Value-Based Purchasing & The Star Rating Program

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Value Based Purchasing & The Star Rating Program

Questions to Be Asked & Answered

Q: Does anyone even look at this stuff?
Q: Outcomes don’t affect my reimbursement do they?
Q: But my patients are getting better aren’t they?

P4P: Myth or Not?

• “Pay-for-performance” is a catch-all term for initiatives aimed at improving the quality, efficiency, and overall value of health care.
• The Affordable Care Act expands the use of P4P approaches in Medicare in particular and encourages experimentation to identify designs and programs that are most effective.
• Policy makers have been concerned with the incentive structure built into US health care system.
• The typical P4P program provides a bonus to health care providers if they meet or exceed agreed-upon quality or performance measures.
• P4P programs can also impose financial penalties on providers that fail to achieve specified goals or cost savings.
• As part of the 2015 Final Rule, agencies are expected to report a minimum amount of quality data as a requirement for full annual payment update.
• The first performance period for which this compliance level is measured is July 1, 2015 through June 30, 2016 and the minimum compliance standard for this period is 70%.
• HHAs with compliance levels below 70% for this period will see a two percentage point reduction in their annual payment update (APU) for calendar year (CY) 2017.

Value Based Purchasing

• Included in the 2016 Proposed Rule for HH released July 6, 2015
• Intended to tie a provider’s payment to its performance to reduce inappropriate or poorly furnished care and to identify and reward those who furnish quality care
• Modeled after the 2014 implementation of the Hospital VBP program
• HH VBP will reduce or increase Medicare payments by 3% the first year and would eventually increase to 8% in subsequent years, depending on degree of quality performance in selected measures.

Included Measures

• 6 Process measures assess the performance of activities that have been demonstrated to contribute to positive health outcomes for patients.
• 10 Outcome measures refer to the effects that care had on patients
• 5 HHCAHPS measures assess patients’ perception of the quality of care they have received and their satisfaction with the care experience in the HH setting
• 3 new measures reported through a special web portal
### Outcome Measures

<table>
<thead>
<tr>
<th>Title</th>
<th>OASIS Item Data Source</th>
<th>Other Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in Ambulation-Locomotion</td>
<td>M1860 (Ambulation-Locomotion)</td>
<td></td>
</tr>
<tr>
<td>Improvement in Bed Transferring</td>
<td>M1850 (Transferring)</td>
<td></td>
</tr>
<tr>
<td>Improvement in Bathing</td>
<td>M1830 (Bathing)</td>
<td></td>
</tr>
<tr>
<td>Improvement in Dyspnea</td>
<td>M1400 (Shortness of Breath)</td>
<td></td>
</tr>
<tr>
<td>Discharged to Community</td>
<td>M2420 (Discharge disposition)</td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospitalization: Unplanned hospitalization</td>
<td></td>
<td>Claims data</td>
</tr>
<tr>
<td>during first 60 days of HH; hospitalization during 30 days of HH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Dept. use without Hospitalization</td>
<td></td>
<td>Claims data</td>
</tr>
<tr>
<td>Improvement in Pain Interfering with Activity</td>
<td>M1242 (Frequency of pain interfering)</td>
<td></td>
</tr>
<tr>
<td>Improvement in Management of Oral Meds</td>
<td>M2020 (Management of Oral Meds)</td>
<td></td>
</tr>
<tr>
<td>Prior Functioning ADL/IADL</td>
<td>M1900 (Prior Functioning ADL/IADL)</td>
<td></td>
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### Process Measures

<table>
<thead>
<tr>
<th>Title</th>
<th>OASIS Item Data Source</th>
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</thead>
<tbody>
<tr>
<td>Care Management: Types &amp; sources of assistance</td>
<td>M2102 (Types &amp; sources of assistance)</td>
</tr>
<tr>
<td>Influenza Vaccine Data Collection Period</td>
<td>M1041 (Influenza vaccine)</td>
</tr>
<tr>
<td>Influenza Immunization Received for Current Flu Season</td>
<td>M1046 (Influenza vaccine received)</td>
</tr>
<tr>
<td>Pneumonia Vaccine Ever Received</td>
<td>M1051 (Pneumonia vaccine)</td>
</tr>
<tr>
<td>Reason Vaccine Not Received</td>
<td>M1056 (Reason vaccine not received)</td>
</tr>
<tr>
<td>Drug Education on All Meds Provided to Patient/ Caregiver During All Episodes</td>
<td>M2051 (Patient caregiver drug education interventions)</td>
</tr>
</tbody>
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### HHCAHPS Measures

<table>
<thead>
<tr>
<th>Title</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care of Patients</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Communications between Providers &amp; Patients</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Specific Care Issues</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Overall Rating</td>
<td>HHCAHPS</td>
</tr>
<tr>
<td>Willingness to Recommend</td>
<td>HHCAHPS</td>
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### New Measures

<table>
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</thead>
<tbody>
<tr>
<td>Influenza Vaccination Coverage for HH Care Personnel</td>
<td>New measure, reported through web portal</td>
</tr>
<tr>
<td>Herpes Zoster (Shingles) Vaccination: Has patient ever received shingles vaccination?</td>
<td>New measure, reported through web portal</td>
</tr>
<tr>
<td>Advance Care Plan</td>
<td>New measure, reported through web portal</td>
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Value Based Purchasing & the Star Rating Program

VBP Included Areas
- CMS implemented the Home Health Value Based Purchasing (HHVPB) Model in nine states representing each geographic area in the nation which was modeled after the 2014 Hospital VBP.
- States in this group were chosen because they have HHAs that tend to be for-profit, have very high utilization rates, and have a higher proportion of dually-eligible beneficiaries relative to other states.
- Arizona, Florida, Iowa, Nebraska, North Carolina, Maryland, Massachusetts, Tennessee and Washington.

VBP Details
- Some HHAs will receive higher payments than standard fee for service and some would receive less
- Agencies will need to achieve a minimal threshold in quality performance
- Initiative will use data from CY 2015 as the base year and the first performance year will be 2016.
- Beginning with Jan-Mar 2016, CMS will issue quarterly reports so agencies can monitor their data. (first report will be July 2016)
- Payments & penalties will become effective Jan 2018 for the results of 2016
- Pilot program will be budget neutral but NAHC projects that eventually 10% of providers will receive payment reductions ranging from 2.26 to 3.0%.

Star Rating Program
- Research has shown that using quality symbols such as stars to represent performance are useful to consumers
- Intended to help consumers compare the quality and safety of care they should expect from U.S. healthcare providers
- Star ratings for all Medicare certified HHAs where there is adequate amount of data will be published on HHC website starting in July 2015
- Agencies to be rated on 9 measures
  - 3 process measures
  - 6 outcome measures

Method Used for Selecting Measures
The Star Ratings methodology includes 9 of 22 currently reported process and outcome quality measures. Measures included in HHC Star Ratings were chosen based on the following criteria. The measures:
1. Apply to a substantial proportion of HH patients, and have sufficient data to report for a majority of HHAs.
2. Show a reasonable amount of variation among HHAs, and it should be possible for a HHA to show improvement in performance.
3. Have high face validity & clinical relevance.
4. Be stable and not show substantial random variation over time.
Star Rating Program

<table>
<thead>
<tr>
<th>Process Measures</th>
<th>Outcome Measures</th>
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<tr>
<td>Timely Initiation of Care</td>
<td>Improvement in Ambulation</td>
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<tr>
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<td>Improvement in Bed Transferring</td>
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<td>Improvement in Dyspnea</td>
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<td></td>
<td>Acute Care Hospitalization</td>
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</tbody>
</table>

Each agency must have at least 20 complete quality episodes for inclusion in Home Health Compare (HHC)

- Completed episodes are paired start or resumption of care and end of care OASIS assessments.
- Episodes must have discharge date within the 12-month reporting period regardless of admission date.
- Half stars are used to report results

Important Dates

|-------------------------------------------------------|----------|------------|-----------|----------|

Agencies have an opportunity to review their Star Rating each quarter prior to them being posted on HHC.

Preview Reports

The Preview Report includes:

- An overall HHC Star Rating for the provider
- A description of how the HHC Star Rating is calculated, and
- A “scorecard” showing the actual calculation of the HHC Star Rating for the provider. The scorecard will show the following elements for each measure:
  1. The HHAs Score
  2. The Initial Decile Ranking
  3. The Number of Cases (N) for the agency
  4. The National (All HHA) Median
  5. The HHA Statistical Test Probability Value (p value)
  6. The Statistical Results (is the p-value ≤ 0.050?) “Yes” or “No”
**Preview Reports**

- The scorecard will also show the HHAs overall average adjusted rating, the average adjusted rating rounded, and the overall star rating. In addition, the report will include a process for requesting a review of the report if the agency believes there has been an error in the calculation.
- HHAs have about two and a half weeks to request review of their HHC Star Rating.
- The agency must have evidence that missing or inaccurate data have affected quality measure results and that the volume of missing or inaccurate data is significant enough to potentially affect the final HHC Star Rating.

**Frequently Asked Questions**

CMS will continue to solicit & welcome comments & suggestions on HHC Star Ratings methodology. A “Frequently Asked Questions” document is posted on the CMS website and will be updated based on questions received:


**Components of an Incentive Program**

- **Process measures** assess performance of activities that have been demonstrated to contribute to positive health outcomes for patients
- **Outcome measures** refer to the effects that care had on patients
- **Patient experience** measures assess patients’ perception of the quality of care received and their satisfaction with the care experience in the HH setting
- **Structure measures** relate to facilities, personnel, & equipment used in treatment

**Evaluate What's Already in Place**

- Understanding a quality episode
  - SOC/ROC to TX/DC
  - must be a complete episode
- What am I monitoring and/or measuring?
- Who is responsible?
- I have the information, now what?

**What Should Be in Your QA/PI Plan?**

The key elements in a QA plan:

- Description of purpose, priorities, policies & goals of QA program
- Description of organizational systems needed to implement program, including QA committee structure & functions, descriptions of accountability, roles & responsibilities
- Process for gaining consumer input
- Core measures & measurement processes
- Description of communication & evaluation plan

**Organizational System**

- Describe the organizational structure, roles and responsibilities, timeline for reporting findings and improvement strategies, and training/support provided for project staffs. Describe how leadership provides support to QA activities.
  - Who? What? When?

**Identify Areas for Improvement**

- List and prioritize your QA projects
- Don’t tackle more than you can possibly handle at one time
Goals & Objectives

- Define key program goals and objectives for the current year.
- Be specific in your plans. Be sure goals are attainable and measureable.

Example: By June 2016 (time bound), increase percentage of patients improving in Bathing (specific & relevant) by 5 percent to 65% (measurable & achievable)

Measuring Progress

Describe how the quality program is measured, data is collected, monitored & analyzed

- State QIO reports
- Casper Reports
- Benchmarking reports from vendor
- What corrective actions will be taken when deficiencies are found

Communication & Follow Up

- Describe how quality will be communicated throughout the organization on a regular basis and what the process will be if changes need to take place.
- Are you able to drill down on reports to determine what days problems are occurring and which clinicians may need assistance

Finally... Approval & Annual Evaluations

- Describe how evaluation will be done
- When it will be done
- Who will be responsible for developing it
- How the results will be documented & communicated
- Who is responsible for reviewing & approving it
- When will problem areas be addressed again

Resources

Thanks for Attending!
Feel free to contact us with any questions.
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