Before We Get Started...

- Audio is through computer speakers or select "Use Telephone" on Audio Pane to call in. All attendees are muted.
- You can ask questions via the GoToWebinar Question Pane throughout the presentation.
- Handout link can be found in reminder email & on the Handout pane in the GotoWebinar Control Panel.
- On-demand video will be made available following the webinar.

About HEALTHCAREfirst

Industry leader in Web-based software, outsourced services & advanced analytics for hospice and home health.

We enable our customers to:
- Make timely and accurate decisions for excellent patient care
- Adapt quickly to changing requirements and needs
- Automate agency functions quickly & with high value
Value-Based Purchasing (VBP)

• Value quality rather than quantity
• The Triple Aim
  o Improving patient experience, including quality and satisfaction (Better care)
  o Improving the health of the populations (Healthier people)
  o Reducing the per capita cost of health care (Smarter spending)

National Business Coalition on Health’s Value-Based Purchasing Council (NBCH)

• Re-engineer health care delivery via effective value-based purchasing
• Reward effective health care services and high performing health care providers with:
  o Improved reputations through public reporting
  o Enhanced payments through differential reimbursements
  o Increased market share through purchaser, payer, and/or consumer selection

Elements of NBCH VBP

• Element One: Standardized Performance Measurement
  o Measurement should be able to answer the question, “Is care safe, timely, efficient, effective, equitable, and patient-centered?”
• Element Two: Transparency and Public Reporting
  o Standardized performance measures must be converted into useful, accessible information for purchasers, payers, and consumers
• Element Three: Payment Innovation
  o Differential reimbursement, or “pay for performance,”
• Element Four: Informed Consumer Choice
HHVBP Final Rule

- Final rule
  - Final rule published: November 5, 2015
- Implement a HH Value-Based Purchasing (HHVBP) Model: beginning January 1, 2016
  - All Medicare-certified HHAs in selected states
  - Participation required
  - Data reporting mandated
  - Scoring methodology defined
  - Payment adjustments and methodology specified

Basis for HHVBP Model

- Goal: Tie quality to payment
  - Link performance to opportunity and risk for payment adjustment
    - Improve quality of home health care to Medicare beneficiaries
    - Improve quality and efficiency (test for statistical significance)
  - Affordable Care Act
  - President’s Budget
  - Secretary’s reform goal using alternative payment models:
    - Tie 30% of fee-for-service payment to quality by end of 2016
    - Tie 50% of fee-for-service payments to quality by end of 2018
    - Tie 85% of traditional Medicare payment to quality by 2016
    - Tie 90% of traditional Medicare payment to quality by 2018

HHVBP: Overview

- Five performance years
  - Intended results
    - Incentivize HHAs: better care/greater efficiency
    - Study new measure in home health setting
    - Enhance public reporting processes
  - Modeled after
    - Hospital VBP
    - HH P4P Demonstration
  - Quality measures
    - Aligned with National Quality Strategy (NQS) priorities
HHVBP Process

- Assess performance & adjust payment
- Five performance reporting years:
  - First year: 2016
  - Final year: 2020 (unless modified through later rule)
- Payment adjustment years (up or down)
  - CY 2018: 3%
  - CY 2019: 5%
  - CY 2020: 6%
  - CY 2021: 7%
  - CY 2022: 8%

Reports for Participating Agencies

- Quarterly performance report
- Annual payment adjustment reports
- Annual publicly available performance reports

State Selection

- Designed to:
  - Avoid selection bias
  - Be representative of home health agencies nationally
- All HHAs receiving Medicare payment in
  - MA, MD, NC, FL, WA, AZ, IA, NE, TN
- All Medicare patients served (including in reciprocal states)
- Agencies assigned to cohort based on CAHPS participation
  - Larger volume cohort: competing in CAHPS
  - Smaller volume cohort: exempt from CAHPS (fewer than 60 HHCAHPS-eligible patients)
HHVBP Model Plan

- Evaluate agencies’ performance for care to Medicare beneficiaries
  - Achievement
  - Improvement
- Initially: Starter set selected for year one
  - Quality measures
    - OASIS
    - CWF
    - CAHPS
  - New Measures
- Future: additional measures based on IMPACT Act

HHVBP Model Framework

- Six priorities into four HHVBP Measure Classifications:
  - Classification I: Clinical Quality of Care
  - Classification II: Care Coordination and Efficiency
  - Classification III: Person/Caregiver-Centered Experience
  - Classification IV: New Measures

Applicable Measures

- Applicable measure
  - Measure for which the competing HHA has provided 20 home health episodes of care per year
- Benchmark
  - Top decile of HHA performance on specified quality measure during the baseline period
  - Calculated separately for larger volume and smaller-volume cohorts in state
Minimum Number of Cases

- HHVBP participation mandatory
  - Total points calculation based on measures reported
  - New measure reporting required
- No score for Outcome & Clinical Quality measure
  - 20 or fewer episodes per year
- No payment adjustment (except 10% New Measure adjustment)
  - If no score for 5 or more of quality measures
    - Clinical Quality of Care
    - Care Coordination & Efficiency
    - Person and Caregiver-Centered Experience

Measure Selection Objectives

- Use broad measures that capture HH complexity
- Allow flexibility for inclusion of IMPACT measures
- Enable development of second-generation measures
- Ensure balance of process, outcome, patient experience
- Advance the ability to measure cost & value
- Add measures for appropriateness or overuse
- Promote infrastructure investments

Final Measure Selection

- Measures 2016
  - 6 Process
  - 10 Outcome
  - 5 HHCAHPS
  - 3 New
- Future Measures in 2017 per IMPACT Act
Performance Benchmarks & Thresholds

- Achievement Points and Improvement Points
  - By cohort (Large/Small)
  - For each measure
  - Based on
    - Achievement scale between threshold and benchmark
      - Threshold: median of HHA's performance during baseline period
      - Benchmark as top decile of all HHAs' performance
      - Improvement: Points along improvement range of change during performance period and baseline period

Performance Scoring Methodology

- Performance scoring methodology (20 or more episodes)
  - Determine performance standards (benchmarks and thresholds) using the 2015 baseline quality data
  - Score HHAs based on their achievement and/or improvement for each measure
  - Weight each classification by the number of measures employed

Measure Weighting & Scoring Method

- Weighting
  - New Measures:
    - Based on reporting
    - Account for 10% of total score
  - Outcome, Process, HHCAHPS measures:
    - Account for 90% of total score
    - Each weighted the same
      - At individual measure level (not classification)
  - Rationale:
    - Varying needs of individual agency populations
    - Promote improvement for all, not just higher weighted measures
Achievement Scoring

- Achievement Scoring
  - Performance equal to or higher than benchmark
    - Maximum 10 points
  - Performance equal to or greater than performance threshold but lower than benchmark
    - 1-9 points
  - Performance less than achievement threshold
    - 0 points

Improvement Scoring

- Performance equal to or higher than the benchmark score
  - Maximum 10 points
- Performance greater than baseline period score but below the benchmark
  - 0–10 points if within the improvement range
  - 0 points if equal to or lower than baseline period score

Total Performance Scoring

- Using higher of an HHAs achievement or improvement scores for each measure
  - Rounded up or down to the third decimal
  - Quarterly basis
Performance Scoring

- Total Performance Score
  - Numeric score ranging from 0 to 100 awarded to each competing HHA based on its performance
    - Starter set: quality measures (20 or more episodes)
      - 90% of the TPS equal weight to all measures in
        - Clinical quality of care
        - Care Coordination and efficiency
        - Person and Caregiver centered experience
    - New measures
      - 10% equal weight to

Payment Adjustment Methodology

- §484.325 Payment Adjustment
  - CMS will determine a payment adjustment up to the maximum applicable percentage
    - Upward or downward
    - For each competing home health agency
    - Based on the agency’s Total Performance Score
    - Using a linear exchange function
    - Adjustments will be calculated as a percentage of otherwise applicable payments for home health

Payment Adjustment

- Adjustment to maximum applicable percentage for year
  - Using Linear Exchange Function (LEF)
    - Ex: Slope of LEF for CY 2016: estimated aggregate value-based payment adjustments equal to 3-percent of the estimated aggregate base operating episode payment amount for CY 2018
  - Up or down to 3%
  - Based on Total Performance Score (TPS)
  - Calculate percentage of HH payments
  - Multiply HH Prospective Payment final claim payment by payment adjustment percentage
Preview & Recalculation Requests

- Quarterly Performance Report
  - Notify HHA of quarterly performance on quality measures
    - 30 day preview by HHA
      - Submit request for recalculation and specific basis for recalculation if disagree
- Annual TPS and payment adjustment report
  - Notify in August in August previous year
    - 30 day preview by HHA
      - Submit request for recalculation and specific basis for recalculation if disagree
- Review by CMS for approval or denial of request
  - As soon as administratively possible
  - Appeals in accord with process under development

Clinical Quality of Care Measures

- Outcomes
  - Improvement ambulation (M1860)
  - Improvement transfer (M1850)
  - Improvement bathing (M1830)
  - Improvement dyspnea (M1400)
- Process
  - Drug education on all medication provided to patient/caregiver during an episode of care (2015)

Communication/Care Coordination

- Outcome
  - Discharge to community (M2420)
- Process
  - Care management: Types & sources of assistance (M2102)
Efficiency and Cost Reduction

- Outcome
  - Acute care hospital unplanned during first 60 days (CCW)
  - Emergency department w/o hospitalization (CCW)

Patient Safety

- Outcome
  - Improvement pain (M1242)
  - Improvement management of oral meds (M2020)
  - Prior function ADL/IADL (M1900)

Population/Community Health

- Process
  - Influenza data collected (M1041)
  - Influenza immunization received season (M1046)
  - Pneumococcal vaccine ever received (M10510)
  - Reason pneumococcal not received (M1056)
Patient & Caregiver Experience

- CAHPS Outcome (Q 2, 3, 4, 5, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, 24)
  - Care of patients
  - Communication between provider/patients
  - Specific care issues
  - Global type measures
    - Overall rating HHA
    - Willingness to recommend HHA

Home Health Agency Goal

- Delivery of Quality Care through
  - Application of standards of practice to yield
    - Compliance
    - Better outcomes
    - Client/caregiver satisfaction
    - Competitive position in the community
    - Compensation

Improvement Process

- Plan, Coordinate, Deliver
  - Establish goals
  - Identify strategies
  - Review results
  - Regroup, reorganize, reestablish goals
  - Research and incorporate new practices
Pilot and Non-Pilot Agency Action

- Focus on the 24 quality metrics
  - Home Health Compare to establish a ballpark estimate of standing
  - Review the CASPER reports
  - Compare the differences between these reports and Home Health Compare

- Immediately implement strategies to assess readiness
  - Determine OASIS accuracy
  - Provide OASIS education
  - Assess patient experience of care
  - Continuously monitor reports
  - Identify and address trends and issues
  - Develop plans to improve scores

Back to Basics

- Achievement of Goals
  - Best practices
  - Best staff
  - Protocols that align with goals
  - Integration with health care community

- Were goals different from today?
  - Letter of gratitude: 1987
    - My nurse’s qualities: comforting, reassuring, therapeutic
    - Superb team leader who assessed, planned, and coordinated all services
      - Supervised the aide
      - Oversaw ordering and care of equipment, oxygen, medications, meal service
    - Communicated frequently with physician and family
#1 Priority: Staffing

- Strive for: motivated, engaged, participatory, happy staff
  - Determine desired staff qualifications
  - Recruit qualified personnel
  - Establish stable workforce
  - Orient all staff to home health
  - Educate on agency goals and mission
  - Identify of erroneous practices and continuously advise of performance
  - Reward high performers
  - Conduct ongoing staff training
    - Changing clinical practices
    - Individual and agency clinical outcomes
    - Individual and agency CAHPS scores

Back to Basics

- Leadership redesign
  - Establishment of stable employee workforce
  - Optimization of performance
  - Development of staffs’
    - Ability
    - Willingness
    - Confidence
    - Commitment

Back to Basics: Improvement Considerations

- Key Considerations in Care Delivery
  - Formal Care Management program
  - Training: accurate and comprehensive assessments
  - Plan of care aligned to assessment
  - Comprehensive clinical actions (process, not task)
  - Regular, scheduled interdisciplinary meetings (in person or virtual)
  - Consistency in assignments/scheduling
  - Accountability for patient goal management
  - Continuous care: assessment, goal and plan modification
  - Patient/family/caregiver education process, tools, staff preparedness (the cornerstones of disease management)
Back to Basics: Improvement Considerations

- Identify clinicians with best outcomes
  - Identify care delivery practices
  - Apply agency-wide
- Establish coordination processes
- Require physician communication, collaboration and coordination

Resources
- CMS VBP Tools and Assistance
- Home Health Quality Improvement National Campaign
  - https://www.tmfnortheast.org/Health-Care-Providers/Home-Health-Agencies/HHDQ-National-Campaign
- Nursing Practice/Patient Education Publications and Tools
  - EHR embedded tools
  - Care Planning tools:
    - http://www.marrelli.com/
    - http://www.vnaa.org/Files/Education-Quality/Resources/HomeHealthResources_ReducedHospital.pdf
    - http://www.vnaa.org/
  - Patient Education:

Key to Improvement: The Nursing Process

- The Process: Not the Task
  - Assess
  - Identify needs
  - Establish goals
  - Plan interventions
  - Coordinate with team/physician
  - Deliver care
  - Reassess and Revise
The Key: Nursing Process

- Parallel Regulatory Requirements
  - State Licensure
  - Medicare Certification Regulations: Home Health Conditions of Participation
  - Medicare Payment Regulations: Qualifying and Coverage Rules

The Key: Nursing Process

- Basic rule: Understand the multifaceted, compounding nature of care failure
- Failure to address medication management leads to:
  - Increased pathology, uncontrolled symptoms
    - Overlooked effectiveness failure, side effects, drug interactions
      - Dyspnea
      - Elevated BP, blood sugar
      - Weakness
      - Pain
  - Emergency Department use and hospitalization
  - Patient/caregiver dissatisfaction

The Key: Nursing Process

- Basic rule: Understand the multifaceted, compounding nature of care failure
- Failure to address underlying pathology/needs leads to:
  - Increased weakness and pain, lead to
    - Stabilization or decline in
      - Ambulation
      - Transfer
      - Bathing
  - Decline in ambulation, transfer, bathing lead to
    - Emergency Department Use and Hospitalization
    - Patient/caregiver dissatisfaction
New Measures

- Submission via Web-based platform
  - Serves to collect and distribute information from & to HHAs
- New measures to be reported
  - Population/Community Health
    - Influenza vaccine HHA personnel
    - Herpes zoster vaccine: patients
  - Communication and Coordination
    - Advance care plan (patient’s desires if recovery improbable)

Advance Care Planning

- Percentage of patients aged 65 years and older with medical record documentation that
  - Have an advance care plan or surrogate decision maker, or
  - Advance care plan was discussed, but patient
    - Did not wish, or
    - Was not able to name a surrogate decision maker or provide an advance care plan
  - Data reporting beginning 10/7/16
    - For period July 2016 through September 2016
    - Quarterly thereafter
  - Numerator: Number of patients 65 and older that have an advance care plan or surrogate decision maker
  - Denominator: Number of patients 65 and older admitted by agency

Influenza Vaccine Coverage for Personnel

- Data Reporting
  - Begin no later than 10/7/16 and quarterly thereafter
  - For period July 2016 through September 2016
  - Numerator by category: number of personnel who:
    - Received vaccine by agency or other (written report), or
    - Medical contraindication, or
    - Declined/Unknown status, or
    - Don’t meet definition
  - Denominator: Number who work at least one day October 1 through March 31 separately by category
    - Employee
    - Independent practitioner (contractor)
    - Student/Trainee/Volunteer
Herpes Zoster Vaccine for Patients

- Data Reporting
  - Begin no later than 10/7/16 and quarterly thereafter
  - For period July 2016 through September 2016
  - Numerator: total number of Medicare beneficiaries aged 60 and over who report having ever received herpes zoster vaccine during the HH episode of care
  - Denominator: total number of Medicare beneficiaries aged 60 and over receiving services

Future Cross-Setting Measures

- IMPACT Act Requirement
- Timeline January 1, 2017
  - Measures to reflect all-condition risk-adjusted potentially preventable hospital readmission rates
  - Resource Use (to include total estimated Medicare spending per beneficiary)
    - Payment Standardized Medicare Spending Per Beneficiary (MSPB)
  - Discharge to community
    - Percentage residents/patients at discharge assessment who discharged to a higher level of care versus to the community
  - Medication Reconciliation Measure
    - Percent of patients for whom any needed medication review actions were completed

Home Health Solution Suite

What's Included:
- Agency Management (EMR) Software
- Coding Services
- Billing Services
- Business Intelligence
- HHCAHPS
- Payer Connectivity
Home Health Solution Suite Benefits

- Maximize reimbursement while reducing overhead costs.
- Ensure regulatory compliance with accurate, complete and compliant clinical documentation.
- Reduce your risk of takebacks by submitting clean, error-free claims.
- Grow and strengthen high-value referral relationships.
- Simplify vendor management with one expert business partner.

Thank You

- On-demand video will be made available following the webinar.
- We want to hear from you! Please fill out survey.

Contact HEALTHCAREfirst
800-841-6095
www.healthcarefirst.com
Home Health Value-Based Purchasing: Preparing for Success
May 26, 2016

1. When will Hemoglobin A1C be required to be documented? Should we be doing that now?

Palmetto GBA is the only MAC currently requiring the reporting of HbA1c. The Local Coverage Determination (LCD) can be found at L35132. If Palmetto is your MAC, the requirement became effective 10/1/15, with the revision effective 5/1/16.

In order for Home Health patients to be eligible to receive services under the Medicare Home Health benefit the following must be documented for certification/recertification:

- Documentation should show that the patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient.
- The results of the most recent HbA1c.
- Documentation must be legible, relevant, and sufficient to justify the services billed. This documentation must be made available to the A/B MAC upon request.

2. Baseline year is 2015—Is that for all agencies or just the pilot agencies?

CMS propose to implement this model over a total of seven years beginning on January 1, 2016, and ending on December 31, 2022. The baseline year would run from January 1, 2015 through December 31, 2015 and provide a basis from which each respective HHA’s performance would be measured in each of the performance years.

3. I totally agree that staffing is #1 priority. Being that we are in the process of accreditation and certification, we have had a hard time getting the right staff, especially since we have no patients for them and it’s very common for them to work at many companies. Any advice to hire good employees when we are such an infant stage?

Home health agencies are required to provide only one service directly (100% by employees). They have the option to select what that service will be. A new agency that is in the process of recruiting sufficient staff may wish to select one of the smaller disciplines, such as social work as their one direct service. The agency would hire a social worker as an employee who receives a W2 form and have that employee provide all needed social work services. That will give them the flexibility to use all, or a mix of contract workers and employees, for nursing, home health aide and therapy services until more established and able to recruit full time employees.
4. **Which 9 states are currently affected?**

All Medicare-certified HHAs that provide services in Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska, and Tennessee participate in the HHVBP program. If your home health agency cares for Medicare patients in one of those states you should go to the following website to register for the model:


HHAs included in the HHVBP Model are encouraged to take the following steps:

**Establish your Agency's HHVBP Point of Contact:** HHAs in the nine selected states should provide the HHVBP Help Desk, HHVBPquestions@cms.hhs.gov, with the name and email address of a primary point of contact for each CMS Certification Number (CCN). Please also include the Agency name, Agency address and Agency phone number.

**Obtain a User Account on the CMS Secure Portal:** This is an important first step towards registration for the HHVBP Model portal where HHAs will receive performance reports and enter data for new measures.

5. **Do you have clarification on the flu shot info we are supposed to get from affiliated physicians? Does this mean we need to know if every physician that signs our plan of cares we have to get this info on?**

There is no federal regulatory or policy requirement to have the physician sign off on information about patient’s influenza vaccine status.

6. **When can we see the new required updates implemented in HEALTHCAREfirst’s EMR software?**

HEALTHCAREfirst will be releasing new functionality for firstHOMEcare in June 2016 that allows agencies to track the three new manual measures. Additionally, we are working on a report that will assist agencies in reporting the manual measures via the CMS HHVBP portal. Lastly, we will be releasing a new Business Intelligence report that will allow you to track your progress in real-time on submitted measures.

For more information about this new functionality, please contact HEALTHCAREfirst.
7. Please explain the CASPER Reports and where can we find this in order to compare Home Health reports?

Information about home health Outcome Based Quality Improvement (OBQI) and CASPAR reporting can be found here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISOBQI.html.

The OBQI reports represent an aggregation of OASIS-C patient status data collected at the beginning and the end of an episode of care. Since HHAs only submit OASIS-C data on Medicare and Medicaid patients, those are the only patients included in the reports. The CASPER User Manual provides information on how to obtain OBQI Reports from the CASPER system. It describes how to request a report, how to view a report online, and how to print or save a report. This manual can be found on each HHA's OASIS State Welcome Page.

8. Can you provide information on the IMPACT Act?

In CMS’s Open Door Forum for home care providers on May 4, 2016, they stated that the IMPACT Act of 2014 requires CMS to implement “standardized uniform data elements to be nested within the assessment instruments” for four post-acute providers — home health agencies, skilled nursing facilities, inpatient rehab facilities, and long-term care hospitals.

According to CMS, one of the next changes for HHAs due to the IMPACT Act is the addition of three items to OASIS-C2 – M1028 Active Diagnoses, M1060 Height and Weight, and GG0170C. The new OASIS-C2 will take effect next January. Expect more IMPACT Act-related changes in the future, experts warn.


Hospice provisions of the IMPACT Act include:

- Medicare-certified hospice programs will be required to undergo a standard survey at least once every three years through fiscal 2025. Surveys must be conducted by state or local survey agencies or an approved accreditation agency.
The Department of Health and Human Services (HHS) will conduct eligibility re-certification reviews of hospice programs that provide care to individuals if the number of cases in which care is provided for more than 180 days exceeds a percentage threshold of all care cases. The percentage threshold would be set by the department.

Hospice providers could be subject to denial of payment rules if they aren’t re-certified.

Hospice reimbursement and the hospice aggregate cap would align to a common inflationary index.