HHVBP Model Expansion 101

Slide 1: Hello everyone, and welcome to the first learning and technical assistance event for the expanded HHVBP Model. My name is Carrie Kolleck and I will be your moderator for this event. We so appreciate you taking the time out of your very busy schedules to join us here today. The content of this event is for home health agencies. If you are a member of the press, please go ahead and contact the CMS press office at press@cms.hhs.gov. I do want to note that we are recording this event, and the recording and transcript will be available on the expanded HHVBP Model web page in about one to two weeks.

Slide 2: This is the screen view that you should currently see, and if you would like to ask a question to today's speakers, you can do that by clicking on the Q&A button at the bottom of your screen, which you can see right there on the slide.

Slide 3: The intent of this 101 event is to provide an overview of the expanded HHVBP Model. Additional information and resources detailing the model will be available throughout calendar year 2022. As we move through the presentation, we welcome your questions using that Q&A feature. We do have time at the end of the presentation to review some common questions that we've seen through the help desk and address some of the questions that you will post today. And additionally we do have the Frequently Asked Questions document that is now available on the expanded HHVBP Model web page.

Today's agenda includes the following: we'll do a welcome and introductions, and then we'll go over some expanded Model highlights. And then we'll do an overview of the essential topics that you see on the slide right there, including an introduction to participation and cohorts, performance and payment years, quality measures, baseline years, total performance scoring and payment adjustment methodology, performance feedback reports, and we'll wrap it up with public reporting. And then we'll move on to our question-and-answer session. The event will conclude with a review of all of the Model information and resources that are now available to you, as well as those that are coming soon.

Slide 4: And now I would like to introduce our featured speakers today from the Centers for Medicare & Medicaid Services. We have Marcie O'Reilly, who is the acting Program Coordinator for the expanded HHVBP Model. And then we have the HHVBP TA Team joining us. As I mentioned previously, I'm Carrie Kolleck and I will be your moderator. And my colleagues on the TA Team include Linda Krulish and Elaine Gardner from OASIS Answers Inc., as well as Judith Ouellet from the University of Colorado Anschutz Medical Campus. Welcome everyone.

Slide 5: I will now turn it over to Marcie O'Reilly from CMS, who will provide a brief introduction to the expanded HHVBP Model. Marcie?

Slide 6: Thank you, Carrie. The original HHVBP Model, implemented in nine randomly selected states during 2016 through 2021, resulted in an average 4.6% improvement in home health agency quality scores and an average annual savings of $141 million to Medicare. In October of 2020, the CMS Chief Actuary certified that nationwide expansion of the HHVBP Model would reduce net Medicare spending. In January 2021, we announced that the Secretary had determined the original Model met the statutory requirements for expansion and our intent to expand the HHVBP Model via notice-and-comment rulemaking no earlier than January 1, 2022. In the calendar year 2022 Home Health Perspective Payment System Final Rule on November 9, 2021, we finalized the nationwide expansion of the HHVBP Model beginning January 1, 2022.

Slide 7: Building on the successes of the original Model under expansion, CMS will continue to test whether providing payment incentives to home health agencies nationwide improves the quality and delivery of home health care services to Medicare beneficiaries. This model adjusts payments to Medicare-certified home health agencies on the quality of care provided, rather than the volume of services rendered. These payment adjustments are determined based on a home health agency's quality performance measures relative to peers in their national cohort. Please note, the payment adjustment percentage applies only to Medicare home health fee-for-service claims.

Slide 8: The expanded HHVBP Model was launched on January 1, 2022. Calendar year 2022 is a pre-implementation year, allowing home health agencies time to learn about the Model without risk to payments. During 2022 CMS will provide education and support to competing home health agencies, allowing time to prepare for implementation of the expanded Model. Home health agencies can use this time to assess their own performance on a set of quality measures used in the expanded HHVBP Model. Please note, the first performance year is calendar year 2023, beginning January 1. During calendar year 2023, a home health agency's performance will be assessed to determine payment adjustment amounts for eligible home health agencies. CMS will apply these payment adjustments in the first payment year, which is calendar year 2025.

Slide 9: Great, thanks Marcie. And we know that the original Model only included HHAs who are operating in nine select states. Marcie, which agencies are included in the expanded HHVBP Model?

Slide 10: That's a good question, and we received a few inquiries about participation through the HHVBP Model help desk. Participation in the expanded HHVBP Model is mandatory for all Medicare-certified home health agencies with a Medicare certification number or CCN in the 50 states, the District of Columbia,

and the US territories. Participation includes home health agencies that are Medicare-certified and receive payments from CMS for home health care services. These home health agencies will compete on a set of quality measures related to care that they furnish.

Slide 11: Great, thank you, and participation in the HHVBP Model includes being assigned to a cohort. Can you tell us a little more about the cohorts for the expanded Model?

Yes, I'm happy to. Cohorts are determined based on each home health agency's unique beneficiary count in the prior calendar year. HHAs are assigned to a national cohort of similar size and more likely to receive scores on the same set of measures for purposes of setting benchmarks and achievement thresholds and determining payment adjustments. The national smaller-volume cohort is the group of competing home health agencies that had fewer than 60 unique survey-eligible beneficiaries in the calendar year prior to the performance year. The national larger-volume cohort is the group of competing home health agencies that had 60 or more unique survey-eligible beneficiaries in the calendar year prior to the performance year. Home health agencies will be able to identify their cohort assignments on the HHVBP report via iQIES once they're available.

Thank you for joining us today, and I'll turn it back to our moderator Carrie Kolleck from The Lewin Group, our technical assistance contractor, who will describe the essential design elements of the expanded HHVBP Model.

Slide 12: Great. Thank you, Marcie, for reviewing those cohorts. Now understanding the respective timeframes of the expanded HHVBP Model is really important, and there are a few. I'm going to bring in Linda Krulish of OASIS Answers Inc., who is going to give us an overview of the performance and payment years. Linda?

Slide 13: Thanks Carrie. A performance year is the calendar year during which OASIS-based, claims-based, and the HHCAHPS survey-based measure data are used for the purpose of calculating the agency's total performance score, or TPS. The TPS is the numeric score awarded to each qualifying agency based on the weighted sum of the performance scores for each applicable measure. A payment year is the calendar year in which the adjusted payment percentage for a designated performance year gets applied. This table on the slide shows the relationship between the performance years and the payment years. The first performance year will be calendar year 2023, and agencies' performance in 2023 will produce a payment adjustment that will be applied in the calendar year 2025 payment year, and this pattern is true for subsequent years. For example, performance year 2024 will impact payment year 2026 and so on.

Slide 14: This slide shows the timeline for performance and payment years during calendar year 2023 through calendar year 2025. Home health agency

performance during calendar year 2023 again is going to determine the level of payment adjustment that will be applied during calendar year 2025. The timeline also shows calendar year 2022 as our pre-implementation year, and throughout this year CMS will provide home health agencies again with technical assistance and resources to support understanding and help with implementation of the Model.

Slide 15: Great, thanks Linda. Let's shift over to our next topic, which is quality measures that will be used to assess agency performance.

Slide 16: Now it is important to note that the quality measures for the expanded Model include those that are already reported by HHAs in order to reduce reporting burden. Linda, can you provide us an overview of the applicable measures?

Sure. There are 12 quality measures in the expanded HHVBP Model measure set. It includes five that are OASIS-based measures, two that are claims-based measures, and five components of the HHCAHPS survey-based measure, and CMS may consider additional quality measures for the expanded HHVBP Model through future rulemaking. The level of performance on each of these measures will be used in the calculation of an agency's total performance score, which will be compared to other agencies within their cohort to determine the adjusted payment percentage for each agency. So let's look at the three categories of measures. Calculation of the OASIS-based measures use data from the Outcome and Assessment Information Set or OASIS, and quality episodes are used to calculate the OASIS-based measures which include Improvement in Dyspnea, Discharge to Community, Improvement in Management of Oral Medications, Total Normalized Composite or TNC Change in Mobility, and Total Normalized Composite or TNC Change in Self-Care. The claims-based measures are calculated using Medicare fee-for-service claims data. The claims-based measures evaluate the rate of utilization of specific services that might indicate a quality of care concern within an agency, and these claims-based measures include Acute Care Hospitalization and Emergency Department Use without Hospitalization. The HHCAHPS survey-based measure components are from the Home Health Consumer Assessment of Healthcare Providers and Systems, or HHCAHPS survey, which measures the experiences of patients receiving home health care from a Medicare-certified agency. And each of the quality measures are risk-adjusted, which is a statistical process that incorporates the underlying health status of patients when we're looking at healthcare outcomes. Risk adjustment is a common method. It's used across many quality measures so that providers aren't unfairly penalized for risks and variables that are outside of their control, such as patient health status. This risk adjustment effort is really important when assessing healthcare service quality. More detail about the quality measures, including technical specifications and measure exclusions and more about risk adjustment, will continue to become available during this pre-implementation year.

Slide 17: The quality measures in the expanded HHVBP Model measures use data that's already currently reported by agencies. So, as required under the Medicare conditions for participation and as a condition of payment, agencies must already electronically submit all mandatory OASIS data that's collected. And agencies are already required to submit HHCAHPS survey measure data for the Home Health Quality Reporting Program. And agencies are already submitting claims for payment purposes. In many cases, measures that are used in the expanded HHVBP Model overlap with those that are in the current Home Health Quality Reporting Program, so to minimize burden, agencies do not need to submit any additional data at this time for the expanded HHVBP Model. However, in the future CMS may propose new measures that may not already be collected or submitted by agencies.

Slide 18: As far as payers go, the HHVBP Model includes different payers based on the measure category. Calculation of the OASIS-based measures includes OASIS assessment data from Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care patients. Calculation of the claims-based measures only includes data from Medicare fee-for-service patients. And the HHCAHPS measure includes data from Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care patients. Remember that while the data from some of the measures comes from patients with all Medicare and Medicaid payers, an agency's HHVBP payment adjustment will only be applied to Medicare Home Health PPS claims.

Slide 19: Wonderful. Thank you, Linda, for that overview of the quality measures. Now let's turn our attention to the baseline years. Linda, what can you tell us about the baseline years CMS will use for the Model?

Slide 20: Sure. There is a baseline year that's used for calculations at the Model level for each of the two cohorts, and the baseline year that's used for calculations at the individual HHA level. The model baseline year is used to determine the benchmarks and the achievement thresholds for each cohort and each measure. The HHA baseline year is used to determine HHA improvement thresholds by measure for each individual agency. Benchmarks, achievement thresholds, and improvement thresholds are used to determine achievement or improvement of an agency's performance on applicable measures. And CMS may propose an update to the Model baseline year for subsequent years of the expanded Model, and that would happen through future rulemaking.

Slide 21: Great, thanks for clarifying that. Now let's take a look at each baseline year. Linda, what can you tell us about the baseline year used to calculate the achievement threshold?

So the achievement threshold is the median or 50th percentile of all Medicare-certified agencies' performance on each quality measure during the designated

model baseline year, and achievement thresholds are calculated separately for the larger- and the smaller-volume cohorts. Benchmarks are the mean of the top decile, or 90th percentile, of all agencies' performance scored on a specified quality measure during the designated Model baseline year, and these benchmarks are also calculated separately for the larger- and smaller-volume cohorts. The benchmarks are used in the process of calculating 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. And for the calendar year 2023 performance year, which corresponds to the calendar year 2025 payment year, calendar year 2019 will serve as that Model baseline year for calculating the achievement thresholds and the benchmarks for each cohort.

Slide 22: So, different from the Model baseline year and achievement thresholds that we just discussed, let's look at the HHA baseline year and improvement thresholds. The HHA baseline year is the year against which CMS will compare an agency's performance score by measure in a performance year and calculate each agency's unique improvement threshold. The HHA baseline year for calculating an agency's improvement threshold is based on the Medicare certification date of that agency. For all the agencies Medicare-certified prior to January 1, 2019, the HHA baseline year is calendar year 2019. And for all agencies that are Medicare-certified on or after January 1, 2019, the HHA baseline year will be that agency's first full calendar year of services, beginning after the date of their Medicare certification. There is an exception. For agencies that are certified during calendar year 2019, the HHA baseline year is calendar year 2021. All agencies that are Medicare-certified before January 1, 2022 will have their calendar year 2023 performance assessed and will be eligible for a payment adjustment in calendar year 2025. It is important to note that an agency needs to have sufficient data to establish a baseline year for each particular measure, so there could be instances where an agency's quality measures each have a different baseline year for improvement thresholds. And we will discuss what sufficient data means in the total performance score and methodology section of this webinar.

Slide 23: Thank you, Linda. Now there are a lot of timelines to be aware of for the expanded HHVBP Model. Could you provide a summary for agencies?

Yes, there are a lot of timelines that we need to be aware of. The table on the slide summarizes each of the timeframes according to when the agency received their Medicare certification. So, if you look at each of the columns on this table, the first column shows the agency's Medicare certification date. Now if we look at the Model baseline year in column 2, notice that the Model baseline year is the same for each performance year, as was finalized in the calendar year 2022 Final Rule. The designated model baseline year is used to calculate the measure

of achievement thresholds and benchmarks again by cohort. And notice that the agency's Medicare certification date has no relevance in determining the Model baseline year that's used to establish those achievement thresholds and benchmarks in column two. In column three we see the HHA baseline year. The Medicare certification date does matter when determining the HHA baseline year in column three. So for agencies that are certified on or after January 1, 2019, the HHA baseline year for a measure is going to be that first full calendar year of services following the date of the agency's Medicare certification. And remember, the HHA baseline year is used to calculate the HHA's improvement threshold for each measure. And agencies need that sufficient data to establish an HHA baseline to determine the improvement threshold for each particular measure. Because CMS finalized in the calendar year 2022 Final Rule to not use data from calendar year 2020, agencies that are certified on January 1, 2019 through December 31, 2019 will have an HHA baseline year of 2021. And finally, in columns four and five, we see that there's always a two-year gap between the performance year and the payment years when the payment adjustment is applied.

Slide 24: Wonderful. Thank you so much, Linda. Let's go ahead and shift gears now, and we'll head over to our next topic, which is an overview of the total performance scoring methodology for the HHVBP Model. I do want to note that additional details on the TPS will be available later in the pre-implementation year. And I'll now turn it over to Elaine Gardner from OASIS Answers Inc. to lead us through the methodology. Welcome Elaine.

Slide 25: Thank you Carrie. The total performance score, or TPS, is described as the numeric score awarded to each qualifying home health agency as based on the weighted sum of the performance scores for each applicable quality measure. The TPS is determined by weighting and summing the higher of the home health agency's achievement or improvement score for each applicable measure, and we will review these two scores in a moment. Qualifying home health agencies will receive the total performance score in the form of a numeric score ranging from zero to 100.

Slide 26: The purpose of the TPS is to provide for each qualifying home health agency a total score which reflects that agency's performance by weighting and summing their performance scores for each applicable quality measure included in the expanded HHVBP Model. CMS then uses the individual home health agency's total performance score to determine an annual distribution of value-based payment adjustments among the home health agencies in each of the nationwide cohorts. Next, we will provide an overview of the total performance score methodology.

Slide 27: This figure provides a high-level overview of the total performance scoring methodology for the expanded HHVBP Model. Total performance scoring begins with each agency receiving a score for each quality measure for the designated performance year. Next, each agency will receive achievement and improvement points for each applicable measure based on where the home health agency performance score falls compared to other home health agencies in their cohort, as represented in the achievement scores, and in relation to their own baseline performance, as represented in the improvement scores. Then the higher of these scores, achievement or improvement for each measure, is then used to calculate the total performance score. As noted earlier, the total performance score is the numeric score ranging from zero to 100 and awarded to each competing home health agency based on its performance. Note, an achievement score and an improvement score are calculated for each measure only when sufficient data are available in the baseline and performance years.

Slide 28: This slide provides additional context about the achievement score and improvement score, so please note, additional information and resources detailing the total performance score calculation steps will be available in the coming months. Now let's start with achievement. An achievement score can be between zero and 10 points for each applicable measure and is calculated using a formula that includes an achievement threshold and benchmark. The achievement threshold is the median or 50th percentile of Medicare-certified home health agencies' performance scores on each quality measure during the designated baseline year, and it's calculated separately for the larger- and smaller-volume cohorts. The benchmark is the mean, also known as the average of the top decile, or 90th percentile, of Medicare-certified home health agency performance for each quality measure during the designated baseline year. The benchmark is calculated separately for the larger- and smaller-volume cohorts. It is used for calculating both the achievement score and the improvement score. So in between these values, the achievement threshold and the benchmark, lies the achievement range. If and where an agency's performance on a quality measure falls within this range when compared to agencies within the respective cohort, this then determines the home health agency's achievement score for a specific quality measure. So, for the purpose of calculating each measure's achievement threshold and benchmark, the designated baseline year is calendar year 2019 for all agencies.

Slide 29: And now let's focus on improvement. An improvement score can be between zero and nine improvement points for each measure using a formula that incorporates an improvement threshold and the same benchmark as the achievement score uses. The improvements threshold is an individual agency's performance on an applicable measure during the home health agency's designated baseline year. The benchmark is defined in the same manner as for the achievement score. The mean or average of the top decile or 90th percentile

of Medicare-certified home health agency performance on each quality measure during the designated baseline year is calculated separately for the larger- and smaller-volume cohorts. So in between these two values, the improvement threshold and the benchmark, is the improvement range. If and where an agency's performance on a quality measure falls within this numeric improvement range, when compared to agencies within their respective cohort, then determines the home health agency's improvement score for a specific quality measure. So now let's take a look at two examples.

Slide 30: This slide illustrates the scenario of when the achievement score for a measure is greater than the improvement score for that same measure. In this case, where the achievement score for the measure is greater than the improvement score for that measure, then the achievement score for that measure translates into points that are weighted and are included in the total number of points from all measures. Points are then used to determine the total performance score.

Slide 31: And this slide illustrates the scenario when the improvement score for a quality measure is greater than the achievement score for that same measure. So in this case, the improvement score for the measure is greater than the achievement score for that same measure. And, as a result, the improvement score for that measure is included in the total number of points from all measures. This is then used to determine the total performance score.

Slide 32: Now, as we discuss the total performance score it is helpful to keep in mind that the calculation of a total performance score requires sufficient measure data. The minimum threshold of data a home health agency must have per measure per reporting period is the following. For those measures in the OASIS-based categories such as Improvement in Dyspnea: 20 home health quality episodes. For those measures in the claims-based categories such as ACH: 20 home health stays. And for those components in the Home Health CAHPS survey-based measure category: 40 completed surveys. Additionally, a home health agency must have sufficient data to allow calculation of at least five of the 12 measures to calculate the total performance score. A home health agency that does not meet the minimum threshold of data on five or more measures will not receive a total performance score for the applicable performance year or be subject to a payment adjustment for the applicable payment year. Instead, the home health agency will be paid for services in an amount equivalent to what would have been paid under Section 1895 of the Social Security Act. Home health agencies that do not meet the minimum threshold will still receive quarterly interim performance reports or IPRs for applicable measures. And home health agencies will continue to have opportunities to receive a total performance score and be subject to a payment adjustment in the future.

Slide 33: Another factor to keep in mind regarding the calculation of the total performance score is the weighting of the quality measures. Each measure category has a specific weight for the calculation of the total performance score. The measures in the OASIS-based category equal 35%. The measures in the claims-based category equal 35%, and the components in the Home Health CAHPS survey-based measure category equal 30%. If a home health agency is missing all measures from a single measure category, CMS will redistribute the weights for the remaining two measure categories such that the proportional contribution remains consistent with the original weights. So, for example, if a home health agency is missing the Home Health CAHPS survey-based measure, the OASIS-based and claims-based measure categories are weighted at 50% each as part of the total performance score.

Slide 34: Wonderful. Thank you, Elaine, for that review of the total performance scoring methodology. As we mentioned previously, more information and resources on the TPS will become available later in this pre-implementation year. Now let's turn our attention to the payment adjustment methodology. Could you briefly discuss this, please, Elaine?

Slide 35: Sure, thank you Carrie. An equation known as the linear exchange function, or LEF, is used to translate a home health agency's total performance score into that agency's payment adjustment percentage. The LEF is designed so the majority of the payment adjustment percentages fall closer to the median and a smaller percentage of home health agencies will have the highest or lowest level of payment adjustments. Home health agencies that have a total performance score that is average in relationship to other home health agencies in their cohort, or zero percent since the range is minus 5% to plus 5%, then they would not receive any payment adjustment.

Slide 36: Great. Thank you so much, Elaine, for that review of the payment adjustment methodology. Let's go ahead and shift gears to our next topic, which is the HHVBP Model reports. Now CMS will provide reports to HHAs participating in the Model so that they will have the data needed to understand their own performance and how they compare to other HHAs in their cohort. I'm now going to turn it over to Judith Ouellet from the University of Colorado Anschutz Medical Campus to review performance feedback reports. Hi Judith, what can you tell us about the reports, when they'll be available, and what information can HHAs expect to see?

Slide 37: Hi Carrie, thank you. CMS will provide two reports, the Interim Performance Report, or IPR, and the Annual TPS and Payment Adjustment Report, the Annual Report.

Slide 38: The Interim Performance Report, IPR, contains information on the agency's specific quality measure performance based on the 12 most recent months of

available data. CMS will issue IPRs quarterly and confidentially through iQIES beginning July 2023. There will be two versions of each IPR: a preliminary version and the final version. Subsequent quarter IPRs will be available October, January, and April. The IPR provides feedback to agencies about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. In addition, this report provides agencies the opportunity to assess and track their performance relative to peers within their respective cohort. Data in each IPR includes a quarterly update on the agency's total performance score, TNC Change Reference to assist in understanding their performance on individual OASIS items included in the composite measures, scorecard information that will support understanding of how each individual measure contributes to their total performance score, and percentile rankings reflecting their performance relative to the performance of other agencies within their cohort.

Slide 39: The Annual Total Performance Score and Payment Adjustment Report, known as the Annual Report, contains the agency's payment adjustment percentage for the upcoming calendar year, and includes an explanation of when the adjustment will be applied and how this adjustment was determined relative to the agency's performance scores. Beginning August 2024, CMS will issue the Annual Report confidentially through iQIES. There are three versions of the Annual Report: preview, preliminary, and final. Once CMS issues the preview report, the agency has an opportunity to submit a recalculation request, which we will discuss in more detail in the appeals process section of the presentation. The final Annual Report will be available no later than 30 calendar days in advance of the payment adjustment taking effect. The Annual Report issued in August 2024 will be based on the calendar year 2023 performance year. For subsequent years, CMS will issue previews of the Annual Report each August and each August thereafter. Each Annual Report will contain the following information: the agency's total performance score and percentile rankings reflecting the agency's performance relative to the performance of other agencies within their cohort, TNC Change Reference, which will provide information about individual OASIS item performance for the two composite measures, scorecard information that will facilitate understanding of how each measure contributes to the total performance score, and lastly, unique to the Annual Report is the payment adjustment information, which will include the agency’s payment adjustment percentage, which cohort the agency is assigned to, step by step payment adjustment calculations, and the calendar year to which the payment adjustment will be applied. Please note, IPRs are based on the 12 most recent months of performance data, while the Annual Reports are based on data during a given performance year. So there may be differences in the agency's total performance score presented in each report given the different time periods the reports are based on.

Slide 40: This table illustrates the timing of each report for each of the measures included. Know the first IPR will be available to home health agencies July 2023. This report will contain the 12 months of OASIS-based measure data ending March 31, 2023. For claims-based and HHCAHPS survey-based measure data, the July 2023 IPR will include the baseline data only, due to timing of data submissions. For the Annual Report, CMS will first issue the preview version, typically each August starting in 2024.

Slide 41: Great, thanks Judith. Now I know that the final rule references sample reports. What can HHAs expect regarding the sample reports?

Good question. In addition to the IPRs and Annual Reports, CMS anticipates providing sample reports during the calendar year 2022 pre-implementation year as soon as administratively feasible. To support agencies with preparing for the first performance year, CMS will provide sample reports for the purpose of assisting agencies with learning about the Model and the reports available. Now these sample reports will include sample data only, not actual agency data. And these reports are designed to assist agencies with understanding the data required for the expanded Model and how to interpret reports, how CMS calculates the total performance score, and how CMS assesses agencies within their respective cohorts.

Slide 42: Now this timeline shows the timing of the sample reports, the Interim Performance Reports, and the Annual Reports in the context of performance years and payment years through calendar year 2025.

Slide 43: Great. Thank you, Judith. Now as home health agencies review the IPR and the Annual Report and they happen to disagree with the information, is there an appeals process in place?

Yes, there is a process for each report. For the IPR, a home health agency has 15 calendar days from when CMS issues the preliminary IPR to request a recalculation of measure scores if they believe there is an error in the calculation. The agency's final IPR reflects the results of all recalculation requests.

Slide 44: During the review of the preview Annual Report, an agency may submit a recalculation request within 15 calendar days after CMS issues the preview Annual Report if they believe there is an error. If an agency disagrees with the results of the CMS recalculation as reflected in the next version of the report, the preliminary Annual Report, the agency may submit a reconsideration request within 15 calendar days after CMS issues the preliminary Annual Report. Now only agencies that submit a recalculation request may submit a reconsideration request.

Slide 45: Excellent, and finally, where can HHAs find their performance feedback reports once those become available?

HHVBP performance feedback reports will be available on the Internet Quality Improvement Evaluation System, or iQIES. And information on iQIES technical support is shown on this slide and is also available in the first section of the Frequently Asked Questions, which is available on the expanded HHVBP Model web page.

Slide 46: Wonderful, thank you. Now let's turn our attention to our final topic today, which is public reporting. Judith, what can you tell us about public reporting required for the expanded HHVBP Model?

Slide 47: Public reporting of home health agency performance data will begin with calendar year 2023 performance year, calendar year 2025 payment year. Data will be available to the public on the CMS website on or after December 1, 2024, the date by which CMS will issue the calendar year 2023 final Annual Report for each competing home health agency. CMS will follow the same approximate timeline for publicly reporting the payment adjustments for the upcoming calendar year, as well as the related performance data. The data publicly available at the cohort level includes applicable measure benchmarks and achievement thresholds. And the home health agency-level data includes applicable measure results and improvement thresholds, total performance score, TPS percentile ranking, and payment adjustment percentage for a given year. And the agency-level information is for agencies that qualify for payment adjustments based on the performance year.

Slide 48: Excellent. Thank you so much Judith and Marcie, Linda, and Elaine for providing this really great overview of the expanded HHVBP Model. Let's go ahead and move into the Q&A portion of our session today. And to kick things off, we are going to review a few commonly asked questions that we have received through the help desk, and as we're going through these first round of questions, we welcome you to type your questions into that Q&A chat on the Zoom platform.

Slide 49: So for this first question I'm going to pose this one to Linda, which is: Where do I register for the model?

There is no registration required for the expanded Model. CMS is requiring that all Medicare-certified agencies that provide services in any of the 50 states, the District of Columbia, and the US territories to compete in the expanded HHVBP Model. And a competing agency is defined as an agency that has a current Medicare certification identified by a CMS certification number or CCN and receives payments from CMS for home health care service.

Slide 50: Excellent, thanks Linda. For this next question I'll give this one to you as well, which is: Will the expanded HHVBP Model require additional data collection and reporting?

No, all measures in the expanded HHVBP Model use data that's already been reported by agencies through the existing Home Health Quality Reporting Program requirements or Medicare claims submissions. So no additional reporting burden, agencies do not need to submit any additional data at this time for the expanded HHVBP Model.

Slide 51: Excellent, and for the next question I'm going to loop in Elaine. Elaine, what if my HHA does not meet the minimum of five applicable measures in performance year 2023 in order to receive a TPS and payment adjustment in calendar year 2025?

Okay, thank you Carrie. So a home health agency must have sufficient data for at least five of the 12 measures for the home health agency baseline year. A home health agency will not receive a total performance score if it does not have sufficient data to allow calculation of at least five of the 12 measures, and the agency will not be subject to payment adjustments for calendar year 2025. The home health agency will still receive quarterly IPRs containing data for the applicable measures for which there is sufficient data available. And the home health agency will continue to participate in the expanded HHVBP Model and is eligible for future payment adjustments.

Slide 52: Excellent, and I'll give this next question to you as well, Elaine. Are all HHAs eligible for a payment adjustment in calendar year 2025?

Okay, so a home health agency certified prior to January 1, 2022 is eligible for a payment adjustment in calendar year 2025 if the home health agency has sufficient data to allow calculation of scores for at least five of the 12 measures in the baseline year and the performance year, and, in addition, the home health agency meets the minimum threshold of data per measure per reporting period.

Slide 53: Excellent, thanks Elaine. Now let's go ahead and start going through all of the questions that we have received. Thank you all so much for submitting your questions, keep them coming. We'll try to get through as many as possible today. So the first couple questions, let's see here. These relate to participation in the expanded HHVBP Model and the timeline for implementation. The first question is: Do all HHAs need to participate? And I'll toss this question to Marcie from CMS.

Thanks, Carrie. Again, CMS requires all Medicare-certified home health agencies that furnish services in the 50 states, the District of Columbia, and US territories to compete in the expanded HHVBP Model. A competing HHA has a current Medicare certification identified by a CMS certification number or CCN and receives payment from CMS for home health care services.

Great, thanks Marcie, and a follow-up question, what is the timeline for nationwide implementation of the Model?

Yes, on January 1, 2022, CMS launched the expanded HHVBP Model, designating calendar year 2022 as a pre-implementation year to allow HHAs time to prepare and learn about the expectations and requirements of the Model. CMS will not apply a payment adjustment to HHAs for their performance in calendar year 2022 and agencies can use this time to assess their own performance on the set of quality measures used in the expanded Model. The first performance year for the expanded HHVBP Model is calendar year 2023, beginning on January 1st of that year. HHAs' performance during calendar year 2023 will determine their payment adjustment amounts that CMS will apply during the first payment year, which is calendar year 2025.

Great, thanks Marcie. Let's see here, I see a lot of questions about the baseline year, which, I'm going to bring you in, Linda. What year is considered that baseline year and will it change?

So remember, there's an HHA baseline year and a Model baseline year. The HHA baseline year is the year which CMS will compare an agency's performance score by measure during the performance year and calculate each agency's unique improvement threshold. And CMS determines an HHA's baseline year by taking into consideration that agency's Medicare certification date. The Model baseline year is calendar year 2019. That's the year that's used for the purpose of calculating the benchmarks and the achievement thresholds for each measure in the expanded Model. And CMS may propose to update the designated Model baseline year for subsequent years of the expanded Model, and again, that would happen through future rulemaking.

Thanks, Linda. Let's see here, we have another HHA who's asking for a description of the cohort groups and the amount per payment adjustment. Marcie, are you able to answer these questions?

Yes, for the expanded Model CMS established cohorts prospectively, determined by the number of unique HHCAHPS survey-eligible beneficiaries for each HHA in the year prior to the performance year. HHAs will compete in either a nationwide larger-volume cohort or a nationwide smaller-volume cohort. This approach allows for grouping of HHAs that are of similar size and more likely to receive scores on the same set of measures for purposes of setting benchmarks and achievement thresholds and determining payment adjustments. The smaller-volume cohort is the group of competing HHAs that had fewer than 60 unique beneficiaries in the calendar year prior to the performance year. As for the payment amounts in a payment year, an applicable percentage, ranging from minus 5% to 5%, is applied toward the Medicare fee-for-service payments.

Excellent, thanks Marcie. Let's see, we have had quite a few questions come in about quality measures, so I'll toss this one to Linda. First, which measures will CMS be looking at with the expanded Model and which measures will be risk-adjusted?

Under the Model we talked about the 12 quality measures: the five OASIS-based measures, two claims-based, and the five components of HHCAHPS survey-based measure. Those are listed in the slides, and all 12 measures in the measure set are adjusted to account for differences in patient characteristics across agencies.

Great, and I'll give this next question to you as well. Did the weight of each measure change from those used in the original HHVBP Model?

Yeah, the weight of each measure is different since New Measures that were part of the original HHVBP Model are not included in the expanded HHVBP Model. For the expanded HHVBP Model, the measure categories are weighted as 35% for the OASIS-based measures, 35% for the claims-based measures, and 30% for the HHCAHPS measures, and that accounts for 100% of the total performance score.

Super, thank you. Let's see, we have received a lot of questions regarding the report so I'm going to do my best to put these together. Judith, HHAs are asking what reports can HHAs access now, are there any available for the expanded Model, when will the first preview TPS reports be available, and finally, where can they access HHVBP Model reports?

Thanks Carrie, yes, so the reports currently available to agencies are those related to the Home Health Quality Reporting Program. For the expanded Home Health Value-Based Purchasing Model, CMS will publish two types of reports that provide agencies with information on their performance and payment adjustments. The first was the IPR which is issued quarterly. And CMS expects to make the first IPR available July 2023. The second type is the Annual Total Performance Score and Payment Adjustment Report, the Annual Report, which CMS expects to make the first preview version available August 2024. The IPR and Annual Report will be available to each competing agency through iQIES, and CMS will notify each agency through email when the reports are available. For assistance with technical questions related to Internet Quality Improvement Evaluation System (or iQIES) platform registration, navigation, or assistance with accessing reports, you can email iQIES@cms.hhs.gov or call 1-800-339-9313.

Great, and we have someone who oversees more than one home health agency. Will they be able to access the reports for each one of these HHAs?

Oh, I would consider this a technical question, Carrie, so I would recommend they contact the Internet Quality Improvement Evaluation System, iQIES, for

technical questions like these, so they can email iQIES@cms.hhs.gov or call 1-800-339-9313.

Great, thank you Judith. Let's see here. This next question relates to the achievement thresholds and benchmarks. When will this information be available to HHAs? And I will pass this one to Elaine.

Okay, thank you Carrie. So CMS will provide the agencies with the benchmarks and achievement thresholds for all home health agencies as soon as administratively feasible and prior to the start or soon after the start of the applicable performance year.

Okay, and I think we have time for a couple more questions. This one focuses on information that is available to HHAs. For the first question, are there more details available about the payment calculations?

Okay, so in addition to what's included in the calendar year 2022 Final Rule, additional resources about the calculation of the total performance score and payment adjustments will be available during the calendar year 2022.

Alright, and then our final question (this is a more general question), is information and guidance available to HHAs so that they can start preparing?

Okay, thanks Carrie, yes, current resources available to home health agencies on the expanded HHVBP Model web page include the calendar year 2022 Final Rule, newsletters, composite measure documents, Frequently Asked Questions, and webinar slides. Additional resources to assist home health agencies with implementation of the expanded HHVBP Model will be presented in upcoming webinars and made available on the expanded HHVBP Model web page as well.

Great. Thank you, Marcie, Linda, Elaine, and Judith, for talking through those questions that we received. We did receive many questions that were not covered, and they will be considered for future editions of Frequently Asked Questions, so you can watch out for future editions of the FAQs as they become available.

Slide 54: So let's go ahead and move on. So CMS is really committed to supporting all competing HHAs with implementing the expanded HHVBP Model, and before we close out the event, we want to highlight some of the information and resources that is currently available, as well as those that are coming soon.

Slide 55: So this slide shows all of the help desks available to you. This table is also in the FAQs, so you can easily reference it in that document as well. If you have questions that are specific to the expanded Model, please email HHVBPquestions@lewin.com, and there's also a help desk designated to support

agencies with access to iQIES and navigating around iQIES. And there are also some help desks available for questions about the Home Health Quality Reporting Program.

Slide 56: Let's see, and in November CMS launched the expanded HHVBP Model web page, and this is your go-to site where you can find information and resources about the expanded HHVBP Model, including these slides. You can also stay informed by subscribing to the expanded HHVBP Model listserv.

Slide 57: And the following resources are already available on the expanded Model web page. We have links to the HH PPS final rule, and of course we have a copy of this slide deck, the expanded Model FAQs, and some really focused resources on the TNC measures, so one document focuses on the calculation steps and the other is a technical specifications document for those composite measures.

Slide 58: And we also have a lot of resources coming covering the following topics that you see on this slide. You can look out for those on the Model web page in the coming weeks and months. So we're going to have a recording and transcript of this event. We'll have information on the model quality measures, including the TNC measures, more information on risk adjustment in the Model, quality improvement, and the total performance score and payment adjustment methodologies, as well as more information on the performance feedback reports. So definitely stay tuned for more information.

Slide 59: Alright, well, thank you all so much for joining us today. Thank you for your attention and submitting your questions. Enjoy the rest of your day. Bye.