association, an accredited approver with distinction by the American Nurses Credentialing Center's Commission on Accreditation.

Participants who attend the entire session as demonstrated by signing in and who complete the post-workshop evaluation confirming their participation in the resource activity will be awarded 1.5 contact hours. Certificates will be emailed to participants by OASIS Answers within 30 days of completion of the workshop.

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89