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Home Health Value-Based Purchasing: Preparing Your Agency

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Disclosures

- **Financial**
  - None
- **Nonfinancial**
  - None

Learning Goals

- Participants will understand the three goals of the HHVBP model
- Participants will be able to identify two positive outcomes that have been realized due to HHVBP
- Participants will understand the financial impacts of the HHVBP model
- Participants will be prepared for any changes due to the HHVBP model

Overview

- **Background and rationale**
  - Goals
  - Financial impact
  - Total Performance Score
- **Results**
  - Spending
  - Utilization
  - Outcomes
  - Payers
  - Patient experience
- **Unintended impacts and the future**

Background and Rationale

Background and Rationale: Overview

- The Home Health Value Based Purchasing Model (HHVBP) was initiated in 2016 to test the impact of financial incentives on home health agencies based on quality of care
- Initially expected to end December 31, 2020; however, due to plans to expand HHVBP, this will end one year early
- Currently impacting agencies in nine states

Arizona: 8.3%	Nebraska: 3.8%
Florida: 47.4%	North Carolina: 8.6%
Iowa: 7.6%	Tennessee: 6.5%
Maryland: 2.7%	Washington: 3.3%
Massachusetts: 11.8%	–

Background and Rationale: Goals

- Provide financial incentives to agencies to provide better-quality care with greater efficiency
- Study new quality and efficiency measures for appropriateness in home health
- Enhance the public reporting process around home health quality measure

Background and Rationale: Financial Impact

Medicare payments are adjusted up or down based on data from two years prior and an agency's Total Performance Score (TPS) relative to peers in its state

Calendar year	Payment adjustment	Maximum payment adjustment
2016	No	–
2017	No	–
2018	Yes, based on 2016 TPS	+/− 3%
2019	Yes, based on 2017 TPS	+/− 5%
2020	Yes, based on 2018 TPS	+/− 6%
2021	Yes, based on 2019 TPS	+/− 7%
2022	Yes, based on 2020 TPS	+/− 8%

Background and Rationale: Total Performance Score

- To be eligible for inclusion in the TPS calculations and payment adjustments, an agency must meet the following criteria:
  - Have data for at least five measures in both the baseline and performance periods,
  - Have 20 or more episodes of care (for OASIS-based or claims-based measures), and/or
  - Have 40 completed HHCAHPS surveys in both the baseline and performance periods
- TPS calculations come from 20 performance measures, which are obtained from Medicare claims, OASIS, HHCAHPS, and Agency Self-Reporting
- In the first four years of the HHVBP model, CMS has found higher TPS values for agencies in the states that are part of the model compared to those that are not part of the model

Background and Rationale: COVID-19

- CMS made no changes to the Financial Methodology or the Timeline regarding HHVBP
- Exceptions were granted on reporting requirements in that agencies were not required to report data for the following quarters:
  - 10/1/19–12/31/19
  - 1/1/20–3/31/20
  - 4/1/20–6/30/20

Background and Rationale: Summary

- The three goals of HHVBP are
  - Incentivize agencies to provide better quality care
  - Study new quality and efficiency measures
  - Enhance the public reporting process
- Payment adjustments are made based on data from two years prior; therefore, the results of the current work will not be seen immediately

Results

Poll Question

- **Question**
  - How does your agency currently track metrics?
- **Responses**
  - External reporting software
  - Electronical medical record
  - Internally developed reports
  - We don’t

Results: Key Findings

- CMS released the 4th Annual Report Evaluation of the HHVBP Model in May 2021
- Total Medicare spending has decreased
- Healthcare utilization for unplanned hospitalizations and SNF visits has declined
- Total performance scores continue to be higher in HHVBP states

Results: Spending

- 2.4% decline in average spending per day for inpatient services, a savings of $381.4 million
- 4.2% decline in average spending for SNF services, a savings of $164.9 million
- 6.1% ($65.3 million) increase in spending for outpatient ED visits and observation stays

Results: Utilization

- When compared to rates pre HHVBP implementation
  - Unplanned hospitalization rates decreased 1.1%
  - Use of SNFs decreased 4.9%
  - Outpatient ED use increased 2.6%; however, a 1.1% decrease in ED use resulting in an inpatient stay was also noted
- Agencies may coordinate services to better address the reason for hospitalization prior to being admitted to home health
- Front-loading was seen to have increased in agencies in HHVBP states

Results: Outcomes

- **Medicare claims**
  - Emergency room use without hospitalization
  - Unplanned acute care hospitalization
- **Agency self-reported measures**
  - Influenza vaccination coverage for agency personnel
  - Herpes zoster vaccination for patients
  - Advance care plan documentation

Results: Outcomes (cont.)

- **OASIS**
  - Dyspnea
  - Management of oral medications
  - Total normalized composite change in self-care
    - Grooming
    - Upper and lower body dressing
    - Bathing
    - Toileting hygiene
    - Eating
  - Total normalized composite change in mobility
    - Toilet transferring
    - Bed transferring
    - Ambulation

Results: Outcomes (cont.)

- **HHCAHPS**
  - Care provided in a professional way
  - Communication with patients
  - Team discussed medicines, pain, and home safety
  - Overall care from the agency
  - Likelihood to recommend the agency

Results: Outcomes (cont.)

- Total Performance Scores (TPSs) are higher in agencies in HHVBP states compared against those in non-HHVBP states
  - Improvement was seen from 2016 to 2017 and 2017 to 2018
  - 2019 saw a decline, which is likely due to changing the weights of claims-based measures
- Higher TPS scores are almost exclusively due to higher OASIS-based outcome measures

Results: Financial Impact

- Payment adjustments are based on data from two years prior. An agency's performance in 2019 will be the basis of payment adjustments in 2021.
- CMS looked at Cost Report date from 2012 to 2018 for freestanding and hospital-based agencies. Almost 70% of freestanding agencies had a positive profit margin in 2018, with the median being 15.9%.

Results: Payers

- Differences were seen in Medicaid and non-Medicaid patients. Specifically, the decreases in unplanned hospitalizations and greater improvement in functional scores were not observed in Medicaid patients.
- Widening disparities between Medicaid and non-Medicaid patients have been seen in Total Normalized Composite scores since the HHVBP model went into effect

Results: Patient Experience

- Five patient experience measures are pulled from the HHCAHPs
- All have remained relatively high in both HHVBP and non-HHVBP states
  - HHVBP has had no impact on three of the measures in the first four years of the model
  - HHVBP was associated with a decline in two measures, although scores range from 82% to 86%
    - Communication with patients
    - Discussing medications, pain, and home safety

Results: Summary

- Medicare spending has declined as a result of HHVBP
- Total performance scores remain higher in HHVBP states, and these are due primarily to OASIS-based outcomes measures

Unintended Impacts and the Future

Unintended Impacts: Results

- No evidence has been found on Medicare spending for home health utilization or access to home health
- Differences were seen based on Medicaid coverage
- Agencies with branches in various states may have implemented processes across the entire agency

Unintended Impacts: The Future

- Continue to examine “spillover” effects
- Evaluate changes due to the patient-driven groupings model and how agencies adapt to visit management, such as front-loading of visits
- Continue to review the impacts of HHVBP on vulnerable populations

Unintended Impacts: The Future

- Expand the HHVBP model beginning January 1, 2023 to all Medicare certified agencies in the 50 States, District of Columbia and the territories
- CY 2023 would be the first performance year and CY 2025 would be the first year with payment adjustments
- The baseline year to measure improvement would be 2019
- The proposed expansion includes measures that align with HHQRP New measures may be added in future years that align within the six National Quality Service (NQS) domains

Unintended Consequences and the Future: Summary

- No evidence has been found on Medicare spending for home health utilization or access to home health
- Differences were seen based on Medicaid coverage
- Further evaluation is needed on the impact of PDGM on HHVBP as well as the impact it has had on vulnerable populations
- CMS expanded HHVBP to all 50 states in the 2022 final rule

Summary

- The goals of HHVBP are to provide incentives to agencies to provide higher-quality care as well as to study new quality and efficiency measures and enhance the public reporting process
- Agencies can see their payments increase or decrease based on data from two years prior
- Overall spending by Medicare has declined as a result of HHVBP
- Total Performance Scores remain higher in HHVBP states, supporting the goal of providing higher-quality care
- Due to this the HHVBP model is likely to be expanded in the future as indicated in the proposed rule for 2022

Question and Answer Session

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