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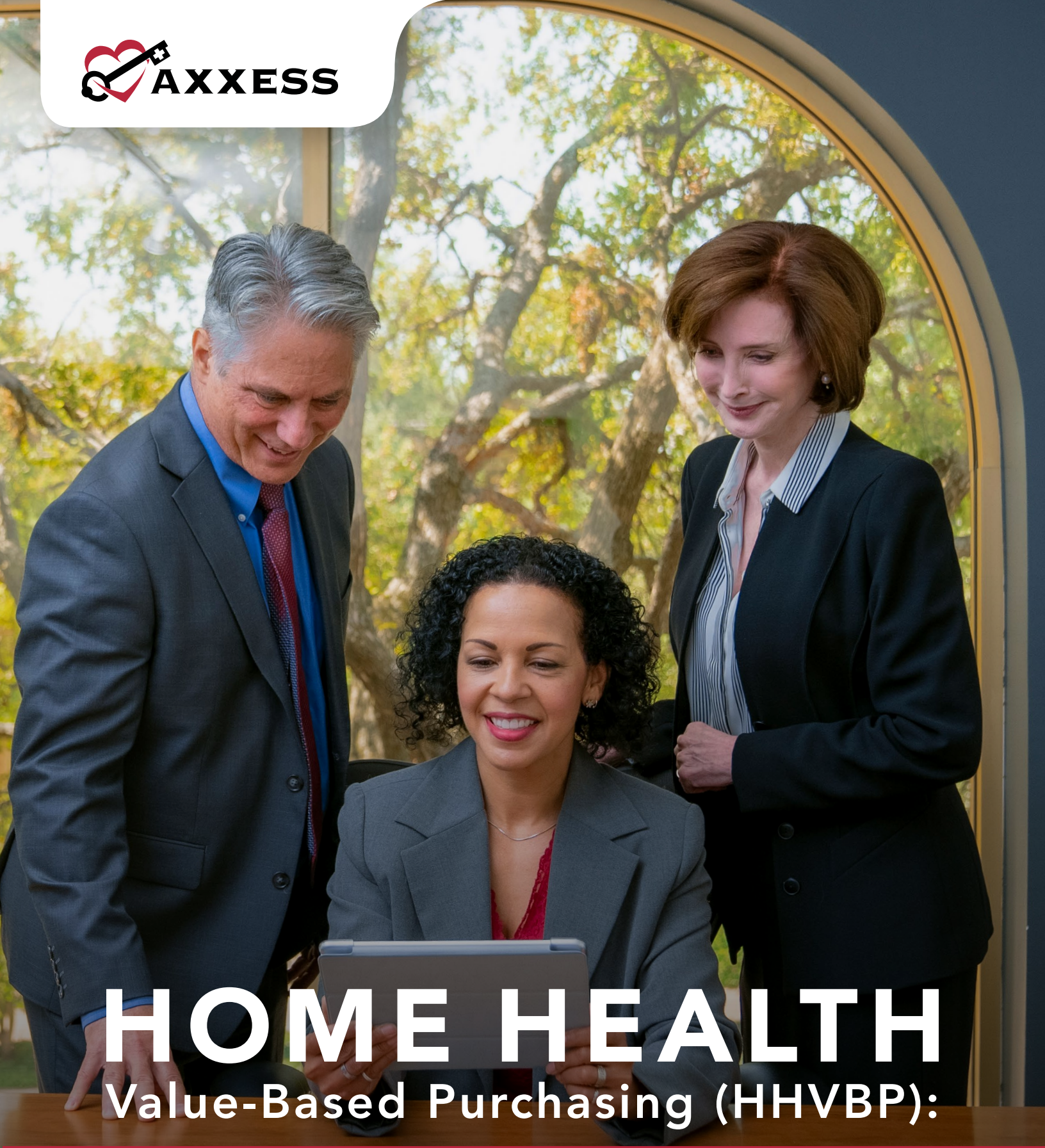

HOME HEALTH
Value-Based Purchasing (HHVBP):
Achieve Success Through Quality Improvement

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Home Health Value-Based Purchasing (HHVBP) is a new model of payment reimbursement by the Centers for Medicare and Medicaid Services (CMS) that incentivizes the quality of care over the quantity of services delivered in the home.

HHVBP was originally designed to benchmark and score similarly sized and geographically located home health agencies (HHAs) and reward those that perform the highest quality of care. Organizations are incentivized to achieve optimal patient outcomes and goals while those with low performance will be penalized.

CMS originally launched the program in nine states. Following successful implementation and demonstrated annual Medicare cost savings of $141 million while improving quality care scores by 4.6%, CMS adjusted the original model to expand nationwide as described in the CY 2022 Final Rule.

The pre-implementation phase of data collection began in 2022 and is designed to give organizations a year to track quality improvement and prepare. 2022 will be the last year for the rural add-on.

CMS delayed implementation one year, making 2023 the first performance year. All Medicare providers certified prior to January 1, 2022 must participate and will be eligible to receive an annual total performance score based on their 2023 performance.

VBP national expansion, quality reporting program updates to the OASIS and the use of OASIS-E begins for all home health organizations in 2023. Providers will need to collect "Transfer of Health" (TOH) Information to Provider Post-Acute Care (PAC) measure, the TOH Information to Patient-PAC measure and certain Standardized Patient Assessment Data Elements (SPADEs) beginning January 1, 2023. CMS will require that providers begin collecting data on the two TOH measures beginning with discharges and transfers on January 1, 2023 on the OASIS-E.

2025 is the first payment year and adjustments based on performance will have a maximum of a plus or minus five percent in reimbursement.

By focusing on quality improvement, patient-centered care and operational efficiency, organizations can achieve success under HHVBP. This resource provides best practices and tips for home health leaders and managers concerning common areas to focus on and improve to maximize reimbursements and ensure long-term success.

More Axxess resources on HHVBP are available on Axxess.com.

Financial Impact and Importance of VBP Preparation

2022 provides an opportunity for organizations to track and assess their quality performance data for improvement, helping them forecast the potential impact of VBP on reimbursements with up to 5% adjustments based on their performance.

To demonstrate the possible impact of reimbursement adjustments, we have created the following example of a hypothetical organization with an average daily Medicare census of 500 patients and used an average episodic reimbursement of $1,784 per 30-day billing period regardless of patients' case mix groupings to simplify the calculations.

For the purposes of our analysis, our assumptions are that the patient census would remain the same given similar monthly discharge and referral or intake levels, and that reimbursement rates would also be similar month-to-month given the organization made no efforts to improve or change care quality or lower costs of delivery.

The first chart, The Cost of Low Quality, represents an annualized reduction and the second chart, The Value of High Quality, represents the annualized payment add on.

The Cost of Low Quality

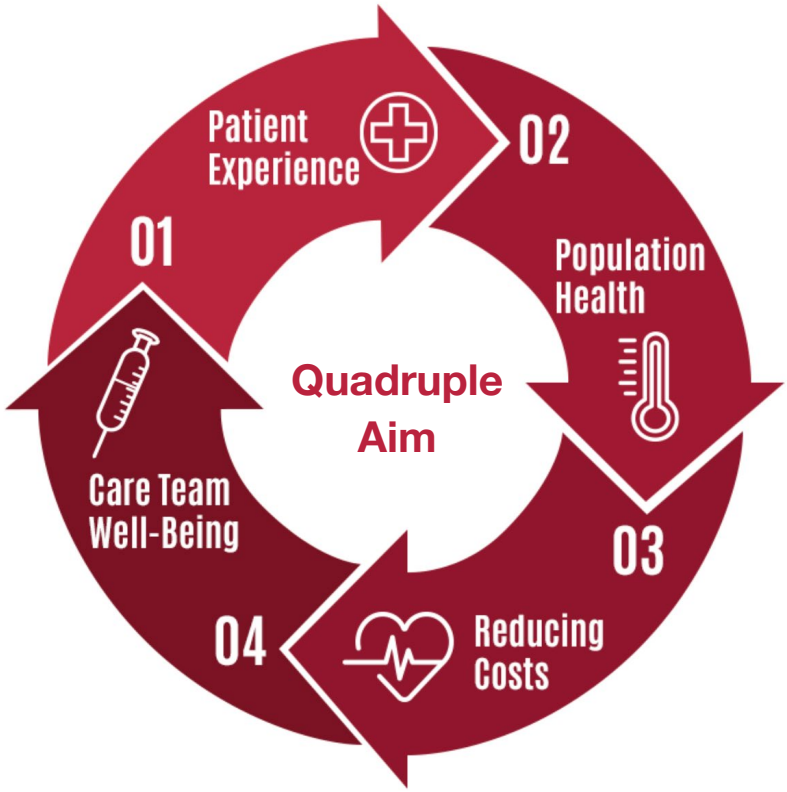
Average Monthly Reimbursement	$892,000
Total Monthly Performance Score Adjustment of -5%	($44,600)
Annual Payment Reduction	($535,200)
Annual Medicare Revenue	**$10,168,800**

The Value of High Quality

Average Monthly Reimbursement	$892,000
Total Monthly Performance Score Adjustment of +5%	$44,600
Annual Payment Increase	$535,200
Annual Medicare Revenue	**$11,239,200**

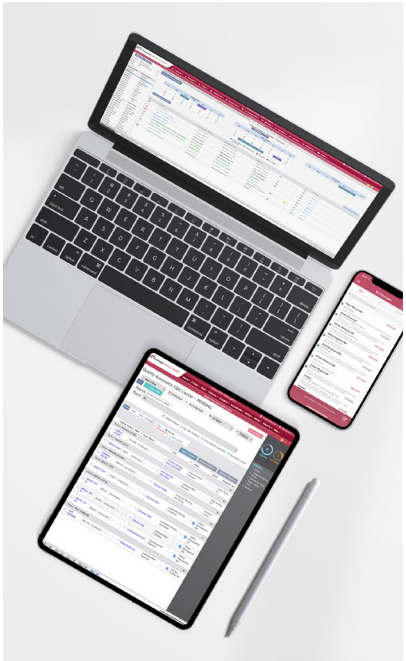
As these financial impact scenarios show, it will be important for organizations to use 2022 to prepare to ensure maximum reimbursements in the coming years.

For many years, the home healthcare industry has equated quantity with quality like other healthcare settings. However, the industry has begun to recognize that payment should be more closely aligned with performance. The VBP programs are one of CMS' tools for aligning payment with quality care, therefore organizations will need an effective quality plan that will show measurable improvement in patient outcomes to remain sustainable and thrive.



The Patient-Driven Groupings Model (PDGM) provided a framework for the realignment of reimbursement with patient diagnosis and care services provided while maintaining the quality of patient care delivered in the home. The VBP program requires organizations to efficiently deploy and align resources and practices to deliver measurable quality care and provide the quality of care that patients deserve.

The Institute for Health Improvement first created the Triple Aim to summarize the key challenges identified in the U.S. healthcare system over the prior four decades. The analysis looked at how to deliver the best patient care possible to the greatest population of people, at a sustainable cost. The importance of the healthcare team was later added as an additional critical element to delivering exceptional patient care and hence the Quadruple Aim was created.



The Quadruple Aim serves as an organization's roadmap for delivering value-based care by summarizing the key documented challenges faced by the U.S. healthcare system, and CMS' area of focus. The key elements for an organization to focus on are delivering the highest quality patient care in the most cost-efficient manner with the best patient experience and an empowered care team. Organizations that create a culture focused on all aspects of the Quadruple Aim will continually deliver quality care.

- **Improving Health of a Population:** Home health organizations are focused on improving the health of their population of patients, starting with the initial admission and assessment, their ongoing care, and ultimately their transfer or discharge to address their primary needs. By being focused on addressing their individual needs, including taking action to connect them to resources in the community to help with social determinants of health, an organization can ensure quality patient outcomes.

- **Reducing Costs:** The focus of delivering cost-effective care ensures an organization optimizes their workflow and processes to maximize their resources and meet patient needs. Delivering cost effective care does not always involve spending less but seeking to offer the best value while still achieving optimal patient outcomes. For example, with clinician visit utilization and resource optimization, nurses can call or do telehealth visits with high-risk patients between regular visits to monitor and identify problems which can be addressed before they escalate or lead to acute complications.

- **Improving the Patient Experience:** The ability for healthcare organizations to empower patients to become more involved in their care and improve their overall experience has shown to improve patient outcomes and decrease care costs. In addition to focusing on multi-disciplinary and holistic care approaches to improving patient outcomes, there are other factors that home health organizations can look at that can improve the patient experience. One example is additional communication through a patient portal that can provide reminders and visibility for progress on goals and care. Other examples include caregiver matching and using preventative care measures. The Home Health CAHPS survey is an objective tool for measuring patient experience and includes a set of the HHVBP measures CMS uses for determining payment.

- **Improving Care Team Wellbeing:** It is important for organizations to ensure staff are aligned around addressing patient needs to achieve the other three aspects of the Quadruple Aim. Empower staff, especially clinicians, to practice to the full extent of their license and training and eliminate any technology barriers to their care delivery. Try minimizing the staff's administrative overhead and optimizing their visit schedules. These are crucial steps to avoid burnout. When recruiting new staff, look for people who are going to be a strong fit for your company culture. When staff express any safety concerns, listen to them and take noticeable action. These steps will help keep staff engaged with your organization and better able to deliver quality care.

The CMS focus on delivering quality care especially as outlined by the Quadruple Aim will allow organizations to be successful long-term, regardless of whichever programs they implement.

There are several items to consider when building a quality plan for value-based payment. The following steps will help in designing and implementing a targeted performance improvement plan in clinical, operational and financial areas.

Step One: Review and Analyze Existing Data

- **Clinical:** Use 2019-2021 data retrieved from Certification and Survey Provider Enhanced Reports (CASPER) and available OASIS scrubber reports (Home Health Gold, SHP, etc.) to evaluate where improvements in the patient care process and outcome measures should be made. Axxess provides interactive quality improvement dashboards in Axxess Business Intelligence to show performance and trending of at-risk areas at an aggregate level. Tools such as the OASIS Analysis in the Quality Assurance Center or VBP reports enable clinical managers to drill down to a patient level to see measures improving or declining.

- **Operational:** Analyzing Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) scores and patient feedback can help the team identify strengths and weaknesses. Knowing where the organization has been over the past few years will provide an understanding of which quality improvement areas need to be addressed first. Achieving five-star ratings is possible using Axxess CAHPS as your preferred patient engagement partner with integrated market and competitive information for local, state and national benchmarking.

- **Financial:** Software such as Axxess DDE and Axxess RCM enable financial managers to see breakdowns of current reimbursement rates, common claims errors from documentation inconsistencies and timeliness or eligibility issues. Review the current mix of payers and ensure a diversity of referral sources to reduce organizational risk of losses due to VBP payment reductions. Have financial leaders involved in tracking specific metrics and communicating with the clinical team to determine what clinical grouping and VBP changes may affect forecasted reimbursement. Based on tools like the Axxess PDGM Revenue Impact Analysis and Modeling tools that show the clinical strengths and most profitable case-mix opportunities of the organization, discuss specialty programs as another way to serve the community needs while attracting more patient referrals in areas where the organization is already strong.

Step Two: Assess Opportunities for Increasing Staff Competency through Training

- **Clinical:** Staff competence and accurate OASIS assessments are critical to improving CAHPS star and quality ratings. Inadequate documentation of OASIS is costly. With VBP, clinicians must be confident and competent in how each item is coded. Since many of the OASIS items impact other areas, an OASIS skills assessment of every clinician will ensure the staff can properly complete documentation.

- **Operational:** Ongoing training of staff to complete an individualized comprehensive patient assessment will be critical to VBP success. Employee training through online courses like the Axxess Certification Program can ensure standardization of industry knowledge and competency for completing documentation and OASIS scoring.

- **Financial:** Alongside the work of the clinical and operational teams, tracking weak points and ensuring tight processes of claims submission will help the organization maximize reimbursement. Staff education through online courses like the Axxess Certification Program can ensure standardization of regulatory knowledge and billing processes.

Step Three: Evaluate the Patient Intake Process

- **Clinical:** Clinicians leading the intake process and collecting as much information as possible about the patient prior to the start of care will result in a more accurate clinical assessment during that initial visit. For example, gathering data such as immunization records, current medications, a face-to-face physician visit, etc., will provide information that can help the clinician properly complete timely start-of-care documentation.

- **Operational:** Using evidence-based practices for timely initiation of care and appropriate and timely discharges will help improve care for high-risk and problem-prone areas of agency function. Intake departments often function with non-clinical staff so it is important that intake practices be carefully reviewed for 'best practice' techniques for assessing patient needs. Use software integrations for interoperability that can streamline the intake and document management process. Secure communication and document sharing of patient information will enable more patient-centric care. For a full list of Axxess integrations, visit the industry partners page.

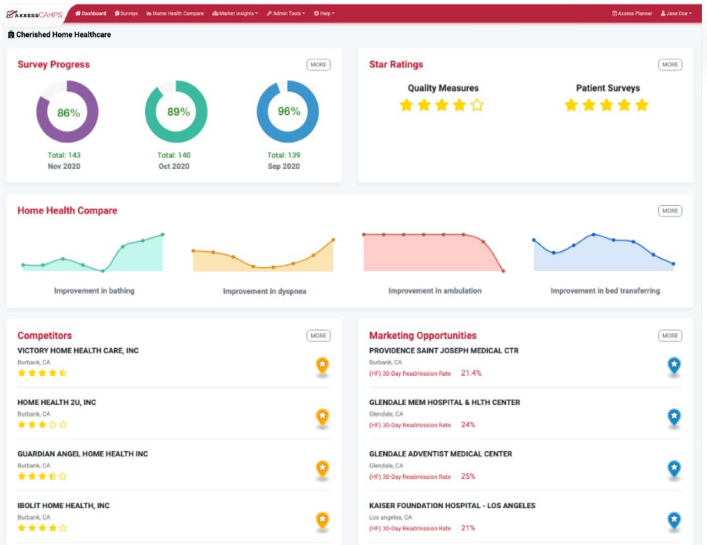
- **Financial:** Diversifying payer mix is important for long term sustainability. During patient intake, capturing the patient's payer(s) and payer requirements will ensure appropriate planning for VBP and other quality reporting that impacts revenue.

Step Four: Analyze Staffing Levels and Consider Technology Solutions for Delivering Quality Care

- **Clinical:** Evaluate your staffing levels today and identify any gaps you can project in 2022. Create an environment conducive to a "happy" workplace. Front-line home care staff increasingly deal with added stress, leading to burnout and turnover. Promoting a positive clinician experience is a critical component of the Quadruple Aim. Consider easy-to-use mobile documentation solutions to help speed up notes, reducing overtime and burnout. Continued Low Utilization Payment Adjustment (LUPA) issues could cause disruption in the future simply due to clinical staff shortages. Organizations will need to think 'outside the box' and utilize technology like electronic medical records software Axxess Home Health and scheduling and staffing technology solution Axxess CARE to find and schedule clinical staff to meet increasing demand. Axxess CARE is used by thousands of home healthcare organizations to connect with available, qualified clinicians to easily fill patient visits. Axxess CARE helps organizations to deliver timely, high-quality care, streamline operations and accept more referrals to grow business.

- **Operational:** The current workforce challenges could disrupt any planned success with VBP. As an industry, it will be necessary to become creative in our solutions to staffing. PDGM forced the home health industry to take a critical look at staffing levels and anticipated visits overall. Axxess CARE, a scheduling and staffing technology solution, is used by thousands of home healthcare organizations to connect with available, qualified clinicians to easily fill patient visits. Axxess CARE helps organizations to deliver timely, high-quality care, streamline operations and accept more referrals to grow business.

- **Financial:** If you have not done research to find the right remote patient monitoring and telehealth technology for your organization, now is the time. Since the COVID-19 pandemic, the healthcare industry has been forced to use technology as a 'partner' in evaluating and treating patients in real time. Physicians quickly adopted telehealth as a means of meeting the needs of their patients. The availability of these new technologies enables clinicians to facilitate interaction with the patient wherever they are, helping assess immediate needs relative to social determinants. Remote patient monitoring is becoming the next "best practice" on the road to improved patient outcomes and reducing costs.



In addition to these strategies, learn tactical approaches organizations can take by using the OASIS and CAHPS surveys as tools to help track progress and improve by reading our downloadable OASIS and CAHPS tip guides.

Summary and Key Takeaways

The success of the home health value-based purchasing pilot program is the reason that CMS is embarking on a national expansion of the reimbursement model. The change moves the healthcare system closer to fully incentivizing the quality of care over the quantity of services provided. Higher-performing organizations will be rewarded while lower-performing organizations will be penalized.

The pre-implementation phase of data collection began in 2022 and is designed to give organizations a year to track quality improvement and prepare. 2023 will be the first performance year with data used to determine the first VBP payment. The first payments will be in 2025 with adjustments that have a maximum of a plus or minus five percent in reimbursement, a significant impact on an organization's finances.

Organizations that create a culture focused on the Quadruple Aim will continually deliver quality care.
The key elements are:

- Delivering the highest quality patient care
- Using cost-effecient practices
- Imrpoving the patient experience
- Empowering the care team

To succeed, organizations will need to create a plan. Start by reviewing and analyze existing data and then assess opportunities to improve staff competency through training. Evaluate the patient intake process and analyze staffing levels. Consider implementing technological solutions that make it easier to deliver quality care.

For additional information or questions, or to learn more about home health technology solutions that can help your team prepare for value-based purchasing, please connect with Axxess.

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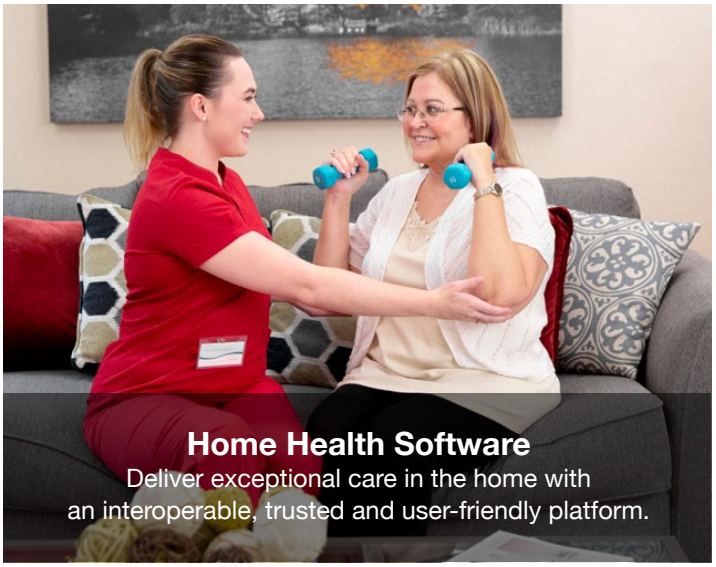
COMPLETE SUITE OF HOME HEALTHCARE SOLUTIONS



Home Health Software

Deliver exceptional care in the home with an interoperable, trusted and user-friendly platform.

Revenue Cycle Management

Get paid more and faster by all payers with real-time eligibility checks, automated claims processing and more.

Patient Engagement Surveys

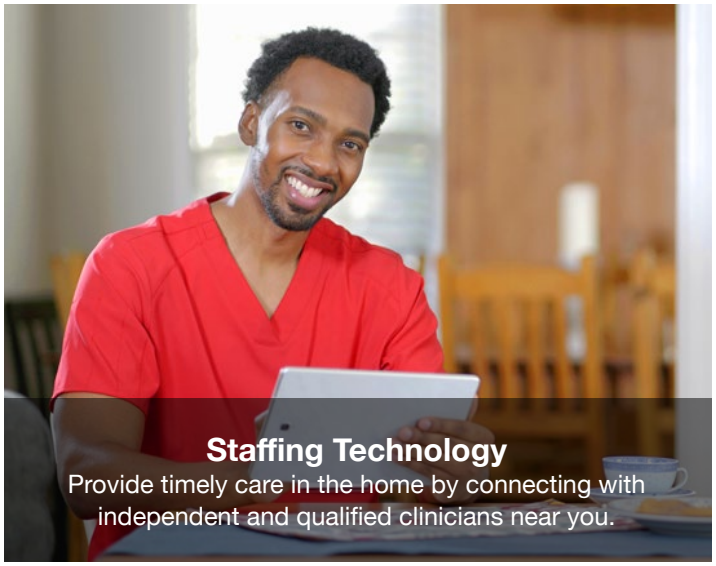
Improve care outcomes and increase referrals by understanding the patient experience and quality data.

Business Intelligence

Gain actionable insights from powerful dashboards with performance analytics across your entire organization.

Training and Certification

Increase staff engagement and competency with continuing education and professional development courses.



Staffing Technology

Provide timely care in the home by connecting with independent and qualified clinicians near you.