



HOME HEALTH VALUE-BASED PURCHASING

Thriving in the New Environment

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Value-based reimbursement represents a shift in how home health agencies think about measuring healthcare. It puts the focus squarely on the results of care, not simply measuring the number of activities clinicians perform.

Over the past several years, hospitals and physicians' offices have transitioned to a pay-for-performance model for reimbursements. Now, as the Centers for the Medicare and Medicaid Services (CMS) launches its value-based purchasing

demonstration for home health, agencies must also adapt to this new structure.

Home health providers now have an opportunity to demonstrate the great work they have been doing and gain additional reimbursement revenue as a result.

The CMS value-based purchasing demonstration uses a complex model that is fraught with potential challenges for home health organizations, but also a number of opportunities for those willing to make the

investments. Details of how the initiative will unfold over time are still uncertain, but one thing is clear: all agencies, regardless of location, will need to prepare for a new way of measuring success.

This whitepaper will provide home health agencies with an understanding of the methodology for reimbursements under the new initiative. Agencies will learn how changes will impact their business and gain a roadmap for preparing for change.

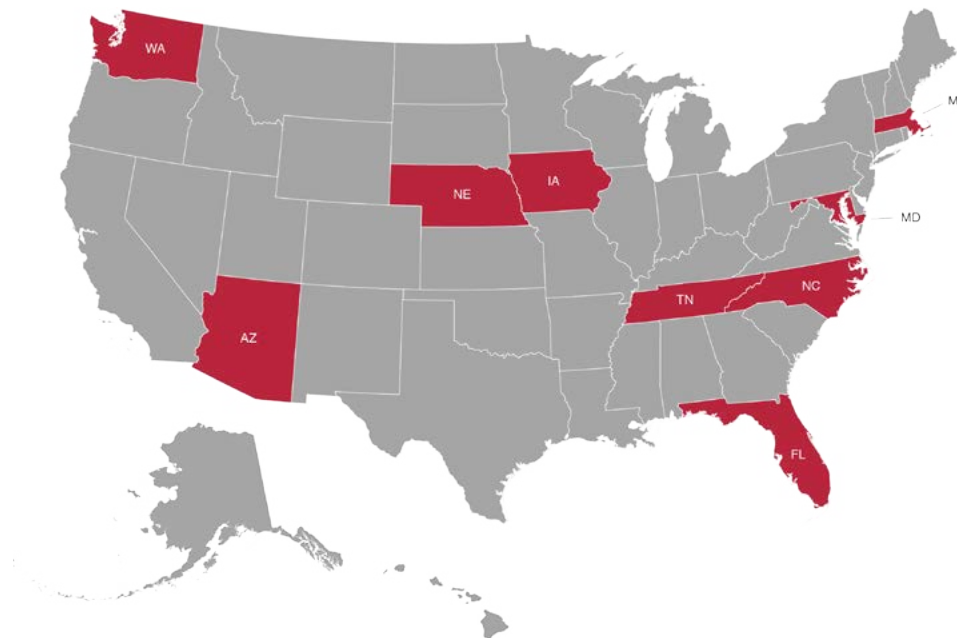


In January of 2016, CMS launched the new pay-for-performance model for home health organizations as a pilot demonstration. CMS has several goals for the initiative:

- Increasing transparency and public reporting
- Measuring cost and rewarding value with payment innovation
- Standardizing performance measurement with other healthcare delivery systems
- Improving shared decision-making and patient activation for informed customer choice and improved outcomes

The prerequisite to measuring value is consistent, accurate data. To launch the demonstration, CMS has selected specific performance measurements that contribute to “value,” across the following domains:

- Clinical quality
- Population health
- Patient safety
- Patient satisfaction
- Efficiency and effectiveness
- Care coordination



The initial rollout impacts home health agencies in nine states.

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

The reimbursements for Medicare and Medicaid patients will be adjusted – up or down – based on a complex scoring model that begins with existing data sources (clinical, claims and patient experience) and compares performance of home health agencies both over time and relative to each other.



Home health agencies have been collecting data for many years. They have been utilizing the Outcome and Assessment Information Set (OASIS) for data collection/assessment since its adoption by CMS in 1999, and the data collection recently centralized to a federal repository instead of states. Also, agencies with 60 or more patients are already required to use the Home Health Consumer Assessment of Healthcare Providers and Systems (HHAHPS) surveys to capture feedback on satisfaction with their service. Claims data submitted by home health agencies for services rendered to Medicare beneficiaries provides insight into utilization of services and patterns of care.

However, these measurements provide a limited window into actual quality performance. They are a starter set, and with the ability of CMS to introduce new measures and reimburse for various aspects of performance on these measures, the foundation for payment for performance will be firmly established moving forward.

UNDERSTANDING THE SCORING METHODOLOGY

There are 24 starter measures included in the pilot program.

+10 Outcome Measures

- Improvement in ambulation
- Improvement in bed transferring
- Improvement in bathing
- Improvement in dyspnea
- Discharge to community
- Acute care hospitalization
- Emergency department use without hospitalization
- Improvement with pain interfering with activity
- Improvement in management of oral medications
- Prior functioning ADL/IADL

+6 Process Measures

- Care management: types and sources of assistance
- Influenza vaccine data collection period
- Influenza immunization received for current flu season
- Pneumococcal polysaccharide vaccine ever received
- Reason pneumococcal vaccine not received
- Drug education on all medications provided

+5 HHAHPS (Patient Experience) Measures

- Composite of patient survey responses about the treatment they received
- Composite of patient survey responses regarding amount, effectiveness and timeliness of

- communications between providers and patients
- Composite of patient survey responses related to the specific care issues, pain discussions, and prescription medication
- Patient's overall rating of home health provider
- Patient's willingness to recommend the agency to family or friends

+ 3 New Measures Impacting Home Health Employees

- Influenza vaccination coverage for agency personnel
- Patient vaccinations for Herpes Zoster viruses (Shingles)
- Advance care plans for patients 65 or older

10 + 6 + 5 + 3 = 24 TOTAL MEASURES

Each of these measures is scored on a scale of 1 to 10, and the data is formulated to calculate the Total Performance Score (TPS). The outcome, process, and HHAHPS measures are worth 90% of the TPS and the new measures 10% of the TPS.



A CLOSER LOOK AT THE NEW MEASURES

• Staff influenza vaccination

This measure includes 12 questions related to the number of staff who have been offered the vaccine, how many received it, (either inside or outside) the agency, and reasons why any employee was not vaccinated, such as allergies, compromised immune systems and previous adverse reactions. It covers employees, licensed independent contractors, students, trainees and volunteers who have worked at least one day from October 1 to March 31, regardless of their function.

• Shingles vaccine

This measure has 13 options for agencies to consider, including nine options for contradictions. At the start of care, clinicians will need to ask patients if they have received the vaccine. If not, they will have to check again at transfer and discharge for updates.

• Advance care

This measure requires documentation of the percentage of patients 65 or older who have an advance care plan or surrogate decision maker noted in the medical record. If no plan or decision maker is noted, there must be documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

The agencies in each state will be divided into small cohorts (agencies with an annual census fewer than 60 patients) and large cohorts (agencies with an annual census of 60 or greater).

In addition to being graded on the agency's individual Improvement score (comparing your improvement against your 2015 baseline with other agencies' improvement), agencies will be compared across their state cohorts for their Achievement score. Two main data points are used in calculating the Achievement score:

- Benchmark score (mean for the top 10% of agencies)
- Threshold score (median of all agencies)

The higher of the Improvement or Achievement score is utilized as the TPS for calculating the agency's reimbursement.

Once an agency's TPS is identified, reimbursement is then calculated based on seven steps:

STEPS		Example 1	Example 2
		TPS = 38	TPS = 35
Step 1	Prior Year Aggregate HHA Payment Amount	100,000	653,222
Step 2	3% Payment Reduction Amount	3,000	19,597
Step 3	Final TPS Adjusted Reduction Amount	1,140	16,657
Step 4	Calculating the Linear Exchange Function (LEF)	1.92	1.92
Step 5	Final TPS Adjusted Payment Amount	2,280	33,319
Step 6	Quality Adjusted Payment Rate	2%	5%
Step 7	Final Percent Payment Adjustment	-1%	2%

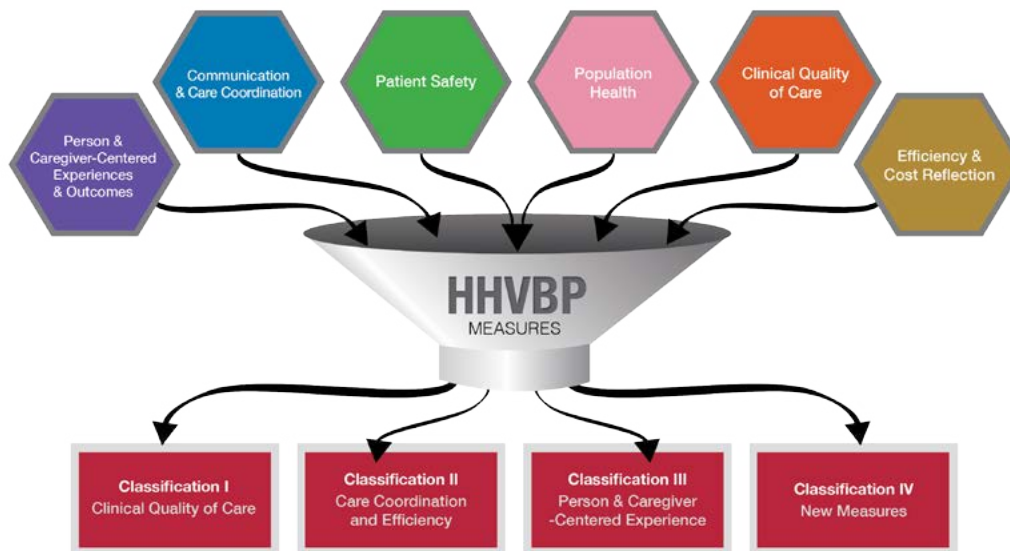


MEASURES WILL EVOLVE

Keep in mind, the nine-state pilot project is just that, a pilot. In addition to requiring agencies in additional states to comply during the five-year period of the demonstration, we expect that CMS will adapt the measures it requires agencies to track.

For example, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires CMS to standardize the reporting of measures across post-acute settings, including home health. CMS has made it clear that the measures used in this standardization will be introduced into HHVBP as they are finalized.

As agency performance reaches a peak, it is likely that CMS will retire some of the pilot measures and replace others, possibly including some behavioral health measures. Every few years, agencies should expect a rotating set of measures to determine reimbursement rates.



Source: [CMS Final Rule](#)

“The potential reward for agencies will increase each year.”



WHO WILL WIN?

Agencies that score well in the new value-based model have the potential to gain additional revenue. Starting in 2018, high-performing agencies will begin to receive bonuses based on their 2016 performance, at a maximum payment of 3% of their 2016 reimbursements.

The potential reward will increase each year. Agencies can receive a 5% bonus in 2019 (based on 2017 performance), 6% in 2020 (based on 2018), 7% in 2021 (based on 2019) and 8% in 2022 (based on 2020).

YEAR PERFORMANCE	YEAR COMPARISON	POTENTIAL BONUS	YEAR BONUS RECEIVED
2015	N/A	N/A	N/A
2016	2015	3%	2018
2017	2015	5%	2019
2018	2015	6%	2020
2019	2015	7%	2021
2020	2015	8%	2022

Agencies can also receive benefits beyond direct financial incentives. Performance measurements and rankings among home health agencies will be publicly available, which means that discharge coordinators and physicians may be

more likely to refer patients to those agencies that score well.

The agencies most likely to garner the full benefits of the new value-based system will be those that understand the measures, know how to analyze pertinent data and can apply the analysis to the ways in which they provide service.

Agencies that are currently working directly with physician groups and hospitals are already quite familiar with the concept of value-based purchasing. Those who have already adapted Quality Assurance and Performance Improvement Standards promulgated by CMS have a head start on achieving excellence.

Forward-looking agencies have recognized that even the current regulatory environment is so cumbersome that having the right tools in place for data collection is the only way forward. If an agency is already using an Electronic Health Records (EHR) system to correctly capture metrics for OASIS and CAHPs, it is already compiling 87% of the necessary data to meet the requirements in the CMS value-based reimbursement demonstration.

WHO WILL LOSE?

Agencies that are not able to demonstrate outcomes will score lower than their peers and be awarded less incentive money, or worse, lose money due to penalties. The money that they lose

will in turn be given higher performing agencies. Just as the incentives increase over time, so do the penalties for underperformance (reducing reimbursements up to 3% in 2018, 5% in 2019, 6% in 2020, 7% in 2021 and 8% in 2022).

PENALTIES REDUCING YEARLY REIMBURSEMENTS			
2018		up to	3%
2019		up to	5%
2020		up to	6%
2021		up to	7%
2022		up to	8%

Agencies should expect that it may require up to a week each quarter, particularly in the beginning stages of the program, to collect, organize and submit data related to employee vaccinations. If they do not submit information in full, their overall submission to CMS may be rejected.

It is clear that agencies need to invest in electronic health records that will enable them to efficiently collect data during routine documentation, and report utilizing analytic tools in order to thrive.

The transition to value-based pricing may be the tipping point that creates a costly administrative burden – combined with potential penalties – that eventually causes the lower tier of home health organizations to shutter their doors.



IF YOU OPERATE IN ONE OF THE NINE STATES IN THE PILOT...

To achieve positive scores, agencies need to take action right away. Depending on your starting point, you'll want to focus on two or three items from the list below.

- 1.** Establish a value-based purchasing planning committee that determines how your agency will address the measures, train clinicians and administrative staff, and track progress overtime.
- 2.** Compare your performance to other agencies using all data available. e.g. Home Health Compare, Certification and Survey Provider Enhanced Reports (CASPER reporting) Star Ratings and chart audits.
 - a.** Look for CMS to release the first segment of 2015 data in 2016. You will be provided achievement and benchmark thresholds, which CMS will release based on 2013 and 2014 data. While these sources don't cover the new measures, they can give you an early sense of how you stack up.
- 3.** Analyze your internal data to identify areas for improvement. For example, if you see a variance in clinicians' outcomes for a given measure, you can dig in to understand the reasons, improve communications or offer training.
- 4.** Start collecting data on employee immunizations. Consider supplying the flu vaccine to staff to have more control over the process and collecting the data.
- 5.** Train quality and clinical managers in the field to encourage patients to get the Shingles vaccine at the beginning of an episode, and document the outcome. This will help reduce any extra time researching the vaccination status.
- 6.** Make sure your agency documents at intake and discharge whether patients have an advance care plan and have the staff member review patients' charts to make sure this data was collected.
- 7.** Enroll in HHCAHPS, if not already doing so, especially with CMS approved vendors that can provide additional value. Even if you are not required to do so, it is a good idea to conduct these types of surveys to gain invaluable insight.
- 8.** If you have an electronic health records system, work with your vendor to set up a template that captures the information on the new measures.





IF YOU OPERATE IN ONE OF THE OTHER 41 STATES...

You will still need to understand the new model and be prepared for the day CMS includes your state.

There is no reason to believe that value-based reimbursement will go away anytime soon. Value-based reimbursement was mandated in the Affordable Care Act (ACA) and will continue to be expanded to all areas of healthcare.

You can take steps to make sure you are prepared for the day your state is required to comply.

- It is important to monitor how CMS reports performance of agencies in the first nine states. You can use the results as a proxy for your own performance. You'll then be able to focus your efforts on areas where you are lagging behind performance benchmarks.
- Now is the time to make sure any data collection methods you use are consistent and efficient. You'll be better prepared to integrate new requirements if your tools and processes are already in place.

THE BOTTOM LINE

High-performing agencies have much to gain in the new reality of value-based reimbursement.

The pay-for-performance model provides home health agencies with a framework to demonstrate to the public that CMS is a wise steward of public resources and that we receive "value" for our investment. Most importantly, it helps agencies more clearly communicate the quality of care they offer patients.

To succeed, home health providers must understand the value-based measurements and incentives, and set themselves up to respond to the new requirements with insight and efficiency.





Axxess is a healthcare technology and solutions company with roots firmly embedded in consulting and software development. Established in 2007 as a consulting firm specializing in the home healthcare industry, Axxess identified an unmet need for software that is comprehensive, fully integrated, user friendly, and scalable.

After assembling a multidisciplinary team of technology experts, home health agency veterans, physicians, nurses and therapists, Axxess launched **AgencyCore** and **AxxessDDE**. Available as web-based software, **AgencyCore**, **AxxessDDE** and **AxxessBilling** help home health agencies run their businesses efficiently.

A nationwide leader in providing integrated software to home health agencies, Axxess is the first and only home health software provider accredited by the American Nurses Credentialing Center, a subsidiary of the American Nurses Association.



Thank you!