

Review of the 2024 Final Rule

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Home Health Fundamentals'
2023 Winter Workshop

That time of year... FINAL Rule!

1.) Payment adjustments

Yearly adjustment increase, plus PDGM recalibration and rebasing of wage index

2.) HHQRP changes

3.) HHVBP changes

4.) Coverage changes

FINAL RULE (Finally!) Published

- CMS published the final rule early November 2023. **The good news: 2024 brings a 0.8% increase in Medicare standard payments!**

The bad news: CMS is still convinced that they are “overpaying” in PDGM and plan on future cuts

CMS also adjusted some of the co-morbidity scores, and the functional scores, but should be “budget neutral”

In other news: As proposed, the HHQRP and the HHVBP will discontinue several measures in 2025 and will be adding “new and improved” measures!

Discharge to community: OASIS M2420 to Claims based

Functional scoring changes: OASIS M1800s to OASIS GGs “as expected”

Hospitalization scoring: ACH in first 60 days to PPH for entire stay

October Quarterly Refresh: Care Compare Update- includes PPH!

How often home health patients had to be admitted to the hospital

↓ Lower numbers are better

This measure was included in the quality star rating calculation.

12.3%

National average: 14.1%
Iowa average: 14.4%



How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital

↓ Lower numbers are better

20.1%

National average: 11.9%
Iowa average: 14.8%



How often patients remained in the community after discharge from home health

↑ Higher percentages are better

Better than national rate

82.7%
National average: 76.6%



How often patients were re-admitted to the hospital for a potentially-preventable condition after discharge from home health

↓ Lower rates are better

Same as national rate

3.5%
National average: 3.9%



How often patients were admitted to the hospital for a potentially preventable condition while receiving home health care

↓ Lower rates are better

Same as national rate

10.6%
National average: 10%



New DCTC

New PPH

OASIS Manual UPDATED!

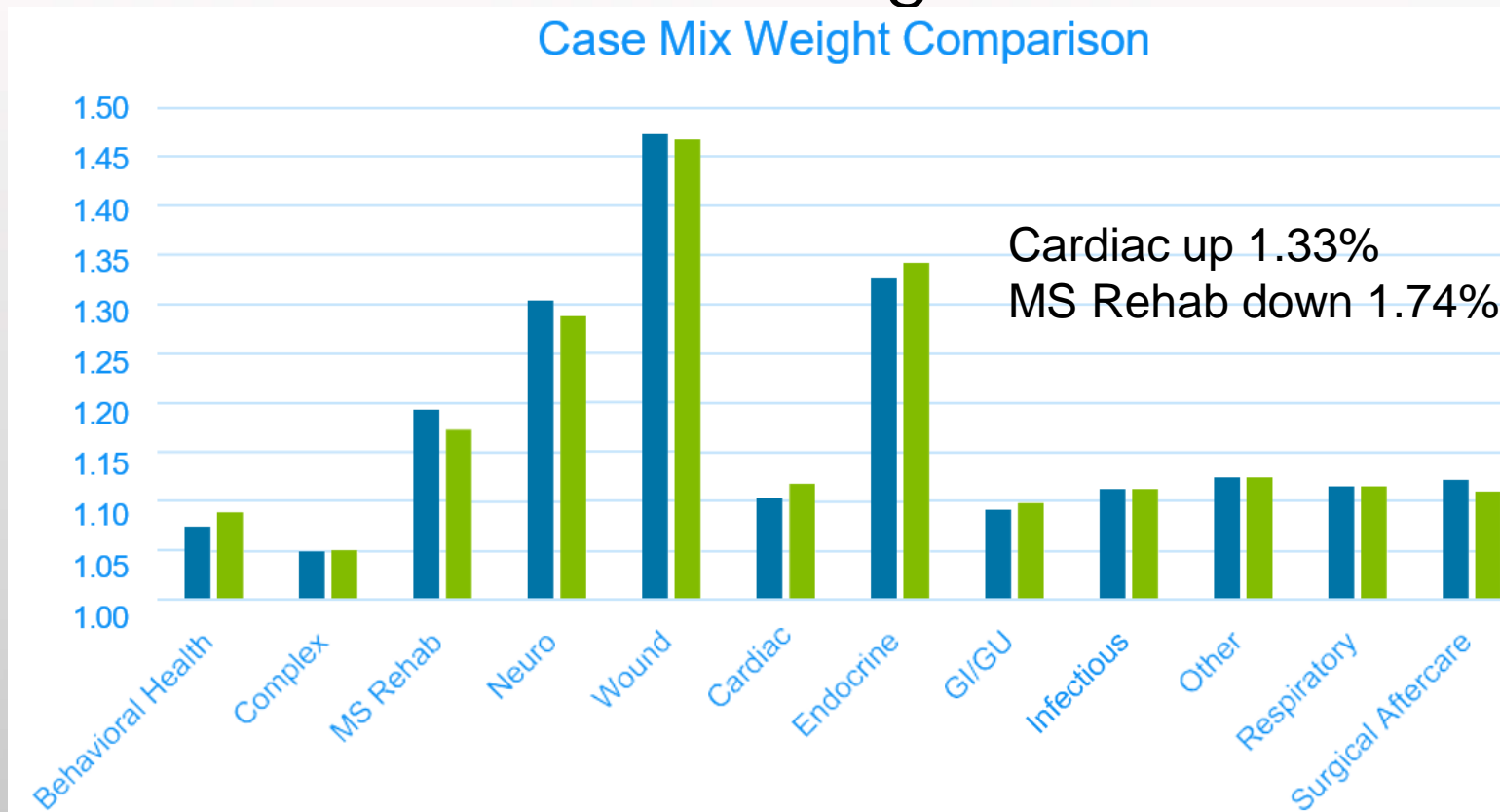
- CMS released on the OASIS CMS website November 7th.
- <https://www.cms.gov/medicare/quality/home-health/oasis-user-manuals>
- Scroll down to “Downloads”
- Download and share the “OASIS Updated 2024” manual.
- Also a “change table” to view what the additions/changes entailed

New OASIS January 1, 2025

- Removal of the “Discharge goals” in GG0130 and GG0170
 - Removal of M0110- Episode timing
 - Removal of M2200- Therapy need
 - Addition of the COVID vaccine measure question-
-
- Specific specifications under “Downloads” at:
<https://www.cms.gov/medicare/quality/home-health/home-health-quality-measures>

Recalibration

- CMS will also "recalibrate" the case-mix items to be more reflective of costs for agencies.



Little changes to functional points...

OASIS Item	OASIS Response	CY2023	CY2024
M1800	0 or 1	0	0
	2 or 3	3	3
M1810	0 or 1	0	0
	2 or 3	5	5
M1820	0 or 1	0	0
	2	4	3
	3	12	11
M1830	0 or 1	0	0
	2	2	0
	3 or 4	10	7
	5 or 6	17	14
M1840	0 or 1	0	0
	2, 3 or 4	6	6
M1850	0	0	0
	1	3	3
	2,3,4 or 5	6	6
M1860	0 or 1	0	0
	2	6	6
	3	5	4
	4,5, or 6	20	20
M1033	4 or more items checked	10	11

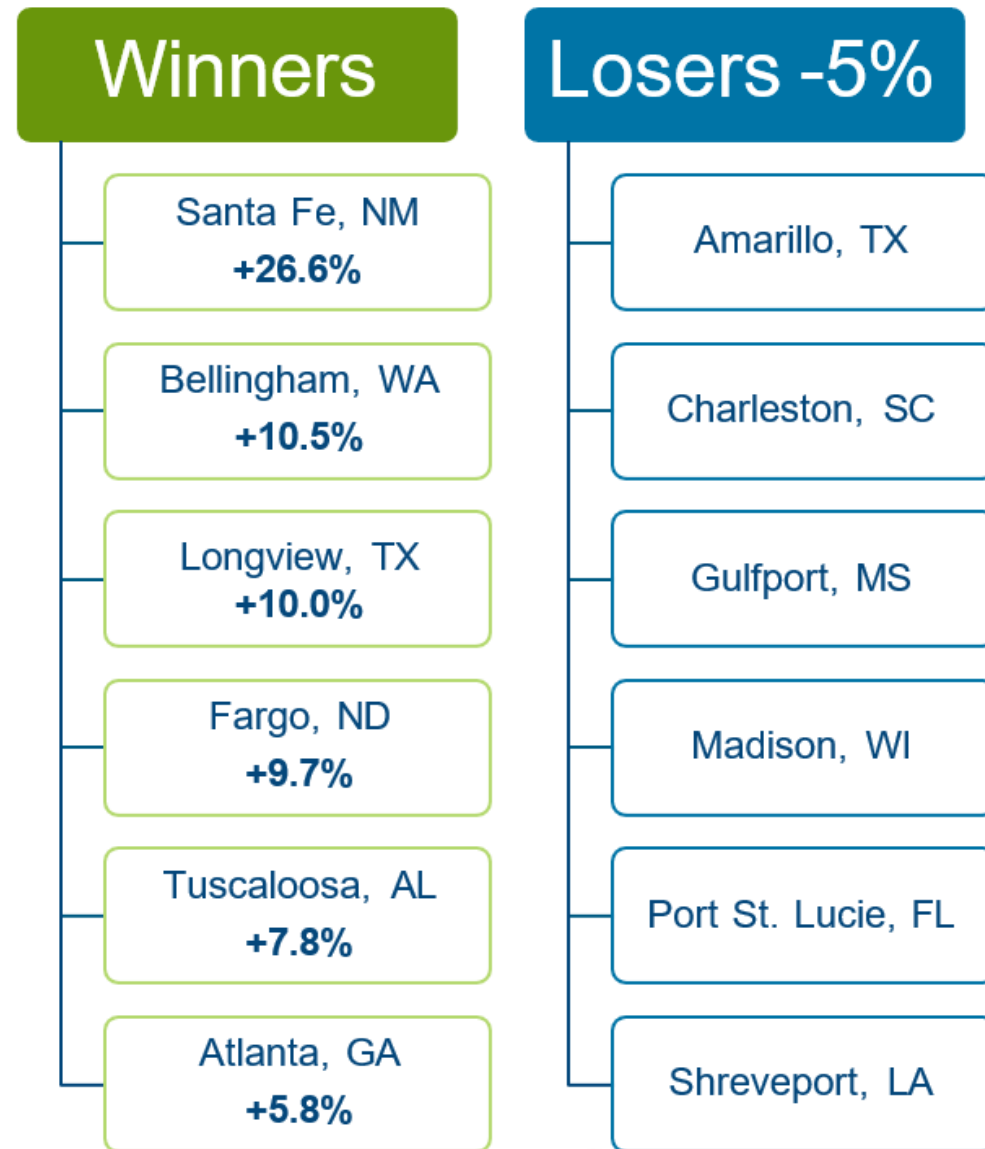
**Easier to get
to
thresholds...**

Clinical Group	Low 2023	Low 2024	Med 2023	Med 2024	High 2023	High 2024
MS Rehab	0 - 33	0-28	34 - 45	29-41	46+	42+
Neuro Rehab	0 - 35	0-34	36 - 51	35-49	52+	50+
Wound	0 - 33	0-28	34 - 51	29-49	52+	50+
Complex Nursing	0 - 33	0-28	34 - 54	29-52	55+	53+
Behavioral Health	0 - 31	0-28	32 - 43	29-41	44+	42+
MMTA Aftercare	0 - 33	0-28	34 - 43	29-39	44+	40+
MMTA Cardiac	0 - 31	0-28	32 - 43	29-41	44+	42+
MMTA Endocrine	0 - 30	0-27	31 - 43	28-39	44+	40+
MMTA GI/GU	0 - 33	0-31	34 - 49	32-46	50+	47+
MMTA Infection	0 - 33	0-28	34 - 45	29-43	46+	44+
MMTA Respiratory	0 - 33	0-29	34 - 46	30-44	47+	45+
MMTA Other	0 - 32	0-28	33 - 43	29-41	44+	42+



Rebasing

- Wage index for your county's CBSA may have changed (check for your county in the Rule!
- Some winners- some losers
 - Max loss is 5%, per this maximum established loss from last year's rule





HHQRP Changes- Removing Process Measure

Admission and Discharge Functional Assessment and Care Plan that Addresses Function

ATTENTION! This means no more column 2 "Discharge goal" for GG0130 and GG0170!! That's correct-- we will no longer be required to report a Discharge Goal (that is, GG0130, Column 2 or GG0170, Column 2) on the OASIS beginning with patients admitted on April 1, 2024 (and this column will be removed at next OASIS revision).

HHQRP Changes- Adding

- **CMS is proposing the public reporting of four measures:**

(1) Discharge Function; CMS drives this based on our discharge GG self care and mobility items, and compares your patient's improvement to what was statistically expected for improvement, based on a number of other factors.

- (NOTE: Important to lessen our use of the "not attempted responses" now! Try to decrease your 07, 09, 10 and 88 scores as much as accurately possible!) CMS will "fill in the blank" if you use an NA code!

(2) Transfer of Health (TOH) Information to the Provider — Post-Acute Care (PAC) Measure (TOH-Provider); (based on the current transfer OASIS item)

(3) Transfer of Health (TOH) Information to the Patient — Post-Acute Care (PAC); (based on the current DC OASIS item)

(4) COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date. A new OASIS item will have to be added, expected in January of 2025, simply asking "Is the patient up to date on COVID-19 vaccination-- __ Yes __No."

- TEP voted "no"- CMS moved forward with measure anyway for data purposes only



Discharge Function Score for Home Health Agencies (HHAs)

Technical Report



June 2023

Submitted to:
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Contract No. 75FCMC18D0014, Task Order 75FCMC19F0001

Submitted by:
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6130 Executive Boulevard
Rockville, MD 20852

When and what

- **Measure Time Period** This measure is calculated using 12 months (four quarters) of data. All HH episodes with a discharge date that falls within this target period, except those that meet the exclusion criteria (refer to Section 3.3.2 for details), are included in the measure.
- **Data Source** This measure uses GG data from the OASIS. (NOTE- this is the first time we are using GG data in a end result quality measure!!)
- **Denominator** The denominator is the total number of HH episodes with an OASIS record in the measure target period, which do not meet the exclusion criteria.

Exclusions

- Patients with an incomplete stay. Patients with incomplete stays include patients who are unexpectedly discharged to an acute care setting (Short-stay Acute Hospital, Critical Access Hospital, Inpatient Psychiatric Facility, or Long-term Care Hospital); patients who die; and patients with an HH episode that is less than 3 days
- Patient is in a coma, persistent vegetative state, has complete tetraplegia, locked-in state, severe anoxic brain damage, cerebral edema, or compression of the brain.
- Patient is younger than 18 years: Age in years is calculated based on the truncated difference between admission date and birth date, i.e., the difference is not rounded to nearest whole number
- Patient is discharged to hospice (home or institutional facility)

Items Used

Item	Item Description
GG0130A	Eating
GG0130B	Oral Hygiene
GG0130C	Toileting Hygiene
GG0170A	Roll Left and Right
GG0170C	Lying to Sitting on Side
GG0170D	Sit to Stand
GG0170E	Chair/Bed-to-Chair Transfer
GG0170F	Toilet Transfer
GG0170I	Walk 10 Feet
GG0170J	Walk 50 Feet with 2 Turns
GG0170R	Wheel 50 Feet with 2 Turns

CMS reviews the scores

- Measure is only to view scores (no more simple compare and contrast SOC/ROC to DC) from the DC and compare to “expected discharge function” for this type of patient
- Will determine if this looks like the “Expected” outcomes- based on this type of patient from other OASIS and claims data
- If the GG item is scored “not assessed” with a 09, 88, 07 or 10, then CMS will provide a “statistical imputation” (or educated guess) what that score may have been upon assessment if the clinician could have rated the patient on this item
- TAKEAWAY- limit your use of not assessed codes or CMS will score for you!

“This type of patient”... how do they know?

- Age at time of SOC/ROC
- Admission functional score (GGs added up- give score 10-60)
 - If NA- CMS will impute here too
- Prior surgery
- Prior functional level/device use
- Pressure ulcers
- Cognitive functioning
- Incontinence
- Availability of Assistance and Living Arrangements
- Admission source

More on how CMS knows...

- • Body Mass Index These covariates indicate whether the patient has a low BMI ($12 \leq \text{BMI} \leq 19$) or high BMI (>50).
- • Risk for hospitalization These covariates indicate a history of falls, multiple hospitalizations, multiple ER visits, decline in status, non-compliance, or polypharmacy prior to SOC/ROC.
- • Confusion These covariates indicate whether the patient has moderately frequent or severely frequent confusion in the 14 days prior to SOC/ROC.
- • Vision These covariates indicate whether the patient has partial or severely impaired vision.
- • Medication Management Needs These covariates indicate whether the patient needs medication management assistance for oral or injectable medication.
- • Supervision and Safety Sources of Assistance These covariates indicate whether the patient needs and has non-agency caregivers with proper training
- And, specific co-morbidities...

Shew... feels like a bit of a gamble?



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But, there may be less gaming
... that is CMS intent

HHVBP Changes- Remove

- **CMS is removing five quality measures from HHVBP:**

(1) OASIS-based Discharge to Community;

(2) OASIS-based Total Normalized Composite Change in Self-Care (TNC Self-Care);

(3) OASIS-based Total Normalized Composite Change in Mobility (TNC Mobility);

(4) Claims-based Acute Care Hospitalization During the First 60 Days of Home Health Use (ACH); and

(5) Claims-based Emergency Department Use without Hospitalization During the First 60 Days of Home Health Use (ED Use).

HHVBP Changes- Add

- **In place of these retired measures, CMS is proposing to add the following measures:**
 - (1)** The claims-based Discharge to Community-Post Acute Care (DTC-PAC) Measure for Home Health Agencies;
 - (2)** The OASIS-based Discharge Function Score (DC Function) measure; and
 - (3)** The claims-based Home Health Within-Stay Potentially Preventable Hospitalization (PPH) measure.

Expanded Home Health Value-Based Purchasing (HHVBP) Calendar Year (CY) 2025 Measures & Reports At a Glance

Calendar Year (CY) 2025 is the third performance year for the expanded HHVBP Model. Home health agency (HHA) performance for the CY 2025 applicable measure set will determine performance adjustments that will apply to CY 2027 Medicare fee-for-service (FFS) claims. The Model year for the CY 2024 performance year is CY 2023 for all measures *except* Discharge to Community (DTC-PAC). For the DTC-PAC measure, the Model baseline year is CY 2022.

CY 2025 Performance Year: Applicable Measure Set and Measure Weights

Measure Category	CY 2025 Performance Year Applicable Measures	Measure Weight
		Larger-Volume Cohort
OASIS-based Measures	Improvement in Dyspnea	6.00%
	Improvement in Management of Oral Medications	9.00%
	Discharge Function Score (DC Function) GG	20.00%
	Sum of OASIS-based Measures	35.00%
	Claims-based Measures	Home Health within-stay Potentially Preventable Hospitalization (PPH)
Discharge to Community – Post Acute Care (DTC-PAC) New DTC		9.00%
Sum of Claims-based measures		35.00%
HHCAHPS Survey-based Measures	Care of Patients	6.00%
	Communication Between Providers and Patients	6.00%
	Specific Care Issues	6.00%
	Overall Rating of Home Health Care	6.00%
	Willingness to Recommend the Agency	6.00%
	Sum of HHCAHPS Survey-based measures	30.00 %
All	Sum of All Measures	100.00 %

Expanded Home Health Value-Based Purchasing (HHVBP) Calendar Year (CY) 2024 Measures & Reports At a Glance

Calendar Year (CY) 2024 is the second performance year for the expanded HHVBP Model. Home health agency (HHA) performance for the CY 2024 applicable measure set will determine performance adjustments that will apply to CY 2026 Medicare fee-for-service (FFS) claims. The Model year for the CY 2024 performance year is CY 2022.

CY 2024 Performance Year: Applicable Measure Set and Measure Weights

Measure Category	CY 2024 Performance Year Applicable Measures	Measure Weight
		Larger-Volume Cohort
OASIS-based Measures	Discharged to Community Old DTC	5.83%
	Improvement in Dyspnea	5.83%
	Improvement in Management of Oral Medications	5.83%
	Total Normalized Composite Change in Mobility (TNC Mobility)	8.75%
	Total Normalized Composite Change in Self-Care (TNC Self-Care) 17.5%	8.75%
	Sum of OASIS-based Measures	35.00%
Claims-based Measures	Acute Care Hospitalization (ACH)	26.25%
	Emergency Department Use Without Hospitalization (ED Use)	8.75%
	Sum of Claims-based measures	35.00%
HHCAHPS Survey-based Measures	Care of Patients	6.00%
	Communication Between Providers and Patients	6.00%
	Specific Care Issues	6.00%
	Overall Rating of Home Health Care	6.00%
	Willingness to Recommend the Agency	6.00%
	Sum of HHCAHPS Survey-based measures	30.00 %
All	Sum of All Measures	100.00 %

Potentially Preventable Hospitalizations

- CMS developed a new measure regarding hospitalizations and observation stays that would be more meaningful and impactful for home health agencies
- New PPH and potentially preventable observation stays (PPOBS) measures uses a list of diagnoses that home health most typically could have an impact in with good disease management, and case management that anticipates the needs of the patient
- <https://www.cms.gov/files/document/proposed-pph-measure-specifications-cy22-hh-qrp-nprm.pdf>
- FINALIZED in the Home Health Final Rule to begin collecting and reporting 1/1/2023
- PROPOSED in the HH Proposed Rule to take the place of current claims based measures of ACH and ED use
- (**Note- Five star still uses old measure and no proposal to change at this time)

The Math...

- This measure calculates a risk-adjusted PPH rate for each HHA. This is derived by first calculating a standardized risk ratio – the predicted number of unplanned, potentially preventable hospital admissions or observation stays at the HHA divided by the expected number of admissions or observation stays for the same patients if treated at the average HHA.
- The standardized risk ratio is then multiplied by the mean potentially preventable admission or observation stay rate in the population (i.e., all Medicare FFS patients included in the measure) to generate the HHA-level standardized hospitalization rate of potentially preventable hospitalization.
- Measure uses 12-month CY data- and includes all Medicare stays, using full dates of service, plus one day after discharge.

The Exclusions

1) Stays where the patients are less than 18 years old.

- Rationale: Patients under 18 years old are not included in the target population for this measure. Pediatric patients are relatively few and may have different patterns of care from adults.

2) Stays where the patients were not continuously enrolled in Part A FFS Medicare for the 12 months prior to the HH admission date through the end of the home health stay.

- Rationale: The adjustment for certain comorbid conditions in the measure requires information on acute inpatient claims for one year prior to the HH admission, and hospitalizations and observation stays must be observable in the observation window following discharge. Patients without Part A coverage or who are enrolled in Medicare Advantage plans will not have complete claims in the system.

3) Stays that begin with a Low Utilization Payment Adjustment (LUPA) claim.

- Rationale: Home health stays designated as LUPAs are excluded because it is unclear that the initial HHA had an opportunity to impact the patient's health outcomes.

More Exclusions...

4) Stays where the patient receives service from multiple agencies during the home health stay.

- Rationale: These home health stays are excluded because it is unclear that the initial HHA had an opportunity to impact the patient's health outcomes.

5) Stays where the information required for risk adjustment is missing.

- Missing beneficiary's birthday information;
- Beneficiary has gender other than male or female;
- Missing payment authorization code information;
- Beneficiary has Medicare Status Code other than the following:
 - o 10: Aged without ESRD
 - o 11: Aged with ESRD
 - o 20: Disabled without ESRD
 - o 21: Disabled with ESRD
 - o 31: ESRD only

Selecting Diagnoses for “Preventable”

CMS sought clinical and TEP advice on why some rehospitalizations/observation stays may have been prevented

- 1) Inadequate management of chronic conditions
- 2) Inadequate management of infections
- 3) Inadequate management of other unplanned events
- 4) Inadequate injury prevention

Excluded Diagnoses

- This measure is focused on inpatient admissions or observation stays that are potentially preventable (PP)
- **Planned** admissions are not counted in the numerator
- Planned inpatient admissions and observation stays are defined by the definition used for the Hospital Wide Readmission¹⁵ and “Potentially Preventable Within Stay Readmission Measure for Inpatient Rehabilitation Facilities¹⁶ measures”
 - <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-AssessmentInstruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Program-Measures-Information-.html>
- If an inpatient or outpatient claim contains a code for a procedure that is frequently a planned procedure, then that inpatient admission or observation stay is designated to be a planned inpatient admission or observation stay, and will not impact PPH

Risk Adjustment on the PPH Score

- Demographics:
 - Age, gender and “enrollment status” (Aged, disabled or ESRD)
 - ADL score: CMS using a composite of a number of ADLs from M1800s
- Proximal Hospitalizations:
 - Because beneficiaries who enter home health care from prior proximal hospitalizations may have different health statuses, this model takes into account beneficiaries’ immediate prior care setting, length of stay in proximal care (1-7 or 8 or more days) principal diagnoses, and procedures.
- Other care in last year
 - Number of: Acute discharges, ED visits, SNF visits, IRF and LTCH visits

Diagnoses Used for PPH (pp 21-37)

<https://www.cms.gov/files/document/proposed-pph-measure-specifications-cy22-hh-qrp-nprm.pdf>

Table 1-1. Preliminary List of Conditions for Defining Potentially Preventable Admissions or Observation Stays with ICD-10 Codes (continued)

Conditions	Subconditions	ICD-10-CM	ICD-10-CM Description
Chronic obstructive pulmonary disease (COPD), continued	COPD* (PQI 05), continued	J42	Unspecified chronic bronchitis
		J430	Unilateral pulmonary emphysema [MacLeod's syndrome]
		J431	Panlobular emphysema
		J432	Centrilobular emphysema
		J438	Other emphysema
		J439	Emphysema, unspecified
		J440	Chronic obstructive pulmonary disease with acute lower respiratory infection
		J441	Chronic obstructive pulmonary disease with (acute) exacerbation
		J449	Chronic obstructive pulmonary disease, unspecified
		J470	Bronchiectasis with acute lower respiratory infection
		J471	Bronchiectasis with (acute) exacerbation
Congestive heart failure (CHF)		I09.81	Rheumatic heart failure
		I11.0	Hypertensive heart disease with heart failure
		I11.0	Hypertensive heart disease with heart failure
		I11.0	Hypertensive heart disease with heart failure

Condition “Groups” in PPH Measure

1. Adult Asthma
2. CHF
3. COPD
4. Diabetes complications
5. Hypo/Hypertension
6. Influenza
7. Bacterial pneumonia
8. UTI/Kidney infection
9. C.Diff
- 10. Septicemia
- 11. Dehydration/Electrolyte issues
- 12. Skin/Subq Infections
- 13. Aspiration pneumonitis
- 14. Arrhythmia
- 15. Intestinal impaction
- 16. Pressure Ulcers

Timeframes...

- CMS is implementing all changes to the applicable measure sets discussed in this rule beginning with the CY 2025 performance (calendar) year, thus all changes will affect the same payment year beginning with the CY 2027 payment year.

Since we would then have two less measures, CMS will adjust the weights for the measures in the OASIS-based and claims-based measure categories starting in CY 2025.

Take aways...

- Know the changes
- Review your current data- Medicare payments to calculate potential loss in 2024, CBSA wage index amount, case mix, functional domain and diagnoses impacts
- Track and review rates for Medicare patient hospitalizations and observations throughout care
- Plan how to impact these areas of need, including continued OASIS training with a focus on GG items as well as the M1800s, M1400, M2020 all impacting PDGM or 5-Star

October IPR HHVBP Report

Keep an electronic folder of each quarter!

Note the quartiles are moving targets



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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.

- CMS will measure each agency's quality measure percentages against the rest of the cohort
- To have a positive outcome, the agency score must meet the "Achievement threshold", or 50th percentile
- To gain the full 10 points for the measure, the agency score must meet the "Benchmark", or 90th percentile

Achievement

Measure	Performance Year Data Period [a] (12-Month End Date)	Your HHA's Performance Year Measure Value [b]	Your Cohort's Achievement Threshold [c]	Your Cohort's Benchmark [d]	Your HHA's Achievement Points [e]	Maximum Possible Achievement Points
OASIS-based Measures						
Discharged to Community	06-30-2023	61.385	72.652	84.249	0.000	10.000
Improvement in Dyspnea	06-30-2023	86.321	86.305	98.512	0.013	10.000
Improvement in Management of Oral Medications	06-30-2023	74.364	80.990	97.899	0.000	10.000
Total Normalized Composite (TNC) Change in Mobility [f]	03-31-2023	0.723	0.744	1.011	0.000	10.000
Total Normalized Composite (TNC) Change in Self-Care [g]	03-31-2023	1.977	2.123	2.733	0.000	10.000
Claims-based Measures						
Acute Care Hospitalizations	03-31-2023	16.103	13.907	7.773	0.000	10.000
Emergency Department Use Without Hospitalization	03-31-2023	10.946	11.782	4.689	1.179	10.000
HHCAHPS Survey-based Measures						
Care of Patients	03-31-2023	84.687	89.254	94.448	0.000	10.000
Communications Between Providers and Patients	03-31-2023	77.172	86.626	93.036	0.000	10.000
Specific Care Issues	03-31-2023	67.849	82.048	91.198	0.000	10.000
Overall Rating of Home Health Care	03-31-2023	83.213	85.941	94.337	0.000	10.000
Willingness to Recommend the Agency	03-31-2023	69.706	79.986	91.202	0.000	10.000

Improvement Threshold

Improvement Threshold

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

- The HHA data will also be compared to the same agency's baseline data. The current baseline year is 2022 for improvement.
- Points will be awarded based on how much improvement has been made. The top points (90th percentile for improvement) will be awarded 9 points, instead of the 10 for achievement

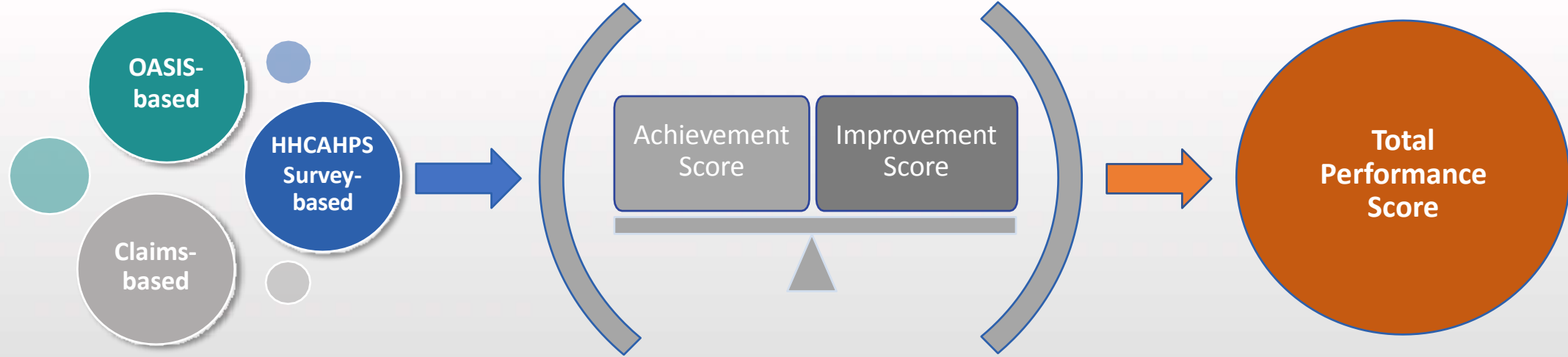
* An HHA must have sufficient data to establish their HHA baseline year for a particular measure.

Improvement Points

Measure	Performance Year Data Period [a] (12-Month End Date)	Baseline Year Data Period [b] (12-Month End Date)	Your HHA's Performance Year Measure Value [c]	Your HHA's Improvement Threshold [d]	Your Cohort's Benchmark [e]	Your HHA's Improvement Points [f]	M P Imp
OASIS-based Measures							
Discharged to Community	06-30-2023	12-31-2022	61.385	59.174	84.249	0.794	
Improvement in Dyspnea	06-30-2023	12-31-2022	86.321	76.831	98.512	3.939	
Improvement in Management of Oral Medications	06-30-2023	12-31-2022	74.364	62.642	97.899	2.992	
Total Normalized Composite (TNC) Change in Mobility [g]	03-31-2023	12-31-2022	0.723	0.673	1.011	1.331	
Total Normalized Composite (TNC) Change in Self-Care [h]	03-31-2023	12-31-2022	1.977	1.869	2.733	1.125	
Claims-based Measures							
Acute Care Hospitalizations	03-31-2023	12-31-2022	16.103	15.036	7.773	0.000	
Emergency Department Use Without Hospitalization	03-31-2023	12-31-2022	10.946	11.731	4.689	1.003	
HHCAHPS Survey-based Measures							
Care of Patients	03-31-2023	12-31-2022	84.687	85.194	94.448	0.000	
Communications Between Providers and Patients	03-31-2023	12-31-2022	77.172	81.852	93.036	0.000	
Specific Care Issues	03-31-2023	12-31-2022	67.849	68.705	91.198	0.000	
Overall Rating of Home Health Care	03-31-2023	12-31-2022	83.213	84.194	94.337	0.000	
Willingness to Recommend the Agency	03-31-2023	12-31-2022	69.706	73.158	91.202	0.000	

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Total Performance Scoring Methodology: Overview



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

The greater of achievement or improvement score for each applicable measure becomes points that are weighted and totaled.

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

Care Points

Measure	Sufficient Data for Measure Inclusion?	Your HHA's Achievement Points	Your HHA's Improvement Points	Your HHA's Care Points [a]	Your HHA's Percentile Ranking Within Your HHA's Cohort [b]
OASIS-based Measures					
Discharged to Community	Yes	0.000	0.794	0.794	25-49
Improvement in Dyspnea	Yes	0.013	3.939	3.939	50-74
Improvement in Management of Oral Medications	Yes	0.000	2.992	2.992	50-74
Total Normalized Composite (TNC) Change in Mobility	Yes	0.000	1.331	1.331	50-74
Total Normalized Composite (TNC) Change in Self-Care	Yes	0.000	1.125	1.125	25-49
Claims-based Measures					
Acute Care Hospitalizations	Yes	0.000	0.000	0.000	<25
Emergency Department Use Without Hospitalization	Yes	1.179	1.003	1.179	50-74
HHCAHPS Survey-based Measures					
Care of Patients	Yes	0.000	0.000	0.000	<25
Communications Between Providers and Patients	Yes	0.000	0.000	0.000	<25
Specific Care Issues	Yes	0.000	0.000	0.000	<25
Overall Rating of Home Health Care	Yes	0.000	0.000	0.000	<25
Willingness to Recommend the Agency	Yes	0.000	0.000	0.000	<25

Total Performance Score

- The numeric score awarded to each qualifying HHA based on the weighted sum of the performance scores for each applicable measure.
- A qualifying HHA will receive a numeric score ranging from zero (0) to one hundred (100).



Measure Scorecard

Your HHA's Cohort

Larger-volume

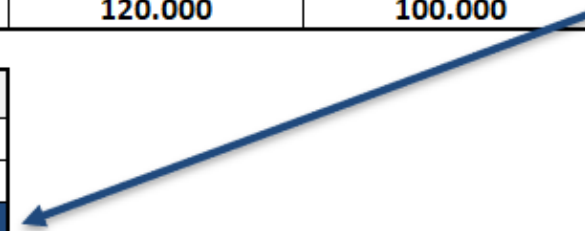
Measure	Your HHA's Care Points	Maximum Possible Points	Measure Weight [a]	Your HHA's Weighted Measure Points [b]
OASIS-based Measures				
Discharged to Community	0.794	10.000	5.833	0.463
Improvement in Dyspnea	3.939	10.000	5.833	2.298
Improvement in Management of Oral Medications	2.992	10.000	5.833	1.745
Total Normalized Composite (TNC) Change in Mobility	1.331	10.000	8.750	1.165
Total Normalized Composite (TNC) Change in Self-Care	1.125	10.000	8.750	0.984
Sum of OASIS-based Measures	10.181	50.000	35.000	6.655
Claims-based Measures				
Acute Care Hospitalizations	0.000	10.000	26.250	0.000
Emergency Department Use Without Hospitalization	1.179	10.000	8.750	1.032
Sum of Claims-based Measures	1.179	20.000	35.000	1.032
HHCAHPS Survey-based Measures				
Care of Patients	0.000	10.000	6.000	0.000
Communications Between Providers and Patients	0.000	10.000	6.000	0.000
Specific Care Issues	0.000	10.000	6.000	0.000
Overall Rating of Home Health Care	0.000	10.000	6.000	0.000
Willingness to Recommend the Agency	0.000	10.000	6.000	0.000
Sum of HHCAHPS Survey-based Measures	0.000	50.000	30.000	0.000
Sum of All Measures	11.360	120.000	100.000	7.687

TPS and Quartile Ranking

Willingness to Recommend the Agency	0.000	10.000	6.000	0.000
Sum of HHAHPS Survey-based Measures	0.000	50.000	30.000	0.000
Sum of All Measures	11.360	120.000	100.000	7.687

Total Performance Score (TPS)	
Number of Measures Included	12
Your HHA's Summed Care Points	11.360
Your HHA's Interim TPS	7.687
Percentile Ranking within Your HHA's Cohort [c]	<25

TPS Statistics for Your HHA's Cohort	
Number of HHAs in Your HHA's Cohort	6,792
25th Percentile	14.648
50th Percentile	23.362
75th Percentile	34.061
99th Percentile	68.395



A different way of thinking...

- HHVBP is over 3/4 though our first “performance year”- where our data counts!
- July brought our first “Interim Performance Reports”- and many of us were surprised we didn’t look better. We have seen some improvement with Octobers’ IPRs- (just released at end of Oct), but other agencies found that the national data improvements hurt their agency (Bell curve!)
- Typical response- Education and QA of OASIS- but HHVBP is so much more
- This session looks at the unique view of how good knowledge and compliance with our COPs will actually aide in improving our HHVBP!

Actions of a Prudent Home Health Agency™

1. Know the changes
2. Know yourself- assess impacts to your agency
3. Plan for the gaps

Questions?



Annette Lee

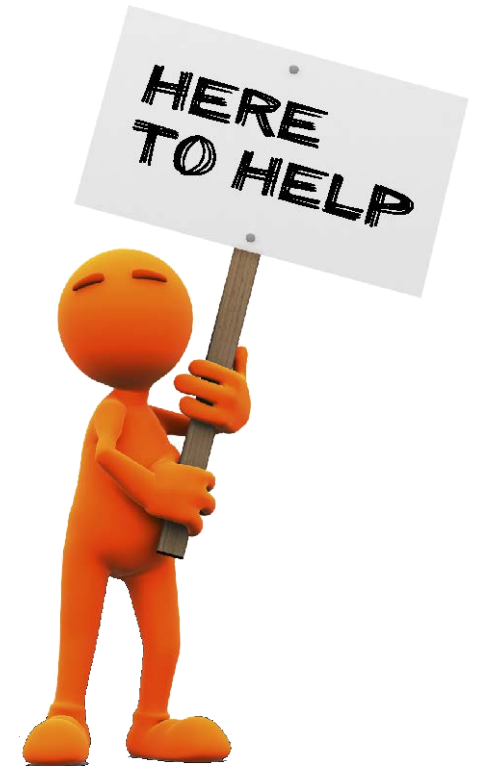
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The information enclosed was current at the time it was presented. This presentation is intended to serve as a tool to assist providers and is not intended to grant rights or impose obligations.

Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.



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