THE ESSENTIAL GUIDE TO THE HOME HEALTH VALUE-BASED PURCHASING PROGRAM

Advanced TeleHealth Solutions

About Advanced TeleHealth Solutions

Advanced TeleHealth Solutions has been a leader in remote patient monitoring for more than a decade. The company deploys the most advanced technologies, strategies, and a URAC-accredited health call center to help healthcare providers, payers, and employers improve health outcomes, reduce avoidable hospital readmissions, and reduce healthcare costs.

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Value-Based Purchasing Comes to Home Care

On January 1, the Centers for Medicare and Medicaid Services (CMS) launched the Home Health Value-Based Purchasing (HHVBP) program as a pilot in nine states: Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska and Tennessee. Modeled after a similar Hospital Value-Based Purchasing program, CMS estimates five-year savings of $380 million by reducing unnecessary hospitalizations and skilled nursing facility usage.

The Hospital Value-Based Purchasing (VBP) program was established as part of the Affordable Care Act of 2010, with financial payments to hospitals being adjusted beginning in fiscal year 2013. VBP is the cornerstone of CMS's long-standing effort to link Medicare's payment system to a value-based system to improve healthcare quality, including the quality of care provided in the inpatient hospital setting. In short, participating hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide.

Value-Based Purchasing Fact Sheet

Projected Medicare Savings
$380 million over 5 years

Participating States
Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska and Tennessee

National Impact
The pilot will impact approximately 20% of home health agencies in the United States

Until now, home health providers have only been indirectly impacted by value-based purchasing, as hospitals and physicians, in many instances, have required home health agencies to achieve certain quality goals as part of obtaining referrals. As such, home health agencies that have not been able to demonstrate a positive impact on hospitals' value-based purchasing objectives have seen referrals dwindle – if not disappear altogether.

With the HHVBP program, the need to achieve specified quality metrics will no longer be driven by the indirect pressure of referral sources, but also by the direct impact of CMS reimbursement. To wit: Home health agencies could see reimbursement shifts – either up or down – that start at 3% and rise to 8% by the end of the pilot, depending on their performance across 24 outcome and process measures established by CMS.

Moving away from fee for service in favor of a risk-sharing and outcomes-based reimbursement model is a major focus for CMS. In addition, like its hospital counterpart, the program is simple in design: achieve certain quality metrics and be financially rewarded; fail to achieve these metrics and be financially penalized. Despite the apparent simplicity of HHVBP, however, the difficulty for home health providers lies in their achievement of specified quality targets.

For home health agencies in the pilot group, CMS will use 2015 as a baseline and providers will not realize the consequences of their 2016 performance until 2018. For providers who achieve financial rewards, the additional payments could offer relief

from the multi-year reimbursement cuts mandated under the Affordable Care Act; that said, failure to achieve quality targets present a significant level of risk.

Even though the nine-state pilot is scheduled to run for seven years through December 31, 2022, home health agencies not part of the test program should not simply ignore it. With the likelihood that HHVBP will become a permanent fixture once the pilot concludes – and with the financial impact substantial – this is an opportunity for non-participating agencies to learn and prepare. By comparison, CMS's hospital value-based purchasing program has reimbursement shifts of only 1.25% to 2%; the stiffer penalties being doled out to home health agencies is not to be taken lightly.

> **"Failure to adopt a data-driven approach to performance, quality, and outcomes today could be a home health agency's financial undoing tomorrow."**

Whether a home health provider is in the nine-state pilot or not, the new strategic imperative is clearly to focus on data-driven performance models as a key to future success. Failure to adopt a data-driven approach to performance, quality, and outcomes today could be a home health agency's financial undoing tomorrow.

The Participating Pilot States

The nine participating states – Massachusetts, Maryland, North Carolina, Florida, Washington, Arizona, Iowa, Nebraska and Tennessee – were selected at random from the nine regions created by the home health value-based purchasing rule. The regions were created to reflect regional variations, but CMS has stated that the composition of these regions could change in the future.

The pilot is not voluntary; all home health agencies in each of the nine states must participate in the HHVBP program. Participation is based upon state-specific provider numbers, meaning that if a provider operates in multiple states, only those provider numbers that are in one of the nine states are required to participate; provider numbers in other states will not participate in the pilot.

Because of regional variations in care, CMS will evaluate agency performance on a state-by-state basis. In other words, home health agencies in North Carolina will only be compared against other providers in that state; those agencies will not be compared against, for instance, home health agencies in Maryland. What this means is that financial rewards and penalties will be calculated by comparing the performance of home health agencies in the same state.

That's not the only nuance to the HHVBP program, however. CMS will place agencies in each state into one of two cohorts – the first consisting of larger-volume providers and the second consisting of smaller-volume providers. Home health agencies that are large enough to participate in the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) will be in the larger-volume cohort, while agencies that do not participate in HHCAHPS will be in the smaller-volume cohort.

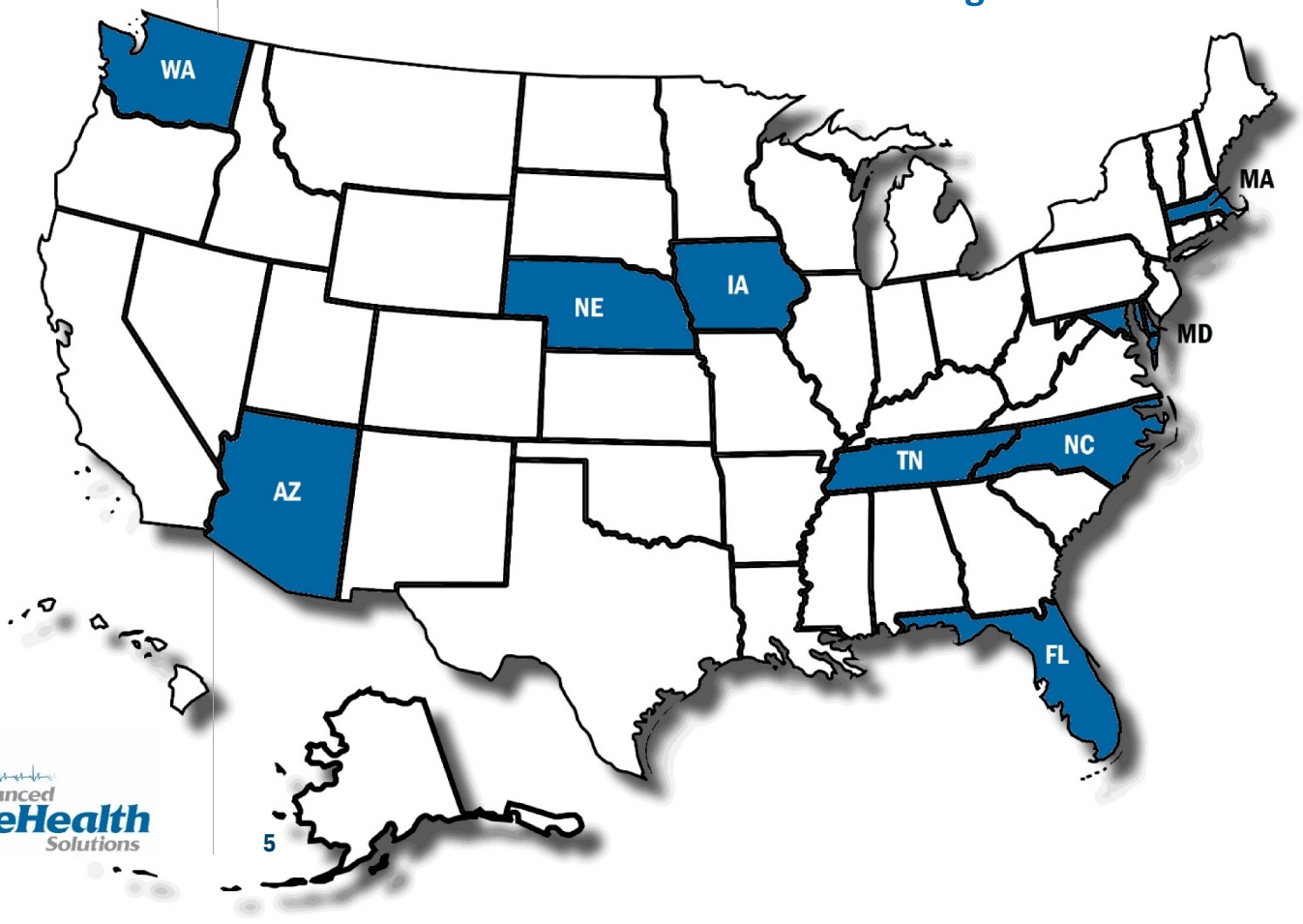
Gathering and Reporting of Data

Calendar year 2015 will serve as the baseline for the purpose of calculating performance scores and peer rankings. CMS will then provide each home health agency with quarterly and annual reports of their performance metrics. The first quarterly report will be issued July 2016, reflecting data from January 1, 2016, through March 31, 2016. Afterward, quarterly reports will be issued in October (April through June data), January (July through September data), and April (October through December data). Each report will include the provider's absolute results for the 24 outcome and process measures, the change for each since the last report, and a comparison to other providers within its state cohort.

The annual report will be issued in August and will include not only the provider's performance for the previous calendar year, but also their payment adjustment that will be applied on January 1 of the next year. In other words, in August 2017, each home health agency will be provided an annual report that displays its 2016 performance, as well as its rate adjustment that will be applied effective January 1, 2018.

The reimbursement risk in 2018, based on 2016 performance, is 3%, increasing to 5% in 2019, 6% in 2020, 7% in 2021, and 8% in 2022.

Home Health Value-Based Purchasing Pilot States



The 24 Outcome and Process Measures

The HHVBP program uses 24 outcome and process measures to determine quality and corresponding rate adjustments. Twenty-one of these measures are included among existing home health agency reporting requirements, while three are entirely new measures that have never been reported before. All agencies in the nine pilot states are required to report these new measures, which include influenza vaccination of home health staff, herpes zoster (shingles) vaccines for home health agency patients, and advanced care planning for home health agency patients. Because these are new measures, providers will receive points simply for reporting these measures – points will not be awarded for actual performance.

3 New Measures

1. Influenza vaccination of home health staff
2. Herpes zoster (shingles) vaccines for home health agency patients
3. Advanced care planning for home health agency patients.

Outcome Measures

1. Improvement in ambulation (OASIS)
2. Improvement in bed transfer (OASIS)
3. Improvement in bathing (OASIS)
4. Improvement in dyspnea (OASIS)
5. Discharged to community (OASIS)
6. Acute care hospitalizations (Medicare Claims)
7. Emergency department use without hospitalization (Medicare Claims)
8. Improvement in pain interfering with activity (OASIS)
9. Improvement in management of oral medications (OASIS)
10. Prior functioning activities of daily living and instrumental activities of daily living (OASIS)
11. Care of patients (HHCAHPS)
12. Communication between providers and patients (HHCAHPS)
13. Specific care issues (HHCAHPS)
14. Overall rating (HHCAHPS)
15. Willingness to recommend the agency (HHCAHPS)
16. Care management/types and sources of assistance (OASIS)

Process Measures

17. Influenza vaccine data collection (OASIS)
18. Influenza immunization received for current flu season (OASIS)
19. Pneumococcal polysaccharide vaccine ever received (OASIS)
20. Reason pneumococcal vaccine not received (OASIS)
21. Drug education on all medications provided to patient/caregiver (OASIS)
22. Influenza vaccination of home health staff (Reported by HHAs through Web Portal)
23. Herpes zoster (shingles) vaccine received (Reported by HHAs through Web Portal)
24. Advanced care planning (Reported by HHAs through Web Portal)

To succeed under the new HHVBP program, home health agencies must focus on 1) the accuracy of their OASIS data, 2) improvements in their OASIS data, and 3) improvements in their HHCAHPS scores. Launching and managing ongoing quality improvement programs aimed at improving OASIS and HHCAHPS results is important not only for the home health agencies in the nine pilot states, but also all other providers who will be absorbed into the program in a few years.

The Total Performance Score

Home health agency performance will be measured using a Total Performance Score that is developed using all 24 measures. The 21 existing measures will count for 90% of the Total Performance Score, with each having equal weight. The three new measures will count for 10% of the Total Performance Score, with each of these also having equal weight.

For each of the 21 existing measures, CMS will award 0 to 10 points based upon the agency's quality achievement score or for its quality improvement score, whichever is higher. The quality achievement score is the actual measure of performance, while the quality improvement score shows the level of improvement the provider has made. By rewarding points for either the actual score or the amount of improvement achieved allows home health agencies to be rewarded for improvement, even if their quality achievement score is still low. The maximum number of points a provider can achieve for existing measures s 210 (21 existing measures x a maximum of 10 points per measure)

To be included in the Total Performance Score calculation, an existing measure must have at least 20 applicable data points annually. If, for example, the home health agency had less than 20 completed HHCAHPS, then the five measures associated with that survey – care of patients, communication between providers and patients, specific care issues, overall rating, and willingness to recommend the agency – would all be excluded from the Total Performance Score calculation. The remaining 16 existing measures would then be weighted equally to count for 90% of the Total Performance Score. In this case, the maximum number of points this home health agency could achieve for existing measures is 160 – which would then be weighted to comprise 90% of the Total Performance Score.

Finally, if a provider has fewer than five applicable measures in a year, then that agency would not be subjected to any payment adjustment.

Calculating the Total Performance Score

21 Existing Measures Worth Up To 10 Points Each

- Total of 210 points possible
- Existing measures worth 90% of Total Performance Score

3 New Measures Worth 0 or 10 Points Each

- All-or-nothing scoring: Each is worth 10 points just for submitting the data or 0 points if the home health agency does not submit the data
- The home health agency can earn 0, 10, 20, or 30 points total.
- New measures are worth 10% of the Total Performance Score

Scoring Example

- Existing Measures: 176 of 210 points earned, or 83.810% -- weighted to 74.429%
- New Measures: Data submitted for two of the new measures, earning 20 of 30 points, or 66.667% -- weighted to 6.667%
- Total Performance Score = 74.429 + 6.667 = 82.095

For the new measures, the home health agency will earn 10 points for each measure it reports. Conversely, for any measure in which the provider fails to report, 0 points will be awarded.

CMS will use 2015 data to establish benchmarks and achievement thresholds for each of the 21 existing measures – calculated separately for each cohort in each state to ensure similar providers are scored against each other. Home health agencies will then be awarded points in the following manner:

- 10 points: The provider's score equals or exceeds the calculated benchmark, which is defined as the mean of the top 10 percent of all home health agencies' performance on that particular measure.
- 1 to 9 points: The provider's score equals or exceeds the calculated achievement threshold, which is defined as the median of all home health agencies' performance on that particular measure. Points will be calculated using a specified formula.
- 0 points: the provider's score is less than the calculated achievement threshold.

Ongoing Improvement Scoring

Home health agencies that do not achieve the full 10 points by meeting or exceeding the calculated benchmark can earn points based on their actual level of achievement or their actual level of improvement. Whichever calculation results in the most points for the provider will be used to determine the home health agency's Total Performance Score.

If the provider's score did not exceed the benchmark, but did exceed its own baseline period score, then it would receive between 0 and 10 points, determined by the following formula:

- 10 x (the provider's performance period score minus the provider's baseline period score) divided by (the benchmark – the provider's baseline period score) minus 0.5.

For example, let's say that the provider's baseline period score for a particular metric was 0, its current score is 4 and the benchmark score is 7. The improvement score is:

- 10 x (4-0) / 7-0 minus 0.5 *or* 40/7 minus five *or* 5.214.

If the provider's current period performance score is less than its baseline period score, then the home health agency would receive 0 points.

To calculate the final Total Performance Score, the total points achieved for the applicable existing measures is divided by the total points possible and then multiplied by 90. The total points achieved for the new measures is divided by 30, and then multiplied by 10. These two numbers are totaled to determine a Total Performance Score between 0 and 100, which is the score used to determine the payment adjustment.

Home Health Agency Example A:

- Total score of 102.671 across 18 applicable existing measures = 51.336 points
- Submits data on all three new measures and achieves 30 points = 10.000 points
- Total Performance Score = 61.336 points

Home Health Agency Example B:

- Total score of 143.012 across 21 applicable existing measures = 61.291 points
- Submits data on two of new measures and achieves 20 points = 6.667 points
- Total Performance Score = 67.958 points

Home Health Agency Example C:

- Total score of 38.755 across 12 applicable existing measures = 29.066 points
- Fails to submit data on all new measures and achieves 0 points = 0.000 points
- Total Performance Score = 29.066 points

Improvement Scoring Formula

$$10 \times \left(\frac{\text{HHA Performance Period Score} - \text{HHA Baseline Period Score}}{\text{Benchmark} - \text{HHA Baseline Period Score}} \right) - 0.5$$

Improvement Score Example Home Health Agency A

$$10 \times \left(\frac{8.336 - 6.712}{8.560 - 6.712} \right) - 0.5 = 8.288$$

Improvement Score Example Home Health Agency B

$$10 \times \left(\frac{9.201 - 6.712}{8.560 - 6.712} \right) - 0.5 = 10.000$$

Transforming the Total Performance Score Into Payment Adjustments

CMS's objected with the Home Health Value-Based Purchasing program is to incent providers to achieve good performance. Achieve or exceed benchmarks and receive financial rewards; fail to achieve benchmarks and be subjected to financial penalties.

Although the pilot began January 1, 2016, the first payment adjustments do not go into effect until January 1, 2018. This allows CMS to establish baselines from 2015 data, measure 2016 performance, and provide each agency with an inaugural annual report in August 2017. Payment adjustments by year are scheduled as follows:

- January 1, 2018 (based on 2016 performance data): +/- 3%
- January 1, 2019 (based on 2017 performance data): +/- 5%
- January 1, 2020 (based on 2018 performance data): +/- 6%
- January 1, 2021 (based on 2019 performance data): +/- 7%
- January 1, 2022 (based on 2020 performance data): +/- 8%

Calculating the Payment Adjustment

Calculating the payment adjustment is tricky. While determining the Total Performance Score is relatively straightforward – even if it does require numerous mathematical functions – transforming that score into a payment adjustment is not nearly as easy.

The first payment adjustment of +/- 3% goes into effect January 1, 2018, and increases to +/- 8% by 2022

The payment adjustment is easy to understand, yet difficult to calculate. Simply put, CMS will calculate the average Total Performance Score for each state's cohort, with the average score being equal to a 0% payment adjustment. Home health agencies with an above-average Total Performance Score will receive a payment increase, while providers with a below-average Total Performance Score receive a payment decrease.

This is where things get difficult. Because CMS will use a linear exchange function to translate Total Performance Scores into payment adjustments, the amount of any increase or decrease will depend upon where the home health agency falls along the curve and the slope of the curve.

This means that a provider's payment adjustment is not only based on its own performance, but also the performance of other home health agencies in its cohort. Depending on the slope of the linear exchange function, a provider could see its payments reduced even if performs well, if for no other reason than other providers in its cohort performed even better.

Review and Recalculation Request

During the HHVBP program pilot, home health agencies will have the opportunity to challenge any payment adjustment, but only if they identify a discrepancy or calculation error. For quarterly and annual reports, home health agencies have 30 days from the receipt of the report to challenge their scores, but CMS will only adjust the scores if it is determined that a mistake was made in calculating the numbers. In addition, the provider will be required to include a specific basis for the requested recalculation.

"A public quality report can be even more damaging to home health agencies, as it can easily influence referrals from hospitals and skilled nursing facilities."

The Public Quality Report and Its Potential Impact

The HHVBP program will include an annual, publicly available quality report designed to provide information on each agency's performance. Although CMS has not yet disclosed what type of information will be available in the public report, based on reports for similar value-based purchasing programs, it is likely to include scoring and/or ranking information, as well as rate adjustments. Similar reports for the hospital VBP program have generated a great deal of media attention, both at the national and local levels, putting lower-performing hospitals on the defensive.

A public quality report could be even more damaging to home health agencies, as it could easily influence referrals from hospitals and skilled nursing facilities. Home health agencies whose scores are lower than competitors could be perceived to be of lower quality, which could cause referral sources to send their patients to "higher quality" agencies.

Because of the methodology CMS will use to calculate rate adjustments – the linear exchange function – providers with good Total Performance Scores could have a relative rank that appears worse than what it actually is. Ideally, the public quality report will include information about the Total Performance Score and what it means, and not just the payment adjustments. However, until the first public quality report is released, how the data will be portrayed by CMS is anyone's guess. If the primary focus is on rate adjustments, then the public quality report could be more damaging to a home health agency than any reduction in payments in might receive.

4 Steps to Success

1. Review your Home Health Compare data and identify improvement opportunities.
2. Look for agency and clinician trends that must be addressed.
3. Conduct performance and documentation reviews with all payers – not just Medicare.
4. Improve low HHCAHPS response rates.

How to Succeed Under HHVBP

First, review your data on Home Health Compare and identify areas of improvement that could impact your Total Performance Score. Also review how often your clinicians are required to correct OASIS-C1 documentation. Maximizing your payment adjustment requires not only good performance, but also that you are submitting good data. Make sure you are successful at both.

Second, pore through your data to identify agency and clinician trends. Improvement opportunities generally won't be global in nature; the improvements that can make a difference could come down to additional training at a single agency or with a couple of clinicians.

Ensure that everyone on staff knows the rules of HHVBP, including the 24 measures that will determine payment adjustments. If they know the specifics of each of these measures, including how performance is scored for each (see Appendix A), then your chance of success will increase.

With that in mind, create training modules for the OASIS and HHCAHPS measures to improve performance, as well as documentation of performance. Create a tracking tool and use this tool at chart reviews, case conferences, and discharge and transfer reporting. Such a tool will help you identify areas of improvement, ongoing performance deficiencies, and/or documentation problems.

Once you identify which clinicians might need extra help, consider conducting home visits with them, if necessary.

Third, when you conduct reviews, ensure you review all payers – not just Medicare. Why? Performance and documentation issues might show up with private payers first. If this is the case, tackling and correcting them before they have an opportunity to bleed over to your HHVBP results is certainly beneficial. In addition, as private payers adopt similar value-based purchasing models – which is certainly plausible – having a jumpstart is not a bad idea.

Fourth, review your HHCAHPS results to make sure you are getting a good response rate. Low response rates could negatively impact your scores, which, in turn, will negatively impact your Total Performance Score. If your survey response rates are low, talk to your vendor about strategies for improving participation. If improvements aren't forthcoming, you then might want to consider changing vendors.

How to Use Remote Patient Monitoring to Maximize Payments

One of CMS's biggest aims of the HHVBP program us to reduce hospitalizations. If home health agencies don't reduce the number of unplanned hospitalizations during the first 60 days of home health, then they stand to lose a substantial amount of revenue. It's easy to dismiss the overall impact of the HHVBP hospitalization metric, as it is only one of 24 measures that comprise the HHA's Total Performance Score. That said, many of the other measures directly influence hospitalizations; as a provider improves its outcome measures, then hospitalizations will improve as well.

For instance, issues in ambulation, bed transfer, bathing, dyspnea, pain management, medication compliance, ADLs, and IADLs – these are specific outcome measures included in an agency's HHVBP Total Performance Score – all influence home health hospitalization rates.

Interestingly, these same measures can be improved through remote patient monitoring. A care manager who is remotely monitoring a patient can proactively identify emerging issues before they become full-blown problems and provide

immediate interventions – leading to improved outcome measures, reduced hospitalizations, and reduced E.D. visits. That's not all. Remote care managers can also improve HHCAHPS scores – just consider the impact a care manager can have on communication between providers and patients. In fact, of the 21 existing measures that make up 90% of a provider's Total Performance Score, remote patient monitoring positively affects 15 of them.

Where remote patient monitoring is most valuable is for patients with one or more chronic conditions, such as congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, hypertension, and asthma. In addition to monitoring biometric readings for these patients and intervening when necessary, care managers can:

- Evaluate patients' medication compliance, including whether a patient has filled a prescription on time or is taking a drug as prescribed.
- Help patients identify the link between the onset of symptoms and a newly prescribed drug.
- Provide education to help patients understand their co-morbidities and how best to manage their conditions.
- Coach patients to better manage their overall health.
- Assist clinicians with monitoring a patient's treatment plan.
- Help patients get the most from their home health visits.

"In a recent survey, 89% of healthcare executives responded that telemedicine will transform the U.S. healthcare system in the near future."

To illustrate the impact a remote care manager can have on a home health agency's outcome, consider a patient with chronic obstructive pulmonary disease; by checking in to see if he is using his maintenance medications every day, the remote care manager can prevent problems that could eventually lead to a hospitalization. Consider the congestive heart failure patient; a recorded spike in the patient's weight could transmit an early warning to the remote care manager that the patient's heart might soon have trouble pumping enough blood through her body. Finally, consider the diabetic patient with crashing blood sugar who would usually wind up in the ED; as the home caregiver records the blood sugar data, it could generate an alert for the remote care manager, who then calls the home and suggests the patient drink appropriate fluids to bring the patient's blood sugar back to normal range.

With these types of patient benefits – coupled with real improvements in healthcare outcomes – no wonder why telehealth has already been embraced by hospital providers across the country. In fact, recent studies estimate that as many as 50% of hospitals use telehealth in some capacity, with another 10% considering a telehealth launch in the near future. What's more, in another survey, 89% of healthcare executives responded that telemedicine will transform the U.S. healthcare system in the near future. Undoubtedly, home health will not be immune to such a transformation.

And for good reason. With recent technological advances in telehealth, it is now commonplace for remote patient monitoring technology to be used to record a patient's vital signs, activities of daily living, dietary habits, medications compliance, and more, with this information easily accessed by and shared with the entire care team – including home health staff, physicians, and family members. Built-in algorithms can trigger alerts and notifications, resulting in rapid interventions, significantly improved communications, better patient care, better results, and better outcomes.

About Advanced TeleHealth Solutions

Advanced TeleHealth Solutions provides customized technology, monitoring, and reporting expertise, without the cost of creating a new system, adding resources, or having start-up time involved. For home health agencies, our scalable remote patient monitoring service delivers timely, actionable data from patients' homes, improving access and outcomes, while decreasing costs.

Our remote patient monitoring solution has dramatically reduced hospitalizations for our clients, including:

- 47% reduction for patients with CHF as a primary diagnosis
- 51% reduction for patients with COPD as a primary diagnosis
- 56% reduction for patients with Diabetes as a primary diagnosis
- 63% reduction for patients with Hypertension as a primary diagnosis

In a six-month CHF study, we achieved a six-month hospitalization reduction of 50% and a 30-day hospitalization reduction of 73%.

Benefits Achieved with Advanced TeleHealth Solutions

- Reduced readmissions for severe disease categories that can be monitored and stabilized at home
- Reduced emergency care visits
- Improved timely and accurate patient information
- Improved patient outcomes
- Improving education and self-care
- Increased efficiency and revenue

Interested? Contact us to learn more.

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Appendix A:
HHVBP Definitions of Outcome and Process Measures

Outcome Measures	Data Source	Numerator	Denominator
Improvement in Ambulation-Locomotion	OASIS	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in ambulation/locomotion at discharge than at the start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Improvement in Bed Transferring	OASIS	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in bed transferring at discharge than at the start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Improvement in Bathing	OASIS	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in bathing at discharge than at the start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Improvement in Dyspnea	OASIS	Number of home health episodes of care where the discharge assessment indicates less dyspnea at discharge than at start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Discharged to Community	OASIS	Number of home health episodes where the assessment completed at the discharge indicates the patient remained in the community after discharge.	Number of home health episodes of care ending with discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.
Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health	Medicare Claims	Number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 60 days following the start of the home health stay.	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

Outcome Measures	Data Source	Numerator	Denominator
Emergency Department Use without Hospitalization	Medicare Claims	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay.	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Improvement in Pain Interfering with Activity	OASIS	Number of home health episodes of care where the value recorded on the discharge assessment indicates less frequent pain at discharge than at the start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Improvement in Management of Oral Medications	OASIS	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in taking oral medications correctly at discharge than at start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Prior Functioning ADL/IADL	OASIS	The number (or proportion) of a clinician's patients in a particular risk adjusted diagnostic category who meet a target threshold of improvement in Daily Activity (that is, ADL and IADL) functioning.	All patients in a risk adjusted diagnostic category with a Daily Activity goal for an episode of care. Cases to be included in the denominator could be identified based on ICD-9 codes or alternatively, based on CPT codes relevant to treatment goals focused on Daily Activity function.
Care of Patients	HHCAHPS	N/A	N/A
Communications between Providers and Patients	HHCAHPS	N/A	N/A
Specific Care Issues	HHCAHPS	N/A	N/A
Overall rating of home health care and	HHCAHPS	N/A	N/A
Willingness to recommend the agency	HHCAHPS	N/A	N/A
Care Management: Types and Sources of Assistance	OASIS	Multiple data elements.	Multiple data elements.
Process Measures	**Data Source**	**Numerator**	**Denominator**
Influenza Vaccine Data Collection Period: Does this episode of care include any dates on or between October 1 and March 31?	OASIS	N/A	N/A
Influenza Immunization Received for Current Flu Season	OASIS	Number of home health episodes during which patients (a) Received vaccination from the HHA or (b) had received vaccination from HHA during earlier episode of care, or (c) was determined to have received vaccination from another provider.	Number of home health episodes of care ending with discharge, or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.

Process Measures	Data Source	Numerator	Denominator
Pneumococcal Polysaccharide Vaccine Ever Received	OASIS	Number of home health episodes during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV).	Number of home health episodes of care ending with discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.
Reason Pneumococcal vaccine not received	OASIS	NA	NA
Drug Education on All Medications Provided to Patient/Caregiver during all Episodes of Care	OASIS	Number of home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems (since the previous OASIS assessment).	Number of home health episodes of care ending with a discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.
Influenza Vaccination Coverage for Home Health Care Personnel	Reported by HHAs through Web Portal	Healthcare personnel in the denominator population who during the time from October 1 (or when the vaccine became available) through March 31 of the following year: (a) received an influenza vaccination administered at the healthcare facility, or reported in writing or provided documentation that influenza vaccination was received elsewhere: or (b) were determined to have a medical contraindication/condition of severe allergic reaction to eggs or to other components of the vaccine or history of Guillain-Barre Syndrome within 6 weeks after a previous influenza vaccination; or (c) declined influenza vaccination; or (d) persons with unknown vaccination status or who do not otherwise meet any of the definitions of the above-mentioned numerator categories.	Number of healthcare personnel who are working in the healthcare facility for at least 1 working day between October 1 and March 31. of the following year, regardless of clinical responsibility or patient contact.
Herpes zoster (Shingles) vaccination: Has the patient ever received the shingles vaccination?	Reported by HHAs through Web Portal	Total number of Medicare beneficiaries aged 60 years and over who report having ever received zoster vaccine (shingles vaccine).	Total number of Medicare beneficiaries aged 60 years and over receiving services from the HHA.
Advance Care Plan	Reported by HHAs through Web Portal	Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advanced 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.	All patients aged 65 years and older.

Appendix B:
HHVBP Frequently Asked Questions

(Source: CMS.gov)

EIDM Registration

What is the website we should use to register our agency?

Obtaining an Enterprise Identity Management (EIDM) User ID from the CMS Enterprise Portal at https://portal.cms.gov/wps/portal/unauthportal/home/ is the first step in the registration process.

What is the purpose of the Enterprise Identity Management (EIDM) site? Is this where we upload information from OASIS?

The EIDM User ID will facilitate access to the Innovation Center Portal and then the Home Health Value-Based Purchasing (HHVBP) Secure Portal, where you will submit New Measure data and view quarterly and annual performance reports and annual payment adjustment reports.

What is the first step to register on the site?

After clicking on the 'New User Registration' link on the landing page of the CMS Enterprise Portal, you will have to agree to the terms and conditions.

Why is my SSN required to register for the HHVBP Secure Portal?

Your SSN will be used for verification purposes only. EIDM does not share your SSN with any other federal or private agency. Identity Verification is the process of providing sufficient information (e.g., identity history, credentials, or documents) to a service provider for the purpose of proving that a person or object is the same person or object that it claims to be. Individuals requesting electronic access to CMS protected information or systems must be identity proofed prior to being given access.

EIDM collects personal information to uniquely identify the user registering with the system. We may also use your answers to the challenge questions and other PII to later identify you in case you forget or misplace your User ID /Password. For security level information please visit: http://cms.gov/About-CMS/Agency-Information/Aboutwebsite/Privacy-Policy.html.

What is the format we must use when creating a password?

The password must: 1) be a minimum of 8 and a maximum of 20 characters; and 2) contain at least 1 number, 1 letter, 1 uppercase letter, and 1 lowercase letter. It cannot contain your User ID and must differ from your previous 6 passwords.

If I want to access reports only, do I need to follow through with the Enterprise Identity Management (EIDM) registration?

Yes. EIDM registration is the first step to gaining access to the HHVBP Secure Portal where quarterly and annual performance reports and annual payment adjustment reports can be viewed.

Do we request access to all of the access catalog items? Which ones are required?

This is part of Steps 2 and 3 of the registration process. You do not need to do anything more at this time.

Is this the same as the HHCAHPS portal?

EIDM and HHCAHPS are separate systems, so each requires its own login. For the HHVBP Model, HHAs will need to register through the CMS Enterprise Portal.

Is it true that each provider number must register, however, one person can be the single point of contact (POC) for each provider, or there can be a different POC for each provider?

HHAs must designate one POC for each of their CCNs. The POC does not need to be the same for all CCNs for an agency with multiple CCNs, but it can be if the agency chooses. The POC needs to register with EIDM.

We are awaiting our Provider Number (CCN). Can we register now?

You may obtain an EIDM User ID, but do not send it to the HHVBP Helpdesk until you have a CCN. Submit your EIDM User ID and point of contact information along with your CCN.

As a Medicare Consultant for all agencies in our company, is there a way to get access to the system without being the primary point of contact?

> When the POC completes the second component of registration (which is to register for the Innovation Center Portal) they will be able to designate additional user roles. These include data entry and reviewer roles.

The main home health office is in Iowa with a non-manned office in Nebraska. Would the agency only have to register one time?

> If each office has a separate CCN, they should register separately. If the offices share a CCN, then they should register only once.

I have Enterprise Identity Management (EIDM) access and have emailed the Helpdesk. What should I do next?

> After obtaining your EIDM User ID, please make sure that the Helpdesk has your POC's name, CCN(s), agency name, address, email, and EIDM User ID. CMS will inform you about next steps in the upcoming weeks.

Does each agency location leader register for their location or is this only by provider number?

> HHAs should assign a POC for each CCN. It is acceptable for one person to be the POC for multiple CCNs.

I have registered as a user on the Enterprise Portal for the EIDM. My only concern is that we are in Virginia, not one of the designated states. The use of this information by non-designated states was unclear to me.

> HHAs in states not selected to be in the Model will not need to register in EIDM or provide this information.

Points of Contact

For registration, for the single point of contact, do you recommend this be someone financial, clinical, or the executive director/administrator?

> The primary point of contact should be someone who understands the daily operations of the HHA and has the authority to delegate/assign tasks. This person will also have the authority to submit measures and review financial reports on behalf of the HHA.

For registration, is it possible to set multiple points of contact for each CCN in case of absence or turnover?

> Each HHA with a CCN will need to appoint a single primary point of contact.

What is a CCN?

> A CCN is a six-digit (all numeric) CMS Certification Number.

For registration, is the point of contact the only person who will be able to access the platform to view the results?

> No, the primary point of contact can assign user roles to staff who will have access to the HHVBP Secure Portal. When the point of contact completes the second component of registration (which is to register for the Innovation Center Portal) they will be able to designate additional user roles. These include data entry and reviewer roles.

Regarding Outreach, can we dial in to the call or into HHVBP Model webinars from our corporate clinical department? Although none of us will be assigned as a specific point of contact, the department has responsibility for locations in all nine states of this pilot. We are working diligently with our performance improvement team to provide the training and support that will be necessary for our offices to excel and provide the highest value to our patients. Is it possible to register the corporate team for the call?

> You will always be asked to provide a CCN upon registration. You may register as a Corporate Point of Contact. To do this you would send your contact information along with the CCN for each agency for which you are responsible.

Can you please add me to the email distribution group for value-based based purchasing? Our company has 29 providers in 7 of the 9 states. As Vice President of Quality, I will be overseeing our improvement initiatives and would like to have all communications that are applicable.

> A representative for each CCN in the HHVBP Model should complete the registration process. Once registered, participants will have access to communications and information regarding the Model. You may register as a Corporate Point of Contact. To do this you would send your contact information along with the CCN for each agency for which you are responsible.

I am not in one of the participating states; however, we would like to start the process. Can we register in the EIDM system? Is there any benefit to doing so?

Any HHA is able to register in the EIDM system. However, HHAs in states not selected to be in the Model will not need or be granted access to the HHVBP Secure Portal or *HHVBP Connect*.

Implementation

What is the contact information of the Home Health Value-Based Purchasing (HHVBP) Helpdesk?

The HHVBP Helpdesk can be reached by email at HHVBPquestions@cms.hhs.gov.

Who will staff the HHVBP Helpdesk?

The Helpdesk will be staffed by a technical assistance contractor, The Lewin Group.

Will HHAs have a project officer?

No. HHAs will receive assistance through the Model's learning and diffusion website, HHVBP Connect and the technical assistance contractor.

What is CMS's plan to share risk adjustment data elements with partners to inform performance improvement efforts?

Risk adjustment elements are the same as what is currently reported on Home Health Compare for those measures that are currently being reported and are based on the OASIS data that are provided to CMS by the HHAs themselves. Technical specifications of calculated measures that are not currently on the CMS website will be provided in early 2016.

I am a little confused as to when the actual VBP begins. Are all HHA's subject to the VBP adjustment beginning on January 1, 2016, or is only the nine selected states?

Beginning January 1, 2016, CMS will implement the Home Health Value-Based Purchasing Model in nine states representing each geographic area in the nation. All Medicare-certified home health agencies that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington, will compete on value in the HHVBP Model.

If the branch office is in a state selected to be in the Model, but has a parent office in a non-selected state and the CCN is for the non-selected state are they required to participate for the patients out of the branch office?

No. Only Medicare-certified home health agencies with a CCN that provide services in one of the nine selected states are required to participate.

How will this payment model impact newly certified agencies?

Newly certified agencies will be included in the Model. They will have access to the HHVBP Secure Portal to submit New Measure Data, the learning and diffusion website, and other resources but will not be subject to the payment adjustment until such time that they generate scores on five or more measures that are used to calculate the Total Performance Score for the HHVBP Model. In order to receive a score on a measure, the HHA must have a minimum of 20 home health episodes of care for the measure.

If you are Medicare-certified, but provide very little services to Medicare (e.g., 10 cases/year), should you still sign up for this?

Yes, all Medicare-certified HHAs that provide services in one of the selected states are required to participate in this Model. They will have access to the HHVBP Secure Portal to submit New Measure Data, the learning and diffusion website, and other resources but will not be subject to the payment adjustment until such time that they generate scores on five or more measures that are used to calculate the Total Performance Score for the HHVBP Model. In order to receive a score on a measure, the HHA must have a minimum of 20 home health episodes of care for the measure.

Is hospice involved in HHVBP?

No.

What do you mean by a "same size cohort"?

Larger-volume cohort means the group of competing home health agencies within the boundaries of selected states that are participating in HHCAHPs in accordance with § 484.250. Smaller-volume cohort means the group of competing home health agencies within the boundaries of selected states that are exempt from participation in HHCAHPs in accordance with § 484.250. Those HHAs in the smaller-volume cohorts will compete with other HHAs that are in the smaller-volume cohort in their state with the exception of where there are too few HHAs in the smaller-volume cohort in each state to compete in a fair manner (that is, when there is only one or two HHAs competing within

a smaller-volume cohort in a given state), these HHAs would be included in the larger-volume cohort for purposes of calculating the total performance score and payment adjustment without being measured on HHCAHPS." HHAs in the larger-volume cohorts will only compete with other HHAs that are in the larger-volume cohort in their state.

OASIS Measures

Will the OASIS-based measures be calculated using OASIS assessments from all the beneficiaries that a HHA provides service or just the Medicare FFS population?

The OASIS-based measures are calculated using assessments from the OASIS assessments from Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid Managed care. However, the measures are risk adjusted to include risk factor elements like the payer for the episode (Medicare/ Medicaid / Managed Care) as well as other risk factors selected using a rigorous, multi-step process that includes clinical review of the scientifically identified risk factors.

Are OASIS measures risk-adjustment state-based or national?

OASIS measures are risk adjusted at the national level. The risk adjustment methodology compensates for differences in the patient population served by different home health agencies, using a predictive model developed specifically for each measure. The OASIS measures tables can be found at this link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html.

There are two measures in the final PY1 measures for which HHA performance will have an impact on the TPS, but these measures have never been publicly reported. These are the measures for Communication and Care Coordination (M2102) and Prior Functioning ADL/IADL (M1900). What are the measure specifications for the coordination of care and prior function measures?

Not all measures selected for the HHVBP Model are currently publicly reported on Home Health Compare, and any additional public reporting of home health measures for this Model will be addressed in future rulemaking. Information about the measures utilized in the first year of the HHVBP Model, including the measure specifications for the coordination of care and prior functioning measures will be presented during a webinar tentatively scheduled for January 2016.

Could risk adjustment change with the implementation of ICD-10 and how will that be accounted for in the baseline performance year (Jan-Sep 2015 and Oct-Dec 2015) and subsequent performance years?

> Currently, the transition to ICD-10 will not have any impact on HHVBP. Only one process measure uses ICD-9 based measures in its risk-adjustment model, and this measure is not used in HHVBP. The risk-adjustment model for this measure has been updated for ICD-10 using the existing ICD-9 to ICD-10 crosswalk and will be re-estimated in 2017 once there is sufficient ICD-10 data.

We proposed that data for the standardized quality measure would be collected using the OASIS-C1 with submission through the Quality improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system." Does this mean that the OASIS-C1 will contain all the measures to be included in the VBP system?

> No. Although the majority of measures selected for the HHVBP Model rely on OASIS data, some rely on other data sources. Specifically, there are two measures that are claims-based, five measures from HHCAHPS, and three new measures reported by HHAs via the HHVBP Secure Portal.

Where can we find the list of codes for the measures that we need to submit on the claims?

> Measure data is not submitted on the claims. CMS will pull submitted claims data to use when calculating performance scores for the two claims-based measures, Acute Care Hospitalization; Unplanned Hospitalization during first 60 days of Home Health and Emergency Department Use without Hospitalization.

Will the baseline data be individual, or based on all the other agencies in the nine states in the Model?

> The baseline data consists of both individual HHA level data as well as aggregate HHA data. HHAs will have access to their own quality measure data from 2015. HHAs will also have access to the benchmark (mean of top decile of 2015 within each state) and the Achievement Threshold (median of all the HHAs in 2015 in each state) for their cohort size.

New Measures

Will New Measure data be based on six months of reporting only?

> No. The New Measures will be reported quarterly.

For the measures being reported through the HHVBP Secure Portal, i.e., flu vaccine taken by employees, when will the reporting of these measures begin? How often is it required to enter the information on the New Measures in the portal?

> Data for New Measures should be entered in the HHVBP Secure Portal beginning on October 1, 2016, for the period covering July 1 - September 30 2016. New measure information should be submitted for each quarter throughout the Model.

Is there a minimum reporting requirement?

> No, HHAs can elect to not report data on the New Measures. However, HHAs that do not report data on all three New Measures can only earn up to 90% of the total possible points for their Total Performance Score.

Can my Agency set up to start reporting on the New Measures if we are not in one of the nine mandated states for Value-Based Purchasing?

> At this time, only Medicare-certified HHAs that provide services in one of the nine selected states will be reporting data on the New Measures.

HHCAHPS Measures

Will the HHCAHPS measures be calculated using HHCAPHS surveys from all the beneficiaries that a HHA provides service or just the Medicare FFS population?

> HHCAHPS surveys from all the beneficiaries for which a HHA provides services are included in the model. All patients 18 years old and older who are covered by Medicare or Medicaid who meet other survey criteria are eligible to be included in the HHCAHPS Survey. This includes patients who are enrolled in Medicare fee-for-service plans and those enrolled in Medicare Advantage (MA) plans or Medicaid managed care health plans.

Will "small" agencies have fewer total TPS points as they do not participate in HHCAHPS or will they not have scores available? How will these agencies be addressed?

> Smaller-volume home health agencies are defined based on whether or not they are exempt from reporting HHCAHPS data, so they will have a lower maximum Total Performance Score than larger-volume home health agencies, which are defined as those that are participating in HHCAHPS. Smaller-volume home health agencies will only be competing with other smaller-volume home

health agencies within their state and HHCAHPS measures will not be included in the calculation of the Total Performance Score. Smaller-volume home health agencies will not have an advantage or disadvantage due to the exclusion on the HHCAHPS measures.

Will HHCAHPS scores be calculated the same way that they are for current public reporting? Or will they use the linear calculations as defined for stars?

The HHVBP Model will not alter the HHCAHPS current scoring methodology. HHCAHPS scores will be calculated as they are for public reporting on Home Health Compare. For calculating total performance scores, we will compare agency performance to both (1) similar sized HHAs within their state and (2) the HHA's own past performance, using the scoring rules described in the Final Rule that was published 11/5/2015 in the Federal Register.

Claims-Based Measures

Will the claims-based measures be based from all the beneficiaries that a HHA provides service or just the Medicare FFS population?

The claims-based measures are only based on the Medicare FFS population since the measures are only derived from Medicare claims. The claims-based measures are risk-adjusted that incorporate five categories of risk factors, including:

1. Prior care setting;
2. Demographic (i.e., age and gender);
3. Health status (i.e., based on hierarchical condition categories);
4. Medicare enrollment status, and;
5. Interaction terms.

Data Submission

How do we submit the data? Or, do we use existing data?

For the majority of the measures, the data utilized is based on information already being reported by HHAs through OASIS. There are also two measures that are claims-based, five measures from HHCAHPS, and three New Measures to be reported by HHAs via the HHVBP Secure Portal. For the New Measures, HHAs will submit data on a quarterly basis beginning October 2016.

Will the data be entered in aggregate or per patient?

Data is entered as it is currently submitted to OASIS, which is patient level data.

How will the data be uploaded for the three New Measures?

HHAs will report data for the New Measures on a quarterly basis via the HHVBP Secure Portal.

When will the reporting portal be available to HHAs?

The HHVBP Secure Portal will be available to the HHAs in March 2016.

What does the system look like to which we will be submitting data? Will we also get a demonstration of that portal?

Yes, CMS will provide HHAs with information about data collection and a demonstration of how to submit information to the HHVBP Secure Portal. It is important that HHAs register for the HHVBP Secure Portal now.

If our EMR software vender creates a data extract function like they have for OASIS and HHCAHPS, can the file created be sent via the portal instead of manual extraction and submission?

That will not be necessary. The implementation contractor who will be calculating each HHA's performance scores will have access to the OASIS and HHCAHPS data you have already submitted. The only data the HHA will submit via the HHVBP Secure Portal is for the New Measures.

Scoring

When will benchmarks and thresholds be available to competing HHAs?

Benchmarks and achievement thresholds for the OASIS measures will be available in April 2016. Benchmarks and achievement thresholds for the HHCAHPS measures and the claims measures will be available by July 2016. However, because benchmarks and achievement thresholds of most measures are based on industry averages that do not vary significantly over a period of several years, we anticipate preliminary aggregate level benchmarks and achievement thresholds for the OASIS, HHCAHPS and Claims measures based on data for 2013 and 2014 will be made available sooner.

While each individual measure is calculated to the third decimal point, will that also be the case for the TPS?

Total performance scores will be calculated to the third decimal point. They will not be rounded to whole numbers. This was a change to the design of

HHVBP that was described in the Final Rule that was published 11/5/2015 in the Federal Register, which states that "all achievement and improvement points will be rounded up or down to the third decimal point."

Is there a threshold number of measures that an agency must have data on in order to participate across classifications? Or must agencies have at least one measure in each classification?

HHAs must have a minimum of 20 episodes of care to be scored on any given measure, and only HHAs measured on a total of any five measures or more will receive a Total Performance Score and be subject to a payment adjustment regardless of how the measures are classified.

Please clarify which of the measures fall under the new classification of "Care Coordination and Efficiency."

Table 4a in the Final Rule that was published 11/5/2015 in the Federal Register describes both acute hospitalization and emergency room visits as efficiency measures. Care Coordination measures are advance care planning, care management, and discharge to community.

We are very small and will have some zeros. How will that impact our score? What happens as we grow next year and those zeros turn into numbers? Does that disadvantage our score?

Only measures that have values will be included in the TPS calculation. A minimum of five measures are need to calculate a TPS and a subsequent payment adjustment. As you grow, additional measures will be included in your TPS calculation if the measure has a minimum of 20 home health episodes of care. Having fewer measures will not have an advantage or disadvantage with respect to the TPS or the payment adjustment.

Reports

Will an agency that does not have 2013 data still be able to receive a preview report?

Only the aggregate level Benchmarks and Achievement thresholds (by state and by cohort size) will be calculated using the 2013 and 2014 data provided to all HHAs. Individual HHA data from 2013 and 2014 will not be provided; however since most of the measures were reported in 2013 and 2014, HHAs have already had access to their individual data for the years that they have been operating.

Please clarify if agencies have either 10 days or 30 days to review performance and payment adjustment reports for potential issues.

> HHAs will have 30 days to review performance and payment adjustment reports and submit a request for recalculation.

Will we have a report prior to July 2016?

> No. The first quarterly performance report provided to HHAs will be in July of 2016.

We were told CMS would be providing agencies with performance data from 2013 and 2014 in January. Is that for educational/informational purposes only, e.g., to get a sense of starting point?

> Yes, in part. CMS is compiling aggregate benchmark and achievement thresholds based on 2013 and 2014 data. Only the aggregate level Benchmarks and Achievement thresholds (by state and by cohort size) will be calculated using the 2013 and 2014 data.

Payments

Are the payment adjustments only applied to a HHA's Medicare payments or will it also apply to Medicaid payments?

> The HHVBP Model payment adjustments will only be applied to HH PPS claims for Medicare FFS beneficiaries.

Will our 2016 results affect payment in 2018, or will payment for 2016 be affected?

> The first payment adjustments for HHVBP occur in January 2018 based on 2016 performance year scores.

Miscellaneous

How were the nine states included in the Model selected?

> Clusters of states were formed that were geographically related and also were alike in terms of important HHA characteristics that were selected to ensure a robust evaluation. Then, we selected one state from each cluster at random. States, and the home health agencies within them, had a similar probability of being selected. See the Final Rule that was published 11/5/2015 in the Federal Register for a detailed explanation of how states were selected for inclusion in the HHVBP Model.

Will we receive a copy of webinar slides?

Slides from all webinars will be placed on HHVBP Connect, the learning and diffusion website established by CMS for HHAs in the nine states who have submitted point of contact information and their EIDM User ID.

Will webinars be repeated?

Webinars will not be repeated, but the recordings of the webinars will be available on *HHVBP Connect*.

Appendix C: Sources Used for This Guide

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