



WISCONSIN DEPARTMENT  
*of* HEALTH SERVICES

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# OASIS Quarterly Forum

December 2023



# Acronyms

CB – Consolidated billing

CDC – Center for disease control

DTC – Discharge to community

HH PPS – Home health prosecutive payment system

HH QRP – Home health quality reporting program

HHRG – Home health resource group

HH VBP – Home health value-based purchasing

HIPPS – Health insurance prospective payment system

iQIES – Internet quality improvement and evaluation system

LRS – Labor related share

# Acronyms

LUPA – Low utilization payment adjustment  
OASIS – Outcome and assessment information set  
OBQI – Outcome-based quality improvement  
OBQM – Outcome-based quality monitoring  
PAC – Post acute care  
PPH – Potentially preventable hospitalization  
PDGM - Patient driven groupings model  
PPS - Prospective payment system  
QM – Quality measure  
QPP – Quality payment program  
QRP – Quality reporting program  
RFA – Reason for assessment  
TOH – Transfer of health

# Final Rule Calendar Year 2024

Prospective Payment System (PPS) Updates  
Increase in the aggregate by 0.8 percent



# Final Rule Calendar Year 2024

## Market Basket

- Adopt a 2021 based home health market basket
- Labor-related share (LRS) is 74.9 percent

# Final Rule Calendar Year 2024

## Home Health Quality Report Program (QRP)

### ■ Add

- COVID-19 Vaccine: Percent of patients/residents who are up to date
- Functional discharge score (DC function)

### ■ Remove

- Application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function

# Final Rule Calendar Year 2024

- Public report
  - Discharge function;
  - Transfer of health (TOH) information to provider
    - Post acute care (PAC);
  - Transfer of health (TOH) information to patient
    - Post acute care (PAC);
  - COVID-19 Vaccine: Percent of patients/residents who are up to date



# Care Compare – Public Reporting

## October 2023 Refresh

- Addition of claim-based measure – Potentially preventable hospitalization (PPH)
- Removal of drug education on all medications provided to patient and caregiver

# Final Rule Calendar Year 2024



# Final Rule Calendar Year 2024

## Home Health Value Based Purchasing (VBP)

- Replace
  - Total normalized composite measures (self-care and mobility) with the discharge function score.
  - OASIS based discharge to community (DTC) with the claims-based discharge to community post acute care (PAC).

# Final Rule Calendar Year 2024

- Acute care hospitalization during the first 60 days of HH use and the emergency department use without hospitalization during the first 60 days of HH with the claims based potentially preventable hospitalization measure.
- Change the weights of individual measures to the change in the total number of measures.
- Update the model baseline to CY2023

# Final Rule Calendar Year 2024

Public reporting of the HH value-based purchasing performance data and payment adjustments will begin in December 2024.



# Data Set Changes

- Starting January 1, 2025
  - Removal
    - ◆ M0110 – Episode timing
    - ◆ M2220 – Therapy needs items
    - ◆ GG0130 and GG0170 – Discharge goal
- Add
  - Section O – Patient's COVID-19 vaccination is up to date

# COVID-19 Vaccine

- Percentage of HH quality episodes in which patients were up to date with their COVID-19 vaccinations as defined by Centers for disease Control and Prevention (CDC) guidelines on current vaccination
- Process measure
- Data source – OASIS
  - Collected at the end of each quality episode (M0100 RFA 6 or 7, 8 or 9)
- One quarter of data

# Discharge Function Score

- Determines how successful each HHA is at achieving an expected level of functional ability for its patients at discharge
- Outcome measure
- Data source – OASIS
  - GG0130 Self-care and GG0170 Mobility
- 12 months (four quarters)
- Medicare patients with eligible stay
- Risk adjusted



# Top Ten Submission Errors

Top Ten Errors (Any)

Rank	Error Code	Error Message	Severity	Assessment Count	Percent of Assessments
1	-915	Patient Information Mismatch: Submitted value(s) for the item(s) listed do not match the values in the QIES ASAP database. If the record was accepted, the patient information in the database was updated. Verify that the new information is correct.	Warning	51,199	5.9%
2	-3330	Record Submitted Late: The submission date is more than 30 days after M0090 on this new record.	Warning	42,826	4.9%
3	-909	Inconsistent Record Sequence: Under CMS sequencing guidelines, the type of assessment in this record does not logically follow the type of assessment in the record received prior to this one.	Warning	23,766	2.7%
4	-907	Duplicate Assessment: The submitted record is a duplicate of a previously accepted record.	Fatal	23,232	2.7%
5	-925	Record Timing Invalid: CMS timing guidelines require recertification follow-up records (M0100=4) at least every 60 days, but no earlier than day 56 of the follow-up cycle.	Warning	5,394	0.6%
6	-3320	Inconsistent Dates: If M0100 is equal to 09, then M0090 minus M0906 should be greater than or equal to zero and less than or equal to 2 days.	Warning	1,964	0.2%
7	-3630	Inconsistent M0150 Values: At least one of the items M0150-1 through M0150-4 must equal 1 or the patient's care is not paid by Medicare or Medicaid.	Fatal	1,693	0.2%
8	-3190	No Match Found: This modification/inactivation record does not match a previously accepted record in the QIES ASAP System. One or more of the items of this record did not match the corresponding items of an existing record in the database.	Fatal	1,630	0.2%
9	-4820	Invalid HIPPS Values: SUBM_HIPPS_CODE and SUBM_HIPPS_VERSION values should match the system-calculated values.	Warning	1,578	0.2%
10	-5480	Invalid Medicare number or Medicare Beneficiary ID	Fatal	1,463	0.2%

# Patient Driven Groupings Model (PDGM)

# Definitions

## Prospective Payment System (PPS)

A payment system, developed for Medicare home health (HH) agencies, which pays agencies an all-inclusive rate for all services.

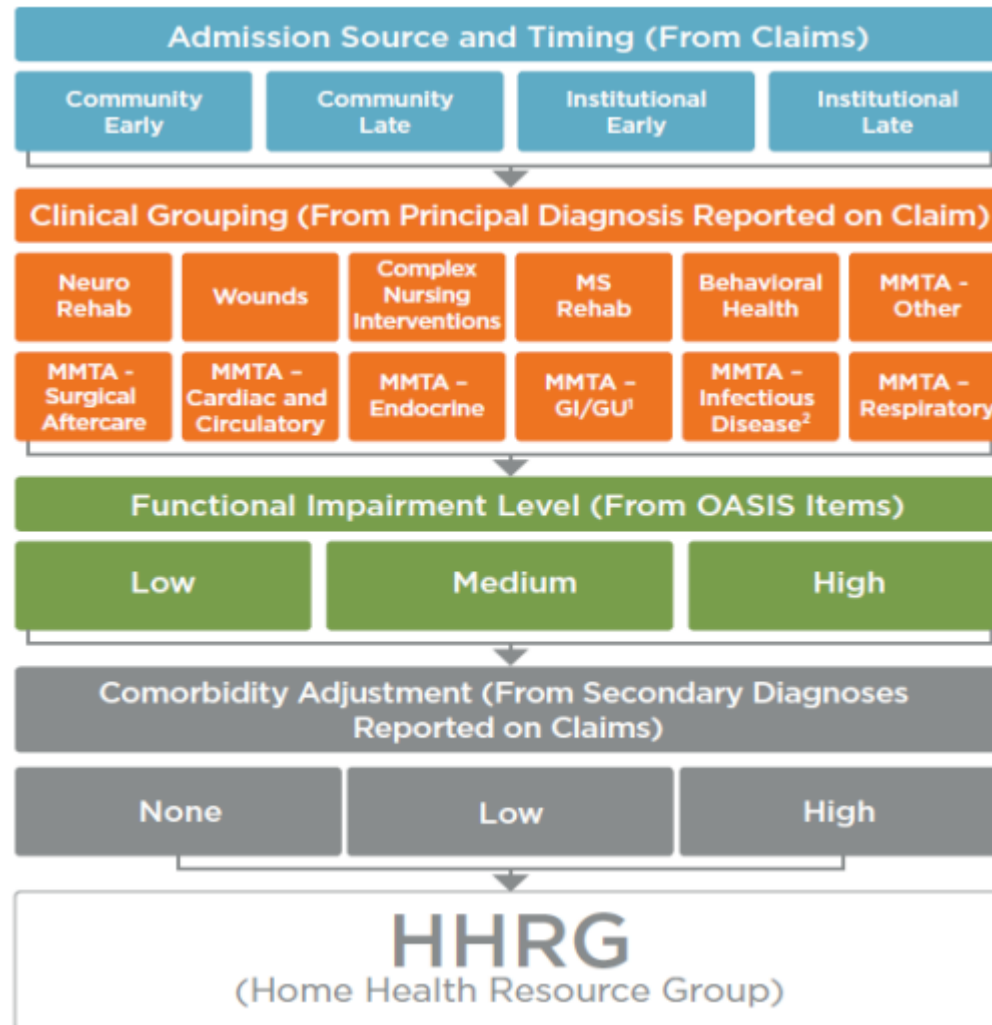
Payment is determined by a case mix classification system that categorizes patients by the type and intensity of resources used.

# Definitions

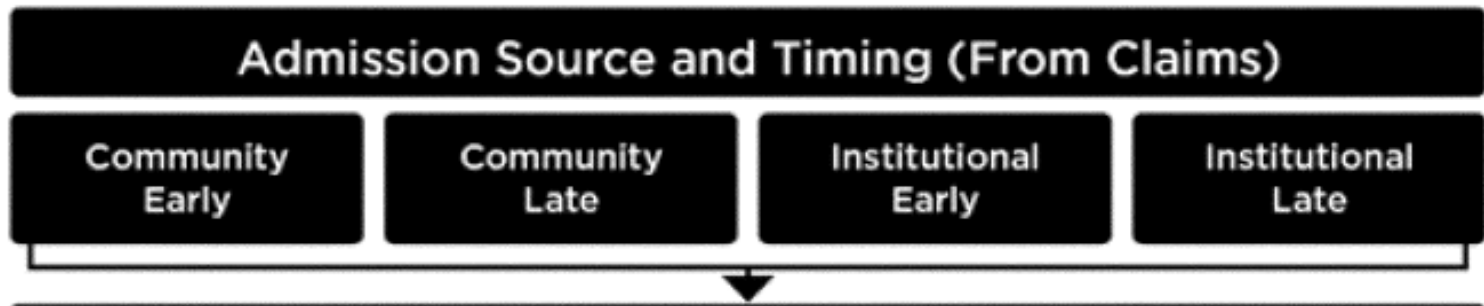
## Patient Driven Groupings Model (PDGM)

A payment model for the home health prospective payment system (HH PPS) that became effective January 1, 2020. The model relies heavily on clinical characteristics and other patient information to place HH periods of care into meaningful payment categories and eliminates the use of therapy service thresholds.

# Patient Driven Groupings Model (PDGM)



# Admission Source and Timing



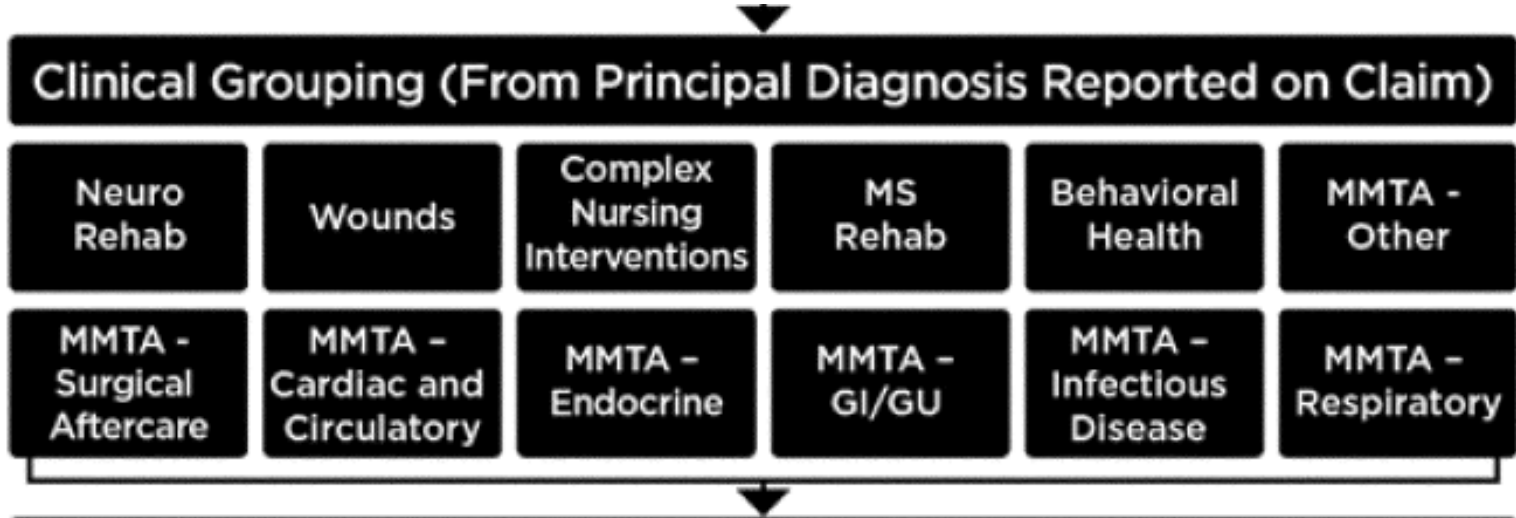
# Admission Source and Timing

## 30-Day Period Timing

- Days 1-30 of stay-at-home health = early
- Days 31-60 of stay-at-home health = late
- Days 61-90 of stay-at-home health = late

When there is a 60 day or greater gap in stay,  
it starts over at days 1-30 = early

# Clinical Grouping





# Clinical Grouping

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
<b>Musculoskeletal Rehabilitation</b>	Therapy (physical, occupational or speech) for a musculoskeletal condition
<b>Neuro/Stroke Rehabilitation</b>	Therapy (physical, occupational or speech) for a neurological condition or stroke
<b>Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care</b>	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions
<b>Behavioral Health Care</b>	Assessment, treatment & evaluation of psychiatric conditions, including substance use disorder
<b>Complex Nursing Interventions</b>	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies

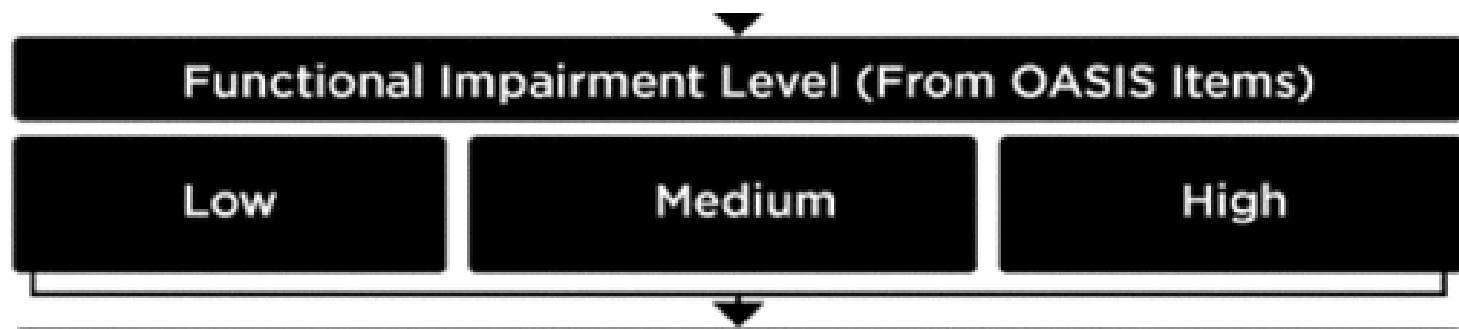
# Clinical Grouping

## **Medication Management, Teaching and Assessment (MMTA)--**

- **MMTA –Surgical Aftercare**
- **MMTA – Cardiac/Circulatory**
- **MMTA – Endocrine**
- **MMTA – GI/GU**
- **MMTA – ID/Neoplasms/ Blood Diseases**
- **MMTA –Respiratory**
- **MMTA – Other**

Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

# Functional Impairment Level



# Functional Impairment Level

Item #	Description
M1033	Risk for Hospitalization
M1800	Grooming
M1810	Current ability to dress upper body safely
M1820	Current ability to dress lower body safely
M1830	Bathing
M1840	Toilet transferring
M1850	Transferring
M1860	Ambulation and locomotion

# Functional Impairment Level

	Responses	Points (2024)	Percent of Periods in 2022 with this Response Category
<b>M1800: Grooming</b>	0 or 1	0	28.0%
	2 or 3	3	72.0%
<b>M1810: Current Ability to Dress Upper Body</b>	0 or 1	0	22.9%
	2 or 3	5	77.1%
<b>M1820: Current Ability to Dress Lower Body</b>	0 or 1	0	10.5%
	2	3	66.0%
	3	11	23.5%
<b>M1830: Bathing</b>	0 or 1	0	2.6%
	2	0	10.9%
	3 or 4	7	50.4%
	5 or 6	14	36.1%
<b>M1840: Toilet Transferring</b>	0 or 1	0	62.4%
	2, 3 or 4	6	37.6%

# Functional Impairment Level

<b>M1850: Transferring</b>	0	0	1.4%
	1	3	20.2%
	2, 3, 4 or 5	6	78.4%
<b>M1860: Ambulation/Locomotion</b>	0 or 1	0	3.2%
	2	6	13.5%
	3	4	65.5%
	4, 5 or 6	20	17.8%
<b>M1033: Risk of Hospitalization</b>	Three or fewer items marked (Excluding responses 8, 9 or 10)	0	61.5%
	Four or more items marked (Excluding responses 8, 9 or 10)	11	38.5%

# Functional Impairment Level

Clinical Group	Level of Impairment	Points (2022)
MMTA – Other	Low	0-28
	Medium	29-41
	High	42+
Behavioral Health	Low	0-28
	Medium	29-41
	High	42+
Complex Nursing Interventions	Low	0-28
	Medium	29-52
	High	53+

# Comorbidity Adjustment





# Comorbidity Adjustment

Calendar Year 2024

- Addition of 22 low comorbidity adjustment subgroups
- Addition of 102 high comorbidity adjustment interaction subgroups



# HHRG

(Home Health Resource Group)

# Composition of HIPPS Codes

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	Clinical Group	Functional Level	Co-Morbidity	Placeholder
1 - Community Early	A - MMTA Other	A - Low	1 - None	1
2 - Institutional Early	B - Neuro Rehab	B - Medium	2 - Low	
3 - Community Late	C - Wounds	C - High	3 - High	
4 - Institutional Late	D - Complex Nursing Interv.			

# Composition of HIPPS Codes

	<b>E</b> - MS Rehab			
	<b>F</b> – Behavioral Health			
	<b>G</b> – MMTA Surgical Aftercare			
	<b>H</b> – MMTA Cardiac & Circulatory			
	<b>I</b> – MMTA Endocrine			
	<b>J</b> – MMTA GI/GU			
	<b>K</b> – MMTA Infectious Disease			
	<b>L</b> – MMTA Respiratory			

# Case Study

## Case Mix Variables

Admission Source and Timing	01-Early
ICD-10-CM Primary Diagnosis (I12.0) Hypertensive Chronic Kidney Disease with Stage 5 Chronic Kidney Disease or End Stage Renal Disease	Clinical Group – (H) MMTA Cardiac and Circulatory
M1033 – Which of the following signs or symptoms characterize this patient as a risk for hospitalization	History of falls, Unintentional Weight Loss, Multiple Hospitalizations, Multiple Emergency Department Visits, Currently Taking 5 or More Meds, Currently Reports Exhaustion (6)
M1800 – Grooming	02- Someone must assist the patient to groom self

# Case Study

## Case Mix Variables

M1810 – Dressing Upper Body	02- Someone must help the patient put on upper body clothing
M1820 – Dressing Lower Body	02- Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes
M1830 – Bathing	03- Able to participate in bathing self in shower or tub, but requires presence of another person
M1840 – Toilet Transferring	02- Unable to get to and from the toilet but can use a bedside commode

# Case Study

## Case Mix Variables

M1850 - Transferring

03- Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast

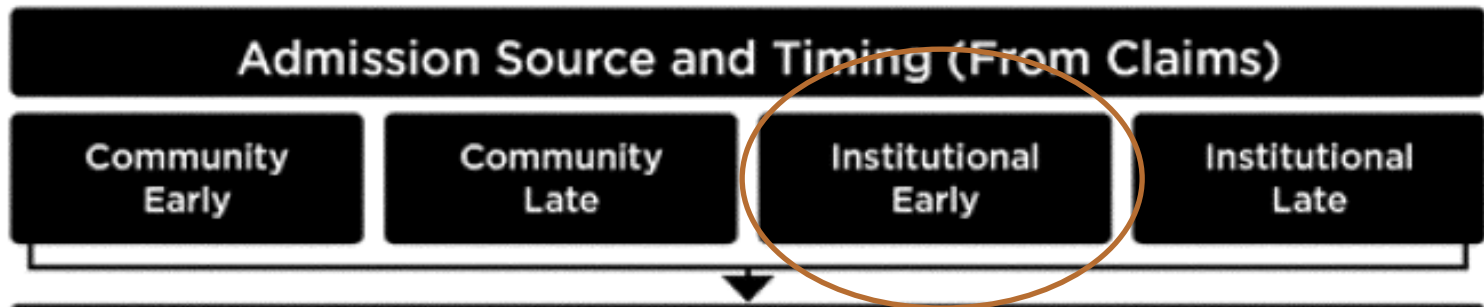
M1860 – Ambulation/Locomotion

04- Chairfast, unable to ambulate but can wheel self independently

Comorbidity Adjustment (Secondary Diagnoses N18.6 End Stage Renal Disease, U07.1 COVID-19

N18.6 – 0  
U07.1 – 0

# Admission Source and Timing

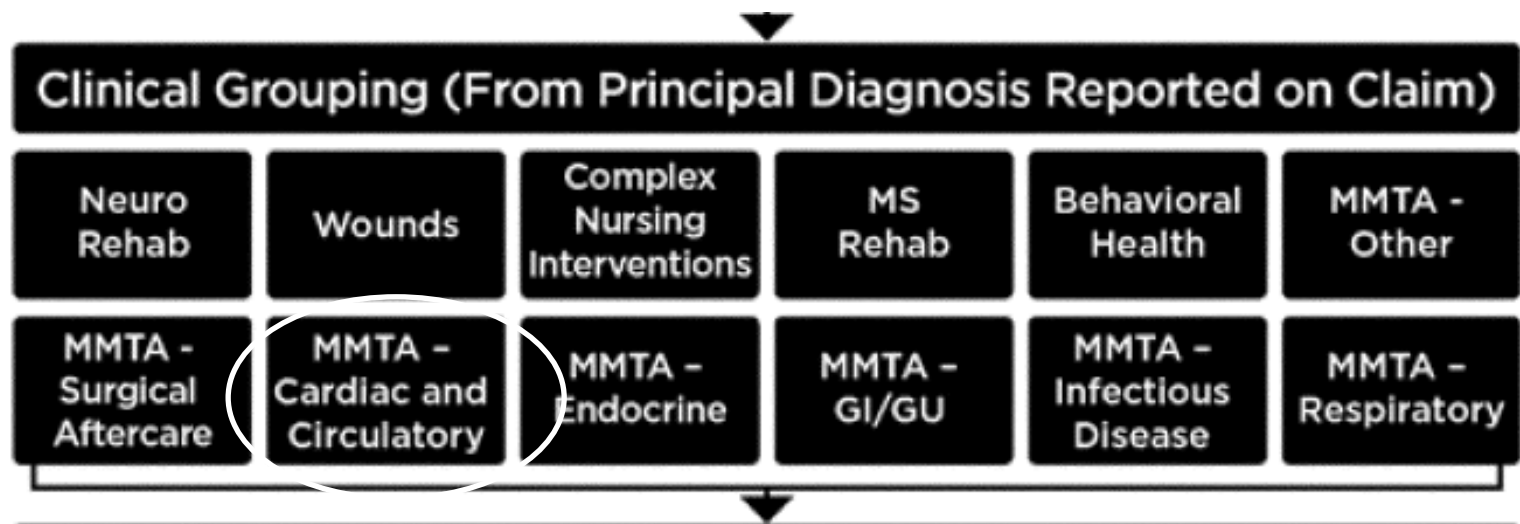




# Clinical Grouping

## Primary Diagnosis Code

Look up ICD-10-CM “I120” and that gives us group H which is MMTA (Cardiac and Circulatory)



# Functional Impairment Level

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	2	0	10.9%
	3 or 4	7	50.4%
	5 or 6	14	36.1%
<b>M1840: Toilet Transferring</b>	0 or 1	0	62.4%
	2, 3 or 4	6	37.6%

Total Points = 24

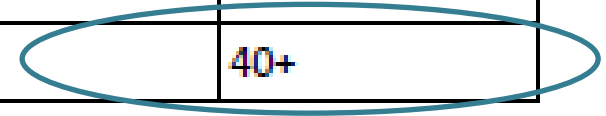
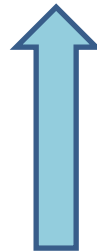
# Functional Impairment Level

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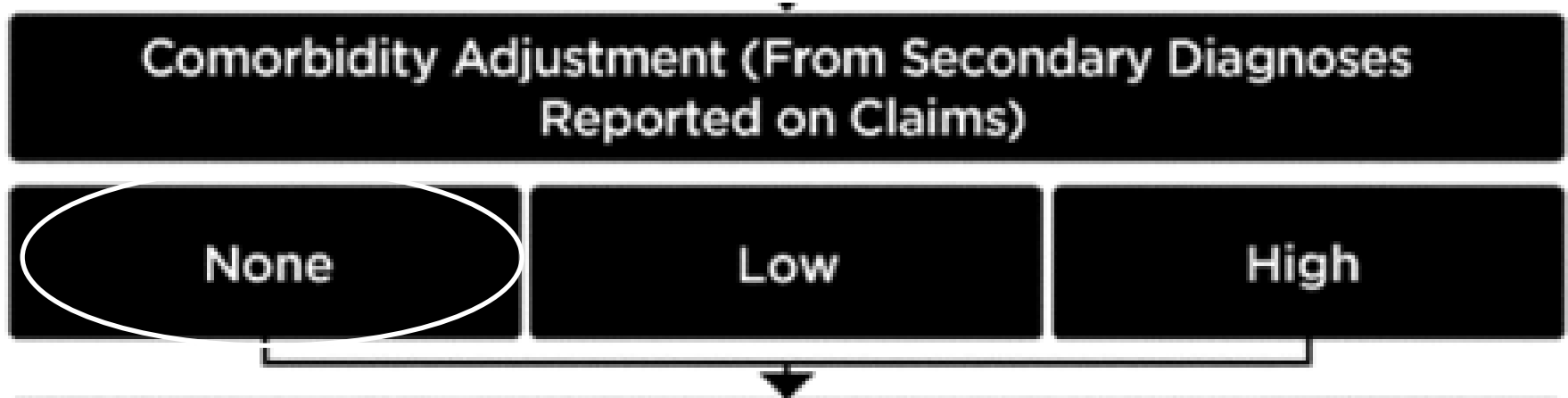
Total Points = 37, plus 24 points from prior items totaling **61 points**

# Functional Impairment Level

MMTA - Cardiac and Circulatory	Low	0-31
MMTA - Cardiac and Circulatory	Medium	32-43
MMTA - Cardiac and Circulatory	High	40+



# Comorbidity Adjustment



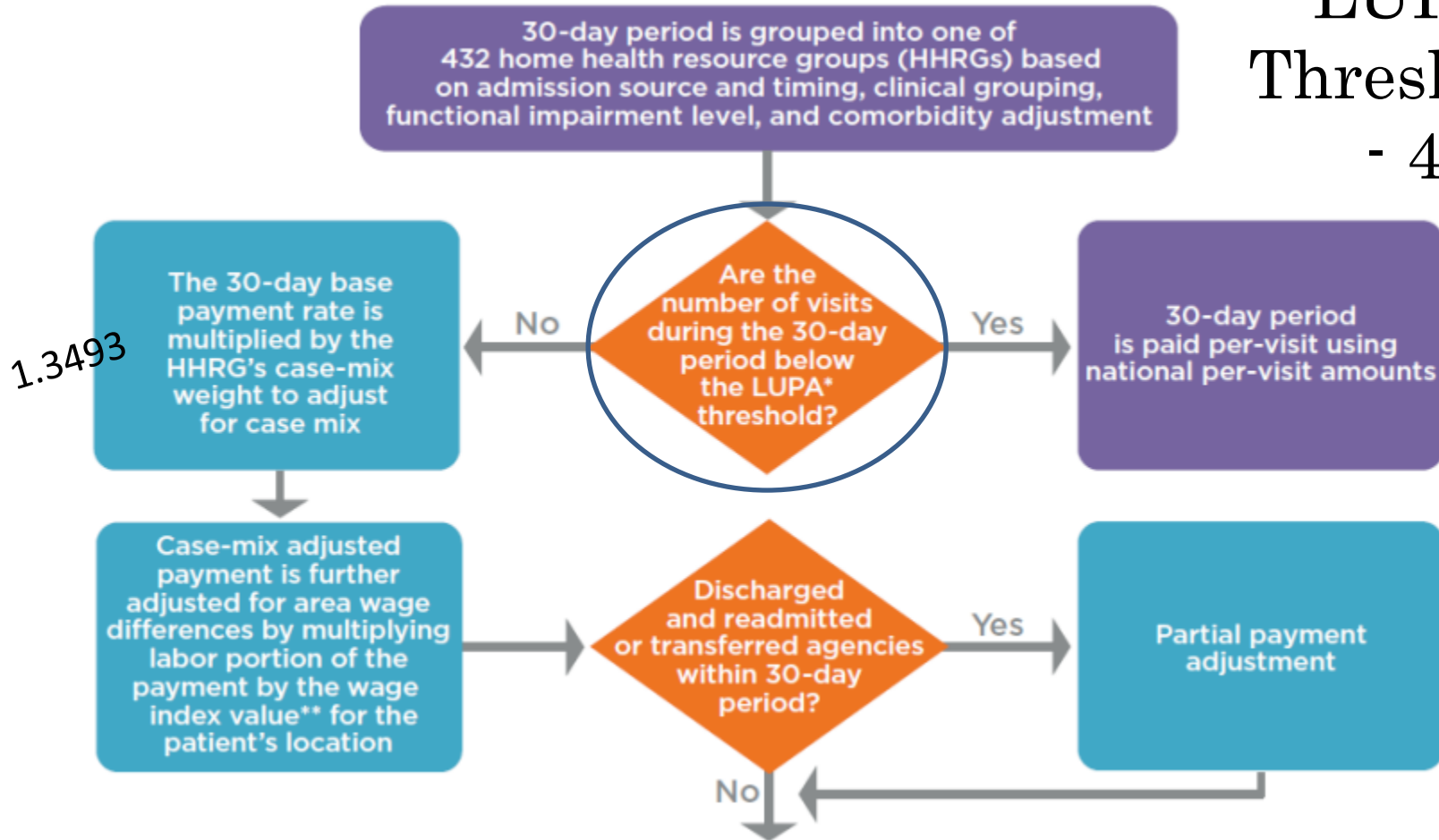
# Putting it Together

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	Clinical Group	Functional Level	Co-Morbidity	Placeholder
1 - Community Early	A - MMTA Other	A - Low	1 - None	1
2 - Institutional Early	B - Neuro Rehab	B - Medium	2 - Low	
3 - Community Late	C - Wounds	C - High	3 - High	
4 - Institutional Late	H - MMTA Cardiac & Circulatory			

# HIPPS – 2HC11

# Payments and Adjustments

LUPA  
Threshold  
- 4

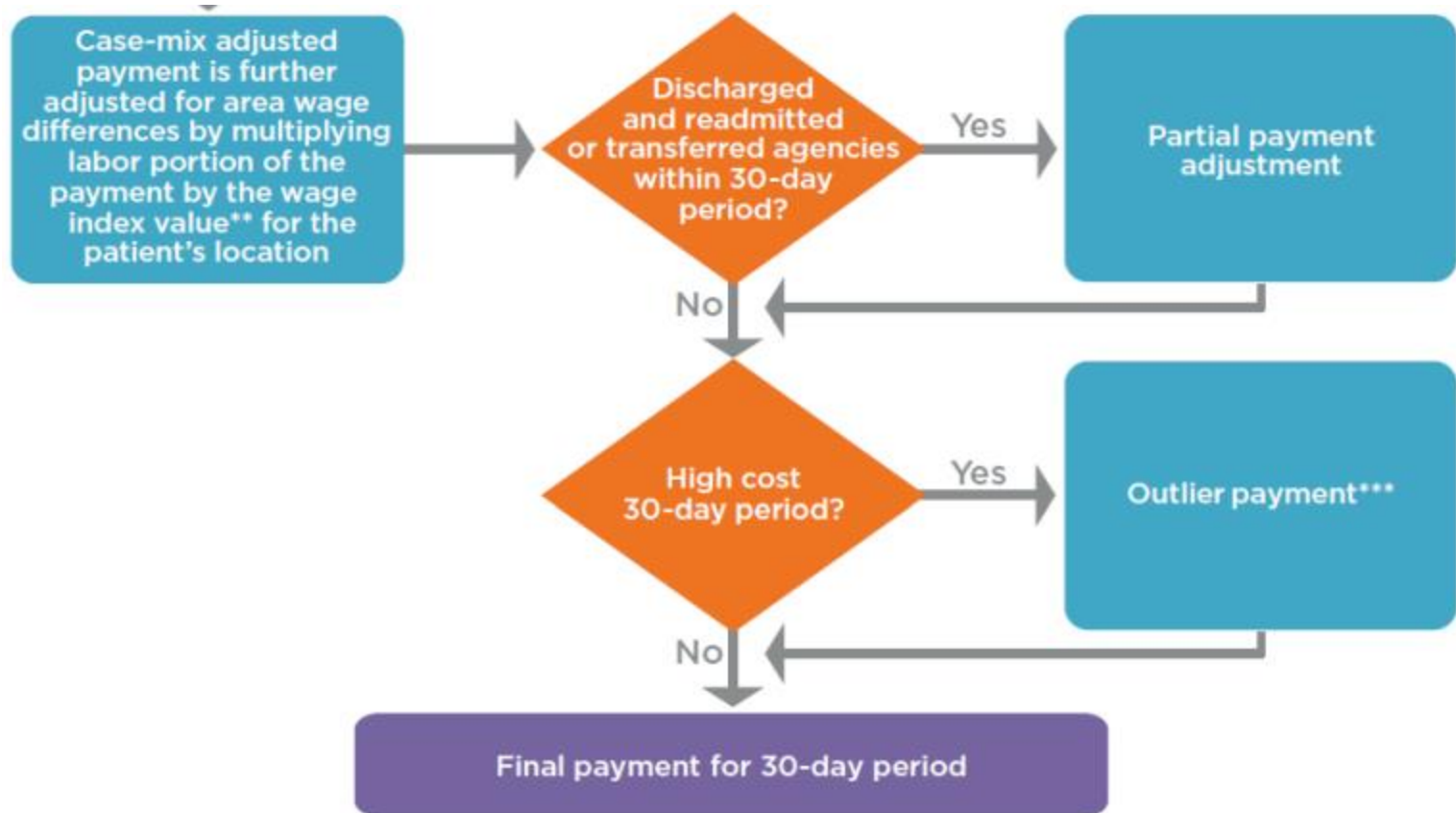


# Wage Index

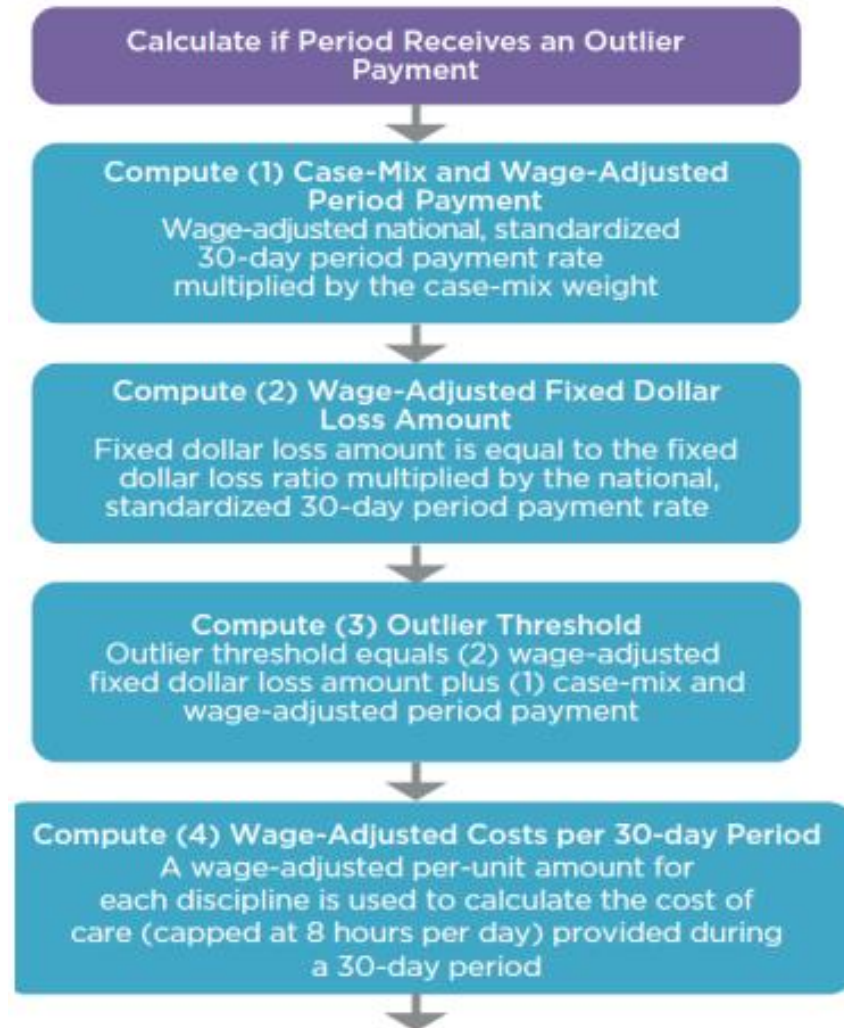
- Urban Area
  - Appleton, 0.9264
- Rural
  - 0.8543



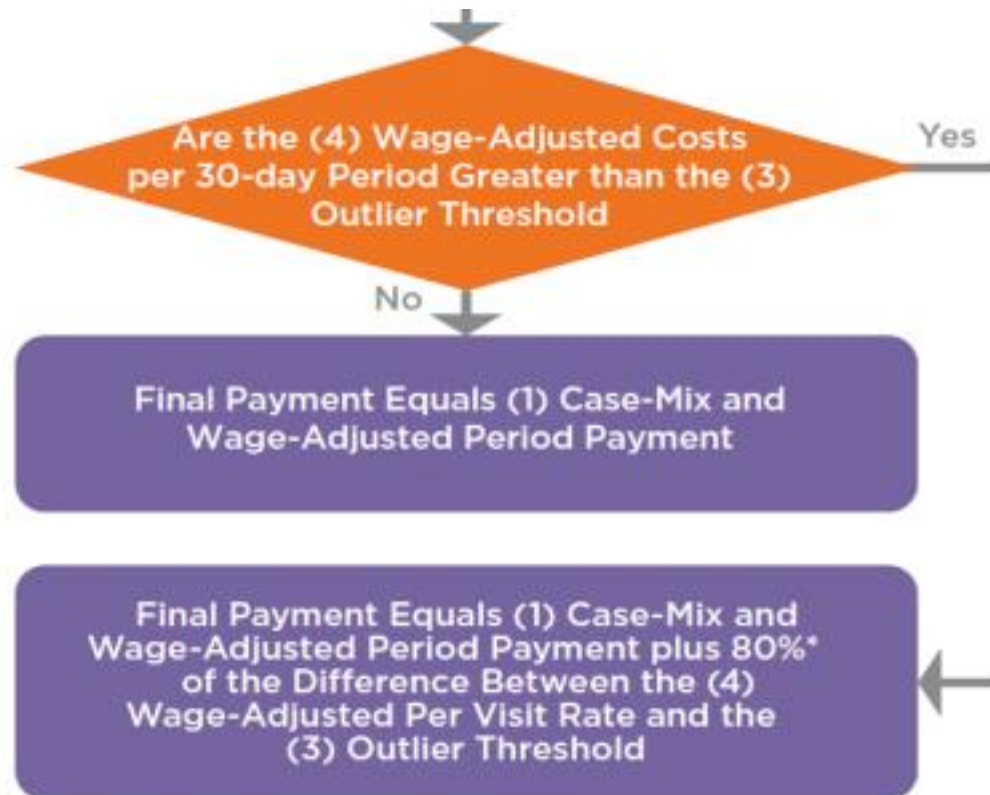
# Payments and Adjustments



# Outlier Payments



# Outlier Payments



\*80% is referred to as the loss sharing ratio

# Consolidated Billing (CB)

- Most HH services must meet CB requirements.
- The following services and supplies must meet CB requirements, and are included in the 30-day period payment:
  - Part-time or intermittent skilled nursing and HH aide services
  - Physical therapy
  - Occupational therapy

# Consolidated Billing (CB)

- Speech-language pathology services
- Medical social services
- Routine and non-routine medical supplies
- An intern or resident-in-training of the program of the hospital providing medical services
- HH services
- Routine and non-routine medical supplies

# Recertification

- The HH PPS allows continuous 60-day patient recertification when the patient remains eligible
- No limit the number of continuous 60-day patient recertifications when the patient remains eligible
- Each 60-day certification can include two, 30-day payment periods
- We require patient recertification at least every 60 days when they need continuous home health care after an initial 60-day certification
- Last five days of the previous certification period

# Questions?



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# References

- CY 2024 [Final](#) Rule
- CY 2025 [removals](#) from OASIS assessment
- CY 2024 HH [Case Mix Weights](#) and LUPA thresholds
- Jan 2024 HH PPS [Grouper Software](#) HH PDGM v05.0.24
- CY 2024 [PPS Wage Index](#)