QUARTERLY OASIS UPDATE

January 22, 2025

PRESENTED BY: OASIS ANSWERS, INC.

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Presenters

Linda Krulish, MHS COS-C
President and CEO

Marian Essey, RN BSN COS-C
Chief Quality Officer

Megan Bernier, MSPT RAC-CT COS-C
Post-Acute Care Senior Clinical Manager

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SESSION HANDOUTS:

OAI Quarterly OASIS Update Slides

CMS OASIS All-Payer Q&As

CMS January 2025 OASIS Quarterly Q&As

Application Scenarios

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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

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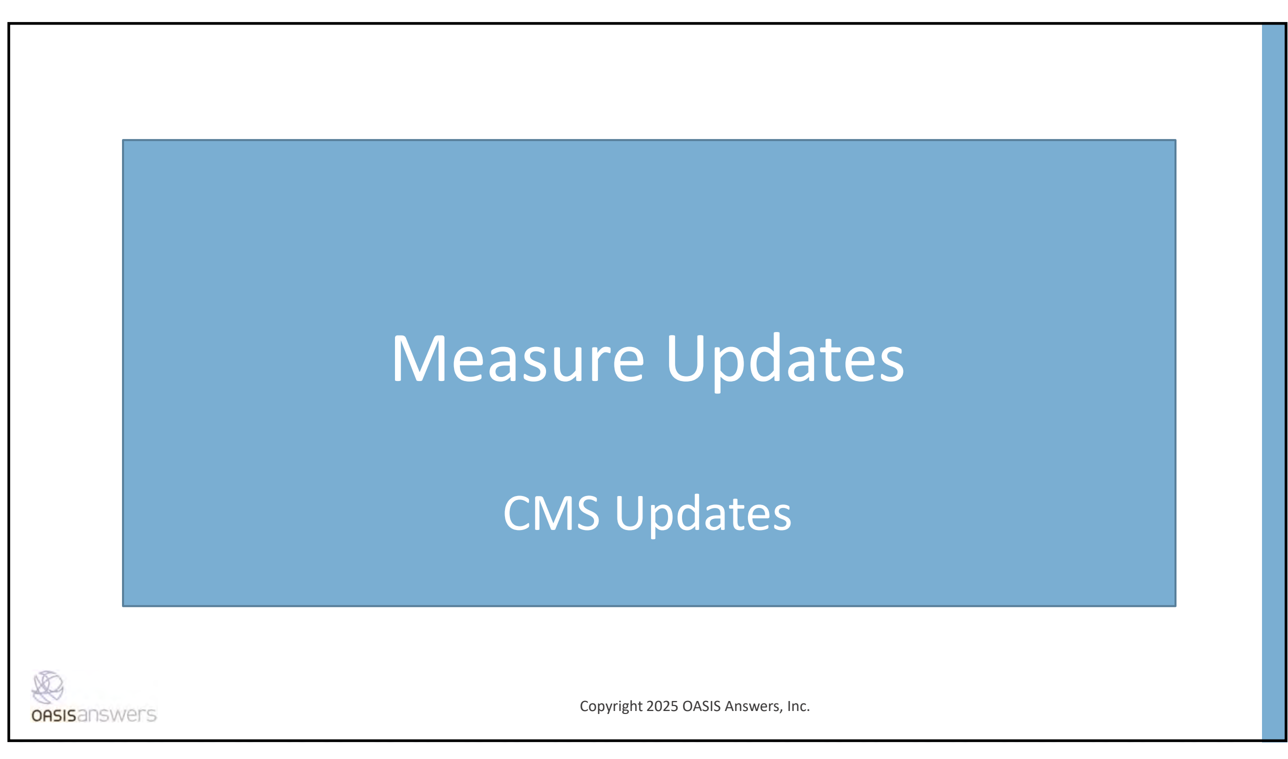

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New Measures on Care Compare and Provider Data Catalog

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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CMS Updates

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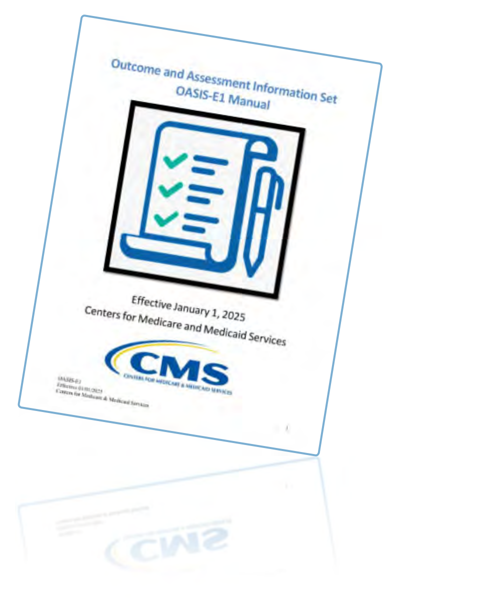
OASIS-E1 Guidance Manual

- 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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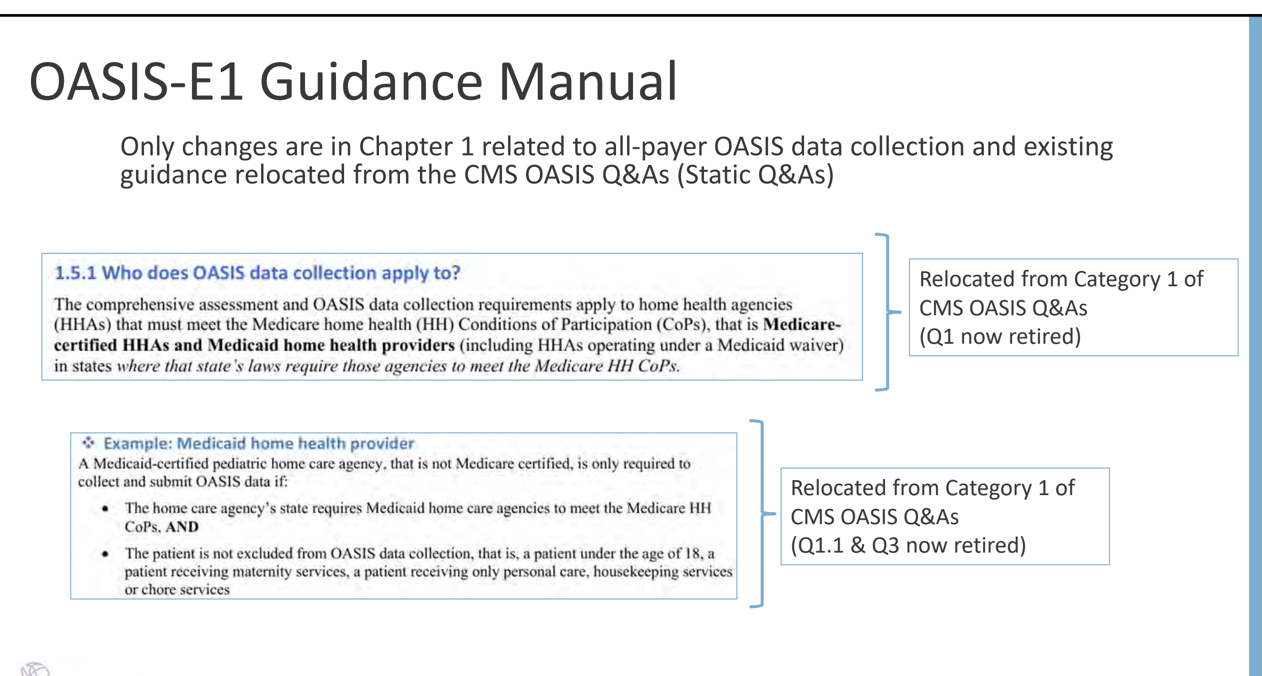

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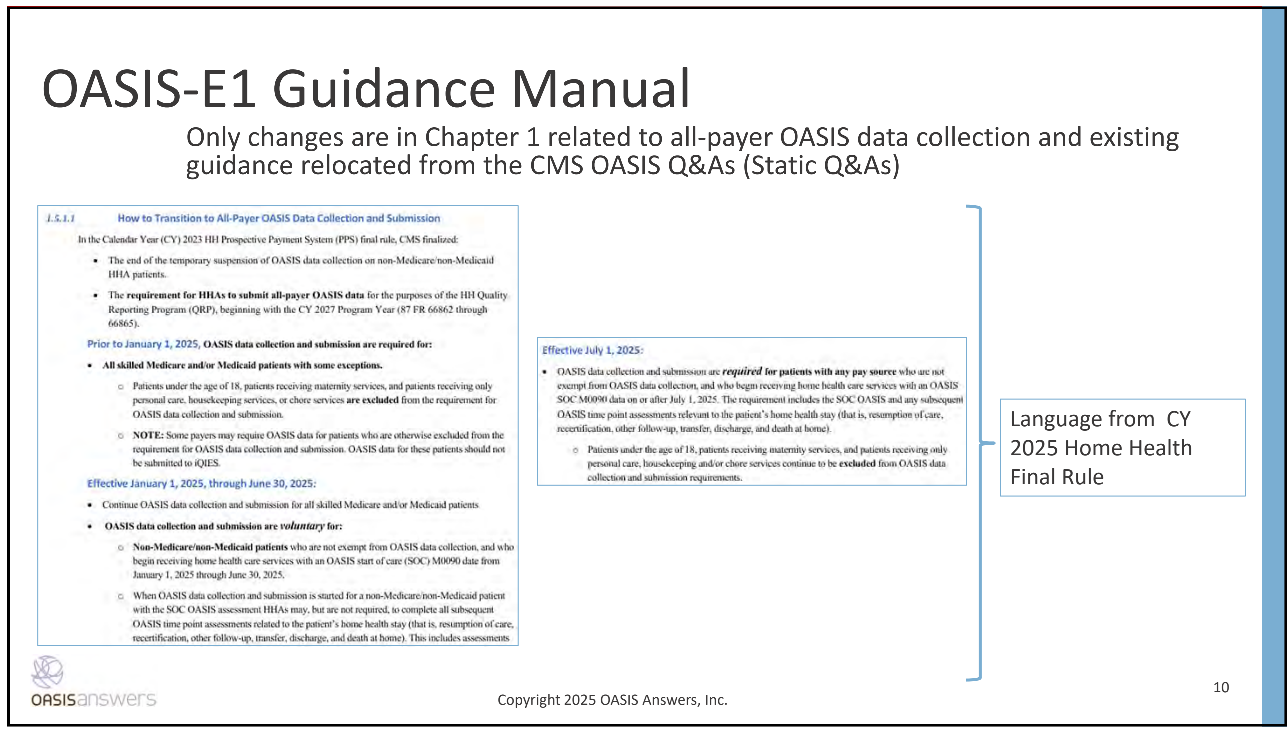

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OASIS-E1 Guidance Manual

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)

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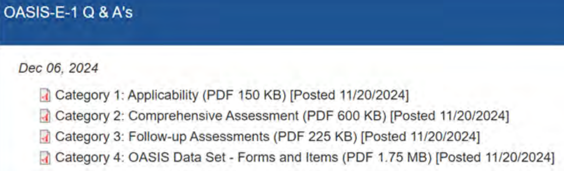
CMS OASIS Q&As


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

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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.

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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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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
not any home care visits have been made in the new episode. The ager
RFA 7, depending on whether the agency anticipates the patient will be
not.

When an RFA 6 Transfer OASIS is submitted, the next expected submi
Resumption of Care (ROC) - RFA 3. If the patient did not resume servic
your internal agency discharge process would occur (with no OASIS co

Updated 2024 Version

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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).

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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.

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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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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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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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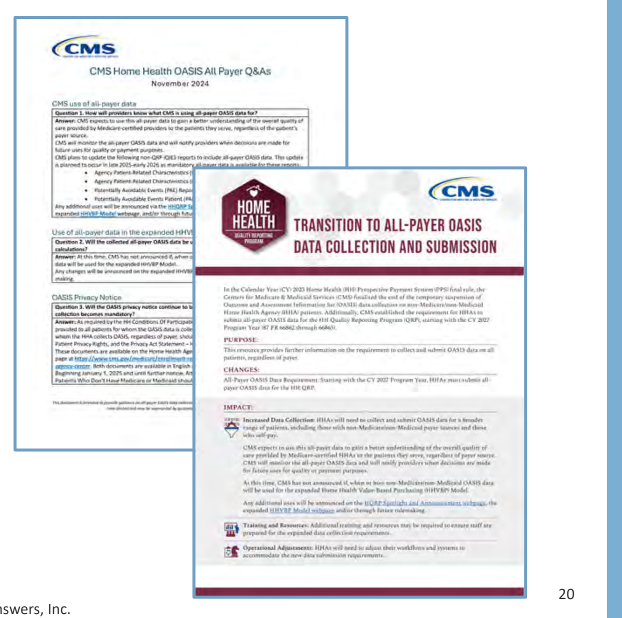
CMS Home Health All-Payer Resources

- November 27th: CMS Home Health All-Payer OASIS Q&As were posted on the HHQRP 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 HHQRP Home Health Quality Reporting Training webpage
  - Available in the download section: https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-training



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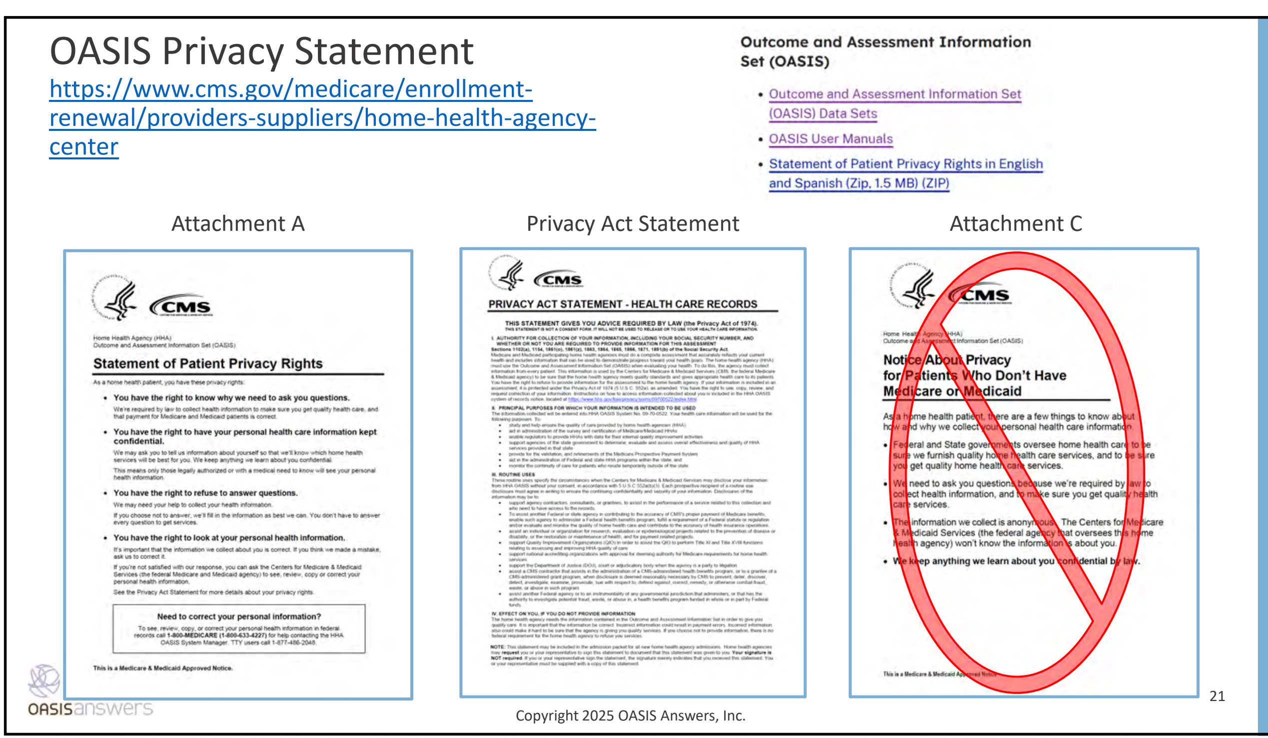

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COVID-19 Vaccination "Up to Date" Definition

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

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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.*

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Coding Update

CMS Updates

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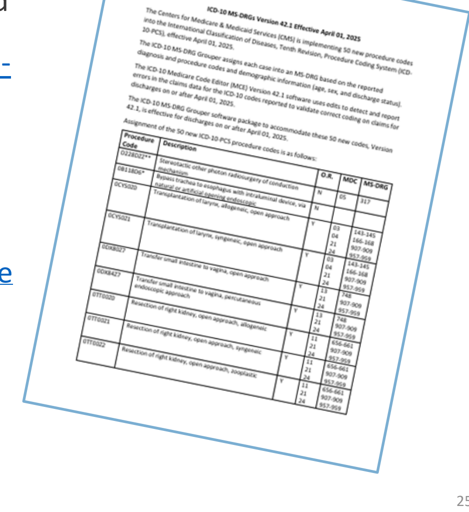
ICD-10 Coding Updates

- 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-DRGs 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 validate 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	O.R.	MDC	MS-DRG
0228DZZ**	Stereotactic other photon radiosurgery of conduction mechanism	N	05	317
0B118D6*	Bypass trachea to esophagus with intraluminal device, via natural or artificial opening endoscopic	N		
0CYS0Z0	Transplantation of larynx, allogeneic, open approach	Y	03 04 21 24	143-145 166-168 907-909 957-959
0CYS0Z1	Transplantation of larynx, syngeneic, open approach	Y	03 04 21 24	143-145 166-168 907-909 957-959
0DXB0Z7	Transfer small intestine to vagina, open approach	Y	13 21 24	748 907-909 957-959
0DXB4Z7	Transfer small intestine to vagina, percutaneous endoscopic approach	Y	13 21 24	748 907-909 957-959
0TT00Z0	Resection of right kidney, open approach, allogeneic	Y	11 21 24	656-661 907-909 957-959
0TT00Z1	Resection of right kidney, open approach, syngeneic	Y	11 21 24	656-661 907-909 957-959
0TT00Z2	Resection of right kidney, open approach, zooplastic	Y	11 21 24	656-661 907-909 957-959

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Home Health Value-Based Purchasing (HHVBP) Updates

CMS Updates

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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
- HHCAHPS 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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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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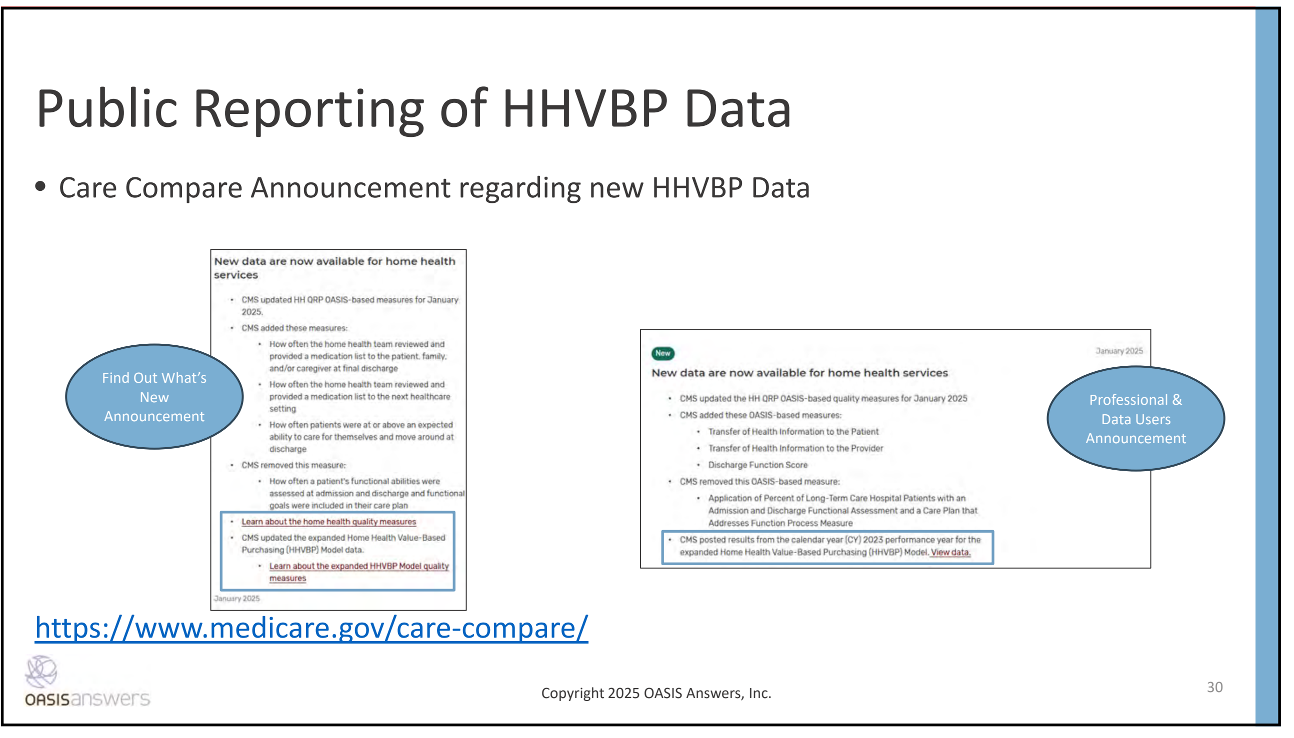

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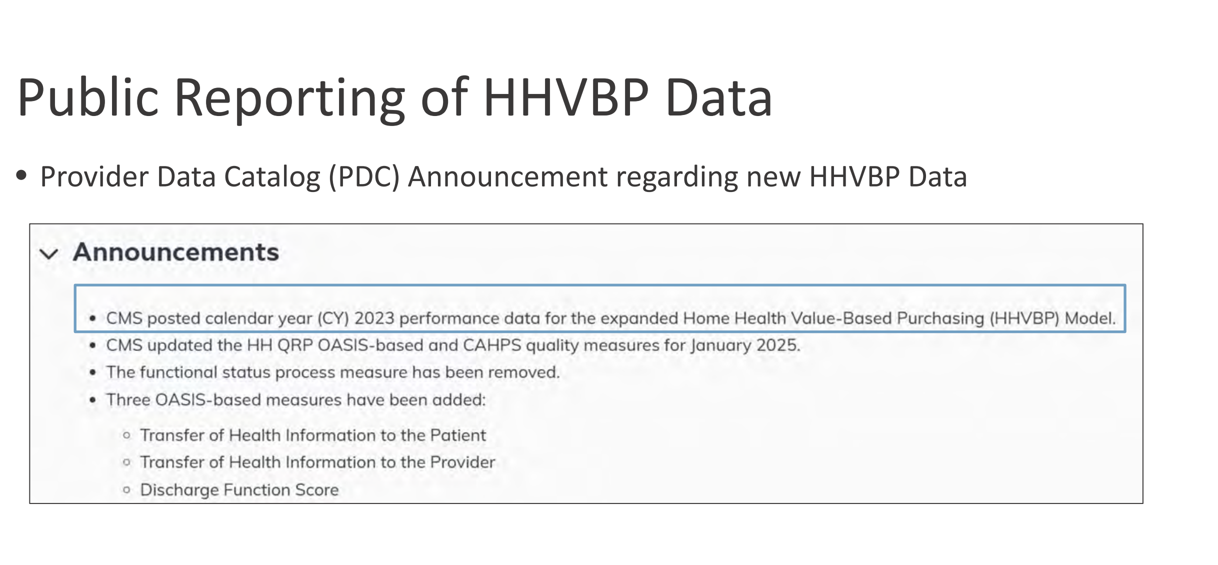

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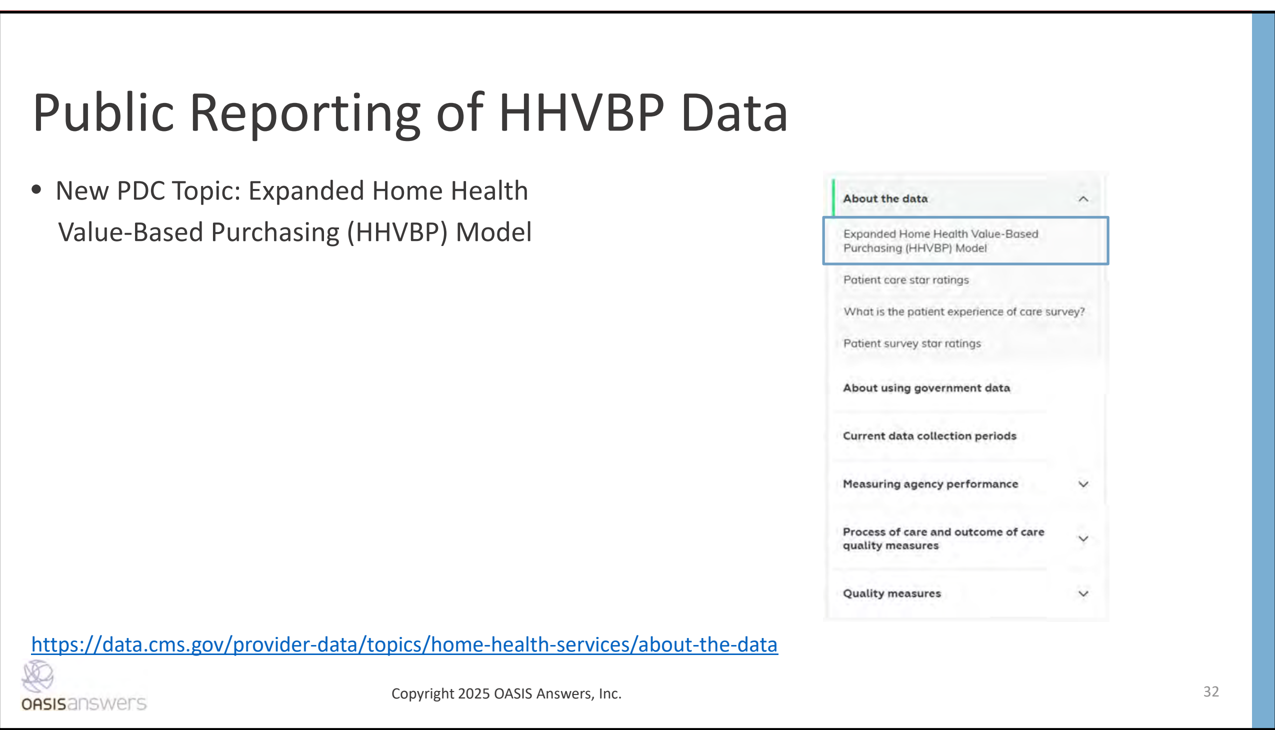

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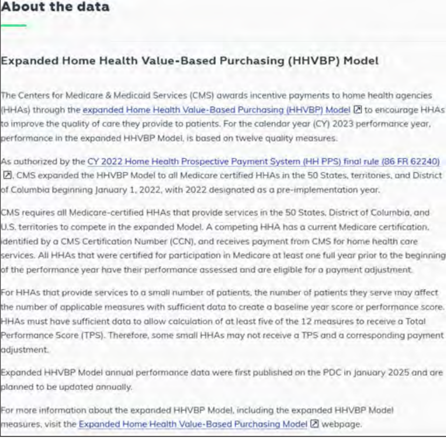
Public Reporting of HHVBP Data

- 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

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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 HHQRP measure results reported on Care Compare.

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

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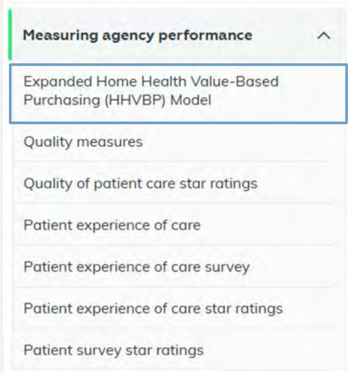
Public Reporting of HHVBP Data

- PDC reference to Expanded HHVBP Measuring Agency Performance



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

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Public Reporting of HHVBP Data

- PDC reference to Expanded HHVBP Measuring Agency Performance

Measuring agency performance

Medicare Care Compare provides several ways you can compare home health agency performance to help you choose a home health agency that will best meet your needs.

Expanded Home Health Value-Based Purchasing (HHVBP) Model

Under the expanded HHVBP Model, home health agencies (HHAs) receive adjustments to their Medicare fee-for-service (FFS) payments based on their performance against a set of quality measures, relative to their peers' performance. Performance on these quality measures in a specified year (performance year) impacts payment adjustments in a later year (payment year). Cohorts are determined based on each HHA's unique beneficiary count in the calendar year prior to the performance year. HHAs are assigned to either a nationwide larger-volume cohort or nationwide smaller-volume cohort to group HHAs that are of similar size and are more likely to receive scores on the same set of measures for purposes of setting benchmarks and achievement thresholds and determining payment adjustments.

Under the expanded HHVBP Model, HHAs receive achievement points for each applicable measure that reflect their performance level on a given quality measure compared to other HHAs in the same cohort in the baseline year. They also receive improvement points for each applicable measure that are based on individual HHA performance compared to performance in the baseline year. HHAs receive care points for each applicable measure that are the higher of the achievement or improvement points. Care points for each measure are weighted, using each measure's assigned weight, and summed to generate the Total Performance Score (TPS) for each HHA. The TPS is a numeric score, ranging from 0 to 100, and is used to determine the payment adjustment percentage for competing HHAs.

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

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Public Reporting of HHVBP Data

- New PDC Datasets for the Expanded HHVBP Model

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

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The Buzz on Home Health Reports

Highlights from HH QRP and HHVBP Reports

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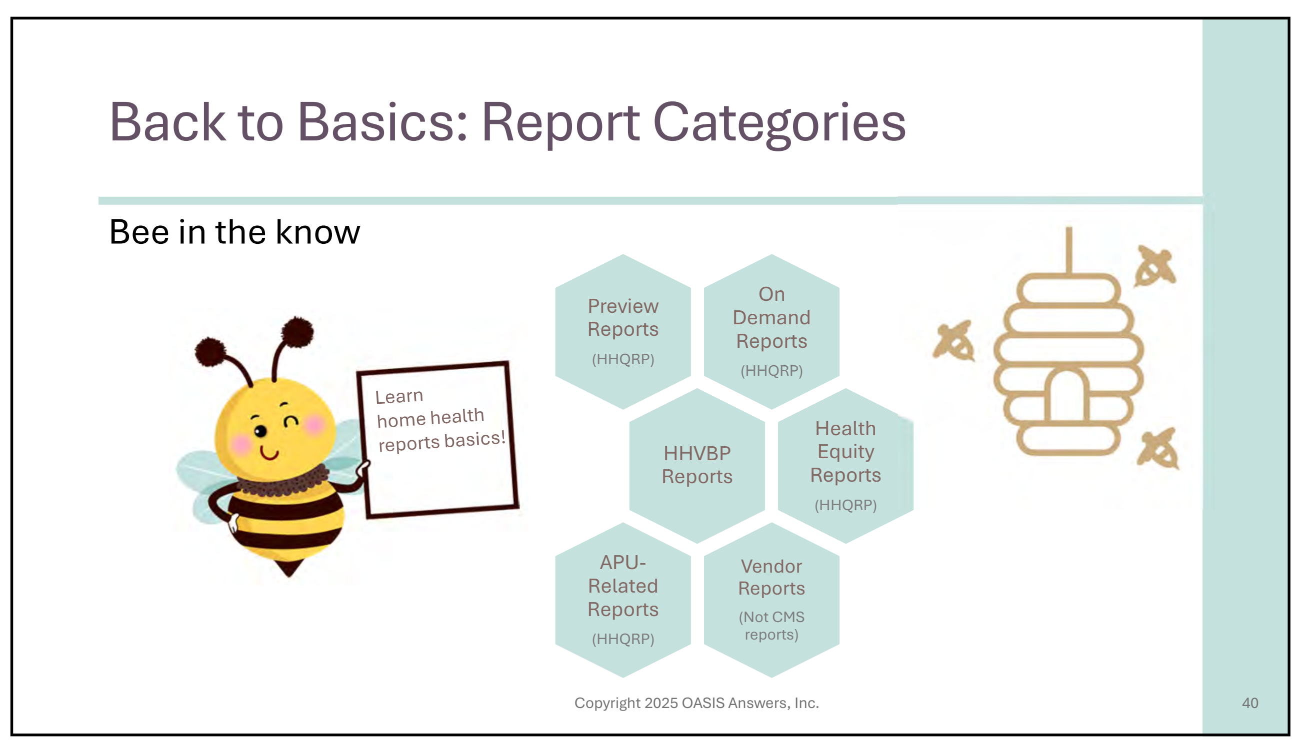

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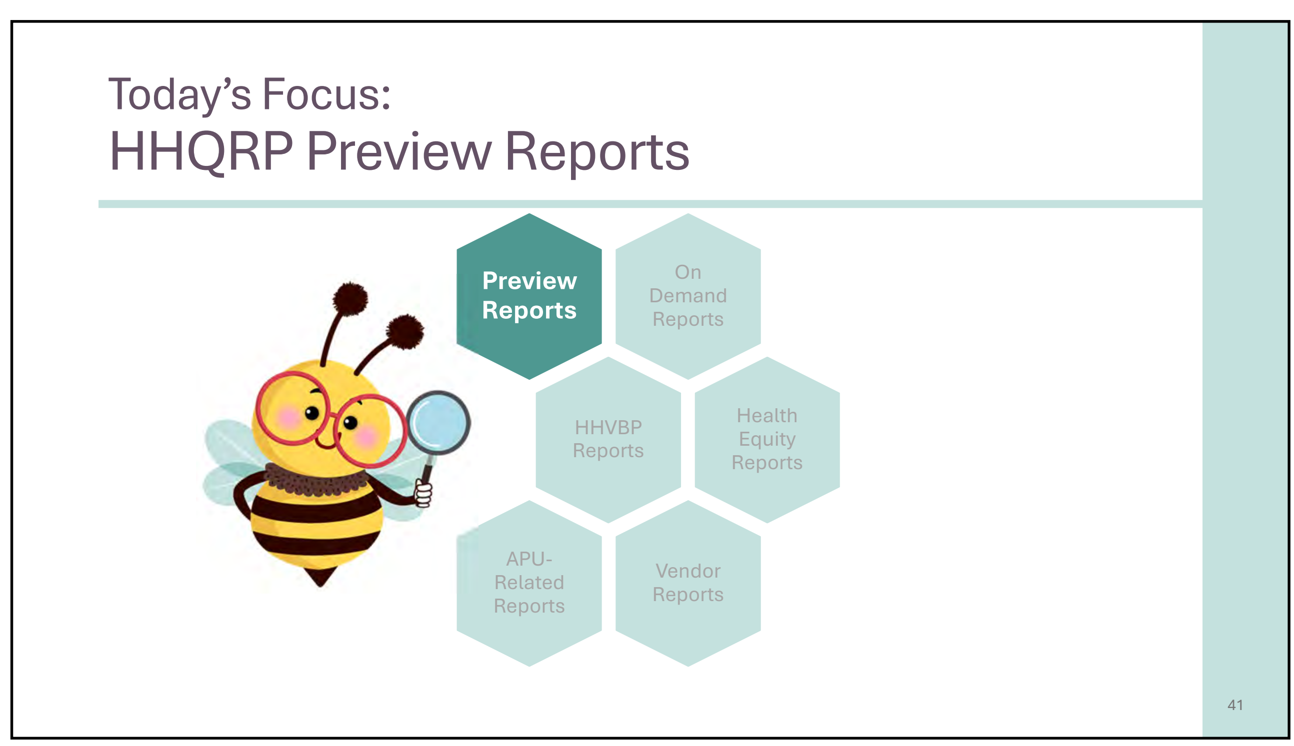

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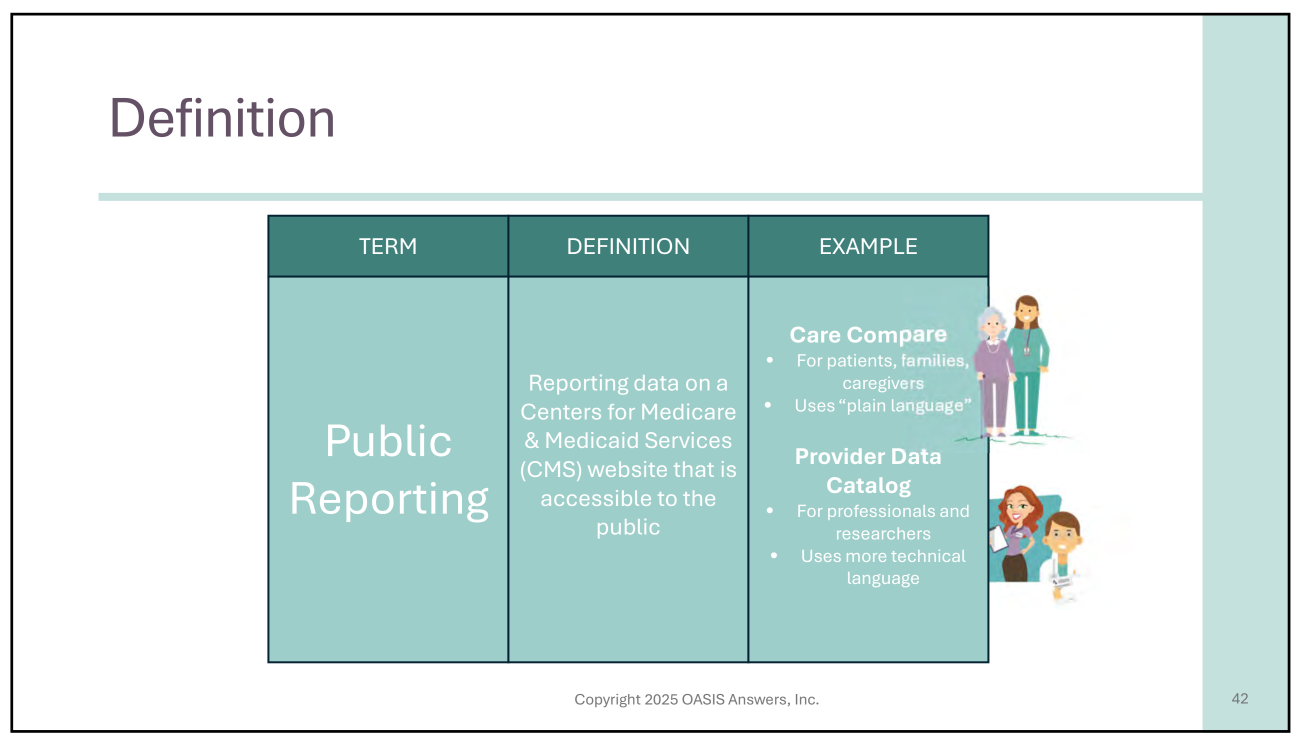

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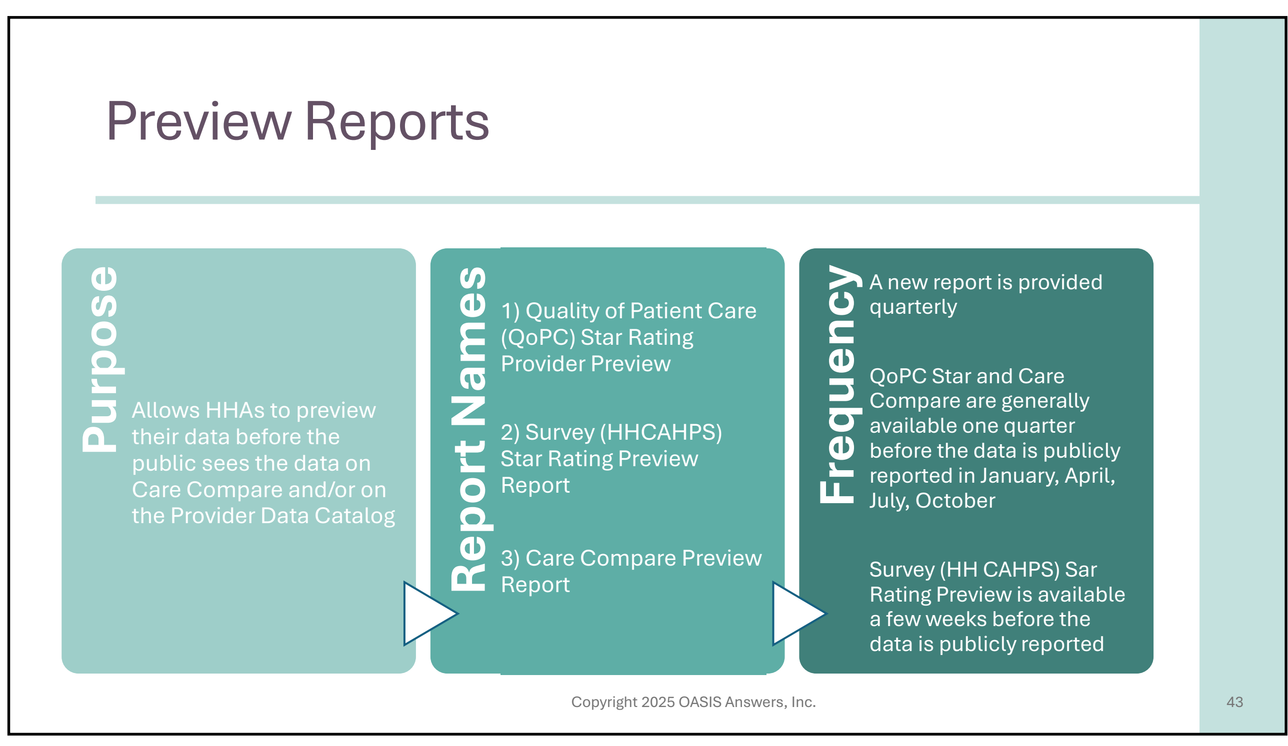

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Quality of Patient Care Star Rating

Preview Report

Preview Report #1

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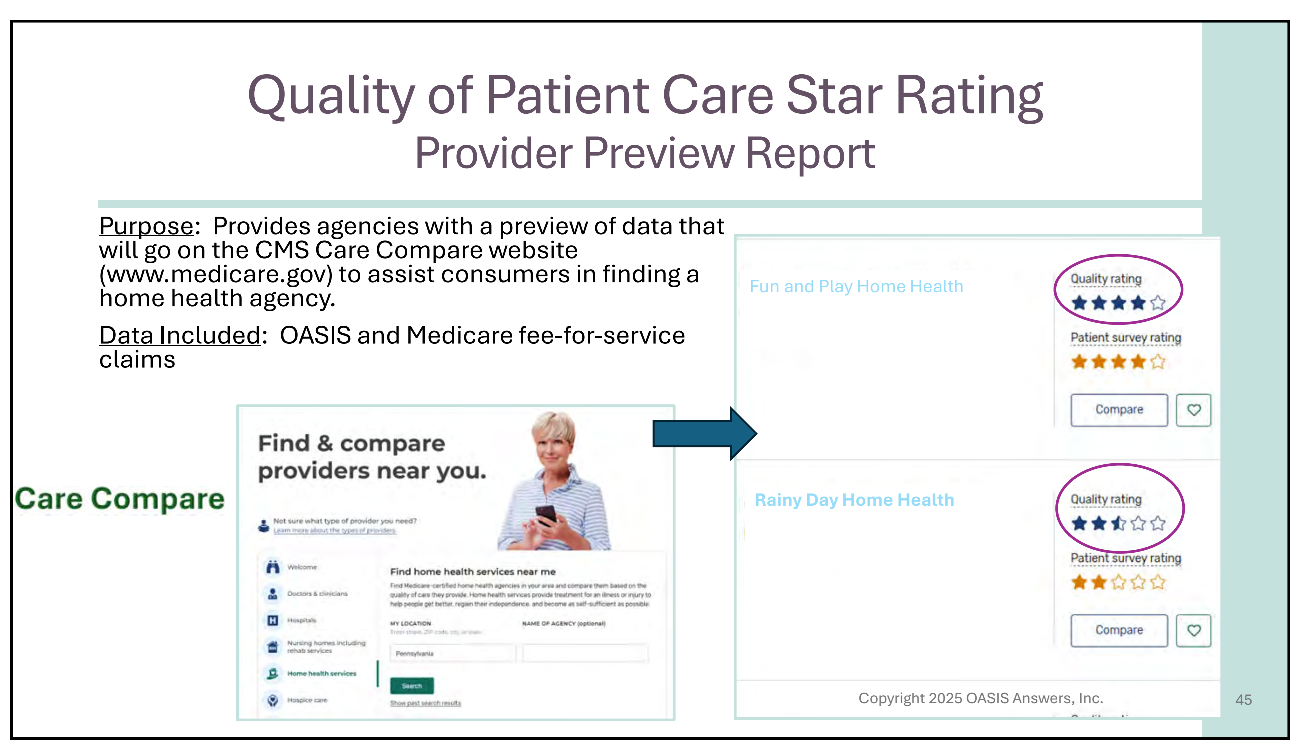

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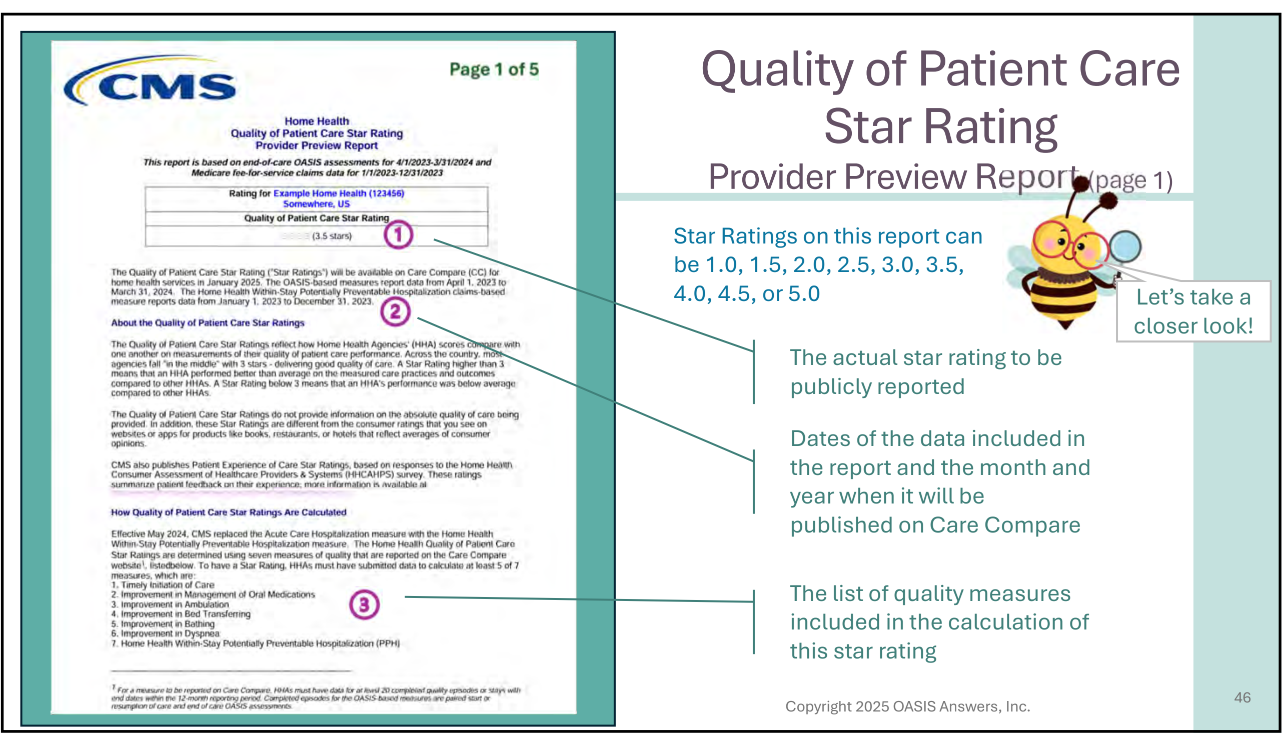

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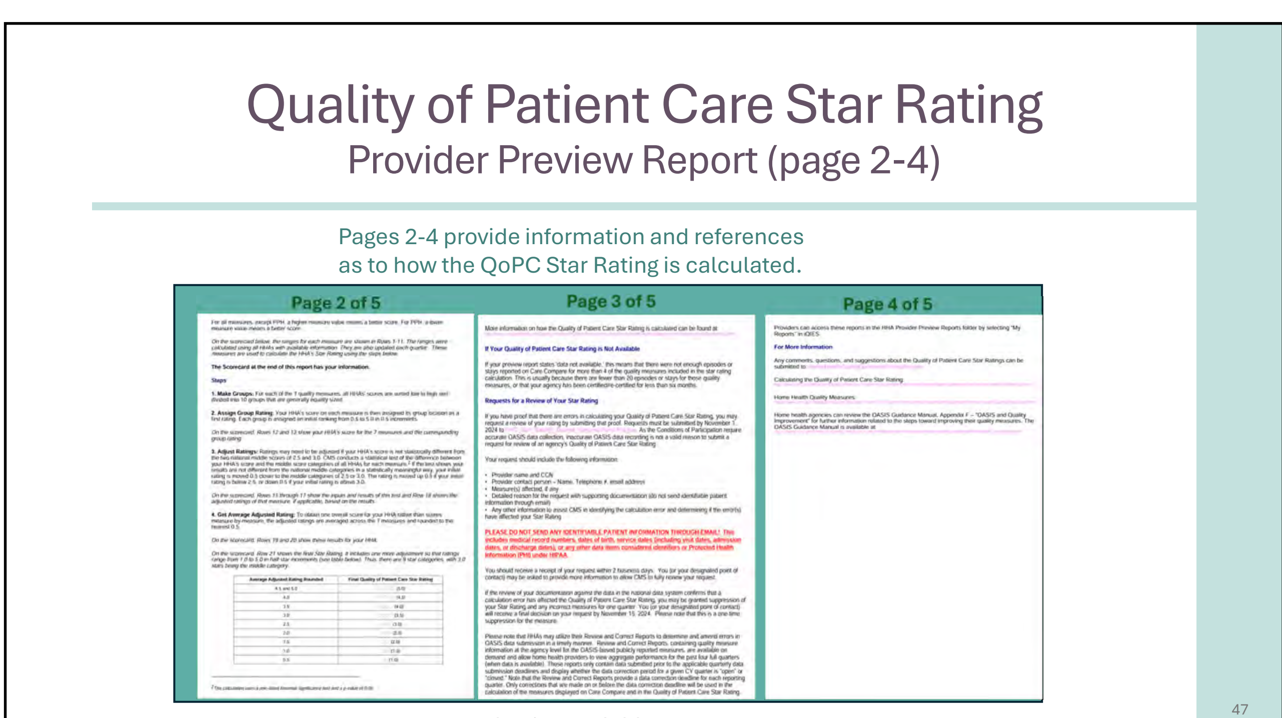

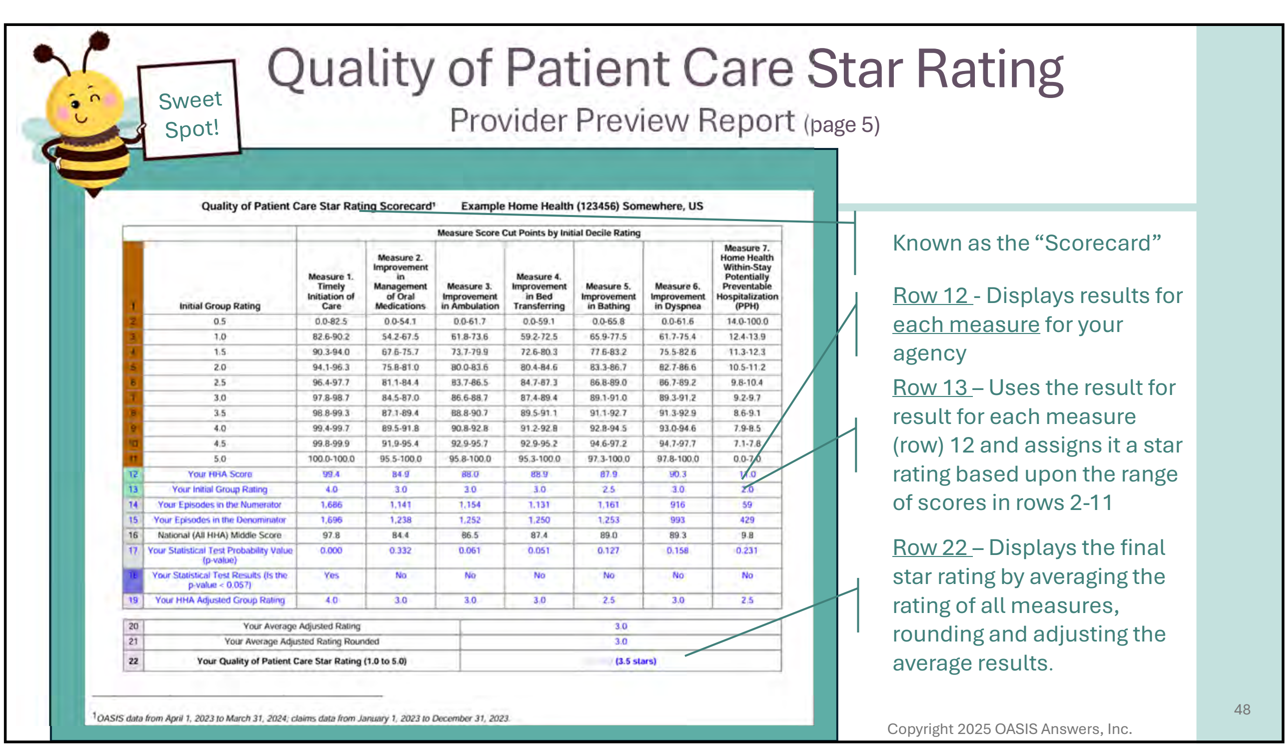

Quality of Patient Care Star Rating Scorecard[1] Example Home Health (123456) Somewhere, US

#		Measure Score Cut Points by Initial Decile Rating						
1	Initial Group 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 (PPH)
2	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	14.0-100.0
3	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	12.4-13.9
4	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	11.3-12.3
5	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	10.5-11.2
6	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	9.8-10.4
7	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	9.2-9.7
8	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	8.6-9.1
9	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	7.9-8.5
10	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	7.1-7.8
11	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	0.0-7.0
12	Your HHA Score	99.4	84.9	88.0	88.9	87.9	90.3	1[illegible].0
13	Your Initial Group Rating	4.0	3.0	3.0	3.0	2.5	3.0	2.0
14	Your Episodes in the Numerator	1,686	1,141	1,154	1,131	1,161	916	59
15	Your Episodes in the Denominator	1,696	1,238	1,252	1,250	1,253	993	429
16	National (All HHA) Middle Score	97.8	84.4	86.5	87.4	89.0	89.3	9.8
17	Your Statistical Test Probability Value (p-value)	0.000	0.332	0.061	0.051	0.127	0.158	0.231
18	Your Statistical Test Results (Is the p-value < 0.05?)	Yes	No	No	No	No	No	No
19	Your HHA Adjusted Group Rating	4.0	3.0	3.0	3.0	2.5	3.0	2.5

#		
20	Your Average Adjusted Rating	3.0
21	Your Average Adjusted Rating Rounded	3.0
22	**Your Quality of Patient Care Star Rating (1.0 to 5.0)**	**(3.5 stars)**

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

Survey (HHCAHPS) Star Rating

Preview Report

Preview Report #2

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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

Find & compare providers near you.

Find home health services near me

Fun and Play Home Health

Quality rating

Patient survey rating

Compare

Rainy Day Home Health

Quality rating

Patient survey rating

Compare

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Care Compare

Preview Report

Preview Report #3

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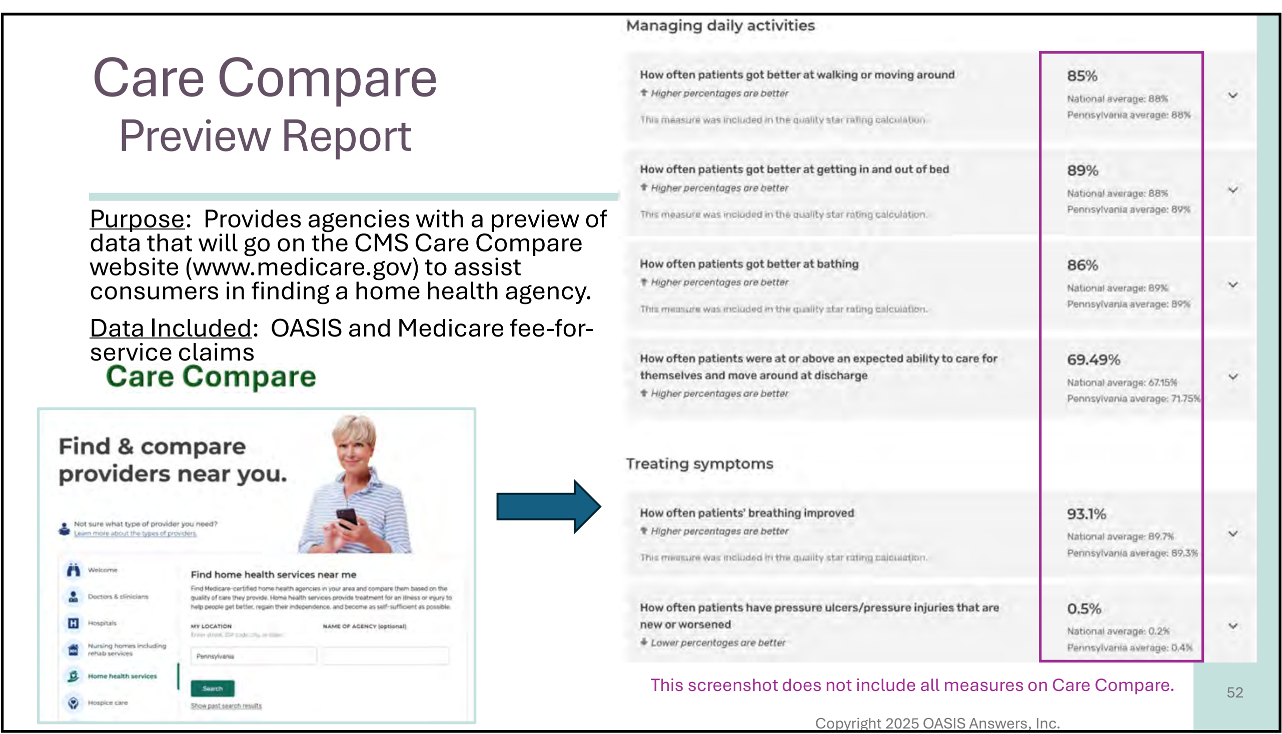

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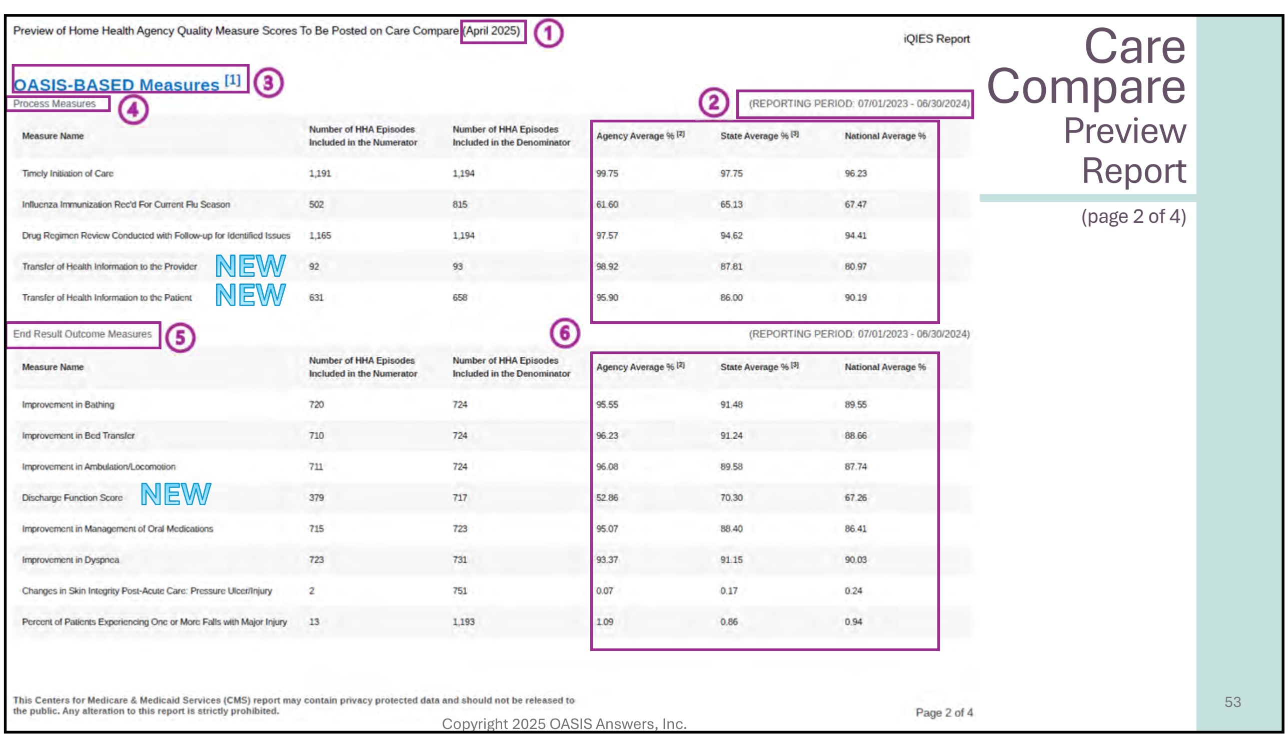

Preview of Home Health Agency Quality Measure Scores To Be Posted on Care Compare (April 2025) ① iQIES Report

OASIS-BASED Measures [1] ③

Process Measures ④

② (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 % [3]	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 NEW	92	93	98.92	87.81	80.97
Transfer of Health Information to the Patient NEW	631	658	95.90	86.00	90.19

End Result Outcome Measures ⑤

⑥ (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 % [3]	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 NEW	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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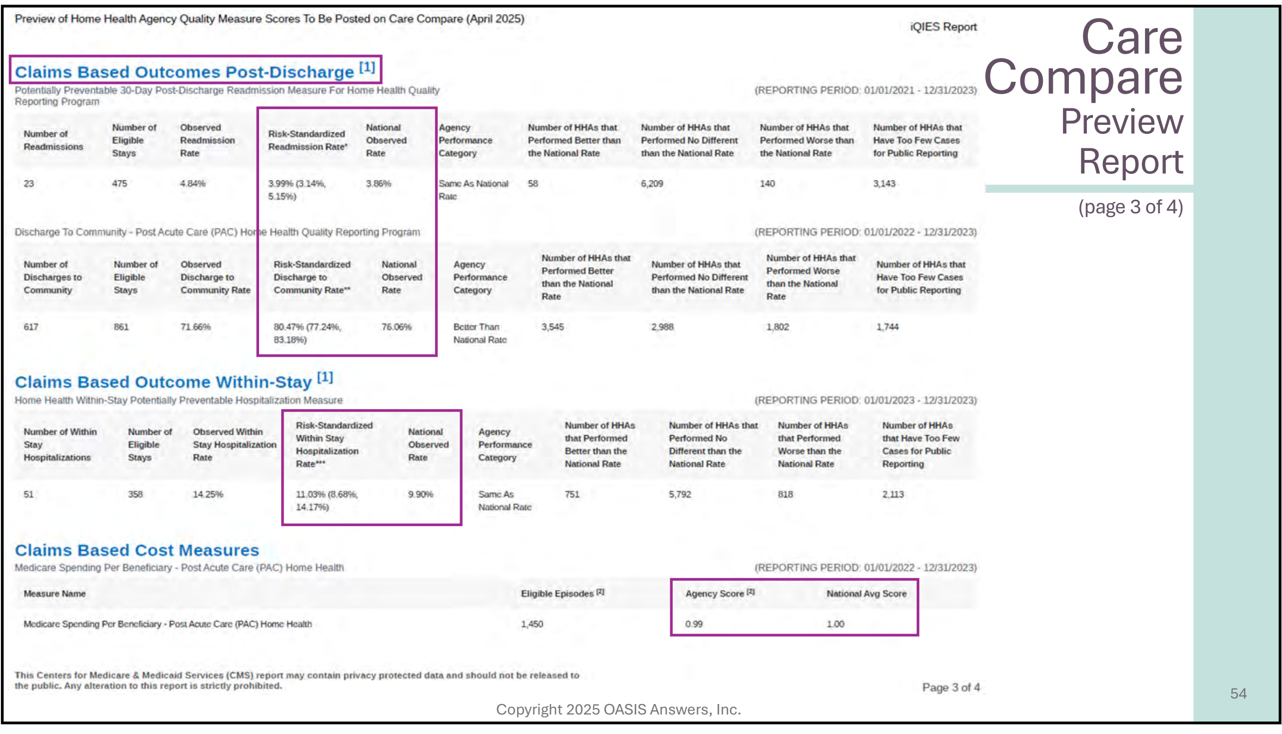

Preview of Home Health Agency Quality Measure Scores To Be Posted on Care Compare (April 2025) iQIES Report

Claims Based Outcomes Post-Discharge [1]

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

(REPORTING PERIOD: 01/01/2021 - 12/31/2023)

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]

Home Health Within-Stay Potentially Preventable Hospitalization Measure

(REPORTING PERIOD: 01/01/2023 - 12/31/2023)

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

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

(REPORTING PERIOD: 01/01/2022 - 12/31/2023)

Measure Name	Eligible Episodes [2]	Agency Score [3]	National Avg Score
Medicare Spending Per Beneficiary - Post Acute Care (PAC) Home Health	1,450	0.99	1.00

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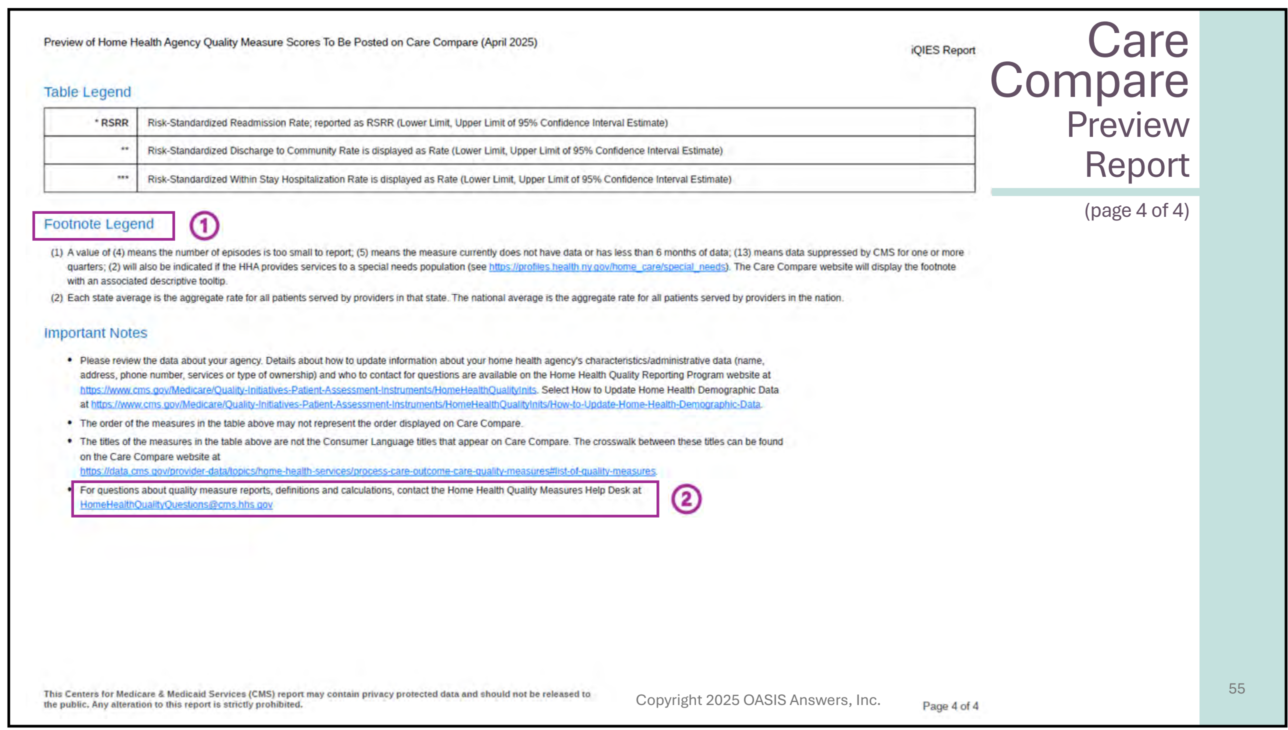

Preview of Home Health Agency Quality Measure Scores To Be Posted on Care Compare (April 2025)

iQIES Report

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) 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://profiles.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/process-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

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Care Compare Preview Report

(page 4 of 4)

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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/	• 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	• Select the "Preview Reports" link under the "For HHAs" tab

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

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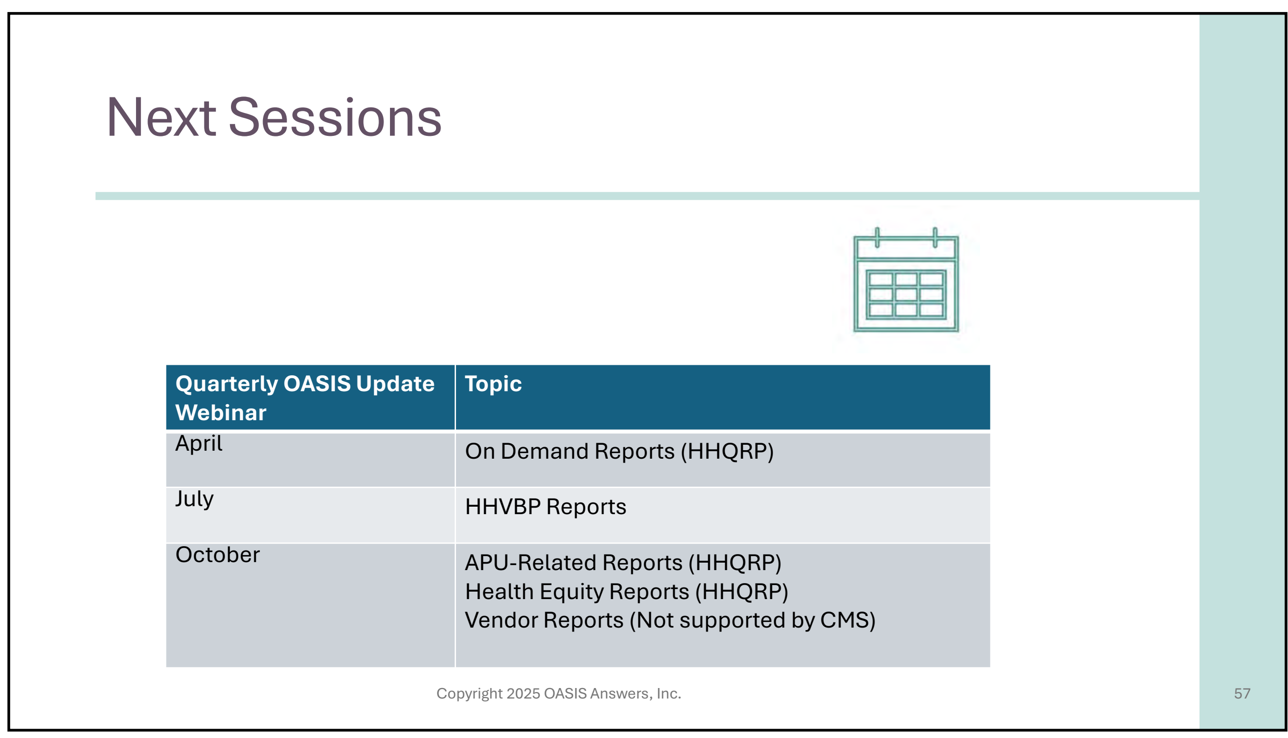

Quarterly OASIS Update Webinar	Topic
April	On Demand Reports (HHQRP)
July	HHVBP Reports
October	APU-Related Reports (HHQRP) Health Equity Reports (HHQRP) Vendor Reports (Not supported by CMS)

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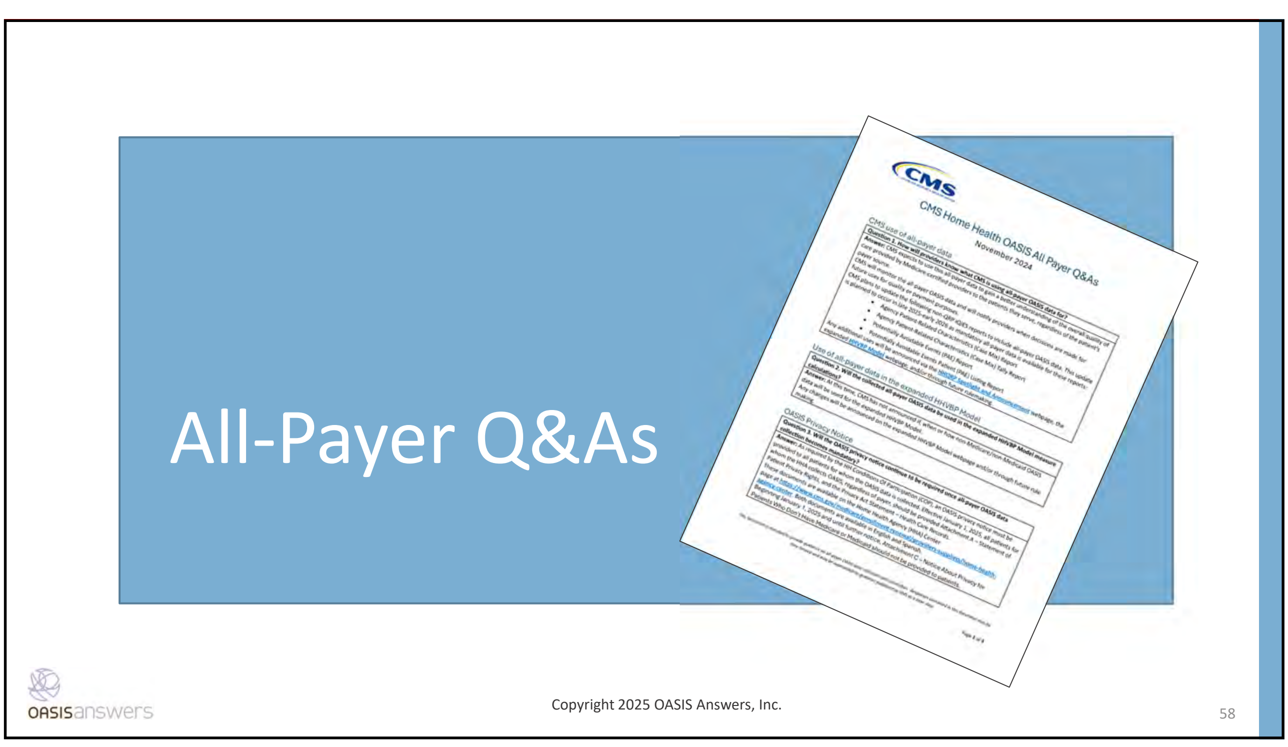

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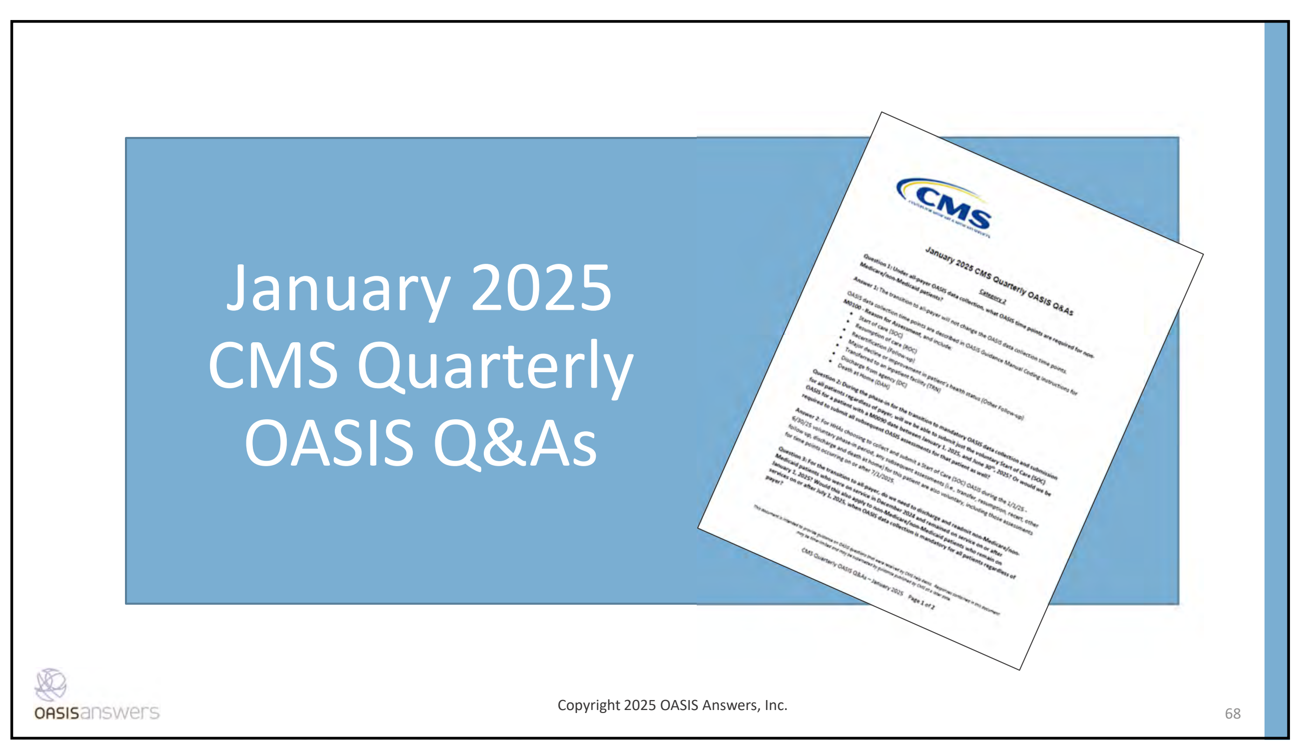

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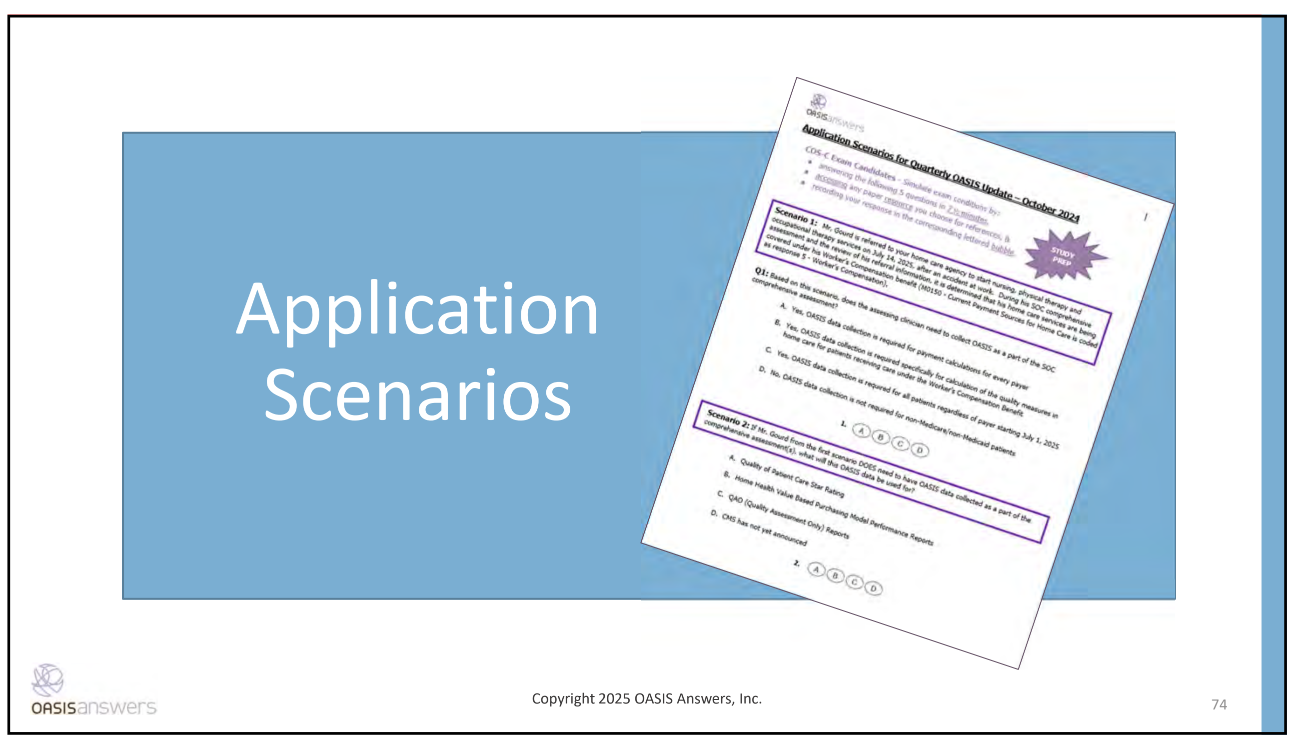

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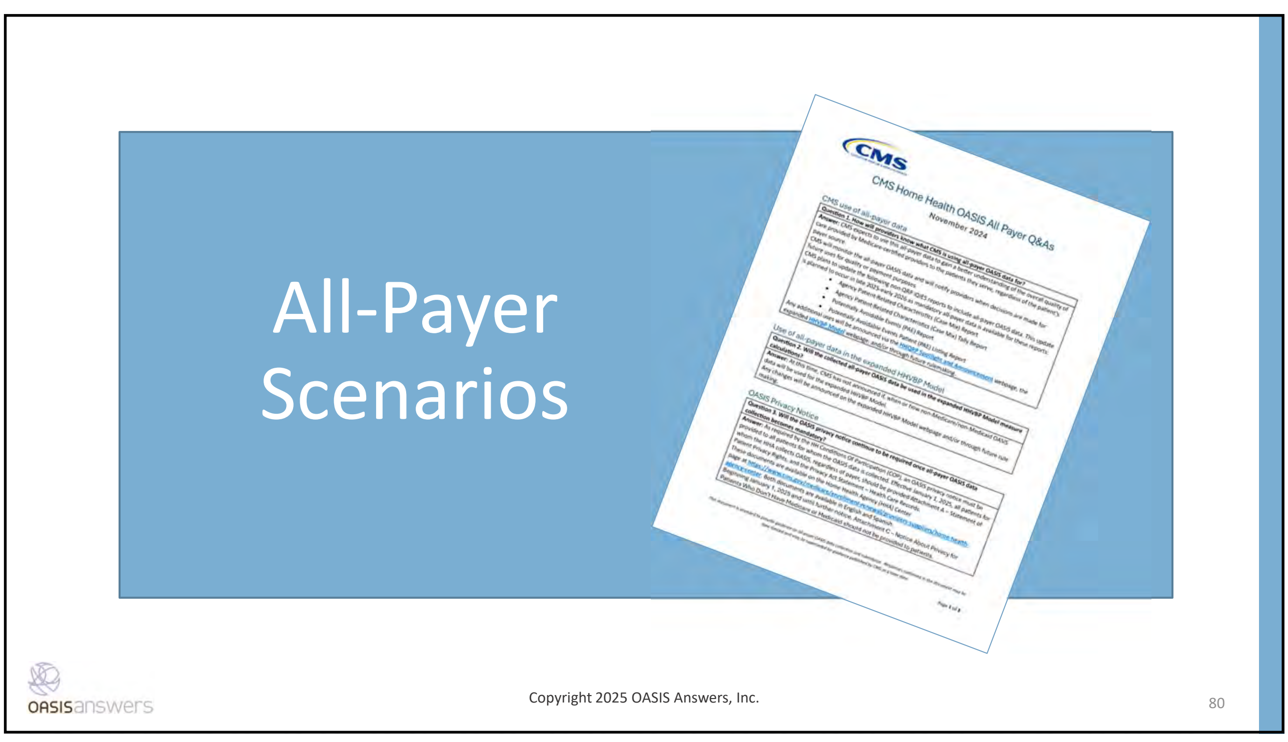

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Questions???

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

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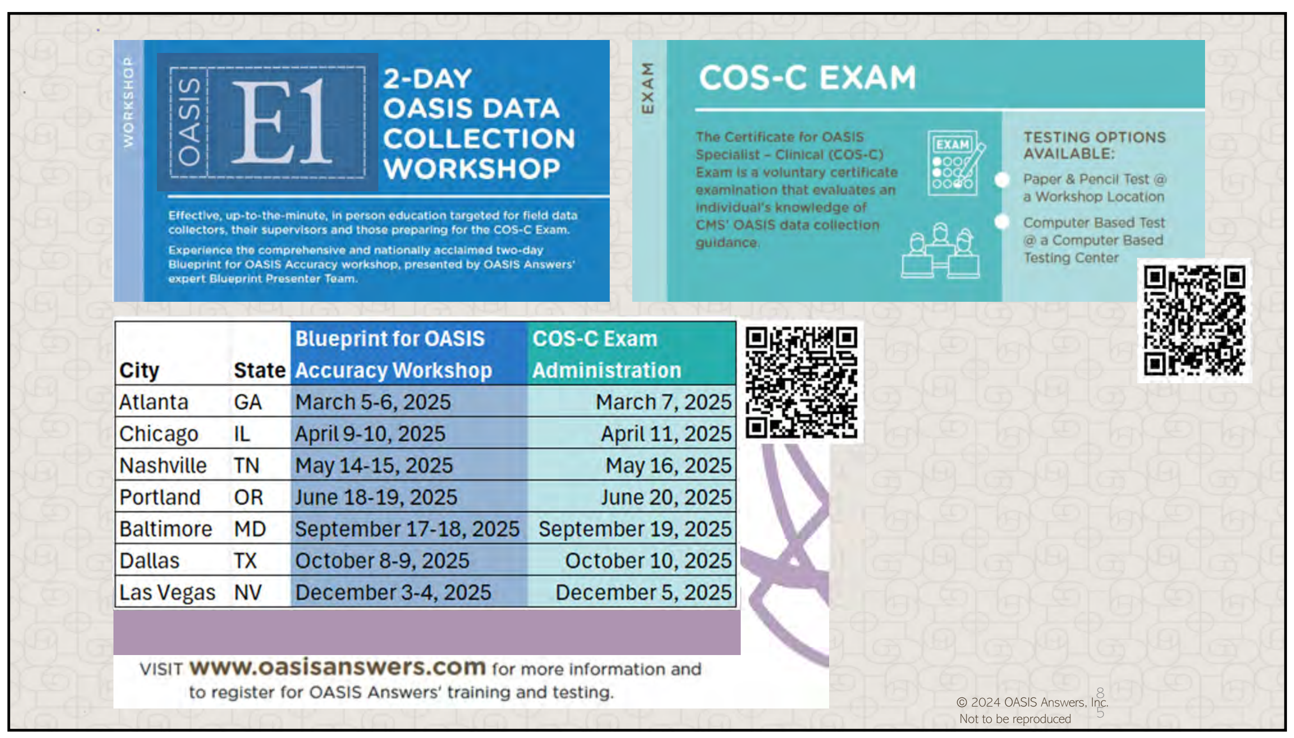

City	State	Blueprint for OASIS Accuracy Workshop	COS-C Exam Administration
Atlanta	GA	March 5-6, 2025	March 7, 2025
Chicago	IL	April 9-10, 2025	April 11, 2025
Nashville	TN	May 14-15, 2025	May 16, 2025
Portland	OR	June 18-19, 2025	June 20, 2025
Baltimore	MD	September 17-18, 2025	September 19, 2025
Dallas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

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RECORDED RESOURCE

COS-C EXAM CRAM

Updated for OASIS-E1 and 2025

OASIS ANSWERS

A virtual exam refresher session with interactive test questions. The webinar is organized to mimic the break-down 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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Nursing Contact Hours Disclosure

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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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