HOME HEALTH
QUALITY REPORTING PROGRAM
PROVIDER TRAINING

PARTICIPANT QUESTIONS FROM THE WEBINAR: ACHIEVING A FULL ANNUAL PAYMENT UPDATE (APU)/MARKET BASKET INCREASE ON JUNE 19, 2019

Current as of August 2019

Acronym List

Acronym	Definition
APU	Annual Payment Update
CASPER	Certification and Survey Provider Enhanced Reports
CMS	Centers for Medicare & Medicaid Services
FVR	Final Validation Report
HH	Home Health
HHA	Home Health Agency
HHCAHPS	Home Health Care Consumer Assessment of Healthcare Providers and Systems
HMO	Health Maintenance Organization
OASIS	Outcome and Assessment Information Set
PHI	Protected Health Information
QAO	Quality Assessments Only
QRP	Quality Reporting Program
QTSO	Quality Improvement and Evaluation System Technical Support Office
SOC	Start of Care

#	Category	Question	Answer
1	APU Determination	To determine the 2-percentage point reduction, will CMS calculate Outcome and Assessment Information Set (OASIS) submission for the past 2 years or only 2019 for 2020?	CMS calculates the 2-percentage point reduction based upon annual OASIS data completions and submissions. The October 2019 Quality Assessments Only (QAO) Annual Performance Report will include OASIS Assessments completed July 1, 2018, through June 30, 2019, that have been submitted by July 31, 2019.
2	APU Determination	Is it a 2-percentage point reduction for OASIS submission and two-percentage point for not having a Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) vendor?	No. When determining compliance with the HH Quality Reporting Program (QRP), both OASIS data submission and the HHCAHPS survey are required. Agencies that do not meet this combined reporting requirement are subject to a 2-percentage point reduction to the Annual Payment Update (APU).
3	APU Determination	Please confirm that our QAO report is the basis for the 2-percentage point reduction.	The OASIS dataset submission is a requirement of the HH QRP, along with the submission of HHCAHPS. The penalty for failing to meet HH QRP requirements is a 2-percentage point reduction in your APU for the reporting fiscal year in question.
4	CASPER Reports	Where can I locate our agency's QAO report to confirm if we are in the 90-percent range?	The QAO Interim Performance Report is automatically generated and placed in your Certification and Survey Provider Enhanced Reports (CASPER) folder quarterly. Typically, this report is available in January, April, and July. The QAO Annual Performance Report is also automatically generated and placed in your CASPER folder. It is available in October.
5	CASPER Reports	Who should I contact if I think that the data posted on CASPER regarding late assessment submission is inaccurate?	Questions regarding CASPER reports should be directed to the technical Quality Improvement and Evaluation System Technical Support Office (QTSO) Help Desk at Help@qtso.com or (800) 339-9313.
6	CASPER Reports	How long should agencies maintain the Final Validation Reports (FVRs)?	The OASIS Agency FVR is automatically generated by the Assessment Submission and Processing system within 24 hours of the submission of a file and placed in the provider's FVR folder. The report can also be user-generated upon request. Refer to your specific agency policy and procedure for guidance regarding accessing and maintaining these reports.

#	Category	Question	Answer
7	CASPER Reports	How often do you recommend the error reports be pulled?	There are four types of error reports to help identify issues with OASIS submission and acceptance. By understanding and correcting these issues, agencies can increase their QAO compliance rate. Agency policy and procedure should guide how often you review these error reports. Consult the CASPER Reporting User Guide for additional information: https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals.
8	CASPER Reports	When submitting records and there is an issue on the audit request for the OASIS submission, we have been told to submit the FVR. Do we black out the other names of the files?	Do not include protected health information (PHI) or other Health Insurance Portability and Accountability Act violations in the documentation being submitted to CMS for review. CMS cannot review requests including PHI. You will be asked to destroy the PHI and resubmit your request.
9	CASPER Reports	If we have a fatal error and we do not understand the reason (therefore cannot fix it), do we email someone for help?	The CASPER Reporting User's Guide is a helpful resource for understanding fatal errors. This guide can be accessed at the following URL: https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals. Additional questions related to data submission and CASPER reports can be directed to the QTSO Help Desk via phone by calling (800) 339-9313 or by email at Help@qtso.com.
10	CASPER Reports	How often would you recommend running the CASPER reports?	Each CASPER report provides different information. How often to run and review CASPER reports should be determined by agency policy and procedure. As an example, the OASIS Agency FVR will verify acceptance or rejection of the OASIS records. It is helpful to review this report after you submit your OASIS data to resolve any potential errors. Consult the CASPER Reporting User's Guide for additional information: https://qtso.cms.gov/providers/home-health-agency-hha-providers/reference-manuals.

#	Category	Question	Answer
11	Data Corrections	What is the timeframe for data correction? Specifically, for the late assessment submission?	The CMS Home Health Conditions of Participation require that a home health agency (HHA) electronically transmit accurate, completed, and encoded OASIS data to a centralized data submission system within 30 days of the completion of the assessment (M0090 Date Assessment Completed). The current CMS policy for submission and/or correction of patient assessment records (including OASIS) allows providers to submit and/or correct records for up to 36 months from the assessment target date. Effective January 1, 2020, the CMS policy for patient assessment submission/correction will be changed to 24 months from the assessment target date. The policy change applies to new, modified, and/or inactivated records.
12	Data Submission	With the new OASIS submission/acceptance deadline of 30 days in effect, what would happen if the submission of OASIS occurred after 30 days? In addition to the possible negative impact in QAO, will this lead to rejection of a claim?	OASIS submission is related to submission and payment of claims, in that it generates the Health Insurance Prospective Payment System code for payment. For assessments that have payment implications (Start of Care (SOC), Resumption of Care, and Recertifications), upon receipt of a final claim, Medicare systems check for a corresponding OASIS assessment. If the OASIS assessment is not found AND the receipt date of the claim is more than 30 days after the assessment completion date reported on the claim, Medicare systems will deny the HH claim. The OASIS dataset submission is a requirement of the HH QRP, along with the submission of the HHCAHPS. The penalty for failing to meet HH QRP requirements is a 2-percentage point reduction in your APU for the reporting fiscal year in question.

#	Category	Question	Answer
13	Data Submission	Will the OASIS submission timing requirement change in 2020?	On April 30, 2019, CMS announced a new policy for the submission of patient assessment records. HHAs will have 24 months from the assessment target date to submit and/or correct records. This policy was originally announced with an effective date of October 1, 2019. The effective date of the policy has been revised to January 1, 2020. To provide HHAs with more information about this policy, a factsheet is now available for HHAs in the downloads section of the Home Health Quality Reporting Requirements page at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html. Note that the OASIS submission deadline is not changing. The CMS Home Health Conditions of Participation require that a HHA electronically transmit accurate, completed, and encoded OASIS data to a centralized data submission system within 30 days of the completion of the assessment (M0090 Date Assessment Completed).
14	Data Submission	Do we need to submit an OASIS on all the patients of an agency that is 10 percent Medicare and 90 percent health maintenance organization (HMO)?	HHAs should not submit OASIS data for patients who are receiving only non-skilled services; for whom neither Medicare, Medicare managed care, Medicaid, nor Medicaid managed care is paying for HH care; who are receiving pre- or postpartum services; or who are under the age of 18 years. For more information, visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html.
15	Data Submission	Is the OASIS 30-day limit equal to 30 days after the SOC date?	OASIS data for all timepoints must be submitted and accepted within 30 days from the date the assessment is completed (M0900).
16	Data Submission	Is there a recommendation for how often we should submit OASIS data?	OASIS data for all timepoints must be submitted and accepted within 30 days from the date the assessment is completed (M0090). Remember that the act of submission does not equal acceptance. It is recommended that you submit data within the first 14 days (ideally 7–14 days) to ensure acceptance by the 30-day deadline.

#	Category	Question	Answer
17	Data Submission	Do we need to collect data on non-Medicare patients?	HHAs should not submit OASIS data for patients who are receiving only non-skilled services; for whom neither Medicare, Medicare managed care, Medicaid, nor Medicaid managed care is paying for home health care; who are receiving pre- or postpartum services; or who are under the age of 18 years. For more information, visit https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Requirements.html.
18	General	Will the closed caption transcript be made available with the slides?	A video recording of the webinar with closed captions will be posted to the HH QRP Training web page at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.
19	General	Slides 52–54 do not match what was in the handouts. Did the handouts change?	The materials posted to the HH QRP Training web page are correct. An edited version of the video recording that is consistent with the materials posted prior to the training will be available on the CMS YouTube Channel. You will be able to link to the video recording from the HH QRP Training web page at the following URL: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.html.

#	Category	Question	Answer
20	General	How is it handled when a patient is applying for Medicaid but does not have approval for several months? Is any consideration given to the fact that the OASIS will be submitted several months late?	The QAO Annual Performance Score is calculated using the previous 12 months of OASIS data. This is determined by the OASIS completion date (M0090) and the assessment submission date (date the assessment was submitted and accepted into the OASIS system). In your example, if the patient did not have a pay source of any Medicare or Medicaid prior to this payer change, no OASIS data collection would have been required prior to the patient having Medicaid. If there is a pay source change that requires 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 including OASIS). The agency does not have to readmit the patient in the sense that it would normally admit a new patient (and all the paperwork that entails a new admission). In your example, assuming that you are describing a situation in which the pay source changed to Medicaid, if this new SOC assessment was then submitted per the Home Health Condition of Participation requirements, this would not negatively impact the QAO Annual Performance Score or the APU determination. Specific questions may be submitted to the Home Health Quality Helpdesk at homehealthqualityquestions@cms.hhs.gov.
21	HHCAHPS	If an agency has a waiver because of a small census, will that agency receive a 2-percentage point deduction?	We believe you are referring to the size exemption that exists for the HHCAHPS survey. If an agency serves 59 or fewer survey-eligible patients, then the agency can apply for a size exemption from the HHCAHPS survey requirement. This exemption is good for 1 year only and your request will need to be resubmitted annually based on the number of eligible patients in your agency. Please note that HH QRP compliance involves both HHCAHPS and timely OASIS data collection and submission. This size exemption is unique to HHCAHPS and does not apply to OASIS.

#	Category	Question	Answer
22	HHCAHPS	If your agency has no qualifying patients in a month, meaning no surveys are submitted, how does CMS know you were still compliant? There would be a gap, as that month would show no submission.	Whenever an HHA does not have any HHCAHPS eligible patients in a month, the HHA contacts its respective survey vendor and tells the vendor the HHA has zero patients that month. Then, the survey vendor completes a header record for that month for the HHA. If an HHA again has no patients in the next month, the HHA again notifies their survey vendor, and the survey vendor completes a header record for that month for the HHA. The survey vendor is only allowed to complete the form for "no patients in a month" if the HHA has notified the survey vendor. Otherwise, the survey vendor records the month as missed, and the HHA will be assumed to have missed the month rather than reported zero patients for that month. Sometimes, an HHA may have in their particular contract a clause that the survey vendor will call and email the HHA to remind them to submit the patient list for the month or reply to the survey vendor that it is not submitting a patient list because there are zero patients for that month.
23	HHCAHPS	We are 10 percent Medicare and 90 percent HMO. Do we need HHCAHPS surveys for all of the above?	HHCAHPS survey-eligible patients include all Medicare, Medicare managed care, Medicaid, and Medicaid managed care patients. If your agency served 59 or fewer survey-eligible patients in the reference year, you are eligible to apply for a size exemption.
24	HHCAHPS	How do you define a new HH exemption for HHCAHPS?	CMS grants a newness exemption for HHCAHPS to agencies that receive a new CMS Certification Number on or after the start of the data collection year. Eligible agencies are automatically exempted from HHCAHPS data submission for 1 year.