

# Expanded HHVBP

And What Does it Mean to YOU?

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Day 2-Session 3  
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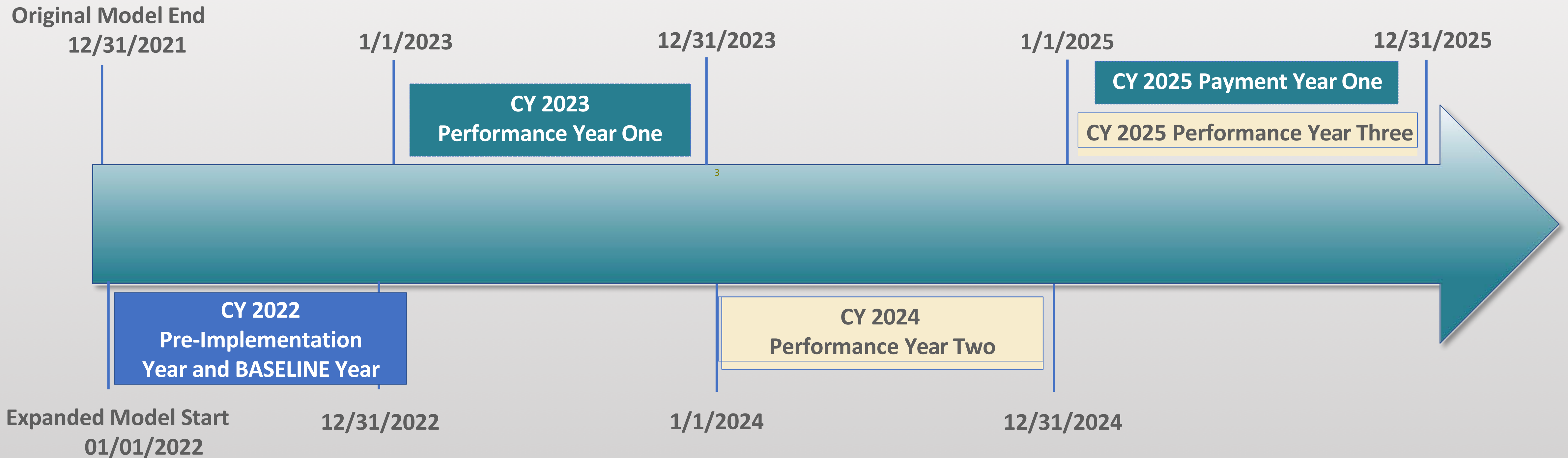


# Who, What, When, Where?

## Or, What Does HHVBP Have to do with Me?

- HHVBP impacts us all! All home health agencies across the US are automatically enrolled! Every clinician makes an impact on our scores!
- HHVBP is a way of rewarding agencies with better outcomes, satisfaction, and reduced hospitalizations
- HHVBP is “LIVE” in 2023 - as all of our data will be used to score each home health agency for a chance to financially reward or penalize
- These scores originate in the patient’s home! How accurate was our assessment? Did we score it correct, based on CMS guidance? Did we give the patient tools to stay out of the hospital? Did we provide good customer service?

# Model Timeline: Initial Rollout CY 2022 – CY 2025



# What's Important? The Measures and Weights

Measure Category and TPS Weight	Quality Measures Within Category	Weight in Category
<b>OASIS= 35% Total Performance</b>	TNC Self Care	25%
	TNC Mobility	25%
	Dyspnea	16.67%
	Discharged to Community	16.67%
	Oral Medications	16.67%
<b>CLAIMS= 35% Total Performance</b>	Acute Care Admission	75%
	Emergency Department Use	25%
<b>HHCAPS= 30% Total Performance</b>	Professional Care	20%
	Communication	20%
	Team Discussion	20%
	Overall Rating	20%
	Willingness to Recommend	20%

# The OASIS Measures

## One point= IMPROVEMENT

Domain	Title	Type	Source	Numerator	Denominator
Clinical Quality	Imp in Dyspnea	Outcome	M1400	Number of episodes of care where DC assessment shows less dyspnea at DC than at SOC	Number of episodes of care ending with a DC during the period
Communication and Care Coordination	Discharge to the Community	Outcome	M2420	Number of episodes where assessment completed at DC shows the patient remained in the community	Number of episodes of care ending with DC or transfer to i/p facility during the period
Patient Safety	Imp in Mgmt of Oral Meds	Outcome	M2020	Number of episodes of care where the value on the DC OASIS shows less impairment in taking oral meds than at the SOC	Number of episodes of care ending with a DC during the period

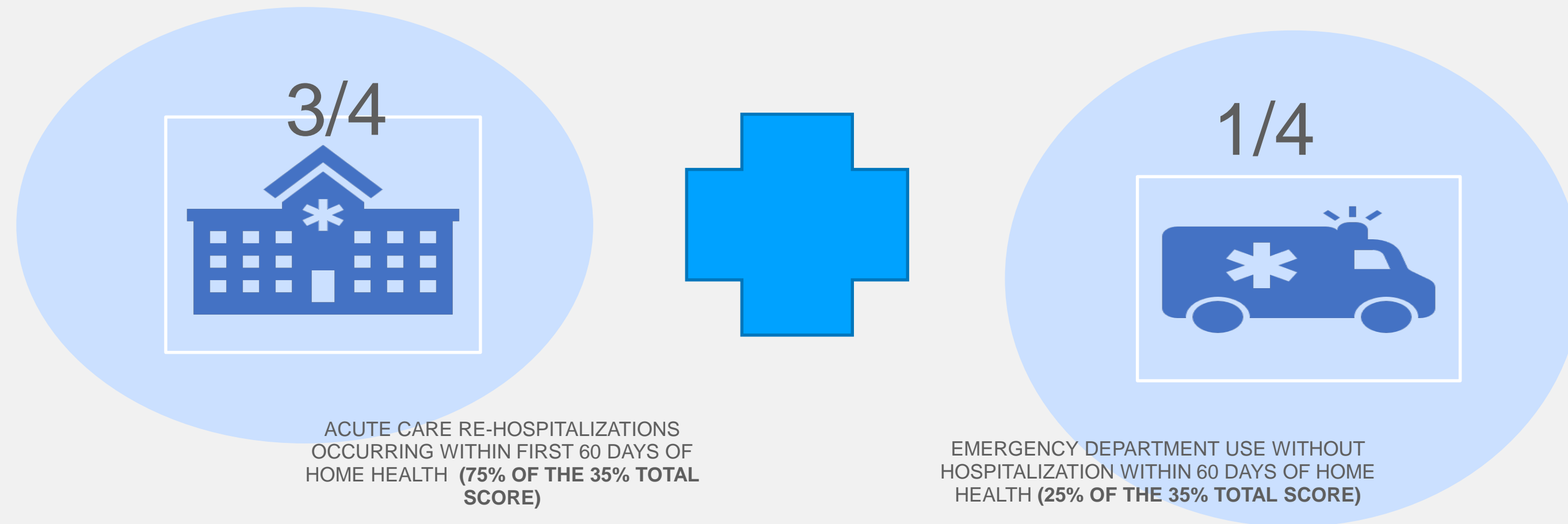
# The OASIS Composites: MORE improvement= More Points!

- \*\*\*The “normalized change” is based on the opportunities to improve- and then the actual improvement.
- This is the first time that agencies are seeing an impact to “How much” a patient improves vs just “improvement”

Domain	Title	Type	Source	Numerator	Denominator
Patient & Family Engagement	Composite Change in Mobility	Outcome (composite score)	M1840 M1850 M1860	Total normalized change in mobility functioning across 3 OASIS items (toilet transfers, transferring and ambulation)	Prediction model is computed at episode level. Based on a risk adjusted rate for the agency
Patient & Family Engagement	Composite Change in Self Care	Outcome	M1800 M1810 M1820 M1830 M1845 M1870	Total normalized change in self care functioning across the 6 OASIS items (grooming, bathing, dressing, toilet hygiene and eating)	Prediction model is computed at episode level. Based on a risk adjusted rate for the agency



# Claims-Based Measures- 35%



# HHCAHPS Measures: The “Other 30%”

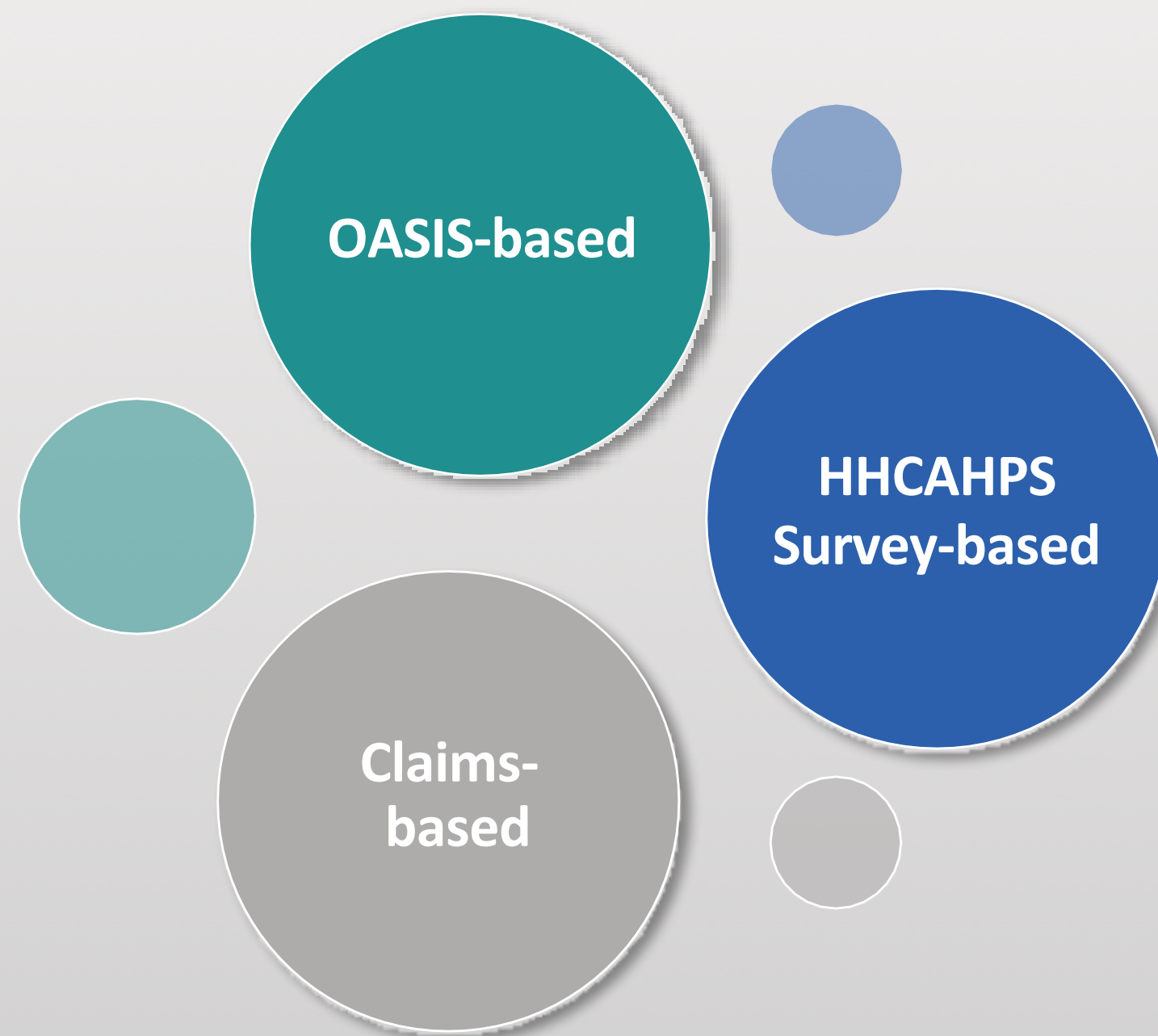
“Patient and Caregiver Experience”, consisting of questions from:

- Care of Patients/Professional Care
- Communications between Providers and Patients
- Specific Care Issues
- Overall Rating
- Willingness to Recommend





# Submission of Quality Measure Data- Already Mandated!



- HHAs must electronically report all **OASIS data** collected in accordance with [§ 484.55](#), in order to meet the Medicare Conditions of Participation (CoPs), and as a condition for payment at [§ 484.205\(c\)](#). HHAs submit the OASIS assessments in [iQIES](#).
- HHAs are required to submit **HHCAHPS** survey measure data for HH QRP. HHAs are required to contract with an approved, independent HHCAHPS survey vendor to administer the HHCAHPS on its behalf ([§ 484.245\(b\)\(1\)\(iii\)\(B\)](#)).
- The **Acute Care Hospitalization (ACH)** and **Emergency Department (ED) Use** measures are derived from claims data submitted to CMS for payment purposes and do not require HHAs to submit additional data.

# Patients Who Impact Scores

The HHVBP Model includes the following payers for each measure category:

- **OASIS-based Measures:** Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid managed care
- **Claims-based Measures:** Medicare FFS
- **HHCAHPS Measure:** Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid managed care.

# Model Baseline Year: Achievement Threshold & Benchmarks

## Achievement Threshold

The median (50th percentile) of Medicare-certified HHAs' performance on each quality measure during the designated baseline year, calculated separately for the larger and smaller-volume cohorts.

## Benchmark

The mean of the top decile (90th percentile) of all HHAs' performance scores on the specified quality measure during the baseline year, calculated separately for the larger and smaller-volume cohorts.

Used to calculate both the achievement score and the improvement score.

- The Model baseline year is the year against which CMS calculates the achievement threshold and benchmarks for each cohort.  
11
- For the CY 2023 performance year/CY 2025 payment year, CY 2022 is the baseline year for calculating the achievement thresholds and benchmarks.

# Total Performance Score Reports



# Total Performance Score (TPS)

- The numeric score awarded to each qualifying HHA based on the weighted sum of the performance scores for each applicable measure.
- Determined by weighting and summing the higher of the HHA's achievement or improvement score for each applicable measure.
- A qualifying HHA will receive a numeric score ranging from zero (0) to one hundred (100).

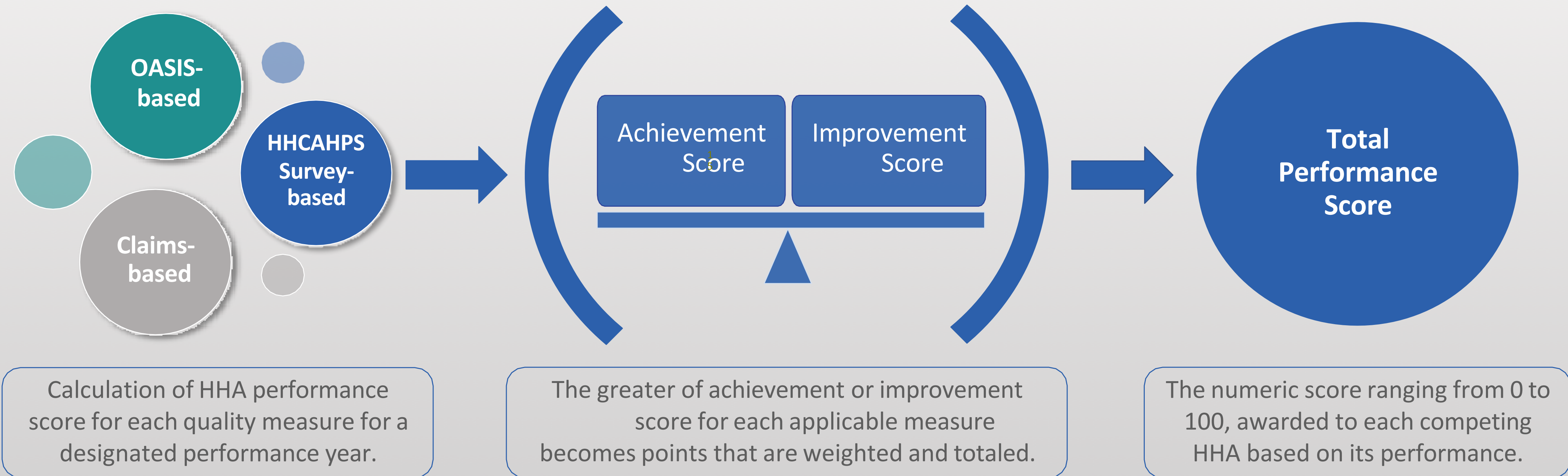
*Additional information about the HHVBP total performance scoring methodology will be made available during the CY 2022 Pre-implementation Year.*



# Purpose of the TPS

- To produce a TPS for each qualifying HHA based on its performance scores on each applicable measure included in the expanded HHVBP Model.
- CMS then uses the HHA's TPS to determine an annual distribution of value-based payment adjustments among HHAs in each cohort.

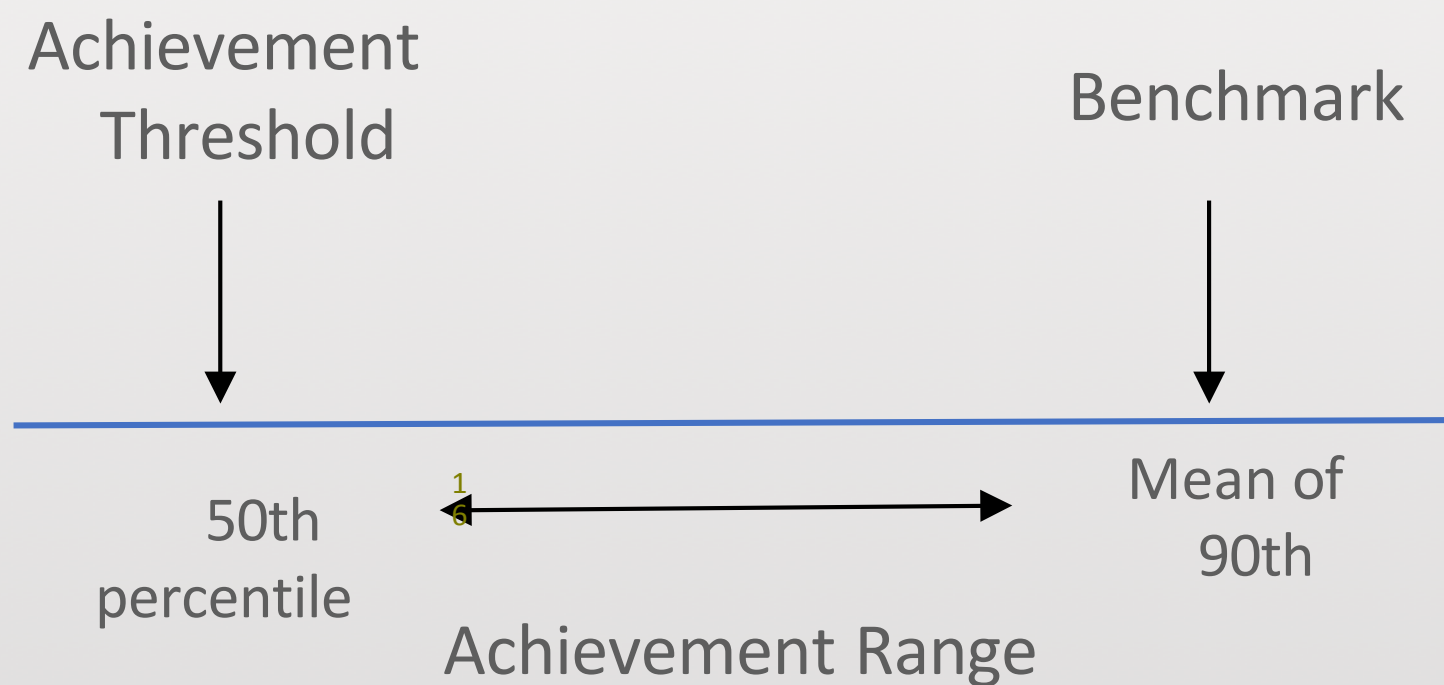
# Total Performance Scoring Methodology



# Achievement and Improvement Thresholds

## Achievement Threshold

The median (50th percentile) of Medicare-certified HHAs' performance on each quality measure during the designated baseline year, calculated separately for the larger and smaller-volume cohorts.



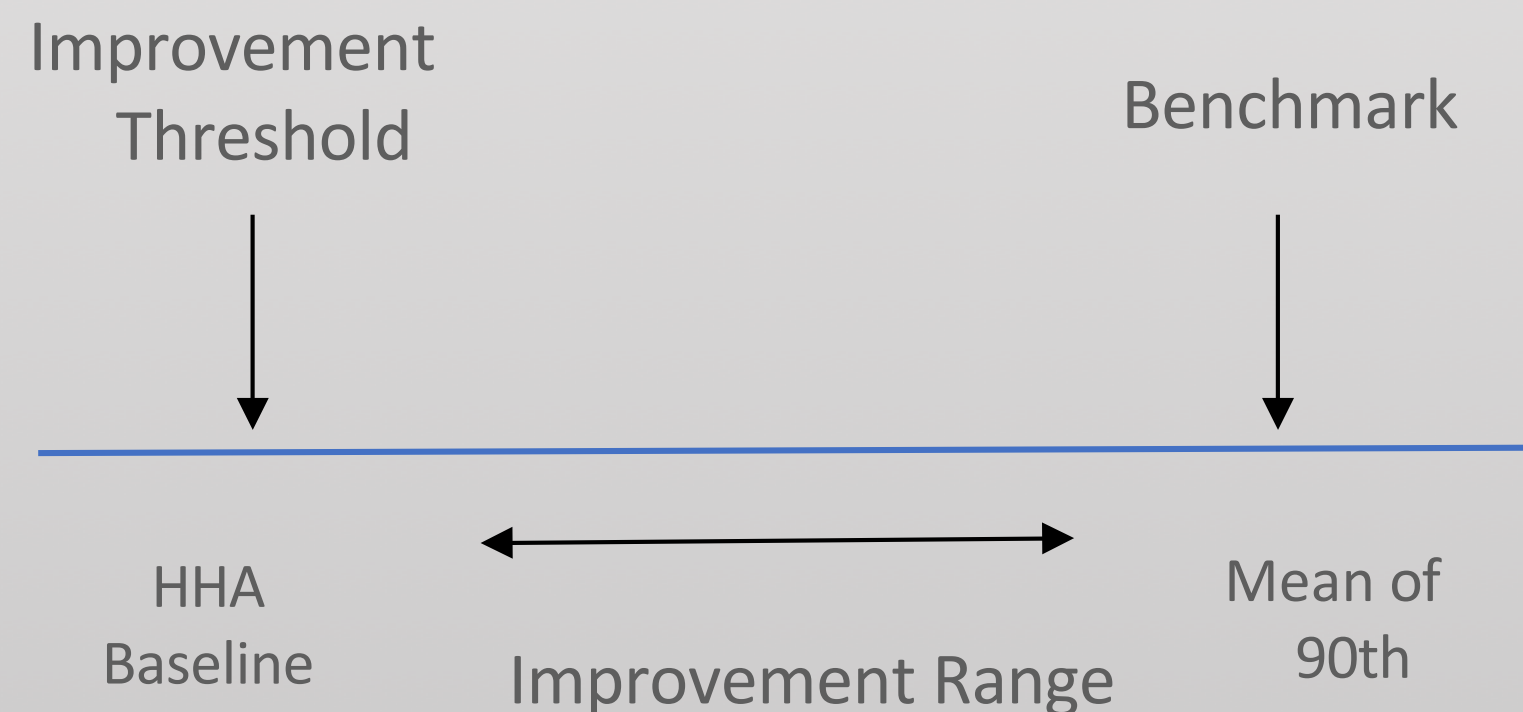
## Benchmark

The mean of the top decile (90th percentile) of all HHAs' performance scores on the specified quality measure during the baseline year, calculated separately for the larger and smaller-volume cohorts.

Used to calculate both the achievement score and the improvement score.

## Improvement Threshold

An individual HHAs' performance on an applicable measure during the HHA's designated baseline year.

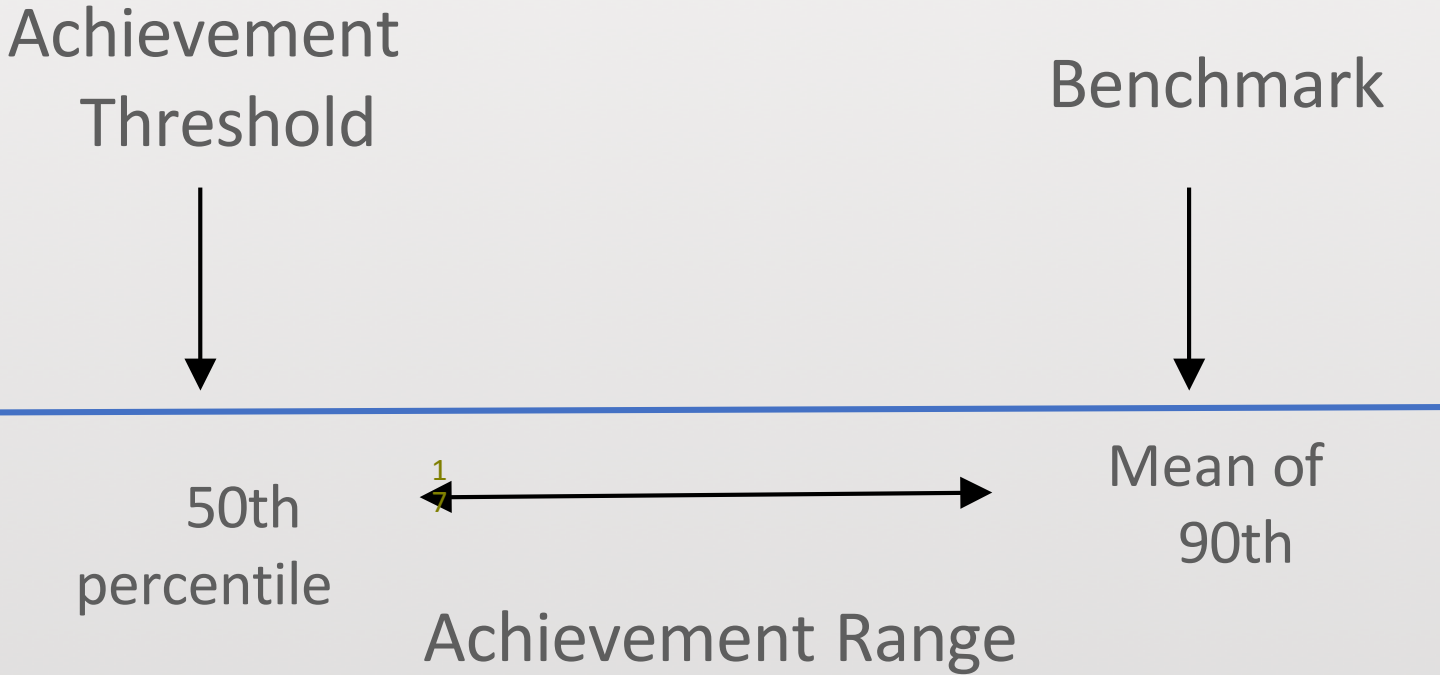




# Achievement and Improvement Thresholds

### Achievement Threshold

The median (50th percentile) of Medicare-certified HHAs' performance on each quality measure during the designated baseline year, calculated separately for the larger and smaller-volume cohorts.



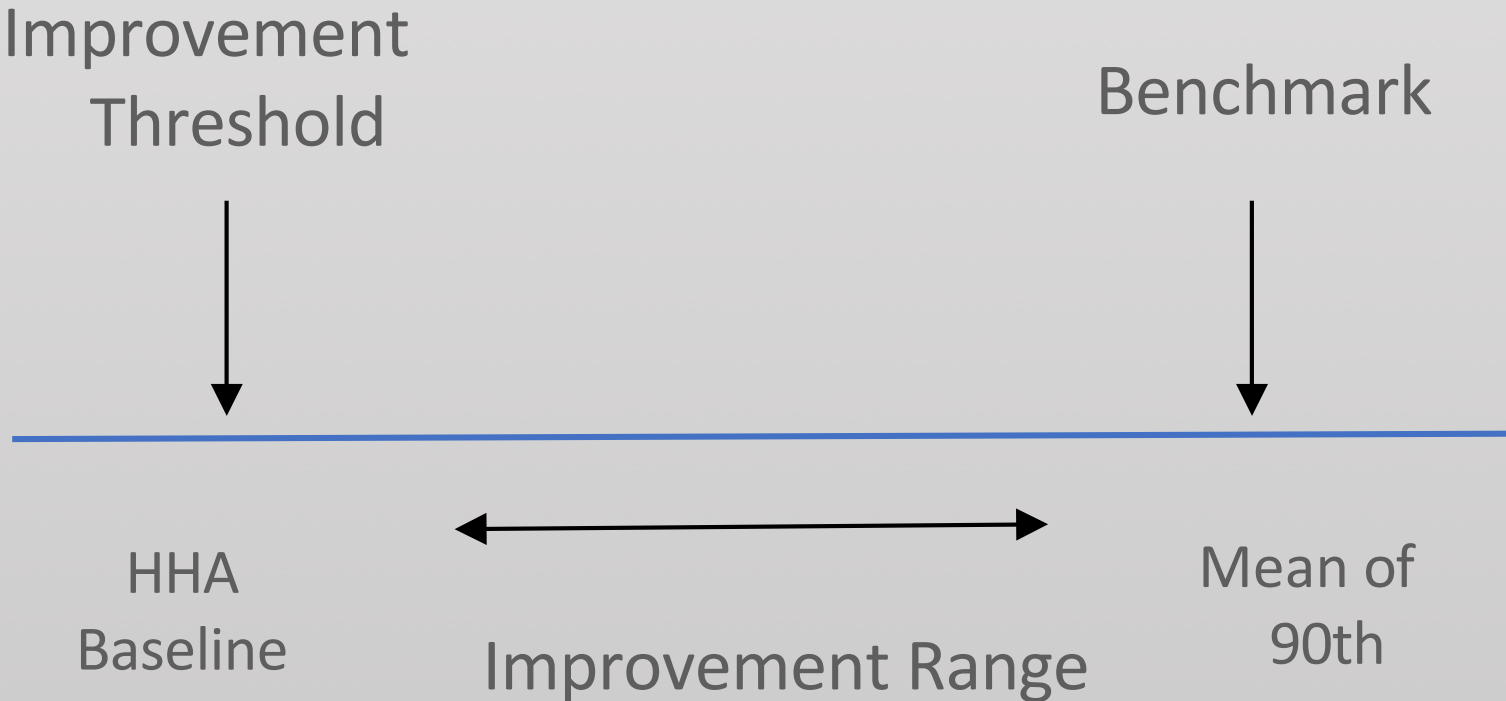
### Benchmark

The mean of the top decile (90th percentile) of all HHAs' performance scores on the specified quality measure during the baseline year, calculated separately for the larger and smaller-volume cohorts.

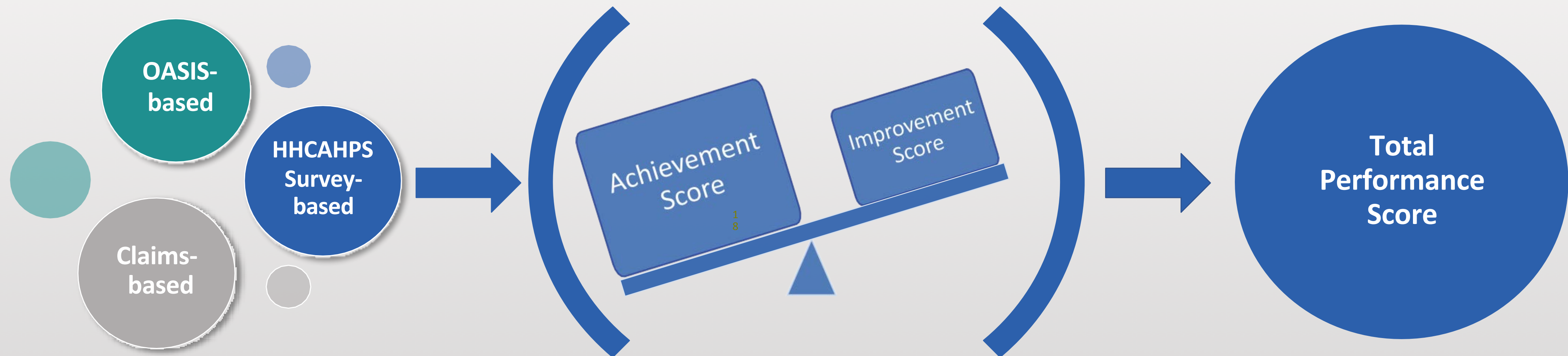
Used to calculate both the achievement score and the improvement score.

### Improvement Threshold

An individual HHAs' performance on an applicable measure during the HHA's designated baseline year.



# Example: Achievement > Improvement



Calculation of HHA performance score for each quality measure for a designated performance year.

The achievement score for the measure is greater than the improvement score for that measure, the achievement score for that measure translates into points that are weighted and are included in the total number of points from all measures

The numeric score ranging from 0 to 100, awarded to each competing HHA based on its performance.

# Example: Improvement > Achievement

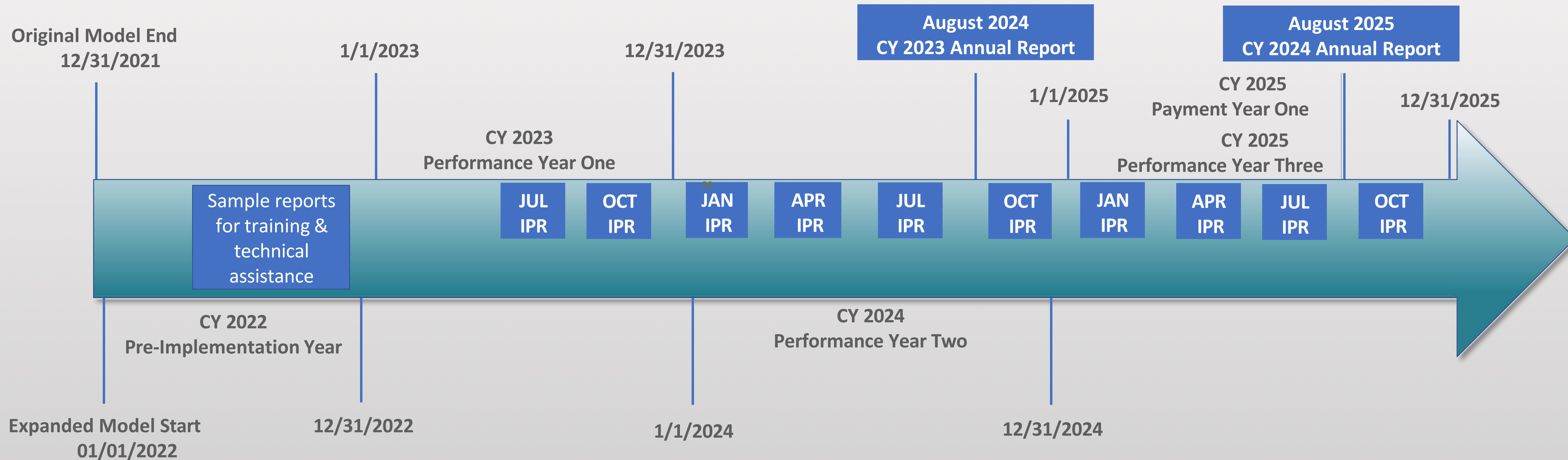



Calculation of HHA performance score for each quality measure for a designated performance year.

The improvement score for the measure is greater than the achievement score for that measure, the improvement score for that measure is included in the total number of points from all measures.

The numeric score ranging from 0 to 100, awarded to each competing HHA based on its performance.

# Expanded Model Timeline: Reports





# Lessons Learned from the Pilot States

With love, From Iowa

# What Got Measured, Did Improve!

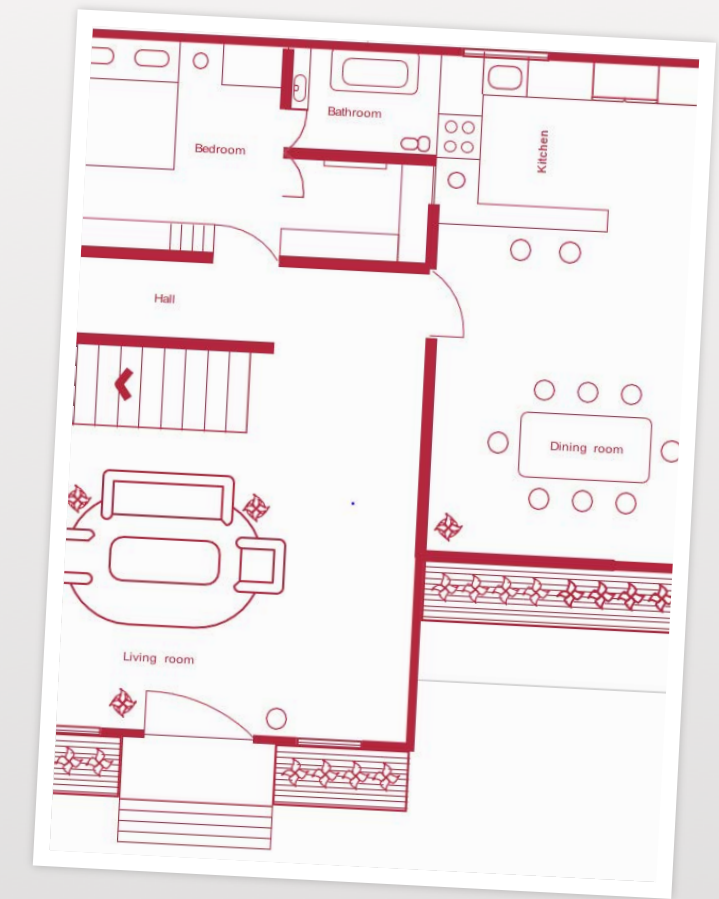
- Low hanging fruit was the OASIS items
  - Many agencies are well on their way to have high scores in the “Improvements” from 2019
  - Coaching, standardization, QA standard with a focused approach, tandem visits with those who do the most SOC/ROC, and standard “expect improvement model” for the DC assessments
- Focus on reducing hospitalizations by intense disease management and case management skills
  - Anticipation of needs, providing tools, requesting PRN medications and visits upfront to plan for changes, adding telehealth, adding calls prior to weekends, ensure appropriate disciplines are in the home (therapies?)
  - By increasing function, medication management and symptoms like dyspnea, the patient improves in end result outcomes, in ACH/ED use, and their experience with HH- impacting HHCAHPS scores
- CAHPS- What is going well, what is not going well. Focus training on customer service mindset- plus those areas that are lagging

# Do the OASIS Bases!

## Running the Bases is a Home Run for Accuracy!



- Greeting at the Door to Living Room/Dining room
  - Watch transitions, turns, uneven areas, ask if steps/stairs
  - Stand to sit/sit to stand with chair
- Assess: Techniques and devices used: Level of safety, were verbal cues, SBA/CG or physical assist needed to maintain safety?



\*\*\*As the clinician, you are constantly “inserting yourself” as the caregiver determining how much support is necessary to make the patient safe in the task.

\*\*\*You can not assume safety with devices you don't have- but you can provide assistance to see what level of “assistance” is needed.



# Assessment to Data

- The OASIS scoring = the holistic assessment + application of CMS guidance “**protocols\***”
  - This is DATA- not just assessment now!
  - May not always be “clinically intuitive”
- OASIS guidance will generally “funnel” you to the correct score to report
- Ensures interrater reliability makes the data MEANINGFUL
  - Avoid “Garbage in- Garbage out!”



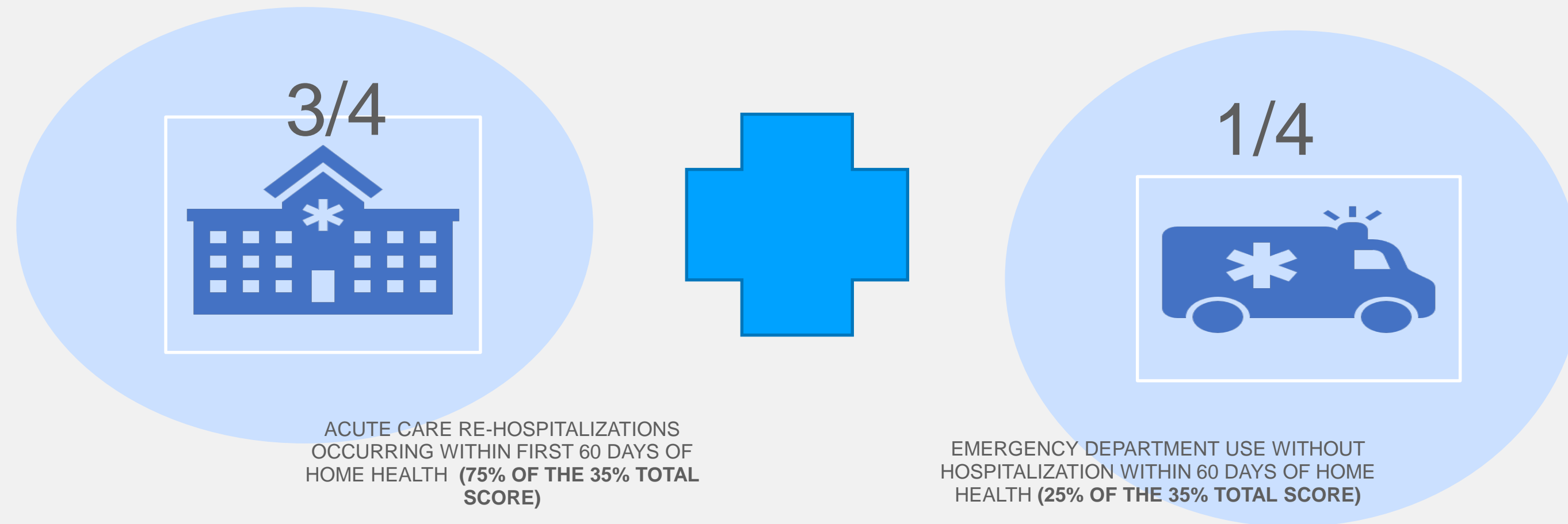
# Protocol: “Assistance” in OASIS

- PEOPLE POWER! Assistance is whenever the patient’s safe ability depends on another person for support
- Not limited to touch/manual labor!
- Includes cues, stand by, contact guard, etc
  
- PRO TIP: If you find you are stepping in to ensure the patient is safe- you just intervened- and that “assistance” should be noted. The easiest way to assess how much assistance is needed to be safe is to ask the patient to perform (when appropriate) and insert yourself as needed. The interventions you provided are a direct answer to the question!
  
- PRO TIP#2: Remember to take note of all of your subtle cues/interventions! Home Health Nurses have SUPER POWERS you don’t even take credit for!

# Protocol- Report “Ability” vs “Performance”

- The OASIS Score is to be based on SAFE ABILITY. (Ability always implies safety was considered)
- Many patients perform beyond their ability – which is risky. Some perform below their ability.
- If a patient’s safe ability is she/he can do a task with assist, but she/he doesn’t have the caregiver to assist them– they may choose to perform above their ability- or not perform the task. The patient’s innate ability did not change.
- If a physician orders a restriction- for example- bedrest– then the OASIS score, based on safe ability, is that the patient is bedfast- despite the patient ambulating to greet you at the door.

# Claims-Based Measures- 35%



# Review the Data...

- WHY do our patients return to the hospital?
  - Specific disease trends?
  - Inadequate education/management of expectations?
  - Provider tells them to go to ER as the “easy” route
- WHEN do our patients return to the hospital?
  - Trend in day of week? Time of day?
  - Within first five days? 30 days? 60 days?

# Could This Be as Simple as Case Management?

- Case managers are not just a task- oriented visit nurse
  - Knows the patients
  - Notes subtle symptoms
  - Communicates routinely with patient/family/physician's office
  - Anticipates needs
    - What would provide control in this patient's situation?
      - PRN orders for visits?
      - PRN medication for uptick in s/s?
      - Green/yellow/red tools?
      - Telephone checkins for at risk

# Awareness is First Step

- Thoughts?
- Can you identify top patients that you feel may be at risk currently?
  - What are you currently doing?
  - What could be next steps?



# HHCAHPS Measures- the Last 30%!

Patient and Caregiver Experience”, consisting of questions from:

- Care of Patients/Professional Care
- Communications between Providers and Patients
- Specific Care Issues
- Overall Rating
- Willingness to Recommend



# How do YOU Rate?

- Review your HHCAHPS Scores
  - Where are your gaps and opportunities?
  - Tools and boundaries to improve
  - Customer service mindset
  - What are YOUR goals personally?





*Questions?*



- **Annette Lee RN MS, HCS-D, COS-C**
- **Zuzana Ton, MHSA**



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# Contact Us

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