2b. Understanding the Pieces: How the Pieces Fit into the Pie

Presented by:

Jennifer Amheiser, BSN, RN, Director of Education Services, HealthCare Consultlink
Value Based Purchasing
Understanding the Pieces: How the Pieces Fit into the Pie
Topics of Discussion

Value-Based Purchasing Explained
Key Terms
Methodology
The Measures used in VBP
Reports
Assembling the Pieces: Steps for Success

Learning Objectives

• Participants will learn about the Home Health Value-Based Purchasing Model and how it continues to drive value over volume to Medicare beneficiaries
• Participants will be able to identify which cohort their agency will belong to in HHVBP
• Participants will learn the components used for calculating the Total Performance Score (TPS)
• Participants will recognize key OASIS questions used for HHVBP scoring
• Participants will be able to describe how hospitalizations and emergency department use impact the TPS
• Participants will understand at least 3 ways to improve patient outcomes and increase the TPS
Value-Based Purchasing for 2023

- The Centers for Medicare and Medicaid Services (CMS) continue to drive improvement in the delivery of healthcare through value-based reimbursement
- The move from volume to value continues
- Original model (2016-2021) showed a 4.6% improvement in home health agency performance and annual savings of $141 million to Medicare (reduced hospitalizations and SNF spending)
- HHVBP expanded nationwide to home health agencies in all 50 states
- Financial incentive for 2023 initiative is up to +/-5%

---

Value-Based Purchasing for 2023

- Calendar year (CY) 2022 is the pre-implementation year.
- CY 2023 will be the first Performance Year
- CY 2025 reimbursements will be adjusted up to +/- 5% dependent on the 2023 Performance Year
- Payment adjustments will be determined based on performance improvement (compared to own baseline year) or performance achievement (compared to agency peers in their national size cohort)
- Payment adjustment applies only to Medicare Home Health fee-for-service (FFS) claims
- Participation is mandatory
Performance and Payment Years

Performance Year: The calendar year during which OASIS-based, claims-based, and HHCAHPS survey-based measure data are used for calculating an agency’s Total Performance Score (TPS)

Payment Year: The calendar year in which the adjusted payment percentage for a designated performance year applies

<table>
<thead>
<tr>
<th>Performance Year (CY)</th>
<th>Payment Year (CY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2023</td>
<td>2025</td>
</tr>
<tr>
<td>2024</td>
<td>2026</td>
</tr>
<tr>
<td>2025</td>
<td>2027</td>
</tr>
<tr>
<td>2026</td>
<td>2028</td>
</tr>
<tr>
<td>2027</td>
<td>2029</td>
</tr>
</tbody>
</table>

Value-Based Purchasing for 2023

Agencies will have a baseline year and a performance year depending on their Medicare-certification date. Most agencies will have CY 2019 as their baseline year. Agency baseline year is dependent on Medicare-certification date. (*Baseline year could change to 2022 based on CY 2023 Proposed Payment Updates and Policy Changes CMS 1766-P)

<table>
<thead>
<tr>
<th>Medicare-certification Date</th>
<th>Modal Baseline Year* (No Achievement Threshold)</th>
<th>HHA Baseline Year** (No Improvement Threshold)</th>
<th>Performance Year (CY)</th>
<th>Payment Year (CY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to January 1, 2019</td>
<td>2019</td>
<td>2019</td>
<td>2023</td>
<td>2025</td>
</tr>
</tbody>
</table>

* CY 2019 is the Model baseline year used to determine the benchmark and achievement threshold.
** For HHAs certified on or after January 1, 2019, the HHA baseline year will be the first full CY of services beginning after the date of Medicare-certification except for HHAs certified on January 1, 2019 – December 31, 2019, where the baseline year is CY 2021.
Terms to Know

**Performance Year:** The calendar year during which OASIS-based, claims-based, and HHCAHPS survey-based measure data are used for calculating an agency’s Total Performance Score (TPS)

**Baseline Year:** The reference year against which measure performance will be compared. For most agencies, it will be CY 2019 (pre-COVID). *proposed CY 2023 rule changes baseline year to 2022*

**Total Performance Score (TPS):** The numeric score given to an agency based on the weighted sum of the performance scores for each applicable measure. CMS determines TPS by weighting and summing the higher of the agency’s *achievement or improvement* score for each measure. The TPS ranges from 0-100.

**Achievement Score:** Based on the agency’s measure performance during the performance year compared to other agencies in their size cohort. 0-10 points can be earned for each measure (Total then multiplied by 10)

**Improvement Score:** Based on the agency’s performance compared to its own measure value in the baseline year. 0-9 points can be earned for each measure. (Total then multiplied by 9)

**Care Points:** The higher of achievement points or improvement points for each measure

**Cohort:** The group in which an agency competes. An agency compete nationally in one of two volume-based cohorts, as defined by the number of HHCAHPS survey-eligible beneficiaries for each agency in the year prior to the performance year

Methodology

- Agencies will be given a Total Performance Score (TPS) based on the weighted sum of the performance scores for each of the applicable measures (12 measures)
- 12 measures: OASIS-based, Claims-based (hospitalizations and ED use), and HHCAHPS survey results based
- The data will then be used to calculate 2 different scores:
  - **Achievement Score:** the agency’s score is compared to other agencies in their national cohort size
  - **Improvement Score:** the agency’s score is compared to their own baseline year
- TPS is determined by weighting and summing the higher of the agency’s achievement or improvement score for each applicable measure
- TPS Score ranges from 0-100
- The TPS is then used to determine an annual distribution of the value-based payment adjustments among agencies in each cohort (up to +/-5%)
Cohorts

**Smaller-volume cohort**
The group of competing HHAs that had fewer than sixty (60) unique survey-eligible beneficiaries in the calendar year prior to the performance year.

**Larger-volume cohort**
The group of competing HHAs that had sixty (60) or more unique survey-eligible beneficiaries in the calendar year prior to the performance year.

---

### Measures Used to Determine Scoring

<table>
<thead>
<tr>
<th>Category</th>
<th># of measures</th>
<th>Quality Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS-based</td>
<td>5</td>
<td>Improvement in Dyspnea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharged to Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement in Management of Oral Medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Normalized Composite Change in Mobility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Normalized Composite Change in Self-Care</td>
</tr>
<tr>
<td>Claims-based</td>
<td>2</td>
<td>Acute Care Hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency Department Use without Hospitalization</td>
</tr>
<tr>
<td>HHCAHPS Survey-based</td>
<td>5</td>
<td>Professional Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Team Discussion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overall Rating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Willingness to Recommend</td>
</tr>
</tbody>
</table>
Achievement Score

• Achievement score is based on the agency’s performance during the performance year compared to other agencies in their cohort in the baseline year
• Achievement = how much have you ACHIEVED compared to other agencies
• Can earn between 0-10 points for each measure (applicable OASIS, claims, surveys)
• Care points are only earned if the measure value exceeds the designated achievement threshold
• Achievement threshold = the median (50th percentile) of Medicare-certified agency performance scores for each quality measure during the baseline year (respective to cohort size)

Improvement Score

• Improvement score is based on the agency’s performance during the performance year compared to their own baseline year
• Improvement = how much have you IMPROVED compared to your baseline year
• Can earn between 0-9 points for each measure (applicable OASIS, claims, surveys)
• Points are only earned if the measure value exceeds the designated improvement threshold
• Improvement threshold = the agency’s baseline year score for the measure
Example

Measure for Example: Improvement in Management of Oral Medications
ABC Home Health is in the Large Cohort.

| ABC Home Health’s Performance Year (2023) Score for measure is 83.213 | Score will be compared to: | ABC Home Health’s Baseline Year (2019) Score for measure: 85.567 (for Improvement score) and | Large Cohort’s Baseline Year (2019) Score for measure: 73.580 (for Achievement score) |

Which is better….the Improvement Score or the Achievement Score?
ABC Home Health did worse when compared to their own baseline score but BETTER when compared to the cohort baseline score. Therefore, CMS will use the Achievement score calculation to compute the Care Points awarded.

*Care Points = the higher of the 2 comparisons; Care points from each measure are then weighted and added together to equal the TPS

Achievement Thresholds and Benchmarks taken from sample report in iQIES
Total Performance Score

Each quality measure is calculated

Measure is compared to other agencies in the same cohort (relative to baseline year)

Both Achievement and Improvement scores are calculated for each measure

The Achievement and Improvement scores are compared. The highest score is the value used.

The value is weighted and used to calculate the TPS

**Achievement Score** = 10 x (Agency Performance Score – Achievement Threshold) / Benchmark – Achievement Threshold

**Improvement Score** = 9 x (Agency Performance Score - Agency Improvement Threshold) / Benchmark – Agency Improvement Threshold

---

Total Performance Score

- The Total Performance Score (TPS) used to award the incentive is based on the HIGHER of the 2 scores (Achievement Score or Improvement Score) for each applicable measure
- TPS is used to determine an annual distribution of value-based payment adjustments among agencies in each cohort using a Linear Exchange Function
- The majority of payment adjustment percentages will fall closer to the median
- Agencies with a TPS that is average in comparison to other agencies in their cohort would not receive any payment adjustment
- Financial incentives can be up to +/- 5%
Measures Used to Determine Scoring

Measures used to determine scoring are OASIS-based, Claims-based, and HHCAHPS survey based:

- Total of 12 quality measures used to calculate improvement or achievement scores
- (5) OASIS-based quality measures (utilize 12 OASIS questions, some of which are used to calculate a composite measure)
- (2) Claims-based measures are related to hospitalization and emergency department use
- (5) HHCAHPS survey-based quality measures

Weighting of Measures

35% OASIS Measures
35% Claims Measures
30% HHCAHPS Measures
### Measures Used to Determine Scoring

<table>
<thead>
<tr>
<th>Category</th>
<th># of measures</th>
<th>Quality Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS-based</td>
<td>5</td>
<td>Improvement in Dyspnea</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharged to Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement in Management of Oral Medications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Normalized Composite Change in Mobility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Normalized Composite Change in Self-Care</td>
</tr>
<tr>
<td>Claims-based</td>
<td>2</td>
<td>Acute Care Hospitalization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency Department Use without Hospitalization</td>
</tr>
<tr>
<td>HHCAHPS Survey-based</td>
<td>5</td>
<td>Professional Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Team Discussion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overall Rating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Willingness to Recommend</td>
</tr>
</tbody>
</table>

*The weights of the measure categories, when one category is removed, are based on the relative weight of each category when all measures are used. For example, if an HHA is missing the HHCAHPS category, the remaining two measure categories (OASIS-based and claims-based) represent 50% each.*

### Individual Measure Weighting for HHVBP

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Quality Measure</th>
<th>All Measures</th>
<th>No HHCAHPS</th>
<th>No Claims</th>
<th>No Claims or HHCAHPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS-Based Measures</td>
<td>Improvement in Self-Care</td>
<td>8.75%</td>
<td>12.5%</td>
<td>13.46%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Improvement in Mobility</td>
<td>8.75%</td>
<td>12.5%</td>
<td>13.46%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>Improvement in Management of Oral Medications</td>
<td>5.83%</td>
<td>8.33%</td>
<td>8.09%</td>
<td>16.67%</td>
</tr>
<tr>
<td></td>
<td>Improvement in Dyspnea</td>
<td>5.83%</td>
<td>8.33%</td>
<td>8.09%</td>
<td>16.67%</td>
</tr>
<tr>
<td></td>
<td>Discharged to Community</td>
<td>5.83%</td>
<td>8.33%</td>
<td>8.09%</td>
<td>16.67%</td>
</tr>
<tr>
<td></td>
<td>Total for OASIS-based measures</td>
<td>15.00%</td>
<td>50.00%</td>
<td>53.83%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Claims-Based Measures</td>
<td>ACH</td>
<td>20.25%</td>
<td>37.5%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>CD Use</td>
<td>8.75%</td>
<td>12.5%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total for claims-based measures</td>
<td>35.00%</td>
<td>50.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>HHCAHPS Survey-based Measure</td>
<td>Professional Care</td>
<td>0.00%</td>
<td>0.00%</td>
<td>9.23%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td>0.00%</td>
<td>0.00%</td>
<td>9.23%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Team Discussion</td>
<td>0.00%</td>
<td>0.00%</td>
<td>9.23%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Overall Rating</td>
<td>0.00%</td>
<td>0.00%</td>
<td>9.23%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Willingness to Recommend</td>
<td>6.00%</td>
<td>0.00%</td>
<td>9.23%</td>
<td>0.00%</td>
</tr>
<tr>
<td></td>
<td>Total for HHCAHPS survey-based measure components</td>
<td>30.00%</td>
<td>0.00%</td>
<td>46.15%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

*The weights of the measure categories, when one category is removed, are based on the relative weight of each category when all measures are used. For example, if an HHA is missing the HHCAHPS category, the remaining two measure categories (OASIS-based and claims-based) represent 50% each.*
Quality Measure Data Collection

- Agencies must submit OASIS assessments per Medicare Conditions of Participation §484.55 and as a condition of payment §484.205(c)
- OASIS data is submitted through iQIES and EMRs
- HHCAHPS (Home Health Care Consumer Assessment of Healthcare Providers and Systems) is a national standardized and publicly reported survey of home health patients’ perspectives of their skilled care received. Agencies are required to contract with an approved, independent HHCAHPS survey vendor to administer survey on its behalf §484.245(b)(1)(iii)(B)
- Claims data related to hospitalizations and emergency room use are derived from claims submitted to CMS for payment purposes. Agencies are not required to submit any additional data.

Minimum threshold of data per reporting period

An HHA must have sufficient data to establish the HHA baseline year for a particular quality measure. An HHA must meet the minimum threshold of data per measure per reporting period on five (5) or more of the applicable measures in the baseline and performance years

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS-based</td>
<td>20 home health quality episodes</td>
</tr>
<tr>
<td>Claims-based</td>
<td>20 home health stays</td>
</tr>
<tr>
<td>HHCAHPS Survey-based</td>
<td>40 completed surveys</td>
</tr>
</tbody>
</table>
Measure Category Weighting

- OASIS-based measures account for 35% of the Total Performance Score weight.
  - Note: This weight can be redistributed if an agency is missing another category measure (i.e., HHCAHPS are missing, therefore OASIS measures and Claims measures will each be weighted 50%)

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>OASIS-based</td>
<td>35%</td>
</tr>
<tr>
<td>Claims-based</td>
<td>35%</td>
</tr>
<tr>
<td>HHCAHPS Survey-based</td>
<td>30%</td>
</tr>
</tbody>
</table>

- OASIS outcome scores are measured from SOC/ROC to end of episode (improvement or decline)
- OASIS outcomes are measured by how much improvement is shown, not simply if they improve (unlike STAR ratings scoring)
- Patients who are fully independent at SOC/ROC will be included in the scoring; any decline will earn a negative score

OASIS-Based Measures (35% of TPS)

- M1400 Improvement in Dyspnea*
- M2420 Discharged to Community
- M2020 Improvement in Management of Oral Medications*
- Total Normalized Composite Change in Mobility
  - M1840 Toilet Transferring
  - M1850 Transferring*
  - M1860 Ambulation/Locomotion*
- Total Normalized Composite Change in Self-Care
  - M1800 Grooming
  - M1810 Ability to Dress Upper Body
  - M1820 Ability to Dress Lower Body
  - M1830 Bathing*
  - M1845 Toileting Hygiene
  - M1870 Feeding or Eating

*Outcome measures also used for STAR ratings (in addition to Timely Initiation of Care and Acute Care Hospitalization)
Important Points about OASIS-based Measures

- OASIS outcomes are measured by how much improvement is shown, not simply if they improve (unlike STAR ratings scoring)
- Clinician education is key for accurate scoring
- Always consider SAFETY with OASIS-based functional measures (i.e. “Is the patient doing this SAFELY?”)
- At discharge, clinicians should be looking at SOC/ROC scores to see if improvement was shown
- Many OASIS-based measures also impact PDGM functional scores and STAR ratings

Claims-Based Measures (35% of TPS)

**Acute Care Hospitalization During the First 60 Days of Home Health Use (26.25%)**
- Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay

**Emergency Department Use without Hospitalization During the First 60 Days of Home Health (8.75%)**
- Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay

*Outcome also used in calculation of STAR rating*
Important Points about Claims-based Measures

- These measures account for 35% of the Total Performance Score!
- Initiate steps to prevent hospitalizations and ED use
  - Identify the high-risk patients (CHF, COPD, recent infection, Diabetic, COVID, etc.)
  - Frontloading visits
  - Patient education
  - Identify and involve a patient’s caregiver
  - Utilize supplemental telehealth visits in between regularly scheduled visits
  - Case conference within the first week of SOC
  - Analyze and evaluate every hospitalization and ED visit: How could it have been prevented?

HHCAHPS Survey-Based Measures (30% of TPS)

- HHCAHPS is the Home Health Consumer Assessment of Healthcare Providers and Systems survey is a nationally standardized and publicly reported survey of home health care patients’ perspectives of their skilled home care
- Surveys are mailed to beneficiaries by the HHCAHPS vendor who then collects the information
- Agencies serving 60 or more patients must contract with an approved vendor to collect data
- Agencies that served 59 or fewer patients in a calendar year can file an exemption request for survey participation
- Survey results are also posted publicly on Care Compare website
The HHCAHPS survey measure score is taken from the 5 individual components of which each is considered a quality measure for HHVBP

- How often the home health team gave care in a professional way? (6%)
- How well did the home health team communicate with patients? (6%)
- Did the home health team discuss medicines, pain, and home safety with patients? (6%)
- How do patients rate the overall care from the agency? (6%)
- Will the patients recommend the agency to friends? (6%)

These survey categories are publicly reported on the CMS public site Care Compare website https://www.medicare.gov/care-compare/

Important Points about HHCAHPS measures

- 3 HHCAHPS measures based on composite questions from survey
- Review specific wording of survey questions asked
- Note how questions can be answered
  - NEVER, SOMETIMES, USUALLY, ALWAYS
  - SAME DAY, 1-5 DAYS, 6-14 DAYS, MORE THAN 14 DAYS
- Review agency process for answering and returning patients’ calls
- Emphasize professionalism and communication practices (calling prior to visits, updating of changed/new orders
- Review discharge processes and how it is communicated to patients
VBP Reports

- Performance feedback reports will be available to agencies to assess performance
- Uses data already reported by HHAs through the Home Health Quality Reporting Program requirements of Medicare claims
- No additional data needs submitted by the HHA
- Sources of data collection for report include OASIS reporting in iQIES, claims reporting, and HHCAHPS reporting (by independent survey contractors)

VBP Reports

CMS will publish 2 types of reports that will provide agencies information on their performance and payment adjustments beginning in 2023

**Interim Performance Report (IPR)** – first available July 2023
- Quality measure performance based on most recent 12 months
- Quarterly report

**Annual TPS and Payment Adjustment Report (Annual Report)** – first available in August 2024
- Agency’s payment adjustment for the payment year
- Annual report

*Will be found in HHA Provider Preview folder of iQIES*
VBP Reports

• Sample reports are available now
• Not agency-specific
• Contain sample data only
• Use these reports to understand how to interpret reports, learn how the TPS is calculated, and identify how a HHA will be assigned to a cohort
Assess Performance Now

- Earliest VBP reports will not be available until July 2023
- Home Health Quality Reporting Program reports available on iQIES
- Can determine probable cohort size based on eligible beneficiary HHCAHPS surveys
- Key Quality Reporting Program reports in iQIES
  - Outcome Report
  - HHA Provider Preview reports (STAR reports and associated Outcome reports)
Improving Outcomes

- Preparation = Education
- Identify learning opportunities for staff regarding accurate OASIS scoring especially at SOC
- Focus on GOALS (agency AND patient identified goals)
- Involve all disciplines
- Make VBP part of QAPI (PIP, Action Plans)
Thank you for attending!

Any questions can be directed to Jennifer Amheiser, BSN, RN at jennifera@hc-link.com

1-888-258-1894
www.hc-link.com

References and Resources


Home Health Care CAHPS Survey https://homehealthcahps.org/


Care Compare website https://www.medicare.gov/care-compare/