Value Based Purchasing – Nationwide Rollout

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Chief Executive Officer

Melinda A. Gaboury, with more than 30 years in home care, has over 20 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving on the NAHC/HHFMA Advisory Board and Work Group and is Treasurer on the Home Care Association of Florida Board of Directors. Melinda is also the author of the Home Health OASIS Guide to OASIS-D1 and Home Health Billing Answers, 2021.

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Home Health Value-Based Purchasing (VBP)

- VBP is required by the Affordable Care Act (ACA) and part of the IHI (Institute for Health Improvement) plan to improve patient outcomes in home health, while lowering costs.
- Transitions home health from fee-for-service payment models toward value-based purchasing
- Rewards HHAs that provide better quality care per outcomes
- The specific goals of the Model are to:

  (1) Provide incentives for better quality care with greater efficiency;

  (2) Study new potential quality and efficiency measures for appropriateness in the home health setting; and

  (3) Enhance the current public reporting process

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HHVBP Model - Demonstration

The maximum payment adjustment percentage increases incrementally over the course of the HHVBP Model in the following manner, upward or downward:

Between 3 - 8 percent in CY 2018 - 2022 - - - Performance Years CY 2016 - 2020

Payment adjustments are based on each HHA's Total Performance Score (TPS) in a given performance year (PY), which is comprised of performance on:

(1) a set of measures already reported via the OASIS, CAHPS surveys, select claims data elements; and

(2) three New Measures for which points are achieved for reporting data.

Payment adjustments for a given year are based on the TPS calculated for performance two years' prior; for example, the CY 2018 payment adjustments were based on CY 2016 performance.

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HHVBP Model - Demonstration

- 5-year pilot starting with Performance Year 2016
- Bonus or Penalty up to 3% first year then – 5-8% in the subsequent years
- Baseline year 2015 used for calculating the median (achievement threshold) and mean of top decile (benchmark) – new items changed to baseline year 2017 in the 2019 update
- 17 OASIS/Claims/HHCAHPS measures (90% of the score) along with 3 "New Measures" - New Measures scored based on self reporting data only (10% of the score)
- Up to 10 Points for Achievement and Improvement for each measure - get the higher of the two - - This was changed to Improvement only being worth 9 points in the final 2 years of the demonstration
- Total Performance Score (TPS) for each CCN is used to calculate the Linear Exchange Function (LEF) to determine the adjustments for the "payment" years

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HHVBP Model - Demonstration

Performance Year 4

- Removed 5 OASIS measures from the applicable measures
- Added two new "Composite" measures – Total Normalized Composite for Mobility and for Self Care
- New Weighting for the measure scores for 90% of the TPS (10% for new measures)
- 35% for the OASIS-based measures (6 outcomes); 35% for the Claims-based measures (2 outcomes); 30% for the HHCAHPS measures (5 outcomes)
- Reducing the maximum points for Improvement from 10 points to 9 points

Performance Year 5

- CMS ended the program early and not applying any adjustments from the PY 5 due to uncertainties from the pandemic and the exempted quarters – 2020 is not being used in any reporting or payment adjustments

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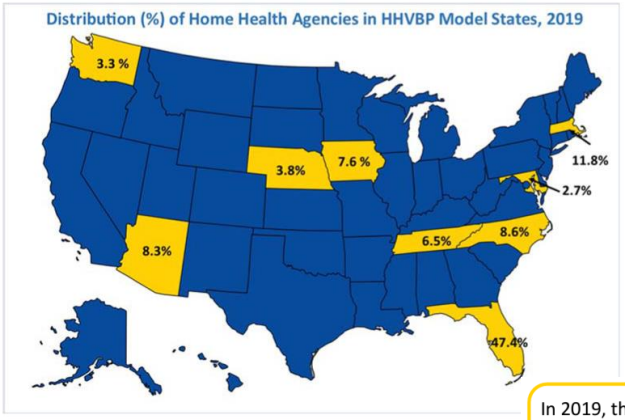
Home Health Value-Based Purchasing Model



PARTICIPANTS

All Medicare-certified HHAs providing services in the following states were included in the HHVBP Model:

- Arizona
- Florida
- Iowa
- Maryland
- Massachusetts
- Nebraska
- North Carolina
- Tennessee
- Washington

In 2019, there were approximately 1,931 HHAs in the nine HHVBP states, representing 18% of all HHAs and 1.4 million home health episodes in the U.S.

Reference: CMS Home Health Value-Based Purchasing Model – Fourth Annual Report - Two Pager: Findings-At-A-Glance Report

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Key Findings from the 4th Annual Report

MEDICARE SPENDING

Overall, there was a decline in total Medicare spending in HHVBP states during and 30 days after home health episodes of care as measured by the average spending per day among fee-for-service (FFS) beneficiaries receiving home health services.

$604.8 million (1.3%) reduction in cumulative Medicare spending, 2016-2019

Driven by:

$381.4 million (2.4%) reduction in inpatient hospitalization stay spending

$164.9 million (4.2%) reduction in skilled nursing facility services spending

Offset by:

$65.3 million (6.1%) increase in outpatient ED & observation stay spending

No effect on Medicare spending for home health care

QUALITY AND UTILIZATION

Results through the fourth year of the model and second year of HHVBP payment adjustments suggest modest gains in quality of care and declines in utilization for some types of services due to HHVBP:

Total Performance Scores were 8% higher among HHAs in HHVBP states than HHAs in non-HHVBP states in 2019

Decrease in unplanned hospitalizations, ED visits leading to inpatient admission, and skilled nursing facility use by FFS beneficiaries using home health

Continued trend toward improvement in functional status, including two new composite measures

Offset by modest unintended changes due to HHVBP:

2.6% increase in outpatient ED visits

0.3% decrease in two of five measures of patient experience: communication and discussion of care with patients

Reference: CMS Home Health Value-Based Purchasing Model – Fourth Annual Report - Two Pager: Findings-At-A-Glance Report

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Key Findings from the 4th Annual Report

HOME HEALTH AGENCY OPERATIONS

Agencies continue to view the model as complementary to other CMS quality initiatives and report leveraging data analytics in coordination with staff training to improve performance and care delivery.

No effect on overall agency entries or closures, use of home health services, or access to home health care.

KEY TAKEAWAYS

The first four years of the implementation of HHVBP (2016-2019) have resulted in cumulative Medicare savings of $604.8 million, a 1.3% decline relative to the 41 non-HHVBP states, as well as improvements in quality. These impacts were observed during 2019, the second year for quality based payment adjustments, as well as the initial three years of the model.

We will continue to evaluate the impact of HHVBP on quality and Medicare spending as the maximum payment adjustments become larger each year.

Reference: CMS Home Health Value-Based Purchasing Model – Fourth Annual Report - Two Pager: Findings-At-A-Glance Report

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Claims & HHCAHPS Items in HHVBP

- Acute Care Hospitalization: Unplanned Hospitalization during the first 60 days of Home Health – Claims
- Emergency Department Use Without Hospitalization – Claims
- Care of Patients - HHCAHPS
- Communications between Providers & Patients - HHCAHPS
- Specific Care Issues - HHCAHPS
- Overall Rating of Home Health Care - HHCAHPS
- Willingness to Recommend Agency - HHCAHPS

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Total Normalized Composite Change in Self-Care Measure

- Measure computes the magnitude of change, either positive or negative, based on a normalized amount of possible change on each of six OASIS-based quality outcomes. These six outcomes are as follows:
  1. Improvement in Grooming (M1800)
  2. Improvement in Upper Body Dressing (M1810)
  3. Improvement in Lower Body Dressing (M1820)
  4. Improvement in Bathing (M1830)
  5. Improvement in Toileting Hygiene (M1845)
  6. Improvement in Eating (M1870)

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Total Normalized Composite Change in Mobility Measure

- Measure computes the magnitude of change, either positive or negative, based on the normalized amount of possible change on each of three OASIS-based quality outcomes. These three outcomes are as follows:
  1. Improvement in Toilet Transferring (M1840)
  2. Improvement in Bed Transferring (M1850)
  3. Improvement in Ambulation/Locomotion (M1860)

Extra data that was self-reported will not be required in the nationwide rollout.

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FY 2022 Final Rule - HHVBP

- The FY 2022 final rule expands the Home Health Value-Based Purchasing Model (HHVBP) to all Medicare-certified HHAs in the 50 States, District of Columbia, and the territories.
- Ends the original HHVBP Model one year early for the HHAs in the nine original Model States, CY 2020 performance data will not be used to calculate a payment adjustment for CY 2022.
- CY 2022 will be a pre-implementation year, with **CY 2023** as the first performance year and CY 2025 as the first payment year, based on CY 2023 performance.
- CMS will provide learning support about the Model to HHAs during CY 2022.
- Total Performance Score and payment adjustment will be calculated based on an HHA's CCN.
- All HHAs certified for participation in Medicare before January 1, 2022, will have their CY 2023 performance assessed and be eligible for a CY 2025 payment adjustment.

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Final Rule – HHVBP Payment Adjustment

- Payment adjustments
  - 5 percent maximum payment adjustment, upward or downward
    - CMS may consider changes to the proposed 5 percent maximum payment adjustment percentage through rulemaking in future years of the expansion, as additional evaluation data from the original Model and expansion become available.
  - Delay in the start of payment adjustments under the expanded Model
    - CY 2025 would be the first payment year, with payment adjustments based on performance in CY 2023
  - The baseline year would be **CY 2019** for the CY 2023 performance year/CY 2025 payment year and subsequent years.

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Final Rule – HHVBP Payment Adjustment

- New HHAs
  - HHAs that are certified by Medicare on or after January 1, 2019, the baseline year under the expanded Model would be the HHA's first full CY of services beginning after the date of Medicare certification, with the exception of HHAs certified on January 1, 2019 through December 31, 2019, for which the baseline year would be CY 2021.
  - New HHAs would begin competing under the expanded HHVBP Model in the first full calendar year (beginning with CY 2023) following the full calendar year baseline year.

TABLE 23 : FINAL HHA BASELINE, PERFORMANCE AND PAYMENT YEAR BASED ON MEDICARE-CERTIFICATION DATE THROUGH DECEMBER 31, 2021

Medicare-certification Date	Baseline Year	Performance Year	Payment Year
Prior to January 1, 2019	2019	2023	2025
On January 1, 2019 - December 31, 2019	2021	2023	2025
On January 1, 2020 – December 31, 2020	2021	2023	2025
On January 1, 2021 – December 31, 2021	2022	2023	2025

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NQS Domains	Measure Full Title/Short Form Name	Data Source	Measure	Measure Full Title/Short Form Name	Data Source
Clinical Quality of Care	Improvement in Dyspnea/Dyspnea	OASIS (M1400)			
Communication & Care Coordination	Discharged to Community	OASIS (M2420)			
Patient Safety	Improvement in Management of Oral Medications/Oral Medication	OASIS (M2020)	Patient & Caregiver-Centered Experience	Home Health Consumer Assessment Healthcare Providers and Systems (HHCAHPS) Survey	CAHPS
Patient and Family Engagement	Total Normalized Composite Change in Mobility*/TNC Mobility	OASIS (M1840) (M1850) (M1860)	Efficiency & Cost Reduction	Acute Care Hospitalization During the First 60 Days of Home Health Use/ACH	Claims
Patient and Family Engagement	Total Normalized Composite Change in Self-Care**/TNC Self-Care	OASIS (M1800) (M1810) (M1820) (M1830) (M1845) (M1870)	Efficiency & Cost Reduction	Emergency Department Use without Hospitalization During the First 60 Days of Home Health/ED Use	Claims

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Final Rule – HHVBP HHCAHPS Measures

TABLE 26: HHCAHPS SURVEY MEASURE COMPONENTS AND COMPONENT QUESTIONS

HHCAHPS Survey-based Component Name/ Short Name and Component Questions*	Type	NQF ID	Data Source	Link to Measure Specs/Response Categories
Care of Patients/Professional Care	Outcome	0517	CAHPS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2062
Q9. In the last 2 months of care, how often did home health providers from this agency seem informed and up-to-date about all the care or treatment you got at home?				Never, Sometimes, Usually, Always
Q16. In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?				Never, Sometimes, Usually, Always
Q19. In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?				Never, Sometimes, Usually, Always
Q24. In the last 2 months of care, did you have any problems with the care you got through this agency?				Yes, No

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Final Rule – HHVBP HHCAHPS Measures

Communications between Providers and Patients/Communication	Outcome	0517	CAHPS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2580
Q2. When you first started getting home health care from this agency, did someone from the agency tell you what care and services you would get?				Yes, No
Q15. In the past 2 months of care, how often did home health providers from this agency keep you informed about when they would arrive at your home?				Never, Sometimes, Usually, Always
Q17. In the past 2 months of care, how often did home health providers from this agency explain things in a way that was easy to understand?				Never, Sometimes, Usually, Always
Q18. In the past 2 months of care, how often did home health providers from this agency listen carefully to you?				Never, Sometimes, Usually, Always
Q22. In the past 2 months of care, when you contacted this agency's office did you get the help or advice you needed?				Yes, No
Q23. When you contacted this agency's office, how long did it take for you to get the help or advice you needed?				Same day; 1 to 5 days; 6 to 14 days; More than 14 days

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Final Rule – HHVBP HHCAHPS Measures

Specific Care Issues/Team Discussion	Outcome	0517	CAHPS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2582
Q3. When you first started getting home health care from this agency, did someone from the agency talk with you about how to set up your home so you can move around safely?				Yes, No
Q4. When you started getting home health care from this agency, did someone from the agency talk with you about all the prescription medicines you are taking?				Yes, No
Q5. When you started getting home health care from this agency, did someone from the agency ask to see all the prescription medicines you were taking?				Yes, No
Q10. In the past 2 months of care, did you and a home health provider from this agency talk about pain?				Yes, No
Q12. In the past 2 months of care, did home health providers from this agency talk with you about the **purpose** for taking your new or changed prescription medicines?				Yes, No
Q13. In the last 2 months of care, did home health providers from this agency talk with you about **when** to take these medicines?				Yes, No
Q14. In the last 2 months of care, did home health providers from this agency talk with you about the **important side effects** of these medicines?				Yes, No
Overall rating of home health care/Overall Rating	Outcome	0517	CAHPS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2581
Q20. What number would you use to rate your care from this agency's home health providers?				Use a rating scale (0-10) (0 is worst, 10 is best)
Willingness to recommend the agency/Willing to Recommend	Outcome	0517	CAHPS	https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2583
Q25. Would you recommend this agency to your family or friends if they needed home health care?				Definitely no; Probably no; Probably yes; Definitely yes

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Final Rule – Align HHVBP with HHQRP

- To align HHVBP with HHQRP - beginning with the CY 2023 under the HHQRP
- Remove:
  - Acute Care Hospitalization During the First 60 Days of Home Health (ACH) measure
  - Emergency Department Use Without Hospitalization During the First 60 days of Home Health (ED Use) measure
- Replaced by:
  - Home Health Within Stay Potentially Preventable Hospitalization (PPH) measure

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Total Performance Score Methodology

TPS under the expanded Model, which is similar to the approach used under the original Model:

1) each HHA would receive a raw quality measure score for each applicable measure during the performance year;
2) the HHA would receive an "achievement score" for each applicable measure, which is defined as a numeric value between 0 and 10 that quantifies an HHA's performance on a given quality measure compared to other HHAs in the same cohort in the baseline year (calculated using the achievement threshold and benchmark, as defined in section III.A.7.b.2. of this proposed rule);

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Total Performance Score Methodology

3) each HHA would also receive an "improvement score" for each applicable measure, which is defined as a numeric value between 0 and 9, that quantifies an HHA's performance on a given quality measure compared to its own individual performance in the baseline year (the improvement threshold, as defined in section III.A.7.b.2. of this proposed rule);
4) each HHA would be assigned a "performance score" on each applicable measure that is the higher of the achievement score or the improvement score, as described in section III.A.7.b.2 of this proposed rule; and

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Total Performance Score Methodology

(5) each performance score would then be weighted, using each measure's assigned weight, and summed to generate the HHA's TPS, as described in section III.A.7.e. of this proposed rule. The result of this process would be a TPS for each competing HHA that can be translated into a payment adjustment percentage using the LEF applicable to each cohort, as described in section III.A.8. of this proposed rule.

The HHA's TPS would reflect all of the claims- and OASIS-based measures for which the HHA meets the minimum of 20 home health episodes of care per year and all of the individual components that compose an HHCAHPS survey measure for which the HHA meets the minimum of 40 HHCAHPS surveys received in the performance year, defined as "applicable measures".

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Total Performance Score Methodology

The claims-based, OASIS assessment-based, and the HHCAHPS survey-based measure categories would be weighted 35 percent, 35 percent, and 30 percent, respectively, and would account for 100 percent of the TPS. If an HHA is missing a measure category or a measure within the OASIS-based measure category, the measures would be reweighted, as described further in section III.A.7.e. of this proposed rule.

Finally, we are proposing to change the potential score range for the TNC Mobility and TNC Self-Care measures from 0 to 15 points for achievement and 0 to 13.5 points for improvement as under the original Model, to 0 to 10 points for achievement and 0 to 9 points for improvement in the expanded Model. This change simplifies and aligns the calculation of the composite measure scores.

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Benchmark and Achievement Threshold

We propose to calculate the achievement score using the following formula:

Achievement Score =

$$10 \times \frac{(HHA\ Performance\ Score - Achievement\ Threshold)}{Benchmark - Achievement\ Threshold}$$

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Calculation of the Improvement Score

The following proposed improvement score formula quantifies the HHA' s performance on each applicable measure in the performance year relative to its own performance in the baseline year by calculating the improvement score:

Improvement Score =

$$9 \times \frac{(HHA\ Performance\ Score - HHA\ Improvement\ Threshold)}{Benchmark - HHA\ Improvement\ Threshold}$$

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Calculation Example #1

Figure 4 shows the scoring for HHA 'A' as an example. HHA A's CY 2022 performance year score for the Dyspnea measure was 98.348, exceeding both the CY 2019 achievement threshold and benchmark, which means that HHA A earned the maximum 10 points based on its achievement score. Its improvement score is irrelevant in the calculation because the HHA's performance score for this measure exceeded the benchmark, and the maximum number of improvement points possible is 9.

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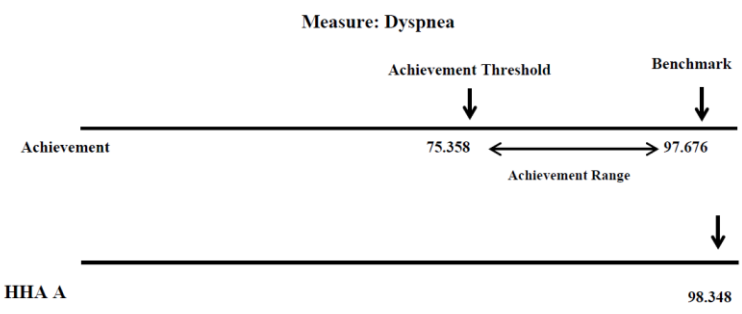
Calculation Example #1

FIGURE 4: EXAMPLE OF AN HHA EARNING POINTS BY ACHIEVEMENT OR IMPROVEMENT SCORING



HHA A Score: 10 maximum points for achievement

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Calculation Example #2

Figure 4 also shows the scoring for HHA 'B.' HHA B's performance on the Dyspnea measure was 52.168 for the CY 2019 baseline year (HHA B's improvement threshold) and increased to 76.765 (which is above the achievement threshold of 75.358) for the CY 2022 performance year. To calculate the achievement score, HHA B would earn 0.630 achievement points, calculated as follows: 10 * (76.765 -75.358)/(97.676-75.358) = 0.63025. Calculating HHA B's improvement score yields the following result: based on HHA B's period-to-period improvement, from 52.168 in the baseline year to 76.765 in the performance year, HHA B would earn 4.864 improvement points, calculated as follows: 9 * (76.765 - 52.168)/(97.676 - 52.168) = 4.864.26 Because the higher of the achievement and improvement scores is used, HHA B would receive 4.864 improvement points for this measure.

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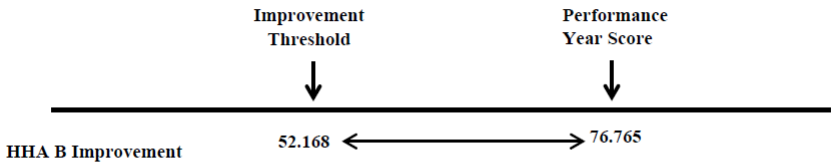
Calculation Example #2



HHA B Score: The greater of 0.630 points for achievement and 4.864 points for improvement.

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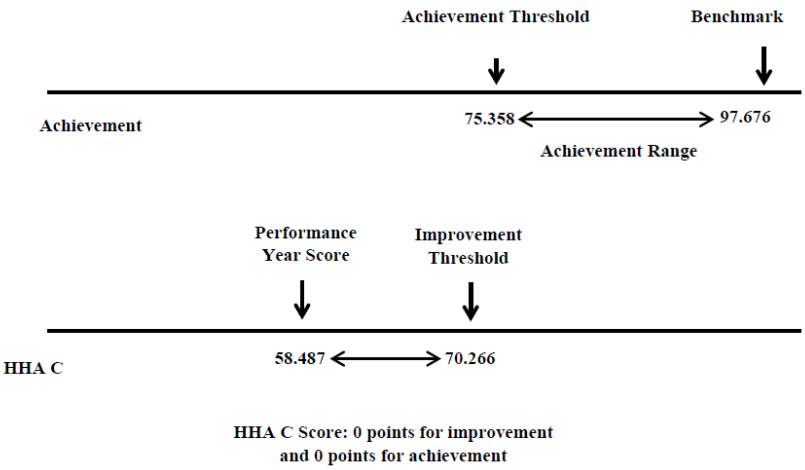
FIGURE 5: EXAMPLE OF AN HHA NOT EARNING POINTS BY ACHIEVEMENT OR IMPROVEMENT SCORING

Measure: TNC Self-Care Measure



HHA C Score: 0 points for improvement and 0 points for achievement

Calculation Example #3

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Calculation Example #3

In Figure 5, HHA 'C' yielded a decline in performance on the TNC Self-Care measure, falling from 70.266 to 58.487. HHA C's performance during the performance year was lower than the achievement threshold of 75.358 and, as a result, HHA C would receive zero points based on achievement. It would also receive zero points for improvement because its performance during the performance year was lower than its improvement threshold.

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TABLE 28: PROPOSED WITHIN-CATEGORY MEASURE WEIGHTS

Measure Category	Quality Measures	Within-category Weight (percentage)
OASIS	TNC Self-Care	25.00
	TNC Mobility	25.00
	Dyspnea	16.67
	Discharged to Community	16.67
	Oral Medications	16.67
Claims	ACH	75.00
	ED Use	25.00
HHCAHPS Survey	HHCAHPS Professional Care	20.00
	HHCAHPS Communication	20.00
	HHCAHPS Team Discussion	20.00
	HHCAHPS Overall Rating	20.00
	HHCAHPS Willingness to Recommend	20.00

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TABLE 29: PROPOSED QUALITY MEASURE WEIGHTING AND RE-WEIGHTING SCHEDULE

	Measure Reporting Scenarios			
Measure	All Measures	No HHCAHPS	No Claims	No Claims or HHCAHPS
OASIS				
TNC Self-Care	8.75%	12.50%	13.46%	25.00%
TNC Mobility	8.75%	12.50%	13.46%	25.00%
Oral Medications	5.83%	8.33%	8.98%	16.67%
Dyspnea	5.83%	8.33%	8.98%	16.67%
Discharged to Community	5.83%	8.33%	8.98%	16.67%
Total for OASIS-based measures	*35.00%*	*50.00%*	*53.85%*	*100.00%*
Claims				
ACH	26.25%	37.50%	0.00%	0.00%
ED Use	8.75%	12.50%	0.00%	0.00%
Total for claims-based measures	*35.00%*	*50.00%*	*0.00%*	*0.00%*
HHCAHPS Survey Measure Components				
HHCAHPS Professional Care	6.00%	0.00%	9.23%	0.00%
HHCAHPS Communication	6.00%	0.00%	9.23%	0.00%
HHCAHPS Team Discussion	6.00%	0.00%	9.23%	0.00%
HHCAHPS Overall Rating	6.00%	0.00%	9.23%	0.00%
HHCAHPS Willingness to Recommend	6.00%	0.00%	9.23%	0.00%
Total for the HHCAHPS Survey-based measure	*30.00%*	*0.00%*	*46.15%*	*0.00%*

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Linear Exchange Function (LEF)

TABLE 32: 5-PERCENT REDUCTION SAMPLE

		Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7
HHA	TPS	Prior Year Aggregate HHA Payment Amount*	5-Percent Payment Reduction Amount (C2*5 percent)	TPS Adjusted Reduction Amount (C1/100)*C3	Linear Exchange Function (LEF) (Sum of C3/ Sum of C4)	Final TPS Adjusted Payment Amount (C4*C5)	Quality Adjusted Payment Rate (C6/C2)	Final Percent Payment Adjustment +/- (C7-5%)
	(C1)	(C2)	(C3)	(C4)	(C5)	(C6)	(C7)	(C8)
HHA1	38	$100,000	$5,000	$1,900	1.931	$3,669	3.669%	-1.331%
HHA2	55	$145,000	$7,250	$3,988	1.931	$7,701	5.311%	0.311%
HHA3	22	$800,000	$40,000	$8,800	1.931	$16,995	2.124%	-2.876%
HHA4	85	$653,222	$32,661	$27,762	1.931	$53,614	8.208%	3.208%
HHA5	50	$190,000	$9,500	$4,750	1.931	$9,173	4.828%	-0.172%
HHA6	63	$340,000	$17,000	$10,710	1.931	$20,683	6.083%	1.083%
HHA7	74	$660,000	$33,000	$24,420	1.931	$47,160	7.146%	2.146%
HHA8	25	$564,000	$28,200	$7,050	1.931	$13,615	2.414%	-2.586%
Sum			$172,611	$89,379		$172,611		

*Example cases.

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Total Normalized Composite Change

The magnitude of possible change for these OASIS items varies based on the number of response options. For example,

- M1800 (grooming) has four behaviorally-benchmarked response options (0 = most independent; 3 = least independent) while
- M1830 (bathing) has seven behaviorally-benchmarked response options (0 = most independent; 6 = least independent).
- The maximum possible change for a patient on item M1800 is 3, while the maximum possible change for a patient on item M1830 is 6.

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Total Normalized Composite Change

Both finalized composite measures will be computed and normalized at the episode level, then aggregated to the HHA level using the following steps:

Step 1: Calculate absolute change score for each OASIS item (based on SOC/Resumption – Discharge)

Step 2: Normalize scores based on maximum change possible for each OASIS item

Step 3: Total score for Total Normalized Composite Change in Self-Care or Total Normalized Composite Change in Mobility is calculated by summing the normalized scores for the items in the measure.

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TNC Change Calculation

Composite Measure	OASIS Item	Status at SOC	Status at Discharge	Max Possible Change	Raw Change	Normalized Change	Sum of Normalized Change
TNC Change in Mobility	Ambulation (M1860) –	5	2	6	3	0.500	
	Toilet Transfer (M1840)	4	2	4	2	0.500	
	Bed Transfer (M1850)	4	2	5	2	0.400	
							1.400

This calculation is made for every episode that is available for calculation. Then all episodes are added together and divided by the total episodes.

Lastly: HHA Risk Adjusted = HHA Observed + (National Predicted – HHA Predicted)

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Total Normalized Composite Change in Self-Care Measure

- Measure computes the magnitude of change, either positive or negative, based on a normalized amount of possible change on each of six OASIS-based quality outcomes. These six outcomes are as follows:

1. Improvement in Grooming (M1800)
2. Improvement in Upper Body Dressing (M1810)
3. Improvement in Lower Body Dressing (M1820)
4. Improvement in Bathing (M1830)
5. Improvement in Toileting Hygiene (M1845)
6. Improvement in Eating (M1870)

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Total Normalized Composite Change in Mobility Measure

- Measure computes the magnitude of change, either positive or negative, based on the normalized amount of possible change on each of three OASIS-based quality outcomes. These three outcomes are as follows:

1. Improvement in Toilet Transferring (M1840)
2. Improvement in Bed Transferring (M1850)
3. Improvement in Ambulation/Locomotion (M1860)

Extra data that was self-reported will not be required in the nationwide rollout.

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Reporting Timing

TABLE 32: TIMELINE FOR CY 2023 PERFORMANCE YEAR AND CY 2025 PAYMENT YEAR BY REPORT TYPE AND DATA TYPE

Report Type (Approximate Date Issued)	OASIS-Based Measures	Claims-Based and HHCAHPS-Based Measures
July 2023 IPR (July 2023)	12 months ending 3/31/2023	Baseline data only
October 2023 IPR (Oct 2023)	12 months ending 6/30/2023	12 months ending 3/31/2023
January 2024 IPR (Jan 2024)	12 months ending 9/30/2023	12 months ending 6/30/2023
April 2024 IPR (April 2024)	12 months ending 12/31/2023	12 months ending 9/30/2023
July 2024 IPR (July 2024)	12 months ending 3/31/2024	12 months ending 12/31/2023
Annual TPS and Payment Adjustment Report (Aug 2024)*	12 months ending 12/31/2023	12 months ending 12/31/2023

*The Annual Report made available to HHAs in approximately August 2024 is the Preview Annual Report. The Final Annual Report is issued after the recalculation and reconsideration request periods and no later than 30 days prior to the calendar year which the payment adjustment will take effect.

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What NOW?

What do agencies do to prepare for the nationwide rollout?

- Understand where you are today in terms of confidence in the outcomes your agency is currently achieving with the impacted OASIS Items.
- Establish what immediate education needs to take place to begin focusing on the specific items that your agency is struggling with..
- Implement processes/systems to assist in ongoing analysis of the agency's outcomes and scoring in real time vs. waiting for delayed CMS reports.
- Review your current rating for Patient Surveys – Home Health CAHPS.
- Establish what can be done to improve the CAHPS scores:
  - Analyze the specific questions that impact any negative CAHPS scores
  - Educate staff on the questions that are asked if they are not familiar
  - Begin the process of educating patients that the survey may be coming etc.
- Review what is being done in the agency to decrease rehospitalization & emergency room use rates

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Thank You For Participating!

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