Home Health Quality of Patient Care Star Rating, Value-Based Purchasing, and OASIS-D1

Home Health Compare uses a star rating (Quality of Patient Care Star Rating) between 1 and 5 to show people how a home health agency (HHA) compares to other HHAs on measurements of their performance. The star ratings are based on eight (effective April 2018) measures of quality that give a general overview of performance.

Across the country, most agencies fall in the middle, with 3 or 3½ stars being the average rating across the nine measures. A star rating higher than 3½ means that an agency performed better than average compared to other agencies. A star rating lower than 3 means that an agency's performance was below average compared to other HHAs.

Value-Based Purchasing (VBP) was a pilot program that began January 1, 2016, in nine states across the country, and it continued through 2020. All Medicare-certified HHAs that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee were required to participate in the Home Health VBP model, where payment is tied to quality performance.

CMS has finalized that effective January 2023 there will be a nationwide rollout of the Home Health Value-Based Purchasing (VBP) program. All agencies that are Medicare certified and were certified prior to January 2022 will be required to participate starting January 2023.

Table 3.4 is a chart that acknowledges the OASIS M items that are currently identified as subject to the calculations for VBP and the Quality of Patient Care Star Rating.

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The follow-up/recertification (FU) assessment must be completed when a patient is being recertified to continue care for additional 60-day episodes of care. The regulations require that a comprehensive assessment be completed at least every 60 days, and this must occur in the five-day window (days 56–60) before the end of the current episode.

Example

The start-of-care date of a patient is 01/15/20. The episode would be 01/15/20–03/14/20. The FU assessment should be completed in the last five days of the episode (03/10/20–03/14/20) to meet the requirement. There is only one situation in which this form is not required:

- A patient is transferred to the hospital on day 45 of the home health episode. The patient returns home from the hospital on day 58 of the episode. The agency intends to recertify the patient for an additional episode. The agency would complete only the resumption-of-care (ROC) assessment, and the information from that form would be the same information used to recertify the patient.

The other follow-up (OFU) assessment is required when a patient experiences a significant unexpected change in condition that was not anticipated in the original plan of care. Some agencies never complete this form, but that failure is a huge compliance issue with OASIS regulations. *The OASIS-D Guidance Manua*l emphasizes that a comprehensive assessment is required when there is a major decline or improvement in a patient's health status, noted as a significant change in condition. The OFU assessment will have a potential impact on case-mix weight and corresponding payment under PDGM – effective January 1, 2020. With the 30-day payment period – any change in condition that is identified and an OFU is completed, the subsequent 30-day payment period case-mix weight may be impacted.

The following Mxxxx/GGxxxx items are included on the FU and OFU assessments:

- Update Patient Tracking Sheet information, if needed
- M0080–M0100, M0110: Clinical Record Items
- M1021–M1023, M1030: Patient History & Diagnoses (all OPTIONAL effective 1/1/20)
- M1200, M1242: Sensory Status (all OPTIONAL effective 1/1/20)
- M1306, M1311, M1322–M1342: Integumentary Status (all EXCEPT M1306 - OPTIONAL effective 1/1/20)

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- In Response 5, decline in mental, emotional, or behavioral status refers to significant changes occurring within the past three months that may impact the patient's ability to remain safely in the home and increase the likelihood of hospitalization.
- In Response 7, medications include over-the-counter medications.
- Response 9—Other risk(s), may be selected if the assessing clinician finds characteristics other than those listed in Responses 1–8 that may indicate risk for hospitalization (for example, slower movements during sit to stand and walking).

PDGM CASE-MIX QUESTION ALERT

M1033 WILL BE UTILIZED IN THE CALCULATION OF THE FUNCTIONAL IMPAIRMENT LEVEL OF THE PATIENT IN THE PDGM CASE-MIX CALCULATION IN CONJUNCTION WITH ADL ITEMS IN THE M1800 SECTION.
If the clinician marks 4 or more of the responses 1-7 below the calculation for Functional Impairment Level will include 12 additional points.

1 History of falls (2 or more falls – or any fall with an injury – in the past 12 months)
2 Unintentional weight loss of a total of 10 pounds or more in the past 12 months
3 Multiple hospitalizations (2 or more) in the past 6 months
4 Multiple emergency department visits (2 or more) in the past 6 months
5 Decline in mental, emotional, or behavioral status in the past 3 months
6 Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
7 Currently taking 5 or more medications
8 Currently reports exhaustion
9 Other risk(s) not listed in 1 - 8
10 None of the above

(M1041) (TD)

—Influenza Vaccine Date Collection Period: Does this episode of care (SOC/ROC to transfer/discharge) include any dates on or between October 1 and March 31?

- Definition of episode of care is from SOC/ROC to Transfer or Discharge.
- Question should be answered "yes" or "no" based solely on the dates of the care episode as defined earlier.

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Quality of Patient Care Star Ratings Alert

This item is used in the calculation of the Star Ratings that is published on the Home Health Compare website. These Star Ratings are used by caregivers, payers, etc., to evaluate the level of quality care that your agency provides to your patients.

Tip: Educate staff on the importance of the Star Ratings and the agency's expectations as to the level of rating it will attain. This item is used in the calculation of the improvement in Pain Interfering with Activity measure. THIS ITEM WILL NO LONGER BE REPORTED AS OF APRIL 2020.

(M1306) (SRFOD)

—Does this patient have at least one Unhealed Pressure Ulcer/Injury at Stage 2 or Higher or designated as unstageable? (Excludes Stage 1 pressure ulcers and all healed pressure ulcers/injuries.)

- Identifies presence or absence of unhealed Stage 2 or higher or unstageable pressure ulcers/injuries only.
- HHAs may adopt the National Pressure Ulcer Advisory Panel (NPUAP) guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP. When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the *OASIS Guidance Manual* and CMS Q&As, providers should rely on the CMS OASIS instructions.
- Pressure ulcers are defined as localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction.
- Terminology referring to healed vs. unhealed ulcers/injuries can refer to whether the ulcer/injury is closed vs. open. Recognize, however, that Stage 1 pressure ulcers and suspected deep tissue injury (DTI), even if on closed (intact) skin, would not be considered healed. Unstageable pressure ulcers, whether covered with a non-removable dressing or eschar or slough, would not be considered healed.
- Enter Response 0 (No) if the only pressure injury is one or more Stage 1 OR healed pressure ulcer/injuries (of any previous stage) AND the patient has no other pressure ulcers/injuries.

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Value-Based Purchasing Alert

This item is set to be included in the calculation of the Total Performance Score (TPS) in the 2023 Value-Based Purchasing Nationwide Rollout. Please educate heavily on the impact of this item.

Tip: Observe the patient during transfer and ambulation to determine whether the patient has difficulty with balance, strength, dexterity, pain, and so on. This level of observation will aid in answering other ADL and IADL questions.

This item is set to be included in the 2023 Composite Outcome Measures: Total Normalized Composite Change in Mobility.

Quality of Patient Care Star Ratings Alert

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Tip: Educate staff on the importance of the Star Ratings and the agency's expectations as to the level of rating it will attain. This item is used in calculating the Improvement in Bed Transferring measure.

(M1860) (SRFOD)

—Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces

- Identifies the patient's ability and type of assistance needed to safely ambulate or propel self in a wheelchair over a variety of surfaces

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