Home Health Value-Based Purchasing (HHVBP) Model

HHVBP Model Report and Payment Guide

September 2019

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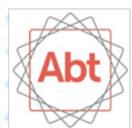

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Section 1: Welcome to the HHVBP Model

Welcome to the Home Health Value Based Purchasing (HHVBP) Model! The HHVBP Technical Assistance Team developed this guide to serve as a comprehensive resource for home health agencies (HHAs) implementing the HHVBP Model in their agencies. The Centers for Medicare and Medicaid Services (CMS) contracted with the Lewin Group to lead the HHVBP Technical Assistance (TA) Team. Partners on the HHVBP TA Team include Abt Associates, OASIS Answers, Inc., and University of Colorado, Anschutz Medical Campus.

This section of the guide includes information designed to assist HHAs or individuals new to the HHVBP Model prioritize and organize their initial efforts to engage in the Model.

Steps for Getting Started (1st Month)

Action items to complete in the first month of joining the HHVBP Model:

- ☐ Read through this guide.
- ☐ Designate a Primary Point of Contact (PPOC) and notify the HHVBP Help Desk **(Section 3). This is critical, as your agency's current PPOC must be on file with the Help Desk in order for CMS to grant access to the HHVBP Secure Portal. In your email to the HHVBP Help Desk, please include the following information: the PPOC name and email address, agency CCN(s), agency name and address.**
- ☐ Register for the HHVBP Secure Portal (see detailed instructions in **Section 5: HHVBP Secure Portal**).
- ☐ Register for *HHVBP Connect* (see detailed instructions in **Section 4: *HHVBP Connect***).
- ☐ Contact the HHVBP Help Desk with outstanding questions:
  a. **HHVBP Help Desk (Email: hhvbpquestions@cms.hhs.gov)**: Contact for **program and registration questions**, including new PPOC or CPOC information and general Model questions about IPRs, New Measures, Scoring, data submission, etc.
  b. **Collaboration Sites Business Operations Support Center (CBOSC): Phone: 1-844-280-5628:** Contact for **technical issues** with gaining access to the HHVBP Secure Portal. Please stay on the line until your issue is resolved. Examples of technical inquiries are password resets, report download errors, EIDM name or email address updates, etc.

Key Action Checklist (by 3rd Month)

Now that you have registered for *HHVBP Connect* and the HHVBP Secure Portal, take the following actions to use the available resources within the first three months of joining the HHVBP Model:

- ☐ Ensure your credentials for both of the HHVBP Model websites work and allow you to log in. Confirm your role (See **Section 5: HHVBP Secure Portal**) in HHVBP within your agency and ensure you have the necessary access in the HHVBP Secure Portal to correspond with your role. Follow the steps in Appendices C, D, and E to gain access to the HHVBP Secure Portal.

- ☐ Develop a system for collecting data for the three HHVBP Model New Measures. Take advantage of the New Measures template available in the *HHVBP Connect* Library to capture and track your data.
- ☐ Meet with agency staff to educate them about the HHVBP Model and its impact on their daily routines.
- ☐ Review the quality measures in the HHVBP Model for the current calendar year and how your agency currently performs using the Interim Performance Reports (**See Section 8: HHVBP Reports**)
- ☐ Explore the *HHVBP Connect* library and review resources and previous learning events as indicated throughout this guide.

For questions or corrections to this guide, or if you find yourself in need of assistance, please contact the HHVBP Help Desk. We are here to help you succeed in the HHVBP Model!

Section 2: Introduction to the HHVBP Model

This section of the guide provides the HHVBP Model objectives and how it impacts HHAs in the Model states.

HHVBP Model Overview

The HHVBP Model began on January 1, 2016 and will continue through the end of Calendar Year (CY) 2022. The HHVBP Model incentivizes Medicare-certified HHAs to provide higher quality and more efficient care within the Medicare Home Health Prospective Payment System (HH PPS). In 2017, about 3.4 million Medicare beneficiaries received home care, and the program spent $17.7 billion on home health services. Medicare spending for home health care more than doubled between 2001 and 2017, and this care accounted for about 3 percent of Medicare fee-for-service (FFS) spending in 2016.[1] The HHVBP Model will test whether higher payment incentives will improve provider performance. The HHVBP Model also aims to test new quality measures in the home health setting and to enhance current public reporting of quality.

In the HHVBP Model, each agency's Medicare Home Health Prospective Payment System (HH PPS) final claim payments will depend upon their performance on a set of quality measures. Each agency in the Model will receive a Total Performance Score, or TPS, based on the quality of care they deliver as measured by their performance on the HHVBP quality measures. CMS will compare this score to the performance of their peers within their state (and cohort, if applicable), as well as to their own past performance on the measures included in the HHVBP Model to determine payment adjustments.

"Our agency's address is not in a HHVBP Model state, but we see patients in a Model state. Do we need to participate?"

The agency CCN will determine if the agency is included in the Model. Agencies with a CCN in one of the nine select states will be included in the Model. In your example, if your CCN is not associated with a Model state, you would not be included in the Model even though you care for patients in a Model state.

The HHVBP Model includes nine states: Arizona, Florida, Iowa, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington. The Model requires that every Medicare-certified HHA located in the nine HHVBP Model states participates in the Model. An agency's TPS for each calendar performance year determines their payment adjustment for all their HH PPS claims for the corresponding payment year. All Medicare-certified agencies with a CCN in the selected states are eligible for Medicare HH PPS payment

[1] Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. 2019; http://medpac.gov/docs/default-source/reports/mar19_medpac_ch9_sec.pdf?sfvrsn=0. Accessed April 4, 2019.

adjustments regardless of their registration or active participation in the Model. Medicare-certified agencies that do not bill Medicare PPS and do not receive Medicare PPS payments are at no risk for Medicare PPS payment adjustments. All agencies in the Model have access to the HHVBP Secure Portal (to submit New Measure data and access Model-specific reports), *HHVBP Connect* (the collaboration website), and other resources. To receive a TPS and Adjusted Payment Percentage (APP) calculation, an HHA must have a complete calendar year (12 months) of data on at least five performance measures for both a baseline year and performance year. Each of the five performance measures must also have:

- A minimum of 20 episodes of care on OASIS or claims-based performance measures; or
- A minimum of 40 completed HHCAHPS surveys.

For most HHAs in the HHVBP Model states, the baseline year for most measures is 2015 and the first performance year is 2016. However, for some HHAs the baseline and performance years differ for one or more measures.

The APP is calculated with the Linear Exchange Function (LEF). The LEF methodology ensures budget neutrality for home health agencies. The TPS value provides a measure of how the HHA performs relative to all other HHAs in their comparison group (state or cohort within a state). The Payment Adjustment tab of the Annual TPS and Payment Adjustment Report describes the LEF formula. Examples of the LEF and other calculations that make up the APP are found later in this document, in section "Payment Adjustment Calculation Examples." The APP calculation (using the LEF) may be found in the CMS Home Health PPS Final Rule for CY 2016, available at https://www.gpo.gov/fdsys/pkg/FR-2015-11-05/pdf/2015-27931.pdf.

Publication of the HH PPS Final Rule Each Calendar Year

CMS implemented the federal rules governing the HHVBP Model in the CY 2016 Home Health Prospective Payment System (HH PPS) Final Rule. CMS published the CY 2016 HH PPS Final Rule for the HHVBP Model on November 5, 2015. Then on November 4, 2016, the CY 2017 HH PPS Final Rule became available. CMS published the CY 2018 HH PPS Final Rule on November 7, 2017. CMS published the CY 2019 HH PPS Final Rule on November 13, 2018. The Final Rules contain detailed information on the calculations, scoring, and payment used in the HHVBP Model. Prior to the publishing of each annual Home Health Final Rule, the Notice of Proposed Rulemaking (NPRM) is published in the Federal Register. This allows the public to preview and provide comments on these proposed regulations. The NPRM is published each year approximately four months before the Home Health Final Rule. For official information from CMS regarding the HHVBP Model, please visit the CMS HHVBP Model website: https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model.

Payers Used in the HHVBP Model

The payment adjustments in the HHVBP Model apply only to Medicare Home Health PPS claims.
The measures in the HHVBP Model include all payers (health care insurances) that are currently included in the measure calculations:

- OASIS-Based Measures – include Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care
- Claims-Based Measures – include only Medicare fee-for-service
- HHCAHPS Measures - include Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care.

The following payers (healthcare insurances) are included in the measure calculations for the New Measures and include patients who currently have any of these payers regardless if these payers are used to pay for home health services:

- Herpes Zoster (Shingles) Vaccination is calculated for Medicare beneficiaries, including Medicare fee-for-service and Medicare Advantage (Medicare managed care) beneficiaries, and the Medicare/Medicaid dually eligible;
- Advance Care Plan is calculated for all payers (Medicare – including Medicare Advantage/Medicare managed care, Medicaid – including Medicaid managed care, commercial insurance, Veterans Administration, self-pay, charity, etc.) and all Medicare beneficiaries, including Medicare/Medicaid dually-eligible beneficiaries;
- Influenza Vaccination Coverage for Home Health Care Personnel is calculated for staff and therefore the payer for the patient is not a consideration.

Payment Adjustment Schedule

CMS applied the first payment adjustment in CY 2018 based upon the agency's quality measure performance in CY 2016. Payment adjustments to each HH PPS final claim may result in greater payment (a positive adjustment), less payment (a negative adjustment), or no change in payment (no adjustment). To determine the percentage and direction of each HHA's payment adjustment, CMS calculates a TPS for each competing HHA (each CMS Certification Number/CCN) competing in the Model. **Exhibit 1** illustrates when payment adjustments will occur based upon performance in respective calendar years.

Exhibit 1: HHVBP Model Payment Adjustment Dates and Rates

Calendar Year for Performance	Calendar Year for Payment Adjustment	Maximum Payment Adjustment (positive or negative)
2016	2018	3%
2017	2019	5%
2018	2020	6%
2019	2021	7%
2020	2022	8%

Change of Ownership (CHOW)

If an agency is in the process of changing ownership and the agency has a CCN in one of the HHVBP selected states, the new owners should follow the registration steps and participate in trainings. Indicate in your emails to the HHVBP Help Desk the change of ownership effective date, the CCN and the new PPOC. If the new owner is not accepting assignment of the CCN, they should register once the new CCN is approved, and so state in the email to the HHVBP Help Desk.

According to the CY 2016 HH PPS final rule, participation in the Model depends on an agency's state specific CMS Certification Number (CCN). If a change of ownership results in the use of a new CCN, neither the baseline nor the performance year score would transfer to the new CCN. If the agency continues to use the same CCN, then the scores would transfer to the new owners.

For a current list of HHVBP resources, please refer to the "*HHVBP Connect* Inventory" document, found on *HHVBP Connect*.

CY 2019 HH PPS Final Rule

The CY 2019 HH PPS Final Rule (CY 2019 Rule), published on November 13, 2018, brought four refinements to the HHVBP Model, effective January 1, 2019. These four refinements are reflected for the first time in the July 2019 IPRs and the Performance Year 4, CY 2020 Annual Report. The sections below provide more detail on these refinements.

Refinement 1: Remove Two OASIS-based Process Measures

The CY 2019 Final Rule removed two OASIS-based process measures – Influenza Immunization Received for Current Flu Season and the Pneumococcal Polysaccharide Vaccine Ever Received – from the applicable measure set beginning Performance Year 4, CY 2019.

Stakeholders and a Technical Expert Panel convened in 2017 provided input on this change. For details, please review the corresponding section in the CY 2019 Final Rule.

Refinement 2: Replace Three OASIS-based Outcome Measures with Two Composite Measures

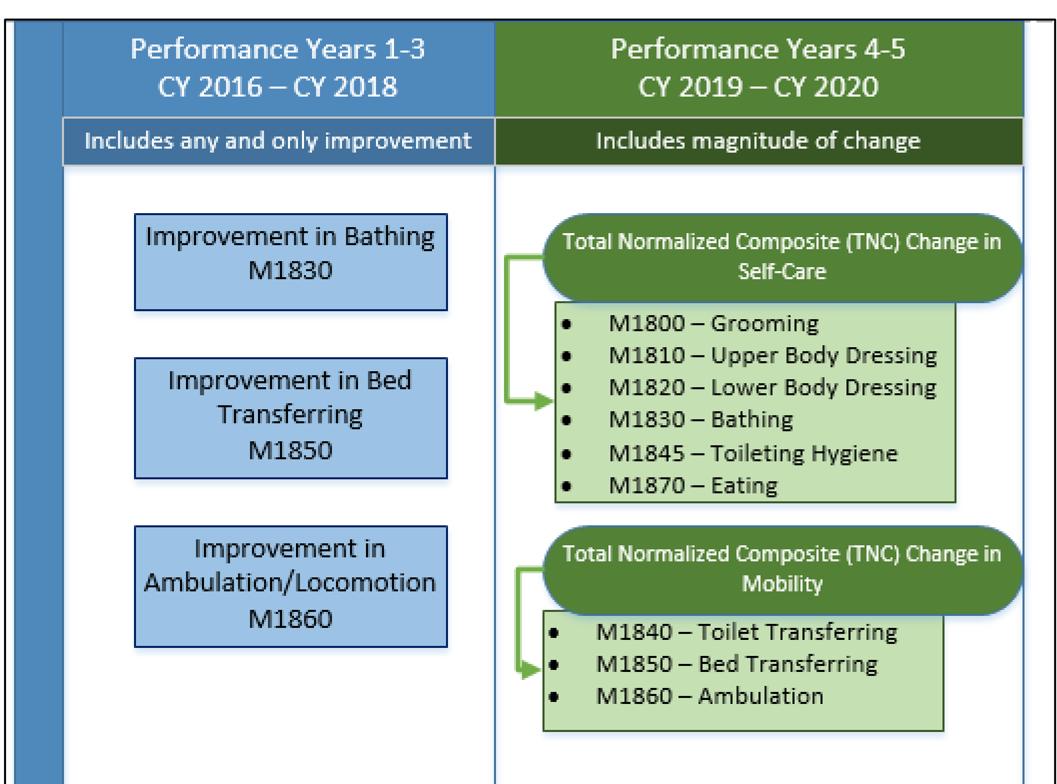
Changes as a result of the 2019 HH PPS Final Rule are first reflected in the July 2019 IPR and the Performance Year 4, CY 2020 Annual Report.

Beginning in Performance Year 4 (CY2019), two composite measures – Total Normalized Composite (TNC) Change in Self-Care and Total Normalized Composite (TNC) Change in Mobility – replaced the three Activities of Daily Living-related OASIS-based outcome measures. These measures are:

- Improvement in Ambulation/Locomotion
- Improvement in Bed Transferring, and
- Improvement in Bathing

This adjustment allows for a more comprehensive assessment of agency performance across a broader range of patient outcomes related to Activities of Daily Living. Note that the HHVBP Model currently measures agency performance based on any improvement in patient status, while the composite measures report the magnitude of change (either improvement or decline) across six self-care and three mobility patient activities. **Exhibit 2** shows the measures that CMS removed on the left side of the table, while the right side shows the two composite measures that CMS added.

Exhibit 2: Three OASIS-based Outcome Measures Replaced with Two Composite Measures, Effective CY 2019



The CY 2019 Final Rule specifies that the maximum number of points available for Improvement is "9" and that the composite measures are weighted at 1.5 times the other OASIS-based measures. This information is combined to compute the Improvement Points for the two new composite measures. The Improvement Points are calculated using the Improvement formula multiplied by 1.5 to obtain the Improvement Points for each of the two composite measures.

The calculation of Achievement Points is similar. According to the CY 2019 Final Rule, the maximum number of points available for **Achievement** is “10” (with the exception of the composite measures, for which the maximum number of Achievement Points is “15”) and, as mentioned above, the composite measures are weighted at 1.5 times the other OASIS-based measures. Using this information, the Achievement Points are calculated based on the Achievement formula and then multiply this value by 1.5 to get the Achievement Points for each of the two composite measures.

Exhibits 3 and **4** show the formulas for calculating Improvement Points and Achievement Points, respectively, for TNC Change in Self-Care and TNC Change in Mobility.

Exhibit 3: Improvement Point Formula for TNC Change in Self-Care and TNC Change in Mobility

$$[9 * (\frac{HHA\ Performance\ Year\ Score - HHA\ Baseline\ Period\ Score}{Benchmark - HHA\ Baseline\ Period\ Score}) - 0.5] * 1.5$$

Exhibit 4: Achivement Point Formula for TNC Change in Self-Care and TNC Change in Mobility

$$[10 * (\frac{HHA\ Performance\ Year\ Score - Achievement\ Threshold}{Benchmark - Achievement\ Threshold}) + 0.5] * 1.5$$

Appendix G(a): Applicable Measure Set Beginning Performance Year 4 details the applicable measure set for the HHVBP Model beginning CY 2019, Performance Year 4. **Appendix G(b): Applicable Measure Set Beginning Performance Year 4** identifies the individual OASIS M items included in each composite measure.

Two additional resources on the composite measures can be found in the *HHVBP Connect* Library:

- *“Step by Step Guide to Computing the Composite Measures”*
- *“HHVBP Technical Specification Resource for Composite Outcome Measures”*

Refinement 3: Reweight the OASIS-based, Claims-based, and HHCAHPS Measures

The third refinement is the change in weighting used to calculate the 90% of the TPS based on claims-based, OASIS-based, and HHCAHPS measures. The remaining 10% of the TPS based on submitting New Measures data remains unchanged.

Beginning in Performance Year 4, the OASIS-based measures and the claims-based measures each account for 35 percent, while the HHCAHPS measure category accounts for 30 percent of the TPS points. Please see **Appendix H: HHVBP Performance Years 1-3 Measure Weights vs. Performance Years 4-5 Measure Weights** for a table that provides a detailed presentation of the differences between the previous and finalized TPS measure weights.

Within the claims-based and OASIS-based measures, there are other changes in individual measure weighting:

- For claims-based measures, the weight of the Acute Care Hospitalization measure increased to three times the weight of the Emergency Department Use without Hospitalization measure.
- For OASIS-based measures, the weight of the two new composite measures, Total Normalized Composite (TNC) Change in Self-Care and Total Normalized Composite (TNC) Change in Mobility, is one and a half times the weight of the remaining OASIS-based measures, since these two composite measures combine information from a total of nine different OASIS items.

Refinement 4: Reduce the Maximum Number of Improvement Points

The maximum number of Improvement points HHAs can earn for most measures reduces from 10 to 9 points, beginning in Performance Year 4.

For the two new composite measures, TNC Change in Self-Care and TNC Change in Mobility, the maximum improvement points are set to 13.5. These 13.5 points represent 90 percent of the maximum 15 Achievement points available for each of the two composite measures.

Section 3: The HHVBP Model Websites

This section of the guide provides guidance on what HHAs should do first when registering for the Model. It also introduces the HHVBP Secure Portal and *HHVBP Connect*. You will learn about the functionality differences for each site and the importance of ensuring you can access both websites.

Key Step: Email the Help Desk with PPOC Information

HHAs in the nine HHVBP states should provide the HHVBP Help Desk, HHVBPquestions@cms.hhs.gov, with the name and email address of a Primary Point of Contact (PPOC) for each CMS Certification Number (CCN). Please also include the agency name, agency address and agency phone number. The person applying to be the PPOC should be someone who understands the daily operations of the HHA and has the authority to delegate/assign tasks (for more information on the PPOC role, please refer to **Section 5: HHVBP Secure Portal Roles**). Once approved to be the PPOC for that CCN, this PPOC will be instructed on how to request access to the HHVBP Secure Portal and *HHVBP Connect*, and begin receiving communications from the HHVBP Model Team, including emails inviting you to register for upcoming learning events.

Overview of the HHVBP Model Websites

HHAs will regularly use two websites as part of the HHVBP Model (**Exhibit 5**):

- **HHVBP Secure Portal** -- The site where agencies submit HHVBP New Measures data (Herpes Zoster Vaccine, Advance Care Plan, and Staff Influenza Vaccination), access Interim Performance Reports and Annual TPS and Payment Adjustment Reports, and submit recalculation/reconsideration requests.
- ***HHVBP Connect*** -- A collaboration and information website where agencies in the Model can stay up-to-date on HHVBP Model news and resources. HHAs can connect with their peers by engaging via the "Chatter" page to post questions, and share ideas and strategies. The *HHVBP Connect* site houses a library of all HHVBP resources and recorded learning events. You may also view and register for upcoming events on *HHVBP Connect* through the calendar tab.

Access to both websites takes time, up to several weeks, so you should begin the registration process as early as possible. These two separate websites require two separate sets of login credentials.

Exhibit 5: Functionality of HHVBP Model Sites

HHVBP Secure Portal	*HHVBP Connect*
• Submit HHVBP New Measures data • Access Interim Performance Reports • Access Annual TPS and Payment Adjustment Reports • Submit recalculation and reconsideration requests	• Engage with other HHAs in the HHVBP Model • Access resources and recorded learning events • View calendar of events and access event registration links

Section 4: HHVBP Connect

Now that you have learned about the differences between the HHVBP Secure Portal and *HHVBP Connect,* this section of the guide provides more information about *HHVBP Connect*.

All HHA staff involved with the HHVBP Model can benefit from the resources on the *HHVBP Connect* site. After registering and gaining access to the *HHVBP Connect* site, navigate to the login page at https://app.innovation.cms.gov/HHVBPConnect/CommunityLogin to begin. The horizontal navigation panel in *HHVBP Connect* includes seven tabs:

1. **Chatter**: Share best practices and "chat" with your colleagues in the HHVBP Model
2. **People**: View users and other active organizations within the HHVBP Model
3. **Groups**: Join groups and converse with a specific subset of the HHVBP Model community
4. **Calendar**: View HHVBP Model milestones and register for upcoming events
5. **Libraries**: Search the database of the most current and important HHVBP Model resources available
6. **Help**: Find Help Desk contact information and additional support
7. **Knowledge**: A repository of all current Frequently Asked Questions (FAQs)

For more information on how to navigate through *HHVBP Connect*, review the *HHVBP Connect* User Manual or the recorded learning event titled "*HHVBP Connect* Website Overview" from February 2016, both available in the *HHVBP Connect* Library.

HHVBP Connect Registration

Agencies that have provided the HHVBP Help Desk with a PPOC or CPOC will receive an email with instructions to register for the *HHVBP Connect* site. Both PPOCs and additional staff who wish to have access to *HHVBP Connect* can use the self-registration process to register for a *HHVBP Connect* account:

1. Navigate to *HHVBP Connect* (https://app.innovation.cms.gov/HHVBPConnect/CommunityLogin*).*
2. Click on "New User? Click here."
3. Fill out and submit the registration form.
4. You will receive an email from the CMMI Connect Team. (CMMIConnectHelpDesk@cms.hhs.gov) asking follow up information to complete *HHVBP Connect* registration. New users should be prepared to identify their HHA's current PPOC.

After CMS approves the request, the new user will receive an email with their *HHVBP Connect* User ID. If you do not receive an email from CMMIConnectHelpDesk@cms.hhs.gov, please be sure to add this email address to your safe sender list, or check your spam mailbox for an email from CMMIConnectHelpDesk@cms.hhs.gov.

If you need help setting up an *HHVBP Connect* account, please contact the CMMI Help Desk at 1-888-734-6433, Option 4, or email at CMMIConnectHelpDesk@cms.hhs.gov. The Collaboration Sites Business Operations Support Center (CBOSC) is available Monday through Friday, 8:30 AM to 6:00 PM ET, except federal holidays. If you call outside of these hours, you have the option to leave a voicemail message. Your call will be returned on the next business day.

Section 5: HHVBP Secure Portal

This section provides an overview of the HHVBP Secure Portal and step-by-step instructions on how to register.

The HHVBP Secure Portal website resides within the CMS Enterprise Portal Innovation Center, home to many CMS quality-related programs. This portal allows the CMS program teams and participating providers to securely submit and access confidential provider-specific data and information. HHVBP Model PPOCs must obtain access to the HHVBP Secure Portal to submit data for New Measures, view and download HHA-specific reports, and request recalculation/reconsideration requests, if needed. **Exhibit 6** shows the three steps to gain access to the HHVBP Secure Portal.

Exhibit 6: Steps to Gaining Access to the HHVBP Secure Portal

Step 1	Step 2	Step 3
Register for EIDM	Request access to the Innovation Center	Request access to the HHVBP Secure Portal

Enterprise Identity Management (EIDM), Innovation Center, and HHVBP Secure Portal Registration

Steps 1-3 below lists all of the information you need to register for the HHVBP Secure Portal. You must follow the steps in the order listed to gain access to the HHVBP Secure Portal.

Step 1: EIDM Registration

Obtaining EIDM login credentials is the first step in registering for the HHVBP Secure Portal. If you already have an EIDM login from another CMS program, please continue to Step 2.

1. Navigate to the CMS Enterprise Portal.
    - On the CMS Enterprise Portal landing page, click the “New User Registration” button.
    - On Step #1: Choose Your Application page, select “IC: Center for Medicare and Medicaid Innovation (CMMI) Innovation Center (IC)” from the Choose Your Application drop-down list.
    - Read and agree to the user Terms and Agreement by selecting the checkbox for “I agree to the terms and conditions.”
    - Click “Next.”
2. Fill out your contact information.

- Please note that personal information is only used to verify your identity in the event that your account is locked. It is very important that you enter accurate information because errors could delay your access to the HHVBP Secure Portal during verification.
- All fields are required unless marked "Optional."
- After providing all information, click "Next."

3. Create a User ID and password.
    - User ID must be a minimum of 6 and a maximum of 74 characters
    - Passwords must adhere to the following requirements:
        i. Must be a minimum of 8 and a maximum of 20 characters
        ii. Must contain at least: 1 number, 1 letter, 1 uppercase letter, 1 lowercase letter, and 1 special character
        iii. Cannot contain your User ID and must differ from your previous 6 passwords
        iv. Must be changed every 60 days (EIDM will prompt you for password change via email 7 days before the password is due to expire)
        v. Can only be changed once daily
        vi. Cannot use 3-6 letter words
        vii. Cannot contain years between 1900-2100
        viii. Cannot contain common letter and number strings (For example, 123abc, qwerty, 123123). EIDM also restricts the following number and letter strings: 1022, 1225, 1234, 1313, 2112, 2222, 4444, 5252, 5555, 5683, 6969, 7007, 7777, 1022, 1225, 1234, 1313, 111111, 121212, 123123, 123456, 123abc, 131313, 1a2b3c, 1p2o3i, 1q2w3e, 1qw23e, 654321, 666666, 696969, 888888
        ix. Cannot contain these special characters: ?<>{}'"/ |&@
    - Helpful hint: Think of a song and apply the rules to create a new password. Below is an example:
        i. Song: Twinkle-twinkle little star how I wonder what you are…
        ii. Password: Tt1shIwwy@
    - After providing all information, click "Next."
4. After entering the user ID and password, select a question in the Select Security Question #1 drop-down list and enter the answer you want to save.
    - Continue to select a question and enter an answer for Question #2 and Question #3.
    - After answering the three questions, click "Next."
5. Review the information you entered on the Registration Summary page, make any necessary changes, then click the "Submit User" button. You will be notified of account creation on-screen and via email to the email address provided.
6. If you have not already, please email your agency's PPOC (and CPOC, if applicable) to the HHVBP Help Desk with your CCN(s) and organization name. **This step is critical to be able to continue with HHVBP Secure Portal Registration (Step 3), as your agency's current PPOC must be on file with the Help Desk in order for CMS to approve your HHVBP Secure Portal request.**

Step 2: Requesting Access to the Innovation Center

Follow the steps below to register for the Innovation Center, which houses the HHVBP Secure Portal. You may refer to the webinar "HHVBP Gaining Access to the HHVBP Secure Portal" in the *HHVBP Connect* Library

for additional instructions. See **Appendix C: Screenshots for Creating an EIDM User ID and Requesting Access to the Innovation Center** for related screenshots.

1. Navigate to the CMS Enterprise Portal.
2. Click the "Login to CMS Secure Portal" button and log in using your EIDM User ID and password.
3. You can access the catalog by selecting the "My Access" option from the Welcome drop-down list in the top navigation bar or by clicking the "Request/Add Apps" tile on the My Portal page.
4. Search for the Innovation Center in the access catalog by typing "IC" in the search box, and press enter to find the IC widget.
5. Click the "Request Access" button in the IC widget.
6. When prompted, choose the "IC Privileged User" role from the dropdown menu. All HHA users should choose "IC Privileged User" regardless of their roles at the HHA or in the HHVBP Secure Portal.
7. Click "Submit" and continue to follow the prompts to the "identity verification" portion of the registration process.
8. You will be prompted to provide the following information for identity verification purposes:
    - Full name
    - Email address
    - Physical address
    - Phone number
    - Social security number
9. Once you submit this information, you will be prompted to answer a series of questions to prove your identity. These questions might include the date of opening a credit card, confirmation of your current address, the lender of your mortgage, past addresses, or automobile information.
    - It is very important that you answer these questions correctly. Please take the time to make your best-informed choice. If you answer a question incorrectly, the Experian number (1-866-578-5409) will pop up on your screen and you must call Experian to continue with identity verification over the phone.
10. Once you have confirmed your identity, continue to follow the prompts until a "Multifactor Authentication Information" screen appears. You may choose from four device options in which to receive a one-time passcode each time you enter the HHVBP Secure Portal. We recommend that you select the "Email one-time pass-code" or "Text Message/SMS" option.
11. After you select your credential type, enter the email address or phone number where you want to receive passcodes each time you enter the HHVBP Secure Portal. Enter your email or phone number and continue to follow the prompts until you see a confirmation on the screen that the device has been set up.
12. If you completed the steps correctly, the system will automatically approve your IC Privileged User request.

Step 3: HHVBP Secure Portal Registration

Follow the steps below to request access to the HHVBP Secure Portal. You may also refer to the tutorial, "Instructions for Accessing the HHVBP Secure Portal," in the *HHVBP Connect* Library for additional instructions and **Appendix D: Screenshots for Requesting Access to an Application on the HHVBP Secure**

Portal and **Appendix E: Screenshots for Requesting Access to a Role on the HHVBP Secure Portal** for related screenshots.

1. Once you have approved access to the IC, navigate back to the CMS Enterprise Portal. Log in using your EIDM credentials and one-time passcode on the device you have set up.
2. Once logged in, click the "View Apps" button at the top of the screen, then select "Application Console." This option is located in the drop-down menu underneath "Innovation Center" in the upper left corner.
3. On the "Welcome to the Innovation Center" screen, click the "Request New Access" button and choose "Home Health Value Based Purchasing (HHVBP)" from the dropdown menu.
4. Choose the appropriate role from the next dropdown menu.
5. Enter a single CCN into the CCN text field.
6. Enter the note "HHVBP Request" in the comments field.
7. Click the "Submit Request" button.
8. A pop-up notification will appear with your request ID. Save the request ID for your reference, and click "OK." The CMS Enterprise Portal will send you an email when you are approved. You will need to repeat this process for each CCN you represent.

For Your Information

CMS approves PPOC and CPOC requests, but the PPOC for each HHA is responsible for approving access for all Secondary POCs, Data Entry, and Reviewer personnel associated with the HHA.

Approving/Rejecting User Roles in the HHVBP Secure Portal (PPOCs Only)

If you hold the HHA PPOC role, you are responsible for approving and rejecting role requests for the following HHVBP Secure Portal users from your agency: Secondary POC, Reviewer, and Data Entry. As the PPOC, you should also reject previously approved/assigned roles for staff members who once occupied subordinate roles but no longer work for the agency.

Approving/Rejecting New User Role Requests

1. Select the "Launch HHVBP App"
2. Scroll down to the CMMI Approve or Reject Access section in the Application Console
3. Click on the Pending Requests Tab
4. Select "Approve" or "Reject"

Rejecting Existing User Roles

1. Select the "Launch HHVBP App"
2. Scroll down to the CMMI Approve or Reject Access section in the Application Console
3. Click on the Approved tab. This tab should display all of the approved roles under the CCN.
4. Re-assign the role request to yourself and then reject the request to remove someone from a role.

If you need additional assistance, please call the HHVBP Technical Support Help Desk toll free number at 1-844-280-5628 for assistance with rejecting or approving roles in the **HHVBP Secure Portal.**

Troubleshooting HHVBP Model Websites

JavaScript needs to be enabled for successful use of the Enterprise Portal. Additionally, please ensure you use one of the supported browsers when using the HHVBP Model websites:

- Internet Explorer 11
- Firefox
- Chrome
- Safari

If you need additional help in registering for the HHVBP Secure Portal, contact the Collaboration Sites Business Operations Support Center (CBOSC) at 1-844-280-5628.

If you have successfully registered for the HHVBP Secure Portal, but cannot enter the portal because you did not receive a security code sent to your email, check your spam and junk mail folders to ensure you did not receive an email from donotreply@cms.gov. Ensure you are using the type of Multi-factor Authentication (MFA) that you originally selected when you set up your account. For example, if you signed up for text messaging as the mode for MFA, you will receive a text message. Be sure you entered the email address or phone number correctly. If you continue to experience technical issues with gaining access to the HHVBP Secure Portal, please call: 1-844-280-5628.

HHVBP Secure Portal Roles

HHA PPOC Role

- Submits New Measure data
- Accesses all HHVBP reports
- Submits recalculation and reconsideration requests
- Grants additional HHA staff access to the HHVBP Secure Portal
- Communicates Model information and milestones to other staff involved in HHVBP

HHAs in the Model will need to determine which staff at their agency need to access the HHVBP Secure Portal. The first question an agency needs to answer is, "Who at our agency is responsible for accessing our HHVBP reports, assuring our reports are accurate, and submitting HHVBP New Measure data?" The answer to this question will determine who should be the Primary Point of Contact (PPOC) at your agency. Each HHA must designate one PPOC for each of their CCNs and the PPOC needs to register with EIDM (needed to access the HHVBP Secure Portal). The agency will then need to answer the question, "What staff at our agency need to access the HHVBP Secure Portal?" The PPOC will grant access to others at your agency after they register for access to the Portal. The HHVBP Secure Portal includes several staff roles (Corporate Point of Contact, Secondary Point of Contact, Data Entry Personnel and Reviewers). Agencies do not need to fill all the roles within their agency as the PPOC can carry out all the functions of each role. One person can be the PPOC for multiple CCNs. An agency may choose to have only a PPOC. If you need to change the PPOC to another person in the agency, you can request a PPOC replacement by emailing the HHVBP Help Desk at HHVBPquestions@cms.hhs.gov and include the following information: the new PPOC name, email address, CCN(s) the PPOC represents, and the former PPOC's name and email address. Please note, after CMS approves the new PPOC, it may take time for the new PPOC to complete the steps to access the HHVBP Secure Portal.

In addition to the PPOC, CMS recommends that an agency also have a staff member assigned to the role of Secondary Point of Contact (SPOC). The SPOC acts as a back-up to the PPOC and can therefore also carry out all the functions of each role, with the exception of approving and rejecting subordinate roles in the HHVBP Secure Portal and viewing the Annual Total Performance Score and Payment Adjustment Report (Annual Report). An agency must have a PPOC and is encouraged to have a SPOC, but has the option to select staff assigned to the other roles in the HHVBP Secure Portal. To view all information for all your organization's CCNs with one User ID login, you need to select the role of "HHA Corporate POC" (CPOC) when you register for the HHVBP Secure Portal. The CPOC has the ability to view all information of the CCNs under the corporation but cannot enter data, approve data entry, or submit data. **Exhibit 7** outlines all the available HHVBP Secure Portal roles that your agency may use.

Exhibit 7: HHVBP Secure Portal Roles

Role	Function
Primary Point of Contact (PPOC)	• All HHAs must designate a primary point of contact • Understands the daily operations of the HHA • Has the authority to delegate tasks within the HHA • Has the authority to grant access to HHVBP Secure Portal for the agency's Secondary POC, Data Entry personnel, and Reviewer • If the PPOC does not designate individuals to these other roles, they will need to enter and review New Measures data themselves • Can review Model-specific performance reports • Can initiate IPR and Annual Report recalculation and reconsideration requests
Corporate Point of Contact (CPOC)	• Optional role • Can view any of the agency's information already entered into the HHVBP Secure Portal • Can review Model-specific performance reports • Read-only access role not intended for HHA representatives that want to enter the HHVBP New Measures data or have a prominent role in approving the internal HHA team • Has no role in submitting HHVBP New Measures data • Cannot initiate IPR and Annual Report recalculation and reconsideration requests
Secondary Point of Contact	• Acts as a proxy for the PPOC with permissions to enter, review, and submit the HHA's HHVBP New Measures data and initiate IPR recalculation requests • Can view the IPRs • Cannot view the Annual Report
Reviewer	• Can enter New Measure data on behalf of the HHA but cannot submit data • Cannot access Model-specific performance reports • Acts as a quality check mechanism for the HHA Data Entry role • Can review and approve the data entered by an individual with a Data Entry role

Role	Function
Data Entry	• Can enter New Measure Data on behalf of the HHA but cannot submit data • Cannot access Model-specific performance reports

Using the HHVBP Secure Portal

HHA staff involved in data submission for the HHVBP Model will need to access the HHVBP Secure Portal regularly. To navigate to the HHVBP Secure Portal, log in to the CMS Enterprise Portal at https://portal.cms.gov/ and click the "View Apps" button at the top of the screen, then select "Application Console." This option is located in the drop-down menu underneath "Innovation Center" in the upper left corner. The pages and the content available include:

"I requested the Secondary POC/Reviewer/Data Entry role in the HHVBP Secure Portal a while ago and it is still pending. What should I do?"

The Secondary POC, Reviewer, and Data Entry roles are approved by the agency's PPOC, not CMS. If your request for one of these roles is still pending, please verify who the approved PPOC is for the CCN and remind them to approve your request. As a reminder, the PPOC can perform the functions of the Secondary POC, Reviewer, and Data Entry roles; therefore, if you are the PPOC, you do not need to request these roles for yourself.

- The **HHVBP Secure Portal Home Page** provides general information about the Model and tabs for each of the pages on the site.
- The **New Measures Overview** tab provides a brief overview of the New Measures, and the option of downloading an Excel file with all the New Measure questions for your data collection needs and records. We refer to these as the New Measure Templates.
  - The **Staff Influenza Vaccination Measure** section has three tabs for each data collection group: 1) employees, 2) licensed independent practitioners, and 3) trainees and volunteers.
  - The **Herpes Zoster Vaccination Measure** one page section captures and submits all data for this New Measure.
  - The **Advance Care Plan Measure** one page section captures and submits all data for this New Measure.
- The **Reports - Overview** page contains links to reports generated during the Model's lifetime.
  - The **Reports - Interim Reports** page will provide links to the reports once they become available.
  - The **Reports - Annual Total Performance Score and Payment Adjustment Report** page allows agencies to download this report based on a complete performance year of data.
- The **Help** page includes Help Desk information, Frequently Asked Questions (FAQs) grouped by topic, and helpful links to websites outside of the HHVBP Secure Portal. These websites provide additional and helpful material related to HHAs, the HHVBP Model, and other resources of interest.

Changing your Agency's Information in the HHVBP Secure Portal

If you need to update your agency's information for CMS records, you can find contact instructions for how to do so on the CMS website. If your agency has already gone through the process to update your information in your CMS administrative data, then this should be reflected in the next update of the Provider of Service file, which will then be reflected in the HHVBP Secure Portal. We also advise users to update their record in the National Provider Identifier Registry (NPI) to reflect their agency's information.

Section 6: The HHVBP Model Cycle

This section of the guide will focus on describing the HHVBP Model cycle from an HHA's perspective.

The HHVBP Model Cycle

The HHVBP Model cycle encompasses four phases, Registration, New Measures, IPRs, and Annual Reports. **Exhibit 8** illustrates these phases, followed by key points of each step in the cycle.

Exhibit 8: The HHVBP Model Cycle

Registration

Establish PPOC
Email the HHVBP Help Desk with PPOC name, email address, and HHA CCN, name and address.

HHVBP Secure Portal
PPOC gains access to the HHVBP Secure Portal.
PPOC grants access to other staff in the HHVBP Secure Portal.

HHVBP Connect
PPOC and other staff gain access to *HHVBP Connect.*

Quality Measures Data

Data Collection
OASIS, HHCAHPS, & Claims-Based Measures: Follow current data collection systems that are in place at the HHA.

New Measures: Data collection occurs at the individual patient or HHA level.

Data Submission
OASIS, HHCAHPS, & Claims-Based Measures: No new HHA submission-related actions required for these measures.

New Measures: HHAs must submit aggregate data via the HHVBP Secure Portal.

Interim Performance Reports (IPRs)

Preliminary IPRs
Provide *preliminary* score for the achievement and improvement points for each measure for that quarter.
Available in the HHVBP Secure Portal quarterly in January, April, July, October.

Recalculation Requests
HHAs may request a recalculation of performance scores if a HHA has evidence of an error.
Requests must be submitted within 15 days following availability of the IPR on the HHVBP Secure Portal.

Final IPRs
Provide the *final* score for the achievement and improvement points for each measure for that quarter.
Become available about 2 months after the Preliminary IPR.

Annual Reports

Preview Annual Report
Provide an HHA's APP. Available in the HHVBP Secure Portal annually in August.

Recalculation Requests
HHAs may request a recalculation of performance scores if a HHA has evidence of an error.
Requests must be submitted within 15 days following availability of the Preview Report.

Preliminary Annual Report
Available in the HHVBP Secure Portal in September or October after recalculation requests are calculated.

Reconsideration Requests
Only agencies that submit a recalculation request may submit a reconsideration request.

Final Annual Report
PPOCs and CPOCs will be notified their Final Annual Report is available on the HHVBP Secure Portal. Final APP is available no later than 30 days prior to the calendar year for which the APP is applied.

Section 7: HHVBP Quality Measures

CMS calculates each competing HHA's total performance score using measures determined from four data sources:

OASIS-based Measures

OASIS-based measures are calculated using data collected in the Outcome and Assessment Information Set (OASIS) submitted by HHAs for Medicare and Medicaid patients (including Medicare and Medicaid managed care).[2] OASIS data are used for multiple purposes including calculating several types of quality reports provided to HHAs to help guide quality and performance improvement efforts. For more information regarding OASIS, refer to the CMS website. For more information on OASIS-based quality measures, refer to the CMS Home Health Quality Initiatives website.

Claims-based Measures

The claims-based utilization measures represent a subset of outcome measures used in the Home Health Quality Reporting Program calculated using Medicare fee-for-service claims data. They include events such as hospitalization or emergency department care within a certain period. They evaluate the rate of utilization of specific services that may indicate quality of care concerns within the agency. Lower values indicate fewer events for patients at that HHA. For more information on claims-based measures, refer to the CMS Home Health Quality Initiatives website.

HHCAHPS Measures

HHCAHPS Measures use data from the Home Health Consumer Assessment of Healthcare Providers and System® (HHCAHPS) survey and include the payers of Medicare and Medicaid (including Medicare and Medicaid managed care). The HHCAHPS survey, a nationally standardized and publicly reported survey, measures the experiences of patients receiving home health care from Medicare-certified home health care agencies. The survey contains 34 questions administered to a sample of patients who have received at least one skilled visit by the HHA in the sample month, and two skilled visits in the look back period.

HHAs in the HHVBP Model must have a minimum of 40 completed HHCAHPS surveys for purposes of receiving a performance score for any of the HHCAHPS measures. For more information regarding the HHCAHPS measures, visit https://homehealthcahps.org/.

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[2] HHAs do not submit OASIS data for patients receiving maternity-related services and patients under the age of 18.

HHVBP Model New Measures

New Measures Overview

While most of the quality measures included in the HHVBP Model rely on data already collected by HHAs -- OASIS, HHCAHPS, and claims data (see **Appendix A: HHVBP Model Quality Performance Measures for Performance Year 4, Calendar Year 2019**) -- three New Measures are specific to the HHVBP Model and have not been used previously in the home health setting. Points are awarded for submitting data, and are not based on the actual values submitted. This section of the guide will introduce you to each of the New Measures, including when to collect data, when and how to submit data, and how the three New Measures help HHAs earn points toward the agency's TPS.

HHAs submit data for the New Measures via the HHVBP Secure Portal. HHAs must submit Advance Care Plan and Herpes Zoster Vaccine data each quarter and Staff Influenza Vaccination influenza vaccination data annually, to receive full points in the Annual TPS and Payment Adjustment Report. Applicable New Measures data submission periods for Advance Care Plan and Herpes Zoster Vaccination New Measures are in January, April, July, and October. The applicable New Measure data submission period for the Staff Influenza Vaccination Measure is in April.

The New Measures gather data on health care-related information that agencies may not be currently gathering and test these measures within the home health setting. HHAs receive points toward their TPS by submitting New Measures data as a reward for helping CMS collect these data to gain a better understanding of the current performance levels on these New Measures in the home health setting. For the Annual TPS and Payment Adjustment Report, if an agency submits data in every applicable data submission period for a measure, 10 points are applied for that measure. Agencies will see points on the quarterly IPRs that reflect submission for the previous data submission period (see **Exhibit 9**).

Collecting New Measures Data

HHAs collect New Measures data on each patient in their agency based upon the data collection specifications found in the New Measures Templates via the *HHVBP Connect* Library. Agencies collect data at the *individual patient or HHA staff level*, but submit only the *aggregate* information (the sum of each field on the New Measures template for each data submission period). HHAs must develop systems within their agency to collect this data and should continuously collect data for all three HHVBP Model New Measures, regardless of the timing for data submission, because the OASIS data collection system does not currently include the New Measures. Therefore, agencies will need to either work with their software vendor or develop another system to collect data on the three New Measures.

New Measures Data Collection Periods

The data collection period is a full calendar quarter for the Advance Care Plan and Herpes Zoster Vaccination New Measures. For example, the first data collection period of 2019 for the Advance Care Plan and Herpes Zoster Vaccination measures began on January 1 and ended on March 31. The data collection periods continue on a quarterly basis for both measures.

HHAs collect data for the Influenza Vaccination Coverage for Home Health Care Personnel New Measure annually for the period October 1 (or when the vaccine became available) through March 31 each year. For example, the data collection period for the Influenza Vaccination Coverage for Home Health Care Personnel measure started on October 1, 2018 and ended March 31, 2019 (data submitted in April 2019).

Data submission for all three New Measures begins the first day of the month following the end of collection period as illustrated in **Exhibit 9** below.

Exhibit 9: New Measures Data Collection Periods

New Measures	Data Collection Periods	Data Submission Begins
Advance Care Plan and Herpes Zoster Vaccination	January 1st – March 31st April 1st -June 30th July 1st - September 30th October 1st – December 31st	April 1st July 1st October 1st January 1st
Influenza Vaccination Coverage for Home Health Care Personnel	October 1st (or when the vaccine became available) through March 31st each year	April 1st

Staff Influenza Vaccination

The Influenza Vaccination Coverage for Home Health Care Personnel New Measure reflects the percentage of home health care personnel who receive influenza immunization. The measure **denominator** includes all employees, regardless of their duties or interactions with patients, based on three subcategories:

- Employees
- Licensed Independent Practitioners
- Trainees & Volunteers

The **numerator** for this measure includes the subset of personnel from the denominator who received the influenza vaccine during each flu season.

Denominator details

The denominator could include members of a volunteer Advisory Board. However, Corporate/administrative employees who do not physically work at the agency would not be included in the denominator for the Influenza Vaccination Coverage for Home Health Care Personnel measure.

"If a home health agency also has a hospice (2 different CCNs), but some employees work for both the home health agency and the hospice and are paid from a corporate payroll, which employees do we count for the Influenza Vaccination Coverage for Home Health Care Personnel measure?"

For home health agencies that have employees that serve multiple CCNs, the "employee" denominator would include all staff who are paid by the organization and are serving a specific home health agency CCN. In your example, you would count only the employees that serve your home health CCN. This scenario also applies to an agency that is hospital-based. A hospital-based home health agency would report information on the personnel associated with the home health agency CCN.

Contracted staff are not included in the measure calculations. This is not to be confused with per diem or part time staff who are included in this measure in the "employee" denominator category if they receive a direct paycheck from the agency.

An affiliated practitioner refers to a specific practitioner (physician (MD, DO), advanced practice nurse, physician assistant) who has a contractual or legal relationship with the agency to provide services to either the agency staff or the agency patients. This does not include clinical service contracts for agency staff (such as employee assistance programs or work-related injury programs) in which several unspecified practitioners may be in contact with the agency staff as needed. This also does not include practitioners who are merely ordering home health services or making referrals to the agency as their only relationship with the agency. Other licensed personnel such as therapists, nurses, social workers, or dieticians/nutritionists are also not included. For agencies that have contractual relationships with Accountable Care Organizations (ACOs) or that have similar contractual arrangements, physicians, advanced practice nurses, and licensed physician assistants would not be considered an "affiliate" if their role is only to order home health services or make referrals to the agency. A physician who is not an employee of the agency, but provides services such as Medical Director, Board Member, or Clinical Consultant would be considered an affiliate.

Offering the Vaccine

There is no requirement for an agency to offer to administer or pay for the influenza vaccination; however, the Centers for Disease Control (CDC) recommends that healthcare providers offer the influenza vaccine to all healthcare personnel.

When completing the New Measures templates and data entry in the HHVBP Secure Portal, field a-2, b-2, and c-2 asks how many personnel were offered the influenza vaccine. To count personnel in these fields, the agency would need to offer to provide the vaccine to the personnel by either administering the vaccine, or

assisting personnel to receive the vaccine through another source, or the employee could report that the vaccine was offered by another provider such as their PCP or specialist.

Required Documentation:

Per CDC Guidelines, acceptable forms of required documentation for receiving the flu vaccine from a setting outside the HHA include a signed statement or form, or an electronic form or email from the health care worker (HCW) indicating when and where he/she received the influenza vaccine, or a note, receipt, vaccination card, etc. from the outside vaccinating entity stating that the HCW (HHA employee, licensed independent practitioners, and adult students/trainees and volunteers) received the influenza vaccine at that location. Verbal statements are not acceptable for the purposes of this measure.

Herpes Zoster Vaccination

The Herpes Zoster (Shingles) Vaccination New Measure is the percentage of Medicare beneficiaries receiving home health services who have ever received the herpes zoster vaccine.

For this New Measure, the **denominator** includes Medicare beneficiaries aged 60 years or older that were discharged, transferred to an inpatient facility, or died during each quarterly reporting period, even if that means they are reported more than once in the same quarter, or if they are reported in more than one quarter. Medicare beneficiaries include patients with Medicare fee-for-service (or traditional Medicare), Medicare Advantage (also called Medicare managed care), and dually eligible beneficiaries who have both Medicare and Medicaid. Agencies are not required to collect New Measures data for patients who are receiving non-skilled care only.

"As the New Measures of Herpes Zoster Vaccination and Advance Care Plan both include data from start of care, would we include patients even if their SOC date was prior to the current reporting period?"

For the Herpes Zoster Vaccination measure and the Advance Care Plan measure, data are collected for patients who were discharged from the HHA, transferred to an inpatient facility, or died during the reporting period, regardless of their SOC date. The term "during the reporting period" refers to the data collection quarter.

The **numerator** for this New Measure includes the total number of Medicare beneficiaries from the denominator having ever received the herpes zoster vaccine.

Offering the vaccine

The New Measures Template for Herpes Zoster Vaccine asks, "How many patients were then offered the vaccine by the HHA prior to home health discharge, transfer to an inpatient facility, or death during the reporting period?" In this question, "offered" includes patients who were offered to receive the vaccine from the HHA and patients for whom the agency offered to assist in coordinating the administration of the vaccine by another provider (e.g. the patient's physician or pharmacy).

Advance Care Plan

Advance care planning encompasses communication and discussion regarding treatment preferences. It provides patients with an opportunity to consider, discuss, and plan their future care with health professionals. The Advance Care Plan New Measure indicates the percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or who have documentation in the medical record that an advance care plan was discussed.

"Do we have to collect data for the New Measures with every patient transfer as patients may have more than one transfer within a reporting period?"

Yes, you would collect data for each transfer to an inpatient facility that occurred during that reporting period. A patient is included in each reporting period each time they have a qualifying event of a discharge, transfer to an inpatient facility, or death. Patients may be included more than one time in a reporting period if they have more than one of these events (discharge, transfer to an inpatient facility, or death) during that reporting period.

The **denominator** for this New Measure includes all patients aged 65 and older that were discharged, transferred to an inpatient facility, or died during the reporting period, even if that means they are reported more than once in the same quarter, or if they are reported in more than one quarter. HHAs include all payers in the Advance Care Plan measure calculation. Then, out of all the patients from all payers, HHAs will also indicate the number of Medicare beneficiaries (including Medicare fee-for-service, Medicare managed care, and dually eligible beneficiaries). This is collected on the New Measures template as follows: Item (a) asks for all the patients 65 and older (all payers) who were discharged from HHA, transferred to an inpatient facility, or died during the reporting period. Then, (b) is asking how many out of those patients in (a) are Medicare beneficiaries.

The measure **numerator** includes the patients who have an advance care plan or surrogate decision maker documented in the medical record, or 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.

Tip: A patient who has an advance care plan or surrogate decision-maker at Start of Care (SOC**)** would also be included in the responses in fields "e" and "f" on the New Measures Template, which asks about the documentation of an ACP or surrogate decision maker at discharge, transfer to an inpatient facility, or death.

Required Documentation

Agencies should follow guidance in [42 CFR 489.102,] which requires that a provider document in a prominent part of the individual's current medical record whether the individual has executed an advance directive.

Discussions of Advance Care Planning

The intent of this measure includes communication with the patient and/or their caregiver. *Information on end of life planning in Admission Packets does not count as "providing information on an advance care plan."* If, in addition to providing written information, you have a conversation with the patient and/or caregiver, this would meet the requirements for "providing information on advance care plan."

Telephone conversations can be counted as a discussion with HHA staff about an advance care plan or surrogate decision maker, for the HHVBP Model measures. However, while the Advance Care Plan New Measure does not specify that the conversation must occur in person or via telephone, the regulations at 42 CFR 489.102 do state that this process can occur at any time prior to providing care, including the first visit. Since home health care is provided in-person, it is unclear why there would be a need or value of conducting this highly sensitive conversation other than in-person.

The Advance Care Plan New Measure does not specify a discipline; therefore, any agency personnel (LPNs, COTAs, PTAs, and MSWs, etc.) could have the discussion related to the advance care plan or surrogate decision maker. Home health agencies are expected to follow their own policies and procedures that are consistent with their own state laws in deciding who will provide information and discuss advance care planning.

Preparing to Submit Data for the HHVBP Model New Measures

To prepare for successful New Measures data submission, prior to the opening of the submission period, ensure those staff assigned to Model roles in your agency have obtained their CMS EIDM User IDs, and have access to the HHVBP Secure Portal. This step is crucial if you are a PPOC or SPOC and need to submit data on behalf of your agency. Refer to **Section 5: HHVBP Secure Portal** for instructions.

Ensure the appropriate staff has access to the documentation and reports in your agency containing the Staff Influenza Vaccination, Herpes Zoster Vaccine, and Advance Care Plan data. Following the end of the data collection period, aggregate the data for your agency as data are not submitted at the individual patient level.

In preparation for submitting data, we encourage you to utilize the Model resources on *HHVBP Connect*, discussed in the section called "**Additional HHVBP Model New Measures Resources**."

Submitting Data for the HHVBP Model New Measures

Exhibit 10 outlines the six major steps in the process for submitting New Measures data.

Exhibit 10: Six Key Steps for Submitting New Measures Data

Follow the six steps to submit New Measures data through the HHVBP Secure Portal. New Measures data can only be submitted during the data submission period. For training of how to enter and submit New Measures, please refer to the recording, slides and transcript from the November 8, 2018 learning event "Submitting New Measures Data to the HHVBP Secure Portal," available under the Libraries tab on *HHVBP Connect*.

1. Log In to the HHVBP Secure Portal

- Navigate to the CMS Enterprise Portal.
- Log in using your EIDM User ID and password and launch the HHVBP application. Once you have launched the HHVBP application, you will see a notification on your screen reminding you of the data submission period.
- On the "HHVBP Home" page, select your CCN from the drop-down list on the left side of the page.

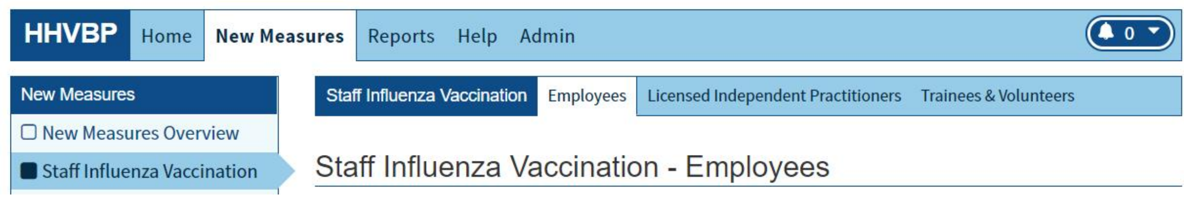
2. Navigate to the New Measures Tab

- Once a CCN is selected, you are ready to navigate to the "HHVBP New Measures" tab on the horizontal navigation pane at the top of the screen. When you click on "HHVBP New Measures" you will see the overview page.
- Note that each of the three New Measures has its own sub-bullet on the left navigation pane, just under this overview page.
- Navigate to each of the separate New Measures tabs on the horizontal navigation pane at the top of the screen.

3. Enter New Measures Data

- There are five pages to enter data:
  - Advance Care Plan: One page
  - Herpes Zoster Vaccine: One page
  - Staff Influenza Vaccination: Three pages – each denominator population has its own tab (Employees, Licensed Independent Practitioners, and Trainees & Volunteers).
    - **Exhibit 11** displays the Staff Influenza Vaccination tab in the HHVBP Secure Portal showing the three pages where HHAs submit data.

Exhibit 11: Staff Influenza Vaccination Tab



4. Save New Measures Data

- After entering the New Measures data in the HHVBP Secure Portal, saving the data allows you to review the data entry later. This step allows for completion, review, and editing internally within your CCN, before HHAs submit data to CMS.

5. Submit New Measures Data

You must click "Submit" at the bottom of each page to submit your data to CMS.

- If there are errors or notifications on the page, the data cannot be submitted to CMS until the errors are corrected. For example, if you click "Submit" and there are blank fields in the data collection instrument, an error message will appear.
- Blank fields are not the same as zeroes. There cannot be blank fields on the page. Your agency does not receive points for submitting "blanks," but you will receive points if you submit "zeroes." Be sure to enter "0" if you have no patients who meet one of the data collection criterion statements. You will be prompted to provide an explanation if you enter all zeroes.
- HHAs may receive an error when trying to submit if they copy and paste text into the Comments Box on the HHVBP Secure Portal. Instead, please try typing your comments directly into the Comments Box. We also recommend avoiding the use of special characters in the Comments Box. Once all fields have a value and there are no blanks, you must click "Submit" again after errors are corrected.

6. Verify Successful Submission

- There are several ways to determine if the New Measures data have been successfully submitted. The PPOC or SPOC will receive a "Successfully Submitted" on-screen notification after clicking the "Submit" button on each page. This indicates that the data on that page have been successfully entered and sent to CMS.
- The PPOC, CPOC, and SPOC should receive an email confirmation after the New Measures data have been "successfully submitted." It may be helpful to take a screenshot of your confirmation message for your records.
- The PPOC or SPOC will see a notification on the home page when any page of data has been successfully submitted to CMS.
- The PPOC or SPOC can navigate to the "New Measures Summary" in the vertical navigation menu and a screen will appear that shows each page of data and the current progress. The PPOC or SPOC can also select the "generate" button, which will create a downloadable format of any submitted data.

As explained above, HHAs submit data for the Herpes Zoster (Shingles) Vaccination and Advance Care Plan measures quarterly in January, April, July, and October. HHAs submit the data for the Staff Influenza Vaccination measure annually in April. All data submission for the New Measures is due by 3AM ET on the 15th of the month (January, April, July, October) for each data reporting period. If the 15th calendar day falls

on a weekend or holiday, the HHVBP Secure Portal will remain open until the end of the next business day. Data submission will only take place during the designated quarterly data submission windows.

Remember that once submitted, data cannot be modified or edited later. It is important to ensure all data are correct at the time of submission.

File Generation Error

This error message is the result of a file generation issue on the New Measure Summary page. After pressing the "Generate" button to obtain a downloadable Excel file, if that file generation fails, users receive this error message. More than one attempt may be necessary to re-generate the file to produce the New Measures Summary Report. However, this is independent from the actual submission of the data. If you received a confirmation email that your New Measures data were submitted successfully, then your data will be in 'submitted' status irrespective of this error message.

Extensions for Submitting New Measures Data

HHAs have 15 calendar days following the end of the data collection period to submit New Measures data in the HHVBP Secure Portal. If the 15th calendar day falls on a weekend or holiday, the HHVBP Secure Portal will remain open until the end of the next business day. CMS will not grant additional extensions.

CMS will send email reminders to PPOCs before and during the data submission periods with the exact dates. The end time included in the deadline is 3 AM ET (Eastern Time).

HHAs are encouraged to submit the HHVBP New Measures data earlier in the data submission period in case there are any questions or concerns. We recommend changes to the PPOC role be completed prior to the next data submission period to ensure the new PPOC obtains HHVBP Secure Portal access for successful submission of data. Available resources include:

- HHVBP Help Desks: Technical and Program-related Help Desk contact information, descriptions and hours are available in **Section 11: Training Resources and Technical Support**. Please take screenshots of any errors or issues when possible.
- FAQ document: Available under the "Libraries" tab on *HHVBP Connect*

The HHVBP TA Team lists scheduled HHVBP Secure Portal outages on the ***HHVBP Connect*** Calendar, but we also encourage you to sign up for email alerts, which will let you know when the Enterprise Portal is down during an **unscheduled** outage. To do so, please navigate to the CMS Enterprise Portal landing page and click "Email Alerts." You will then be asked to provide your email address. Enter the email address associated with your account and you will see a list of subscriptions you are currently subscribed to (if any). Toward the bottom, click "Add Subscriptions" and ensure the following topics are checked:

- Enterprise Portal Notifications
- EIDM PROD Notifications

Both topics are in the "OIS Portal Project" section. Once both are checked, scroll to the bottom of the page and click "Submit."

Obtaining Past New Measures Data Submissions

The CCN's HHVBP Secure Portal HHA roles PPOC, SPOC, CPOC, Reviewer, and Data Entry can download New Measures data submitted in past New Measures data submission periods using the steps below.

Steps

1. Log in to the HHVBP Secure Portal
2. Navigate to "New Measures" tab
3. Navigate to "New Measures Summary" page
4. Select the reporting period from "Performance Year and Quarter" dropdown menu
5. Download file from "Download New Measures Questions and Answers" table
    a. If the file is not generated, click on the "Generate" button.
    b. Once the file is generated, allow up to five minutes, then download file from "Download New Measures Questions and Answers" table

The steps above are also described in the HHVBP Secure Portal Help tab:

1. Navigate to the "Frequently Asked Questions" section
2. Navigate to the "New Measures" section
3. Select "How can I download my HHA's New Measures data?"

Home health agencies are encouraged to keep their own agency records of New Measures data submitted via the HHVBP Secure Portal, after each quarterly submission.

"If my home health agency (HHA) is eligible for a Total Performance Score (TPS) and does not submit New Measure data during one of the New Measures data submission periods, what is the impact on my HHA's reimbursement??"

New Measures data submission for all four quarters of a calendar year determines ten percent of the TPS. The TPS contributes to an HHA's APP in the Annual TPS & Payment Adjustment Report (Annual Report). The higher an HHA's TPS, relative to HHAs in the HHA's cohort, the higher the HHA's APP will be.

If an HHA does not submit data for all four quarters, the HHA only receives partial points for that calendar year's TPS. Refer to **Exhibit 23: Potential New Measure Points Beginning Annual Performance Year 2 (CY 2017) and Subsequent Performance Years.**

Additional HHVBP Model New Measures Resources

To learn more about the HHVBP Model New Measures, refer to the following resources in the *HHVBP Connect* Library:

1. *Frequently Asked Questions (FAQs)* (PDF)
2. *New Measures Template* (MS Excel)
3. November 8, 2018 Learning Event, "*Submitting New Measures Data to the HHVBP Secure Portal*" recording, slides, and transcript
4. "*Steps for Submitting New Measures Data to the HHVBP Secure Portal*" Cheat Sheet

Section 8: HHVBP Reports

This section of the guide is divided into the three subsections below and provides detailed information on the reports used in the HHVBP Model, report timelines, and recalculation and reconsideration requests.

A. **HHVBP Reports Overview**
B. **Interim Performance Reports**
C. **Annual Total Performance Score and Payment Adjustment Report**

A. HHVBP Reports Overview

The HHVBP Model Reports include preliminary and final versions of quarterly Interim Performance Reports (IPRs) and Annual Total Performance Score and Payment Adjustment Reports (Annual Report). **Exhibit 12** shows an example of the timeline for when data collection occurs to inform the IPRs and Annual Report. If you wish to review the data collection periods for the 2018 reports, refer to **Appendix I: Data Included in the 2018 HHVBP Reports**.

Exhibit 12: Data Included in the 2019 HHVBP Reports (See paragraph below for further explanation)

Report (Date First Reported)	**OASIS-Based Measures**	**Claims-Based and HHCAHPS-Based Measures**	**New Measures: Advance Care Plan and Herpes Zoster Vaccination**	**New Measure: Staff Influenza Vaccination**
January 2019 IPR (Jan 2019)	12 months ending **9/30/2018**	12 months ending **6/30/2018**	Quarter ending **9/30/2018** (Data Submitted: October 2018)	**10/1/2017-3/31/2018** (Data Submitted: April 2018)
April 2019 IPR* (April 2019)	12 months ending **12/31/2018**	12 months ending **9/30/2018**	Quarter ending **12/31/2018** (Data Submitted: January 2019)	**10/1/2017-3/31/2018** (Data Submitted: April 2018)
July 2019 IPR** (July 2019)	12 months ending **3/31/2019**	12 months ending **12/31/2018**	Quarter ending **3/31/2019** (Data Submitted: April 2019)	**10/1/2018-3/31/2019** (Data Submitted: April 2019)
Annual TPS and Payment Adjustment Report (Aug 2019)	12 months ending **12/31/2018**	12 months ending **12/31/2018**	12 months ending **12/31/2018**	**10/1/2017-3/31/2018** (Data Submitted: April 2018)
October 2019 IPR (Oct 2019)	12 months ending **6/30/2019**	12 months ending **3/31/2019**	Quarter ending **6/30/2019** (Data Submitted July 2019)	**10/1/2018-3/31/2019** (Data Submitted: April 2019)

* As of April 2019, the IPRs include Achievement Thresholds, Benchmarks, and baseline scores for the two OASIS-based composite measures: Total Normalized Composite Change in Self-Care and Total Normalized Composite Change in Mobility.

**The first report in 2019 to include the four refinements to the Model was the July 2019 IPR

The **July 2019 IPR** includes performance scores for OASIS-based measures for 12 months ending 3/31/2019. The claims-based and HHCAHPS-based measures include data for the entire 2018 performance year. The July 2019 IPR includes New Measure points for the first quarter of 2019 for Herpes Zoster Vaccination and Advance Care Plan (ACP) measures. It also includes New Measures points for data submission (includes data from October 1, 2018 – March 31, 2019) for the Influenza Vaccination Coverage for Home Health Care Personnel (Staff Influenza Vaccination) measure.

The **Annual TPS and Payment Adjustment Report**, released in August 2019, includes 12 months of OASIS-based, claims-based and HHCAHPS measure data ending December 31, 2018. It includes New Measures points for Herpes Zoster Vaccination and Advance Care Plan measures for 12 months ending December 31, 2018. The report also includes New Measure points for the Influenza Vaccination Coverage for Home Health

Care Personnel (Staff Influenza Vaccination) measure for data submitted in April 2018 for the October 1, 2017- March 31, 2018 flu season/data collection period.

The Annual Report reflects the entire previous calendar year (CY = January 1 – December 31) of measure data with the exception of the Influenza Vaccination Coverage for Home Health Care Personnel New Measure. For this measure, the points reflect October 1 – March 31, beginning in the Calendar Year prior to the Performance Year.

The **October 2019 IPR** includes scores for OASIS-based measures for the 12 months ending 6/30/2019, the claims-based and HHCAHPS-based measures for the 12 months ending 3/31/2019, as well as the applicable New Measure points for the quarter ending 6/30/2019. The Influenza Vaccination Coverage for Home Health Care Personnel measure reflects data collected for the period of October 1, 2018 through March 31, 2019.

As demonstrated for the IPRs, the data collection periods differ among the types of measures and there are varying lengths of "lag times" between the end of the data collection periods and when the data are reflected in the reports. Data for two of the New Measures (Herpes Zoster Vaccination and Advance Care Plan) are reported quarterly and reflected in the following quarter's IPR. The Staff Influenza Vaccination New Measure data are submitted annually in April, and those data are reflected in the following July, October, January and April IPRs.

Who Can Access the Reports

The IPRs and the Annual Reports are available only via the **HHVBP Secure Portal**. To access the reports, you will need to register with Enterprise Identify Management (EIDM) and obtain a User ID. This is the first step to gaining access to the **HHVBP Secure Portal** where you can view Model-specific reports. For instructions on how to register for an EIDM User ID and gain access to the **HHVBP Secure Portal,** please refer to Section 5 of this guide.

Primary Points of Contact (PPOCs), Secondary Points of Contact (SPOCs) and Corporate Points of Contact (CPOCs) can view the Interim Performance Reports. Only PPOCs and CPOCs can view the Annual TPS & Payment Adjustment Reports.

Exhibit 13 shows the functions of each HHA role on the **HHVBP Secure Portal** for IPRs, Annual Reports, and New Measures.

Exhibit 13: HHVBP Secure Portal HHA Role Functionality

Tab	Interim Reports (IPRs) Tab				Annual Total Performance Score and Payment Adjustment Report Tab							New Measures Tab	
Access	View Report	Download Individual IPR	Submit Recalculation Request (Include File Upload)	Download Supporting Documents for Recalculation Request	View Report	Download Individual Annual Report	Submit Recalculation Request (Include File Upload)	Download Supporting Documents for Recalculation Request	Submit Reconsideration Request (Include File Upload)	Download Reconsideration Request Supporting Documents	Download Reconsideration Request Decision Letter	Enter Data	Submit Data
HHA Corporate POC	✓	✓		✓	✓	✓		✓		✓	✓		
HHA Primary POC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HHA Secondary POC	✓	✓	✓	✓								✓	✓
HHA Reviewer												✓	
HHA Data Entry												✓	

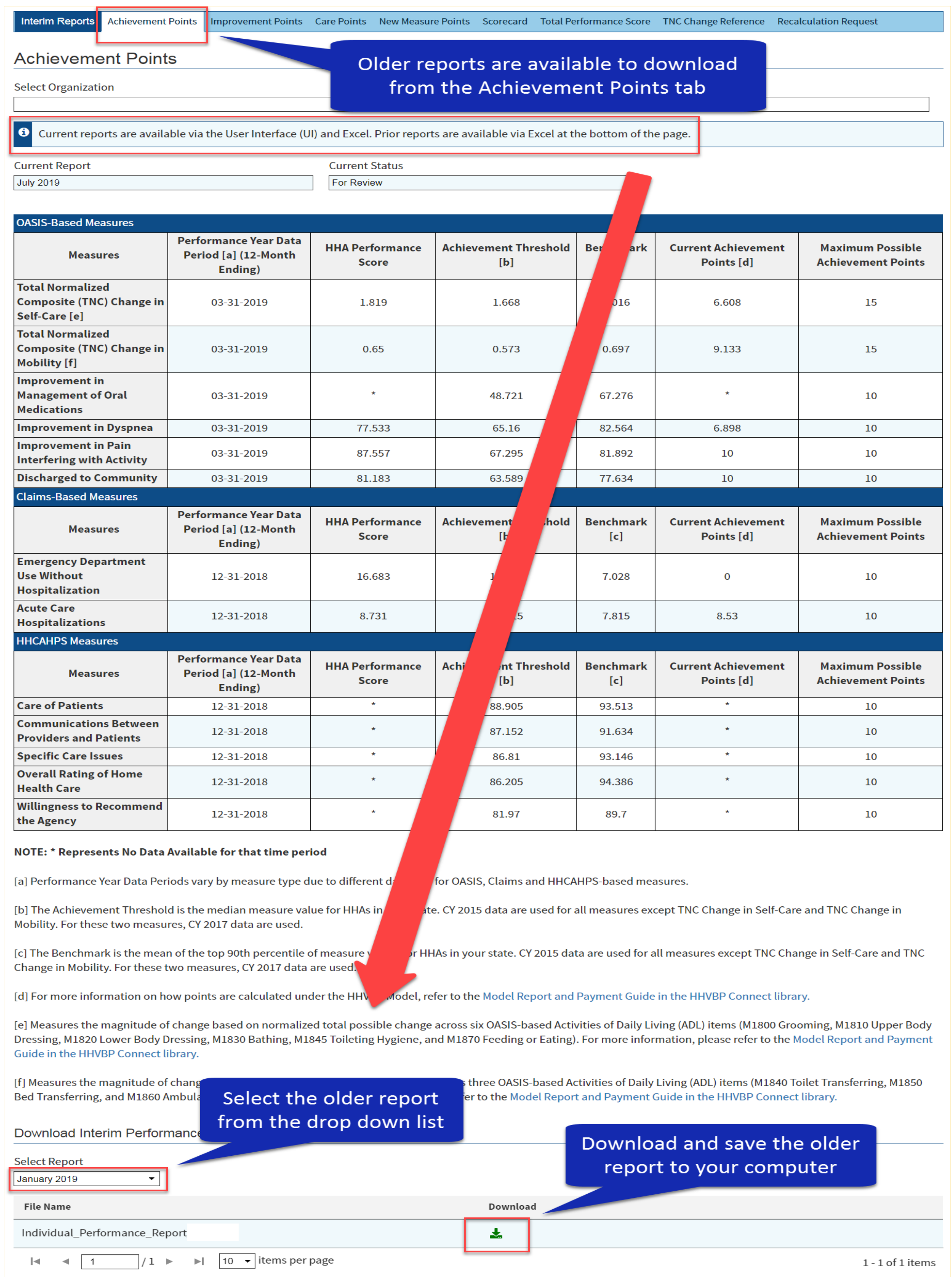
Accessing Older Reports

Current reports are available both on-screen via the User Interface (UI) and in Microsoft Excel spreadsheet format. The UI refers to what a user would see on the device screen when visiting a web page.

Beginning July 2019, older reports are only available for download in Microsoft Excel spreadsheet format. To review older IPRs, download the reports from the Achievement Points tab (bottom of the tab) and save the Microsoft Excel spreadsheets to your computer.

Exhibit 14 shows where HHAs can download older reports from the HHVBP Secure Portal.

Exhibit 14: Where to Download Older Reports in the HHVBP Secure Portal



OASIS-Based Measures						
Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	Achievement Threshold [b]	[illegible]	Current Achievement Points [d]	Maximum Possible Achievement Points
Total Normalized Composite (TNC) Change in Self-Care [e]	03-31-2019	1.819	1.668	[illegible]	6.608	15
Total Normalized Composite (TNC) Change in Mobility [f]	03-31-2019	0.65	0.573	0.697	9.133	15
Improvement in Management of Oral Medications	03-31-2019	*	48.721	67.276	*	10
Improvement in Dyspnea	03-31-2019	77.533	65.16	82.564	6.898	10
Improvement in Pain Interfering with Activity	03-31-2019	87.557	67.295	81.892	10	10
Discharged to Community	03-31-2019	81.183	63.589	77.634	10	10
Claims-Based Measures						
Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	[illegible]	Benchmark [c]	Current Achievement Points [d]	Maximum Possible Achievement Points
Emergency Department Use Without Hospitalization	12-31-2018	16.683	[illegible]	7.028	0	10
Acute Care Hospitalizations	12-31-2018	8.731	[illegible]	7.815	8.53	10
HHCAHPS Measures						
Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	[illegible]	Benchmark [c]	Current Achievement Points [d]	Maximum Possible Achievement Points
Care of Patients	12-31-2018	*	88.905	93.513	*	10
Communications Between Providers and Patients	12-31-2018	*	87.152	91.634	*	10
Specific Care Issues	12-31-2018	*	86.81	93.146	*	10
Overall Rating of Home Health Care	12-31-2018	*	86.205	94.386	*	10
Willingness to Recommend the Agency	12-31-2018	*	81.97	89.7	*	10

NOTE: * Represents No Data Available for that time period

[a] Performance Year Data Periods vary by measure type due to different [illegible] for OASIS, Claims and HHCAHPS-based measures.

[b] The Achievement Threshold is the median measure value for HHAs in [illegible]ate. CY 2015 data are used for all measures except TNC Change in Self-Care and TNC Change in Mobility. For these two measures, CY 2017 data are used.

[c] The Benchmark is the mean of the top 90th percentile of measure [illegible]r HHAs in your state. CY 2015 data are used for all measures except TNC Change in Self-Care and TNC Change in Mobility. For these two measures, CY 2017 data are used.

[d] For more information on how points are calculated under the HHV[illegible]Model, refer to the Model Report and Payment Guide in the HHVBP Connect library.

[e] Measures the magnitude of change based on normalized total possible change across six OASIS-based Activities of Daily Living (ADL) items (M1800 Grooming, M1810 Upper Body Dressing, M1820 Lower Body Dressing, M1830 Bathing, M1845 Toileting Hygiene, and M1870 Feeding or Eating). For more information, please refer to the Model Report and Payment Guide in the HHVBP Connect library.

[f] Measures the magnitude of chang[illegible] three OASIS-based Activities of Daily Living (ADL) items (M1840 Toilet Transferring, M1850 Bed Transferring, and M1860 Ambula[illegible]er to the Model Report and Payment Guide in the HHVBP Connect library.

B. Interim Performance Reports

CMS provides Interim Performance Reports (IPRs) to HHAs in the HHVBP Model in January, April, July, and October. New agencies entering in the HHVBP Model will receive their first IPR in April, but it will only contain baseline data. The first IPR that contains performance year data becomes available in July.

The term Baseline Year refers to the first year in which the HHA participated in Medicare for all 12 calendar months. For most HHAs and measures, Calendar Year (CY) 2015 is the Baseline Year.

- For the two measures added in the CY 2019 Final Rule, Total Normalized Composite (TNC) Change in Self-Care and TNC Change in Mobility, the first possible baseline year is CY 2017 as these new composite measures were not part of the model's starter measure set. As stated in the CY 2019 HH PPS Final Rule, published November 13, 2018, CMS believes that using more currently available calendar year data to assess HHA performance on the new composite measures will result in a more accurate performance score.
- If an HHA began Medicare participation July 1, 2016, **CY 2017** is the HHA's first possible Baseline Year. In addition, if a HHA does not have enough episodes to report a particular measure during its first possible Baseline Year (2017 in this example) CY 2018 may be used as the Baseline Year for the particular measure.

The first Performance Year for an HHA is the year subsequent to the HHA's Baseline Year. For example, if the HHA's Baseline Year is CY 2016, then the HHA's first possible Performance Year is CY 2017. The Interim Performance Report provides feedback to HHAs regarding current performance relative to Achievement Thresholds and Benchmarks. IPRs present preliminary data and do not represent the complete performance year until CMS releases the Annual Report each August. IPRs show how each quality measure in the HHVBP Model contributes to the TPS, which helps agencies identify where performance improvement would have an effect on the agency's total performance scores and overall quality. IPRs:

- Provide HHAs with a quarterly update of their TPS;
- Assist in monitoring the agency's progress on the quality measures used in the HHVBP Model;
- Support data-driven quality improvement efforts; and
- Provide Percentile Rankings reflecting the agency's performance relative to the performance of other HHAs in their state and cohort, if applicable.

The TPS is located within the IPR as one of the spreadsheet tabs within the report. Your HHA will have a TPS calculated if you have performance scores on at least five of the same measures in both the Performance Year and Baseline Year (not counting New Measure submissions). IPRs provide a tool for quality improvement, and HHAs should aim to see improvement in scores from report to report. Look for opportunities for quality improvement and identify mechanisms to incorporate quality improvement into all of the agency's data monitoring activities. While the IPRs help an agency determine how they are progressing on the measures in the Model, the IPRs do not perfectly predict the adjusted payment percentage. CMS does provide performance rankings by TPS on the Interim Performance Reports. These rankings provide the individual HHAs a sense of how they are performing compared to their peers.

PPOCs, SPOCs, and CPOCs will receive an email notification when the IPRs become available on the HHVBP Secure Portal.

The quality measure values on the IPR may differ from those displayed on Home Health Compare or HHAs' Certification and Survey Provider Enhanced Reports (CASPER) folders. The differences may result from different data collection dates between the reports and differences in risk-adjustment calculations between the IPRs and the CASPER reports. The data on the Interim Performance Reports (IPR) is calculated using a subset of the risk adjusted values found on Home Health Compare, as well as other sources such as HHCAHPS and the New Measures. Differences in individual quality measure scores between what is presented on Home Health Compare and found in the IPR are most likely due to differences in the time periods for the data included in the analyses presented on HHC and the Interim Performance Reports.

If you use a vendor for reporting, be advised that CMS cannot provide guidance on data, analysis, or reports from software or data benchmarking vendors. The IPRs are based on OASIS assessment data submitted by HHAs to CMS, Medicare claims data, HHCAHPS data collected by HHA vendors and submitted to CMS, and New Measure data submitted by the HHA via the HHVBP Secure Portal. There could be several reasons why vendor generated reports differ from CMS reports including but not limited to timeframe when the data are pulled by the vendor, the completeness of the data used by the vendor, and/or the formulas and rounding rules used by the vendor when calculating values.

For an explanation of each of the tabs that comprise the IPR, please refer to the subsection of this section called "**Interim Performance Report Worksheets**."

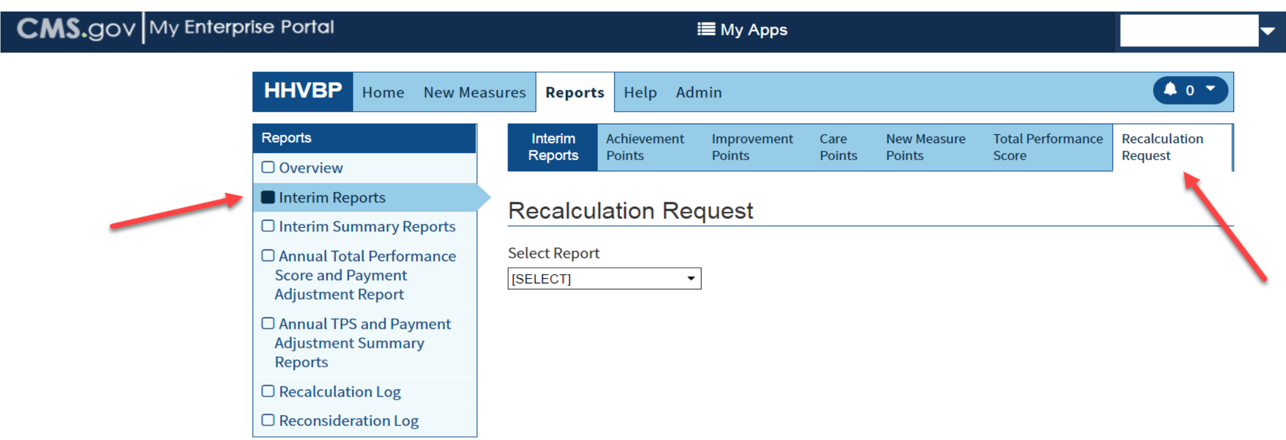
Preliminary Interim Performance Report and Recalculation Requests

The first IPR published each quarter is called the "Preliminary IPR" because HHAs have the opportunity to submit recalculation requests. Recalculation requests provide HHAs with the opportunity to identify and correct calculation errors and resolve discrepancies, thereby minimizing challenges to the annual TPS linked to the APP. HHAs cannot request a recalculation based on inaccurate submission of OASIS data because Medicare Conditions of Participation require OASIS data accuracy. The recalculation request period begins on the same day a report becomes available on the HHVBP Secure Portal and continues for 15 calendar days, per the CY 2017 HH PPS Final Rule (81 FR 76750).

If an HHA has evidence of an error, they may request a recalculation of their performance scores. As a reminder, only the PPOC and SPOC may request a recalculation for IPRs (refer to **Exhibit 14** for an overview of HHVBP Secure Portal role access). An agency must submit CMS-sourced documentation supporting the request. Please note that there is only one recalculation request opportunity per IPR/per CCN.

The PPOC or SPOC may submit recalculation requests only through the Recalculation Request tab in the HHVBP Secure Portal. This form allows the requester to upload five additional documents supporting the request. These documents can be uploaded after the recalculation request is submitted, but it must be within the same 15-day window (HHAs have exactly 15 days from the time the Preliminary IPR is available on the HHVBP Secure Portal). Not submitting supporting documentation with proof of error will result in denial of the recalculation request. **Exhibit 15** displays where agencies may submit recalculation requests for IPRs on the HHVBP Secure Portal.

Exhibit 15: HHVBP Secure Portal IPR Recalculation Requests Page



Requests for recalculation must contain specific information, as set forth in the CY 2016 HH PPS Final Rule (80 FR 68688) regarding the basis for requesting recalculation, including specific quality measure data and/or calculation(s) the HHA believes are inaccurate. A recalculation request must include:

1. Provider's name, physical address, email address, telephone number, and CCN;
2. Basis for requesting recalculation, including specific quality measure data or calculation HHA believes is inaccurate;
3. Contact information for a person at the HHA with whom CMS or its agent can communicate about the request; and
4. Electronic copy of any supporting documentation (**Do not send Protected Health Information (PHI)**)

When uploading a file, please ensure that it follows standard naming convention guidelines:

- Characters (a-z, A-Z)
- Numbers (0-9)
- No special characters except a dash or underscore, and the dash and underscore cannot be in the first or last position of the file name.

Upon receipt of a recalculation request, CMS will provide an email acknowledgement notifying the HHA of the receipt of the request using the contact information provided in the recalculation request. CMS will review the request to determine validity, and determine whether the recalculation request results in a score change, altering performance measure scores or the HHA's TPS. After CMS has acted on all recalculation requests and any needed recalculations are completed, each HHA will receive notification that the "Final" Interim Performance Report has been published in the HHVBP Secure Portal for that quarter.

Final Interim Performance Reports

"Final IPRs" become available about two months after the Preliminary IPR. The Final IPR will reflect any changes from the recalculation request period. Your agency might see a change between your Preliminary and Final IPRs even if your agency did not submit a recalculation request. We strongly recommend that your agency download the Preliminary IPR and save it locally because when the Final IPR becomes available in the HHVBP Secure Portal, it replaces the Preliminary IPR. **If you want to compare your Preliminary and Final IPRs, you need to retain a copy of the Preliminary IPR outside of the HHVBP Secure Portal.**

Final IPRs provide the *final* IPR score for each measure for that quarter. This will not be the score used for the APP. PPOCs, CPOCs, and SPOCs will be notified when the Final IPR becomes available. The HHA must go to the HHVBP Secure Portal to access any HHVBP Model reports, as CMS does not email reports to agencies for information security purposes. Note that there is a one-quarter lag between when HHAs submit New Measures data and when it appears in the IPR. Refer to **Exhibit 12** for details on the data included in each IPR.

Accessing IPRs in the HHVBP Secure Portal

To access your Interim Performance Report, you must have access to the HHVBP Secure Portal as a PPOC, CPOC, or Secondary POC. Please refer to **Appendix F: Step by Step Guide to Download Your Reports** for detailed instructions on how to access your IPR.

All PPOCs, SPOCs, and CPOCs will receive an email announcing the availability of the IPRs, as well as a notification when you log in to the HHVBP Secure Portal.

PPOCs, SPOCs and CPOCs that did not receive the email announcing the availability of the IPRs should:

- Check to be sure that the email was not sent to your spam or junk folder. If this has occurred, add the "from" address on the email to your contacts list and/or your safe sender list. You may need to contact your agency's technology support to assure that this issue is resolved.
- Verify that your email address in the HHVBP Secure Portal is accurate. For assistance with updating your email address in the HHVBP Secure Portal, please contact the HHVBP Technical Help Desk: (844) 280-5628.

After downloading your report, if you are unable to open your report, ensure that you have Microsoft Excel installed on your computer. As an alternative, you can install the Excel mobile app or store documents in OneDrive or Dropbox, where Excel Online opens files in your browser. If the "Show Dismissed Notifications" bar is visible, click on the up arrow next to the system notification bell icon and remove the Show Dismissed Notifications bar. Then select "Download." If you continue to experience difficulty downloading your report, contact the **HHVBP Technical Support Help Desk** at **1-844-280-5628**. The Collaboration Sites Business Operations Support Center (CBOSC) is available to answer your questions Monday through Friday, 8:30 AM to 6 PM ET, except federal holidays.

"I am on the HHVBP Secure Portal, but I don't have an IPR in the Reports Tab."

To be able to view your agency's Interim Performance Report(s), you must:

1. Have a role of either Primary Point of Contact (PPOC), Secondary Point of Contact (SPOC), or Corporate Point of Contact (CPOC).
2. When in the HHVBP Secure Portal, be sure that you have selected the correct date for the report (under the "Select Report" drop down field).
3. Have sufficient data in the Baseline Year and the Performance Year. This means that an agency must have (for OASIS-based and claims-based measures) a minimum of 20 patient quality episodes or (for HHCAHPS measures) a minimum of 40 completed HHCAHPS surveys, for at least one measure in both the Baseline Year and the Performance Year. If you have met these conditions and you are still unable to view your report, please email a description of this problem and the following information to HHVBPquestions@cms.hhs.gov:
   - Your CCN(s)
   - Your agency name
   - Your role on the HHVBP Secure Portal

Interim Performance Report Worksheets

The sections below provides an explanation of the tabs that comprise your HHA's quarterly IPRs. Beginning in July 2019, the IPR contains the following worksheets, or tabs:

1. Achievement Points
2. Improvement Points
3. Care Points
4. New Measure Points
5. Scorecard
6. Total Performance Score
7. TNC Change Reference

Achievement Points Tab

The first tab in your IPR is labeled "Achievement Points" and summarizes the Achievement Points an HHA received for each of the OASIS-based, claims-based, and HHCAHPS measures. These measures used in Performance Year 4 (CY 2019) are listed in the first column of your July 2019 IPR and subsequent IPRs. Recall that CMS removed the "Drug Education on All Medications Provided to Patient/Caregiver During All Episodes of Care" from the HHVBP Model measures beginning Performance Year 3, CY 2018 per the CY 2018 HH PPS Final Rule. **Exhibit 18** illustrates the Achievement Points tab.

Exhibit 18: Example of Achievement Points Tab in the July 2019 IPR

OASIS-Based Measures						
Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	Achievement Threshold [b]	Benchmark [c]	Current Achievement Points [d]	Maximum Possible Achievement Points
Total Normalized Composite (TNC) Change in Self-Care [e]	03-31-2019	2.046	1.69	1.996	15	15
Total Normalized Composite (TNC) Change in Mobility [f]	03-31-2019	0.716	0.606	0.71	15	15
Improvement in Management of Oral Medications	03-31-2019	76.004	51.487	64.208	10	10
Improvement in Dyspnea	03-31-2019	85.4	70.714	85.934	9.184	10
Improvement in Pain Interfering with Activity	03-31-2019	83.018	67.231	81.53	10	10
Discharged to Community	03-31-2019	77.274	70.679	78.229	8.362	10
Claims-Based Measures						
Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	Achievement Threshold [b]	Benchmark [c]	Current Achievement Points [d]	Maximum Possible Achievement Points
Emergency Department Use Without Hospitalization	12-31-2018	11.634	14.395	9.272	5.35	10
Acute Care Hospitalizations	12-31-2018	12.989	16	11.447	6.452	10
HHCAHPS Measures						
Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	Achievement Threshold [b]	Benchmark [c]	Current Achievement Points [d]	Maximum Possible Achievement Points
Care of Patients	12-31-2018	91.492	90.405	94	3.221	10
Communications Between Providers and Patients	12-31-2018	89.836	88.032	92.386	4.229	10
Specific Care Issues	12-31-2018	91.175	84.672	90.836	10	10
Overall Rating of Home Health Care	12-31-2018	89.163	87.153	93.431	3.381	10
Willingness to Recommend the Agency	12-31-2018	86.063	82.703	90.235	4.515	10

NOTE: * Represents No Data Available for that time period

[a] Performance Year Data Periods vary by measure type due to different data lags for OASIS, Claims and HHCAHPS-based measures.

[b] The Achievement Threshold is the median measure value for HHAs in your state. CY 2015 data are used for all measures except TNC Change in Self-Care and TNC Change in Mobility. For these two measures, CY 2017 data are used.

[c] The Benchmark is the mean of the top 90th percentile of measure values for HHAs in your state. CY 2015 data are used for all measures except TNC Change in Self-Care and TNC Change in Mobility. For these two measures, CY 2017 data are used.

[d] For more information on how points are calculated under the HHVBP Model, refer to the Model Report and Payment Guide in the HHVBP Connect library.

[e] Measures the magnitude of change based on normalized total possible change across six OASIS-based Activities of Daily Living (ADL) items (M1800 Grooming, M1810 Upper Body Dressing, M1820 Lower Body Dressing, M1830 Bathing, M1845 Toileting Hygiene, and M1870 Feeding or Eating). For more information, please refer to the Model Report and Payment Guide in the HHVBP Connect library.

[f] Measures the magnitude of change based on normalized total possible change across three OASIS-based Activities of Daily Living (ADL) items (M1840 Toilet Transferring, M1850 Bed Transferring, and M1860 Ambulation/Locomotion). For more information, please refer to the Model Report and Payment Guide in the HHVBP Connect library.

1. The first column lists the measures used in the HHVBP Model for the data collection periods indicated in the IPR. The New Measures are reported on a separate tab.
2. The second column identifies the end date of the 12-month data collection period pertaining to each measure. All measures on this worksheet are calculated using these 12 months of data indicated by

measure. Please refer to Exhibit **12** for further information on the measure-specific end dates of the 12-month data collection period for the Annual Report and four IPRs.

3. The third column, labeled “HHA Performance Score,” is your agency’s performance on the measure for the performance year data period in the second column.

4. The fourth column, the Achievement Threshold, is the median quality measure score for all agencies within a state with sufficient data during the Baseline Year for a given measure. An easy way of thinking about the median quality measure score is that 50% of agencies have scores below and 50% of agencies have scores above this value. To earn Achievement Points, your agency has to **perform equal to or better** than this Achievement Threshold.

5. The fifth column, the Benchmark, is the mean of the best 10% (or the 90th percentile) of all agencies within a state with sufficient data during the Baseline Year. That means when you compare your HHA’s performance to the Benchmark, you are comparing your HHA to the top performing agencies in the state for a given measure. If your agency performs equal to or better than the Benchmark, you will see a “10” (or “15” for the TNC Change measures) in Column 6.

6. The sixth column lists the Current Achievement Points for a given measure. For most measures, the value you see in this column can range between 0 and 10, where 10 is the highest value your agency can earn for each measure. For the two TNC Change measures, the value you see in this column can range between 0 and 15, where 15 is the highest value your agency can earn for each measure. Your agency’s performance score is compared to both the Achievement Threshold and the Benchmark to determine your Current Achievement Points. Refer to Columns 4 and 5 to help you understand what that means. A measure will have zero Achievement Points if the agency’s performance score on that measure has not reached the achievement threshold.

7. The newly added seventh column (as of the July 2019 IPR), Maximum Possible Achievement Points, lists the maximum possible Achievement Points available to each HHA.

In summary, to gain Achievement Points on an OASIS-based and HHCAHPS measure, your agency needs to perform **equal to or better** than the middle performers in a state for a given measure. Once your agency’s performance score is **equal to or higher** than the Achievement Threshold, the Achievement Points increase as the performance score gets closer to the Benchmark and reaches the maximum of 10 points (or 15 points for the two TNC Change measures) when the performance score is equal to or greater than the Benchmark.

Note that this logic is reversed for the two claims-based measures. Emergency Department Use without Hospitalization and Acute Care Hospitalization measures indicate worse performance when one or both values increase. For these two measures, your agency’s performance score must be **equal to or lower** than the Achievement Threshold to receive Achievement Points, which increase as the performance score gets closer to the Benchmark and reaches the maximum of 10 points when the performance score is **equal to or smaller** than the Benchmark.

Improvement Points Tab

The second tab in the IPR is labeled “Improvement Points” and summarizes the Improvement Points your HHA received for each of the OASIS-based, claims-based, and HHCAHPS measures used in the HHVBP Model.

As shown in **Exhibit 19**, Columns 1, 2, 4, and 6, contain the same information as listed on the “Achievement” tab. Column 3 lists the Baseline Year, Column 5 lists the Baseline Score, and Column 7 lists the Current

Improvement Points. The newly added eighth column (as of the July IPRs), Maximum Possible Improvement Points, lists the maximum possible Improvement Points available to each HHA.

Beginning in PY4 and first included in the July 2019 IPRs, the maximum number of Improvement Points for most measures reduces from 10 to 9 points. For the two new composite measures, TNC Change in Self-Care and TNC Change in Mobility, the maximum Improvement Points is 13.5, which represents 90 percent of the maximum 15 Achievement Points that can be earned for each of the two TNC Change measures. The maximum amount of Achievement Points remains unchanged.

Exhibit 19: Example of Improvement Points Tab in the July 2019 IPR

OASIS-Based Measures							
Measures	Performance Year Data Period [a] (12-Month Ending)	Baseline Year [b] (12-Month Ending)	HHA Performance Score	Baseline Score	Benchmark [c]	Current Improvement Points [d]	Maximum Possible Improvement Points
Total Normalized Composite (TNC) Change in Self-Care [e]	03-31-2019	12-31-2017	2.046	1.815	1.996	13.5	13.5
Total Normalized Composite (TNC) Change in Mobility [f]	03-31-2019	12-31-2017	0.716	0.64	0.71	13.5	13.5
Improvement in Management of Oral Medications	03-31-2019	12-31-2015	76.004	51.772	64.208	9	9
Improvement in Dyspnea	03-31-2019	12-31-2015	85.4	73.205	85.934	8.122	9
Improvement in Pain Interfering with Activity	03-31-2019	12-31-2015	83.018	68.104	81.53	9	9
Discharged to Community	03-31-2019	12-31-2015	77.274	72.216	78.229	7.071	9
Claims-Based Measures							
Measures	Performance Year Data Period [a] (12-Month Ending)	Baseline Year [b] (12-Month Ending)	HHA Performance Score	Baseline Score	Benchmark [c]	Current Improvement Points [d]	Maximum Possible Improvement Points
Emergency Department Use Without Hospitalization	12-31-2018	12-31-2015	11.634	14.273	9.272	4.249	9
Acute Care Hospitializations	12-31-2018	12-31-2015	12.989	13.025	11.447	0	9
HHCAHPS Measures							
Measures	Performance Year Data Period [a] (12-Month Ending)	Baseline Year [b] (12-Month Ending)	HHA Performance Score	Baseline Score	Benchmark [c]	Current Improvement Points [d]	Maximum Possible Improvement Points
Care of Patients	12-31-2018	12-31-2015	91.492	92.331	94	0	9
Communications Between Providers and Patients	12-31-2018	12-31-2015	89.836	89.93	92.386	0	9
Specific Care Issues	12-31-2018	12-31-2015	91.175	86.585	90.836	9	9
Overall Rating of Home Health Care	12-31-2018	12-31-2015	89.163	85.49	93.431	3.663	9
Willingness to Recommend the Agency	12-31-2018	12-31-2015	86.063	81.495	90.235	4.204	9

NOTE: * Represents No Data Available for that time period

[a] Performance Year Data Periods vary by measure type due to different data lags for OASIS, Claims and HHCAHPS-based measures.

[b] The Baseline Year varies depending on the measure and data availablity for your HHA.

[c] The Benchmark is the mean of the top 90th percentile of measure values for HHAs in your state. CY 2015 data are used for all measures except TNC Change in Self-Care and TNC Change in Mobility. For these two measures, CY 2017 data are used.

[d] For more information on how points are calculated under the HHVBP Model, refer to the Model Report and Payment Guide in the HHVBP Connect library.

[e] Measures the magnitude of change based on normalized total possible change across six OASIS-based Activities of Daily Living (ADL) items (M1800 Grooming, M1810 Upper Body Dressing, M1820 Lower Body Dressing, M1830 Bathing, M1845 Toileting Hygiene, and M1870 Feeding or Eating). For more information, please refer to the Model Report and Payment Guide in the HHVBP Connect library.

[f] Measures the magnitude of change based on normalized total possible change across three OASIS-based Activities of Daily Living (ADL) items (M1840 Toilet Transferring, M1850 Bed Transferring, and M1860 Ambulation/Locomotion). For more information, please refer to the Model Report and Payment Guide in the HHVBP Connect library.

To earn Improvement Points on the OASIS-based and HHCAHPS measures, your agency's performance on a given measure needs to be better than the Baseline Score in Column 5. If your agency performs equal to or

below the Baseline Score for a measure, you will see a zero for "Current Improvement Points." As with the Achievement Points, the Improvement Points increase as the agency's performance score on a measure gets closer to the Benchmark.

In summary, to improve on a measure, your agency needs to perform better than it did during the baseline period for a measure. If your performance score is higher than your Baseline Score, the Improvement Points increase as your performance score gets closer to the Benchmark and reaches the Maximum Possible Improvement Points when your performance score is equal to or greater than the Benchmark.

Again, the logic is reversed for the two claims-based measures as discussed in the Achievement Points section above. Your performance score must be lower than the Baseline Score to receive Improvement Points, which increase as the performance score gets closer to the Benchmark and reaches the maximum of "9" points when the performance score is equal to or less than the Benchmark.

Care Points Tab

The third tab, labeled "Care Points," is shown in **Exhibit 20**. Care Points are important because they feed into the calculation of the Total Performance Score. Care Points are simply the greater value of either the Achievement or the Improvement Points. Beginning with the January 2019 IPR, the Care Points tab includes the percentile rankings to individual measures, explained in more detail below.

Exhibit 20: Example of Care Points Tab in the July 2019 IPR

OASIS-Based Measures					
Measures	**Sufficient Data for Measure Inclusion (0 = No; 1 = Yes)**	**Current Achievement Points**	**Current Improvement Points**	**Current Care Points [a]**	**Percentile Ranking within Cohort [b]**
Total Normalized Composite (TNC) Change in Self-Care	1	15	13.5	15	75-99
Total Normalized Composite (TNC) Change in Mobility	1	15	13.5	15	75-99
Improvement in Management of Oral Medications	1	10	9	10	75-99
Improvement in Dyspnea	1	9.184	8.122	9.184	50-74
Improvement in Pain Interfering with Activity	1	10	9	10	75-99
Discharged to Community	1	8.362	7.071	8.362	75-99
Claims-Based Measures					
Measures	**Sufficient Data for Measure Inclusion (0 = No; 1 = Yes)**	**Current Achievement Points**	**Current Improvement Points**	**Current Care Points [a]**	**Percentile Ranking within Cohort [b]**
Emergency Department Use Without Hospitalization	1	5.35	4.249	5.35	75-99
Acute Care Hospitalizations	1	6.452	0	6.452	75-99
HHCAHPS Measures					
Measures	**Sufficient Data for Measure Inclusion (0 = No; 1 = Yes)**	**Current Achievement Points**	**Current Improvement Points**	**Current Care Points [a]**	**Percentile Ranking within Cohort [b]**
Care of Patients	1	3.221	0	3.221	50-74
Communications Between Providers and Patients	1	4.229	0	4.229	50-74
Specific Care Issues	1	10	9	10	75-99
Overall Rating of Home Health Care	1	3.381	3.663	3.663	50-74
Willingness to Recommend the Agency	1	4.515	4.204	4.515	50-74
Number of Applicable Measures (AM) used for TPS Calculation					13
Raw Total Points (RTP)					104.976

NOTE: * Represents No Data Available for that time period

[a] Care Points are the higher of Achievement or Improvement Points.

[b] Your HHA's Care Points percentile ranking compared to HHAs in your cohort:

- 1-24 indicates that, on this measure, your HHA is performing in the lowest quartile for all HHAs in your cohort.
- 25-49 indicates that, on this measure, your HHA is performing in the second lowest quartile for all HHAs in your cohort.
- 50-74 indicates that, on this measure, your HHA is performing in the second highest quartile for all HHAs in your cohort.
- 75-99 indicates that, on this measure, your HHA is performing in the highest quartile for all HHAs in your cohort.

1. Column 2, labeled “Sufficient Data for Measure Inclusion” identifies whether the measure had sufficient data available to receive Achievement, Improvement, and thus Care Points. If you see a “1” in this column, your HHA submitted sufficient data for the measure. A measure with insufficient data available to calculate a performance score can earn neither Achievement nor Improvement Points and therefore shows a zero in Column 2 for a measure.
2. The last column, labeled “Percentile Ranking within Cohort” displays the percentile rankings for individual measures. Please refer to footnote [b] at the bottom of the Care Points tab in the HHVBP Secure Portal for guidance on how to determine where your HHA ranks compared to HHAs in your cohort.
3. The second to last row in the Care Points tab, labeled “Number of Applicable Measures (AM) used for TPS calculation” identifies the total number of applicable measures used for calculating the Raw Total Points (RTP). If your HHA had sufficient data for each of the measures you would receive Raw Total Points, as shown in **Exhibit 20**. The Raw Total Points will be referenced again in the Total Performance Score tab.
4. The Raw Total Points at the bottom of the worksheet comprises 90% of your Total Performance Score. The three New Measures account for the remaining 10%, as discussed in the next section.

New Measure Points Tab

The following three New Measures account for the remaining 10% of the Total Performance Score:

1. Influenza Vaccination Coverage for Home Health Care Personnel;
2. Herpes Zoster Vaccination; and
3. Advance Care Plan.

CMS does not evaluate your HHA on achievement or improvement for these measures. Instead, your agency receives points for submitting data.

As seen in Column 2 in **Exhibit 21**, labeled “Available Points,” you can receive 10 points for each of the three New Measures. If you submitted all your data for a New Measure, you see a “1” in Column 3 and a “10” in Column 4.

Exhibit 21: Example of New Measures Tab in the July 2019 IPR

NOTE: * Represents No Data Available for that time period

New Measures	Available Points	# Quarters Measures Reported [c]	New Measure Points [d]
Influenza Vaccination Coverage for Home Health Care Personnel [a]	10	1	10
Herpes Zoster Vaccination [b]	10	1	10
Advance Care Plan [b]	10	1	10
Total	30	3	30

[a] Data for the Staff Influenza Vaccination measure is only submitted once annually (in April of each year). This is so that the reported data can cover the entire flu season (October-March).

[b] New Measure Points for the Advance Care Plan and Herpes Zoster Vaccination measures are calculated from the prior submission period (three months earlier). For example, for the April 2017 IPR, New Measure Points are calculated using data from the January 2017 submission period.

[c] For Interim Performance Reports, a value of one indicates that the measure was reported for the relevant quarter. Values of zero indicate that the measure was not reported. For Annual Reports, this column reports the number of quarters that the measure was reported. This ranges from 0-4 for the Herpes Zoster Vaccination and Advance Care Plan measures and is either zero or one for the Staff Influenza Vaccination measure, since this measure is only reported once each year.

[d] For Interim Performance Reports, New Measure Points are calculated by multiplying the number of quarters the measures were reported (Column C) by 10 for each New Measure. In the Annual Report, New Measure Points are calculated by multiplying the number of quarters the measures were reported (Column C) by 10 for the Staff Influenza Vaccination measures, by 2.5 for the Herpes Zoster Vaccination, and by 2.5 for the Advance Care Plan measure.

In Performance Year 1, all agencies automatically received 2.5 points on each of the three New Measures for each of the first 2 quarters since no submission for these two submission periods was required. For the Influenza Vaccination Coverage for Home Health Care Personnel measure, agencies received a total of 10 points if they submitted data in October 2016. If they did not submit the Influenza Vaccination Coverage for Home Health Care Personnel data in October 2016, they received 5 points. **Exhibit 22** displays the New Measure Points for Annual Performance Year 1 (CY 2016).

Exhibit 22: Potential New Measure Points for Annual Performance Year 1 (CY 2016)

Data Submitted and Used for Annual Report:	Influenza Vaccination Coverage for Home Health Care Personnel	Herpes Zoster Vaccination	Advance Care Plan
Apr-16*	2.5	2.5	2.5
Jul-16*	2.5	2.5	2.5
Oct-16	5.0	2.5	2.5
Jan-17	0**	2.5	2.5
Minimum Annual Performance Year 1 Points	5	5	5
Maximum Annual Performance Year 1 Points	10	10	10

*No data requested; all HHAs received points for these two reporting periods.

**Data not requested for this quarter.

Remember, the minimum of 5 points per New Measure was unique to Performance Year 1. In Performance Year 2 (CY 2017), all agencies were expected to submit New Measures data for all applicable quarters. For subsequent performance years, the New Measures points will be based on the agency's submission activity

for all 4 quarters for Herpes Zoster and Advance Care Plan and one quarter (that is, April 2017 in Performance Year 2) for Staff Influenza Vaccination. **Exhibit 23** displays the New Measure points available starting in Performance Year 2.

Exhibit 23: Potential New Measure Points Beginning Annual Performance Year 2 (CY 2017) and Subsequent Performance Years

Data Submitted and Used for Annual Report:	Influenza Vaccination Coverage for Home Health Care Personnel	Herpes Zoster Vaccination	Advance Care Plan
January	0*	2.5	2.5
April	10	2.5	2.5
July	0*	2.5	2.5
October	0*	2.5	2.5
Minimum Annual Performance Year Points	0	0	0
Maximum Annual Performance Year Points	10	10	10

*Data not requested for this quarter.

Scorecard Tab

As of July 2019, the IPR now includes the Applicable Measure Scorecard. **Exhibit 24** shows where you can see your overall progress in the Model. This tab is separated into three components, explained further below. This scorecard helps HHAs better understand how each individual measure contributes to the Total Performance Score.

Exhibit 24: Example of Scorecard Tab in the July 2019 IPR

OASIS-Based Measures				
Measures	**Care Points**	**Maximum Possible Points**	**Applicable Measure Weights [b]**	**Applicable Measure Points [c]**
Total Normalized Composite (TNC) Change in Self-Care [a]	15	15	7.5	7.5
Total Normalized Composite (TNC) Change in Mobility [a]	15	15	7.5	7.5
Improvement in Management of Oral Medications	10	10	5	5
Improvement in Dyspnea	9.184	10	5	4.592
Improvement in Pain Interfering with Activity	10	10	5	5
Discharge to Community	8.362	10	5	4.181
Sum of OASIS-Based Measures	**67.546**	**70**	**35**	**33.773**
Claims-Based Measures				
Measures	**Care Points**	**Maximum Possible Points**	**Applicable Measure Weights [b]**	**Applicable Measure Points [c]**
Emergency Department Use Without Hospitalization	5.35	10	8.75	4.681
Acute Care Hospitalizations	6.452	10	26.25	16.937
Sum of Claims-Based Measures	**11.802**	**20**	**35**	**21.618**
HHCAHPS Measures				
Measures	**Care Points**	**Maximum Possible Points**	**Applicable Measure Weights [b]**	**Applicable Measure Points [c]**
Care of Patients	3.221	10	6	1.933
Communications Between Providers and Patients	4.229	10	6	2.537
Specific Care Issues	10	10	6	6
Overall Rating of Home Health Care	3.663	10	6	2.198
Willingness to Recommend the Agency	4.515	10	6	2.709
Sum of HHCAHPS Measures	**25.628**	**50**	**30**	**15.377**
Total Applicable Measures (Sum of OASIS, Claims, and HHCAHPS)	**104.976**	**140**	**100**	**70.768**

Total Performance Score Calculation	
Number of Applicable Measures (AM)	13
Your HHA's Raw Total Points (RTP)	104.976
Total Applicable Measure Points	70.768
Weight	90%
Applicable Measure Final Weighted Score (AMFWS)	63.691
Total New Measure Points	100
Weight	10%
New Measure Final Weighted Score (NMFWS)	10
Total Performance Score (TPS) [d]	73.691

NOTE: * Represents No Data Available for that time period

[a] The maximum number of points for the composite measures is 15. This is attained by applying the same formula for Achievement and Improvement Points used for the other HHVBP measures and multiplying by 1.5. For more information, please refer to the Model Report and Payment Guide.

[b] The weights for each measure may vary depending on the availability of measures within each category. For more information, please refer to the Model Report and Payment Guide.

[c] Applicable Measure Points are calculated by dividing Care Points by Maximum Possible Points and multiplying by the Applicable Measure Weight. The totals for each measure category are computed by summing across the individual measures within the category.

[d] The Total Performance Score (TPS) is calculated by adding the Applicable Measure Final Weighted Score (AMFSW) and New Measure Final Weighted Score (NMFWS).

Column 2 lists your agency's Care Points, Column 3 lists the Maximum Possible Points, Column 4 lists the Applicable Measure Weights, and Column 5 lists the Applicable Measure Points for each HHVBP outcome measure.

The table at the bottom of the "Scorecard" tab shows how an HHA's TPS is calculated:

- Row 1 shows the Number of Applicable Measures (AM);
- Row 2 shows the Raw Total Points (RTP) that originate from the Care Points tab (or the sum of Column 2 in the Scorecard table);
- Row 3 shows the Total Applicable Measure Points, which are derived from the sum of the values in Column 5 of the Scorecard table;
- Row 4 shows how the Total Applicable Measure Points are multiplied by 0.9 as they are weighted at 90% of the TPS, as discussed in the Care Points section above. This results in the Applicable Measure Final Weighted Score (AMFWS) in Row 5;
- Row 6 shows the Total New Measures Points, which are derived from the "New Measures" tab;
- Row 7 shows how the Applicable New Measures Points are multiplied by 0.1 as they are weighted at 10% of the TPS (Row 7). This results in the New Measure Final Weighted Score (NMFWS in Row 8);
- Row 9 shows how the TPS is derived by summing the Applicable Measure Final Weighted Score (AMFWS) and the New Measure Final Weighted Score (NMFWS).

Recall the Applicable Measure Weights shown in Column 4 reflect the changes effective in PY4.

Scorecard Tab – *A Deeper Dive*

This scorecard provides all the details needed to understand and derive your HHA's Total Performance Score. Below are some ways your HHA can use the Scorecard tab:

- Quickly identify the weight for each individual applicable measure, as the weights vary by measure category.
- Understand how each measure contributes to your HHA's Total Performance Score.
- Compare your agency's Care Points to the Maximum Possible Points available for a given measure.
- Track the "scoring elements" used to compute your agency's TPS value. For example, you can see how each measure's Care Points are translated into Applicable Measure Points.
- Review the footnotes, which explain how the values in each of the columns are derived and calculated.

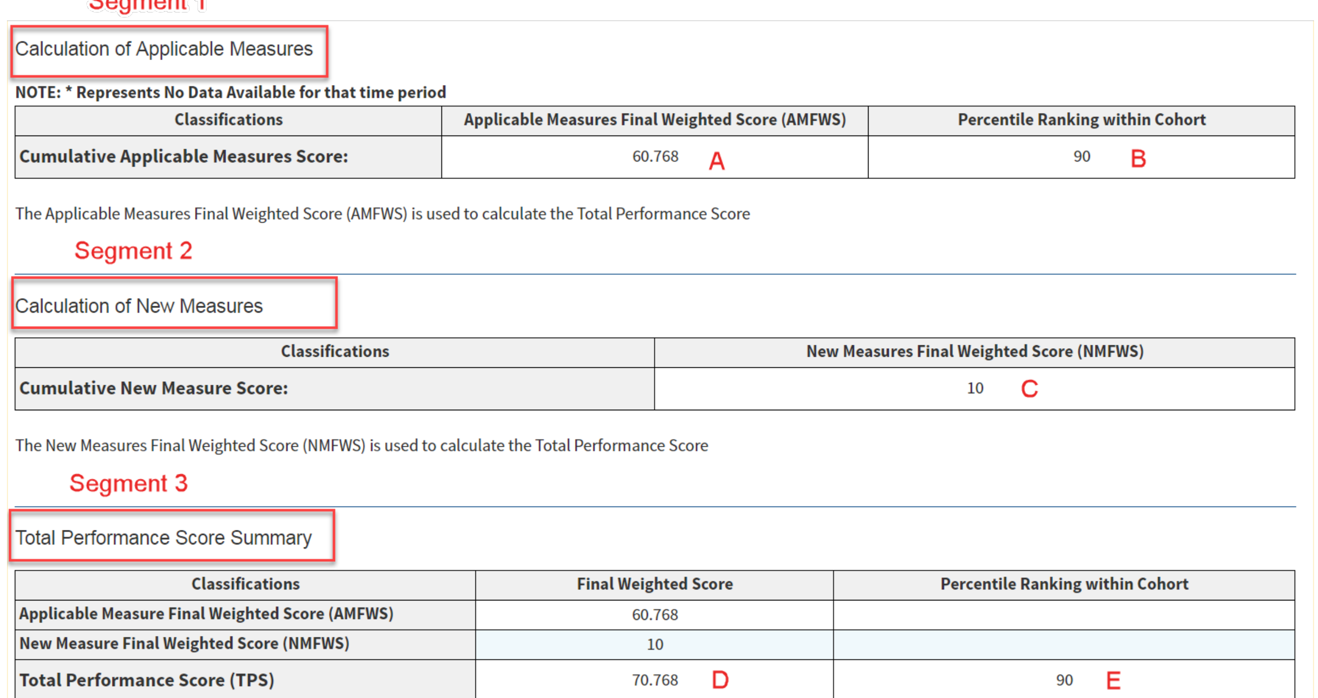
Total Performance Score Tab

The fifth tab is the Total Performance Score, or TPS, worksheet. Beginning with the July 2019 IPR, CMS redesigned the Total Performance Score tab, which contains the same information as in the previous reports, but is now laid out in a slightly different manner. For example, CMS moved the Raw Total Points, Total

Applicable Measure Points, and Weights to the Scorecard tab, discussed in the previous section. The "Total Performance Score Summary" at the bottom of the tab remains the same.

Exhibit 24 shows a TPS tab for a fictitious HHA. Individual components of this tab are discussed on the next pages. This tab is separated into three segments, explained further below.

Exhibit 24: Example of Total Performance Score Tab in the July 2019 IPR



Segment 1

Calculation of Applicable Measures

NOTE: * Represents No Data Available for that time period

Classifications	Applicable Measures Final Weighted Score (AMFWS)	Percentile Ranking within Cohort
Cumulative Applicable Measures Score:	60.768 A	90 B

The Applicable Measures Final Weighted Score (AMFWS) is used to calculate the Total Performance Score

Segment 2

Calculation of New Measures

Classifications	New Measures Final Weighted Score (NMFWS)
Cumulative New Measure Score:	10 C

The New Measures Final Weighted Score (NMFWS) is used to calculate the Total Performance Score

Segment 3

Total Performance Score Summary

Classifications	Final Weighted Score	Percentile Ranking within Cohort
Applicable Measure Final Weighted Score (AMFWS)	60.768	
New Measure Final Weighted Score (NMFWS)	10	
Total Performance Score (TPS)	70.768 D	90 E

Segment 1: Calculation of Applicable Measures

1. **Cell A** shows this HHA's Applicable Measures Final Weighted Score (derived from the "Scorecard" tab).
2. **Cell B** shows this HHA's Percentile Ranking within its Cohort. For more information on Percentile Rankings, please review the definition "Percentile Ranking" in **Appendix B: HHVBP Model Glossary of Terms, Acronyms, and Definitions**.

Segment 2: Calculation of New Measures

1. **Cell C** shows this HHA's New Measures Final Weighted Score (derived from the "Scorecard" tab).

Segment 3: Total Performance Score Summary

1. This segment combines the Applicable Measures Final Weighted Score and New Measures Final Weighted Scores in the Total Performance Score Summary table. In **Cell D**, you see the Total Performance Score. This is the sum of the Applicable Measures Final Weighted Score (**Cell A)** and the New Measures Final Weighted Score (**Cell C).**
2. Finally, the Percentile Ranking within the Cohort is in **Cell E**. This enables each agency to gauge their performance relative to other agencies within the same state or cohort. Percentile ranks for the TPS and the Applicable Measures Final Weighted Score (AMFWS) are reported as 0, 10, 25, 50, 75, and 90.
3. The rankings on the Interim Performance Reports help an agency to understand if their HHA's "Total Applicable Measure Points" is "high" or "low" or "kind of in the middle," relative to other HHAs in their state and cohort, if applicable. If an agency has a TPS of equal to or greater than the 90th percentile TPS value for its state and cohort, if applicable, the ranking you will see is 90. Similarly, if an HHA has a TPS of equal to or greater than the 75th percentile TPS value AND less than the 90th percentile TPS value for its state and cohort, if applicable, the ranking you will see is 75. If an HHA has a TPS of less than the 10th percentile TPS value for its state and cohort, if applicable, the ranking you will see is 0. A higher percentile ranking indicates a higher level of performance.

"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?"

The TPS is adjusted to account for the number of measures available for an agency, so the maximum scores are the same for all agencies. HHCAHPS measures are not used for smaller volume agencies, and, in some states (i.e., states with at least 8 smaller volume agencies), smaller volume agencies are only competing against other smaller volume agencies. In states with fewer than eight smaller volume agencies, smaller and larger volume agencies are competing against each other, but the TPS for each agency is adjusted to account for number of available measures.

TNC Change Reference Tab

As of July 2019, the IPR includes the TNC Change Reference Tab, which contains the OASIS items used for the two Total Normalized Composite (TNC) Change Measures. The TNC Change in Mobility is based on three OASIS items (M1840, M1850, and M1860) and the TNC Change in Self-Care is based on six OASIS items (M1800, M1810, M1820, M1830, M1845, and M1870). This TNC Change Reference tab tells HHAs the percentage of episodes in which there was no change, positive change, or negative change for each OASIS item. The tab also includes the average in each category for your state to allow for comparison. The percentages reported in this tab are based on the observed changes for eligible quality episodes between start of care (SOC) or resumption of care (ROC) and end of care (EOC), and can be compared to the average observed changes for the state. Given the two composite measures take into consideration any change in the underlying OASIS items, the observed percentages of quality episodes that resulted in positive change, no change, or negative change help an HHA identify how each individual OASIS item contributed to the corresponding composite measure.

Exhibit 25 shows the TNC Change Reference Tab.

Please note that the categories do not always add up to 100% due to rounding, which does not affect HHA performance on the two composite measures. The percentages reported on this tab are based on the **observed** changes between start or resumption of care and end of care for eligible episodes. For more information, please refer to the "*HHVBP Technical Specification Resource for Composite Outcome Measures,*" found in the HHVBP Connect Library.

Exhibit 25: Example of TNC Change Reference Tab in the July 2019 IPR

Total Number of Quality Episodes [a] 219

Performance Summary for TNC Change Measures						
OASIS Item [b]	**Changes in OASIS Item Responses between SOC/ROC and EOC as Percent of Quality Episodes [c]**					
	YOUR HHA			**AVERAGE FOR YOUR STATE [d]**		
	No Change	**Positive Change**	**Negative Change**	**No Change**	**Positive Change**	**Negative Change**
Total Normalized Composite (TNC) Change in Self-Care						
M1800 Grooming (0-3)	34%	65%	1%	21%	78%	1%
M1810 Ability to Dress Upper Body (0-3)	37%	62%	1%	19%	80%	1%
M1820 Ability to Dress Lower Body (0-3)	24%	75%	1%	19%	80%	1%
M1830 Bathing (0-6)	18%	80%	3%	15%	84%	1%
M1845 Toileting Hygiene (0-3)	37%	62%	1%	20%	79%	1%
M1870 Feeding or Eating (0-5)	66%	32%	2%	49%	49%	3%
Total Normalized Composite (TNC) Change in Mobility						
M1840 Toilet Transferring (0-4)	64%	35%	1%	25%	73%	1%
M1850 Transferring (0-5)	45%	53%	2%	17%	82%	1%
M1860 Ambulation/Locomotion (0-6)	30%	69%	2%	17%	81%	1%

NOTE: * Represents No Data Available for that time period

This table is a reference tool for HHAs to view their performance on the components of the two TNC change measures. It is not intended to provide HHAs with all the information needed to construct the TNC change measures. HHAs should refer to their CASPER reports or internal databases to track how each patient performed at EOC relative to SOC/ROC. Please refer to the Model Report and Payment Guide in the HHVBP Connect library for more information on the TNC change measures.

[a] The count of quality episodes used in constructing each TNC Normalized Composite measure. For more information on measure specifications, including exclusions, please refer to the Model Report and Payment Guide in the HHVBP Connect library.

[b] Response value range in parentheses. OASIS item response zero (0) indicates independence in performing the activity and higher values indicate less independence in performing the activity.

[c] For each HHA, quality episodes used in constructing the TNC Change measures are categorized as follows:
- The episode is categorized as "No Change" if the End of Care (EOC) item value is the same as the Start of Care (SOC)/Resumption of Care (ROC) item value.
- The episode is categorized as "Positive Change" if the EOC item value indicates greater independence (lower response value) compared with the SOC/ROC item value.
- The episode is categorized as "Negative Change" if the EOC item value indicates less independence (high response value) compared with the SOC/ROC item value.

The counts for each category are divided by the total number of quality episodes to obtain the percentages shown in the table.

[d] "Average for Your State" represents the average percentages by category (No Change, Positive Change, Negative Change) for all HHAs in your HHA's state.

Looking at the example above, two of the OASIS items that are included in the TNC Change in Mobility measure may be examined – M1850 and M1860: About 45%, and 30% of episodes for this agency did not see any changes in these two OASIS items, respectively. But at the state-level, only about 17% of episodes saw no change for M1850 and M1860.

Similarly, the state average of episodes with a positive change is noticeably higher, with 82% and 81%, respectively. As part of its improvement efforts, this HHA may consider identifying strategies to convert more patients with no change to patients with a positive change to improve performance on the TNC Change in Mobility measure.

TNC Change Reference Tab – *A Deeper Dive*

The TNC Change Reference tab provides the details needed to understand how each of the nine OASIS items contributed the two TNC Change Measures. Below are some ways your HHA can use the TNC Change Reference tab:

- Analyze how many episodes of care resulted in patients improving, maintaining, and declining between start or resumption of care and end of care.
    - For example, if your agency had a particularly high number of episodes that resulted in patients declining in grooming or toilet transferring, you may want to focus your quality improvement efforts toward identifying factors that may allow these patients to maintain or improve in these areas.
- Compare your agency's performance to the average across agencies in your state and review your agency's "TNC Change Reference" tab and see if you perform similarly, worse, or better than the average in your state.

C. Annual Total Performance Score and Payment Adjustment Report

HHAs began receiving an Annual Total Performance Score and Payment Adjustment Report (Annual Report) in 2017. This report, available to agencies annually, contains the HHA's TPS based on complete performance year data and the APP that will be applied in the corresponding payment adjustment year. The list below shows the calendar years and the corresponding Performance Years.

- CY 2016 for Performance Year 1;
- CY 2017 for Performance Year 2;
- CY 2018 for Performance Year 3;
- CY 2019 for Performance Year 4; and,
- CY 2020 for Performance Year 5

The APP is based on your quality performance relative to the performance benchmark and achievement thresholds and the performance of your peers; thus, your payments may increase, decrease, or stay the same. The APP under the HHVBP Model applies only to Medicare Home Health PPS claims.

As stated in the CMS Home Health CY 2016 Final Rule, the Model will adjust the HH PPS final claim payment amount to an HHA for each claim in a calendar year by the applicable percentage. Medicare PPS payment adjustments are not made to aggregate revenue, but will occur for each final Medicare PPS claim an agency submits for claims with a payment episode "through date" in the HHVBP payment year.

As a reminder, while Secondary Points of Contact (SPOCs) can access the IPRs, only Primary Points of Contact (PPOCs) and Corporate Points of Contact (CPOCs) can access the Annual Report for the CCNs they represent, and only PPOCs can initiate recalculation/reconsideration requests for the Annual Reports.

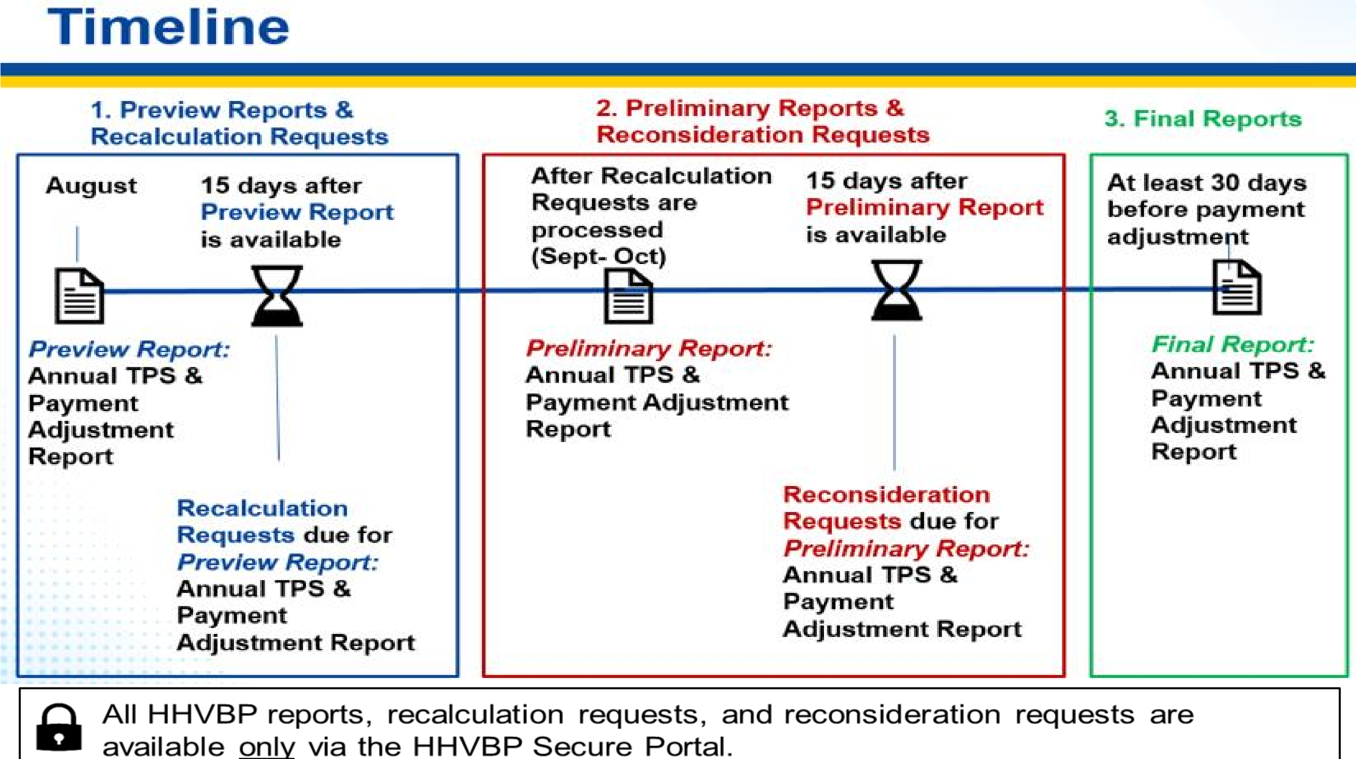
If you are a SPOC and need to access the Annual Report for your HHA, please coordinate with your PPOC (or CPOC, if applicable) to provide the reports to you.

For an explanation of each of the tabs that comprise the Annual Report, please refer to the subsection of this section called " **Annual TPS and Payment Adjustment Report Worksheets**."

Annual TPS & Payment Adjustment Report Versions

There are three versions of the Annual Report: a Preview Report, a Preliminary Report, and a Final Report, explained in detail below. **Exhibit 16** illustrates the timeline when CMS publishes the Annual Reports beginning each year in August.

Exhibit 16: Timeline for the Annual Total Performance Score & Payment Adjustment Report



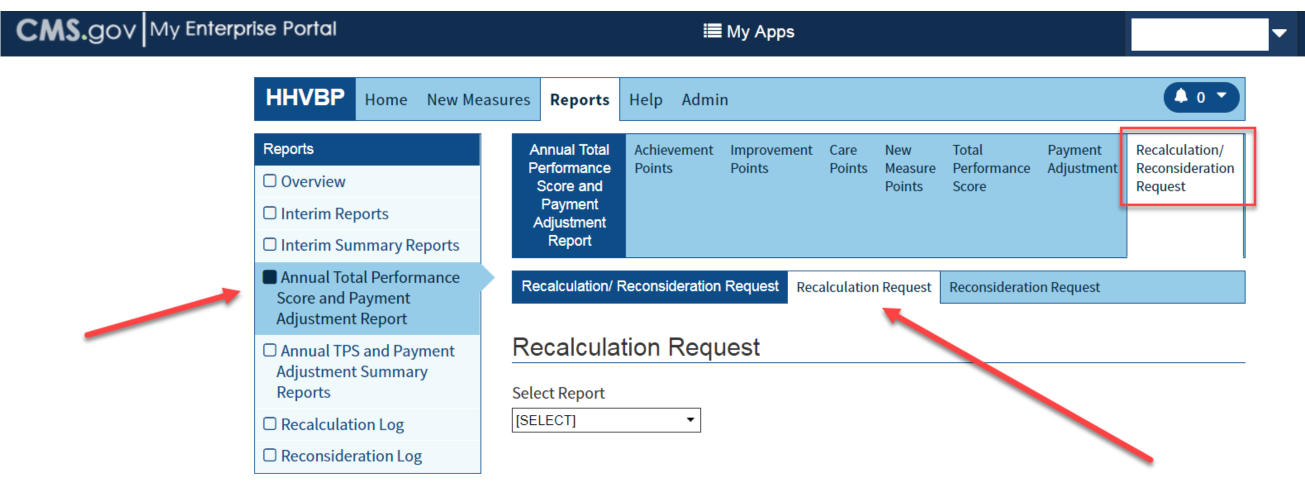
Preview Annual Report and Recalculation Requests

The Preview Annual Report is the first version of the report and is available on the **HHVBP Secure Portal** each August. PPOCs and CPOCs are notified via email when reports are available. Agencies may submit a recalculation request for the Preview Annual Report if they have proof that their data on the Preview Annual Report are inaccurate. As with quarterly Preliminary IPRs, agencies can only submit a recalculation request via the HHVBP Secure Portal within 15 days of when CMS publishes the Preview Annual Report to the HHVBP

Secure Portal. That recalculation, if any, will be reflected in the next iteration of the report: the Preliminary Annual Report.

As a reminder, only PPOCs can submit recalculation requests for the Annual Report on the **HHVBP Secure Portal** within 15 days of the report being published. If you wish to change your role from SPOC to PPOC or CPOC, please have your PPOC email the help desk at HHVBPquestions@cms.hhs.gov authorizing the change and naming the specific CCN(s) for which the change is applicable. **Exhibit 17** displays where agencies may submit recalculation requests for the Annual Reports on the **HHVBP Secure Portal**.

Exhibit 17: HHVBP Secure Portal Annual Report Recalculation Requests Page



Preliminary Annual Report and Reconsideration Requests

After all recalculation requests submitted for the Preview Annual Report are processed, CMS publishes the Preliminary Annual Reports in the HHVBP Secure Portal. The Preliminary Annual Reports are available in September or October. If no recalculation requests are received for the Preview Reports, Preliminary Reports will not be published. If an agency has proof that their data on the Preliminary Annual Report are inaccurate, the agency may submit a reconsideration request. The HHA must submit the reconsideration request within 15 days of when CMS publishes the Preliminary Annual Report to the HHVBP Secure Portal. Please note that an agency may only request a reconsideration following a decision on that HHA's request for recalculation. **In other words, only agencies that submit a recalculation request may submit a reconsideration request.**

Final Annual Report

After reconsideration requests are processed, PPOCs and CPOCs will be notified that their Final Annual TPS & Payment Adjustment Report is available on the HHVBP Secure Portal. As per the CY 2017 HH PPS Final Rule, the final TPS and payment adjustment percentage is provided to competing HHAs in a final report no later than 30 calendar days in advance of the adjusted payment percentage taking effect.

Accessing Annual Reports in the HHVBP Secure Portal

To access your Annual Report, you must have access to the HHVBP Secure Portal as a PPOC or CPOC. CMS has restricted access to the Annual Report to only the PPOC and CPOC due to the sensitive financial data it contains (not available in Interim Performance Reports). It is the PPOC’s responsibility (or the CPOC, if

applicable) to share this report with others in their organization/agency. Secondary Points of Contact (SPOCs) should work with their PPOC (or CPOC, if applicable) to obtain a copy of the Annual Report. For detailed instructions on how to access your Annual Report, please refer to **Appendix F: Step-by-Step Guide to Download Your Reports**.

Annual TPS and Payment Adjustment Report Worksheets

The section below provides an explanation of the tabs that comprise your HHA's Performance Year 3, CY 2019 Annual Report. The Annual Report contains the following worksheets, or tabs:

1. Achievement Points
2. Improvement Points
3. Care Points
4. New Measure Points
5. Total Performance Score
6. Payment Adjustment

Beginning with Performance Year 4, CY 2020 Annual Report, the format will change to reflect the refinements to the HHVBP Model as a result of the CY 2019 HH PPS Final Rule, and will include the measures and tabs as described in Section **8.B. Interim Performance Reports** section.

Achievement Points Tab

The first tab in your Annual Report is labeled "Achievement Points" and summarizes the Achievement Points an HHA received for each of the OASIS-based, claims-based, and HHCAHPS measures. The measures used in Performance Year 3 (CY 2018) are listed in the first column. **Exhibit 26** illustrates the Achievement Points tab of the Annual Report.

Exhibit 26: Example of Achievement Points Tab in the Performance Year 3, CY 2019 Annual Report

NOTE: * Represents No Data Available for that time period

Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	Achievement Threshold [b]	Benchmark [c]	Current Achievement Points [d]
OASIS-Based Measures					
Influenza Immunization Received for Current Flu Season	12-31-2018	89.583	69.718	87.874	10
Pneumococcal Polysaccharide Vaccine Ever Received	12-31-2018	94.22	77.761	92.993	10
Improvement in Bathing	12-31-2018	80.837	69.289	84.161	7.488
Improvement in Bed Transferring	12-31-2018	81.175	60.21	76.332	10
Improvement in Ambulation-Locomotion	12-31-2018	81.109	61.078	77.429	10
Improvement in Management of Oral Medications	12-31-2018	70.892	53.868	69.278	10
Improvement in Dyspnea	12-31-2018	90.47	72.618	87.393	10
Improvement in Pain Interfering with Activity	12-31-2018	90.618	66.746	88.521	10
Discharged to Community	12-31-2018	74.639	71.415	82.064	3.225
Claims-Based Measures					
Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	Achievement Threshold [b]	Benchmark [c]	Current Achievement Points [d]
Emergency Department Use Without Hospitalization	12-31-2018	12.695	13.297	7.406	1.42
Acute Care Hospitalizations	12-31-2018	12.572	14.627	7.821	3.217
HHCAHPS Measures					
Measures	Performance Year Data Period [a] (12-Month Ending)	HHA Performance Score	Achievement Threshold [b]	Benchmark [c]	Current Achievement Points [d]
Care of Patients	12-31-2018	87.761	87.709	93.168	0.586
Communications Between Providers and Patients	12-31-2018	87.099	84.743	90.669	4.078
Specific Care Issues	12-31-2018	83.387	81.587	88.444	2.863
Overall Rating of Home Health Care	12-31-2018	82.6	82.814	92.938	0
Willingness to Recommend the Agency	12-31-2018	79.72	77.205	89.942	2.277

[a] Performance Year Data Periods vary by measure type due to different data lags for OASIS-claims and HHCAHPS-based measures.

[b] The Achievement Threshold is the median measure value in CY 2015 for your state.

[c] The Benchmark is the mean of the top 90th percentile of measure values in CY 2015 for your state.

[d] For more information on how points are calculated under the HHVBP Model, refer to the Model Report and Payment Guide in the HHVBP Connect library.

1. The first column lists the measures used in the HHVBP Model for Performance Year 3 (CY 2018). The New Measures are reported on a separate tab.

2. The second column identifies the end date of the 12-month data collection period pertaining to each measure. All measures on this worksheet are calculated using these 12 months of data. Please refer to **Exhibit 12** for further information on the measure-specific end dates of the 12-month data collection period for the Annual Report.

3. The third column, labeled "HHA Performance Score," is your agency's performance on the measure for the performance year data period in the second column.

4. The fourth column, the Achievement Threshold, is the median quality measure score for all agencies within a state with sufficient data during CY 2015 for a given measure. An easy way of thinking about

the median quality measure score is that 50% of agencies have scores below and 50% of agencies have scores above this value. To earn Achievement Points, your agency has to **perform equal to or better** than this Achievement Threshold.

5. The fifth column, the Benchmark, is the mean of the best 10% (or the 90th percentile) of all agencies within a state with sufficient data during CY 2015. That means when you compare your HHA's performance to the Benchmark, you are comparing your HHA to the top performing agencies in the state for a given measure. If your agency performs equal to or better than the Benchmark, you will see a "10" in Column 6.
6. The sixth column lists the Current Achievement Points for a given measure. The value you see in this column can range between 0 and 10, where 10 is the highest value your agency can earn for each measure. Your agency's performance score is compared to both the Achievement Threshold and the Benchmark to determine your Current Achievement Points. Refer to Columns 4 and 5 to help you understand what that means. A measure will have zero Achievement Points if the agency's performance score on that measure has not reached the achievement threshold.

In summary, to gain Achievement Points on an OASIS-based and HHCAHPS measure, your agency needs to perform **equal to or better** than the middle performers in a state for a given measure. Once your agency's performance score is **equal to or higher** than the Achievement Threshold, the Achievement Points increase as the performance score gets closer to the Benchmark and reaches the maximum of 10 points when the performance score is equal to or greater than the Benchmark.

Note that this logic is reversed for the two claims-based measures. Emergency Department Use without Hospitalization and Acute Care Hospitalization measures indicate worse performance when one or both values increase. For these two measures, your agency's performance score must be **equal to or lower** than the Achievement Threshold to receive Achievement Points, which increase as the performance score gets closer to the Benchmark and reaches the maximum of 10 points when the performance score is **equal to or smaller** than the Benchmark.

Improvement Points Tab

The second tab in the Annual Report is labeled "Improvement Points" and summarizes the Improvement Points your HHA received for each of the OASIS-based, claims-based measures, and HHCAHPS measures used in the HHVBP Model.

As shown in **Exhibit 27**, Columns 1, 2, 4, and 6 contain the same information as listed on the "Achievement Points" tab. Column 3 lists the Baseline Year, Column 5 lists the Baseline Score, and Column 7 contains the Current Improvement Points.

Exhibit 27: Example of Improvement Points Tab in the Performance Year 3, CY 2019 Annual Report

NOTE: * Represents No Data Available for that time period

Measures	Performance Year Data Period [a] (12-Month Ending)	Baseline Year [b] (12-Month Ending)	HHA Performance Score	Baseline Score	Benchmark [c]	Current Improvement Points [d]
OASIS-Based Measures						
Influenza Immunization Received for Current Flu Season	12-31-2018	12-31-2015	89.583	80.911	87.874	10
Pneumococcal Polysaccharide Vaccine Ever Received	12-31-2018	12-31-2015	94.22	78.137	92.993	10
Improvement in Bathing	12-31-2018	12-31-2015	80.837	69.288	84.161	7.265
Improvement in Bed Transferring	12-31-2018	12-31-2015	81.175	60.332	76.332	10
Improvement in Ambulation- Locomotion	12-31-2018	12-31-2015	81.109	66.662	77.429	10
Improvement in Management of Oral Medications	12-31-2018	12-31-2015	70.892	51.842	69.278	10
Improvement in Dyspnea	12-31-2018	12-31-2015	90.47	74.491	87.393	10
Improvement in Pain Interfering with Activity	12-31-2018	12-31-2015	90.618	74.422	88.521	10
Discharged to Community	12-31-2018	12-31-2015	74.639	70.03	82.064	3.33
Claims-Based Measures						
Measures	Performance Year Data Period [a] (12-Month Ending)	Baseline Year [b] (12-Month Ending)	HHA Performance Score	Baseline Score	Benchmark [c]	Current Improvement Points [d]
Emergency Department Use Without Hospitalization	12-31-2018	12-31-2015	12.695	14.07	7.406	1.563
Acute Care Hospitializations	12-31-2018	12-31-2015	12.572	14.609	7.821	2.501
HHCAHPS Measures						
Measures	Performance Year Data Period [a] (12-Month Ending)	Baseline Year [b] (12-Month Ending)	HHA Performance Score	Baseline Score	Benchmark [c]	Current Improvement Points [d]
Care of Patients	12-31-2018	12-31-2015	87.761	89.728	93.168	0
Communications Between Providers and Patients	12-31-2018	12-31-2015	87.099	85.353	90.669	2.784
Specific Care Issues	12-31-2018	12-31-2015	83.387	82.765	88.444	0.595
Overall Rating of Home Health Care	12-31-2018	12-31-2015	82.6	81.84	92.938	0.185
Willingness to Recommend the Agency	12-31-2018	12-31-2015	79.72	75.232	89.942	2.551

[a] Performance Year Data Periods vary by measure type due to different data lags for OASIS-claims and HHCAHPS-based measures.

[b] Baseline Year = Calendar year for which the HHA has 12 months of data.

[c] The Benchmark is the mean of the top 90th percentile of measure values in CY 2015 for your state.

[d] For more information on how points are calculated under the HHVBP Model, refer to the Model Report and Payment Guide in the HHVBP Connect library.

To earn Improvement Points on the OASIS-based and HHCAHPS measures, your agency's performance on a given measure needs to be better than the Baseline Score in Column 5. If your agency performs equal to or below the Baseline Score for a measure, you will see a zero for "Current Improvement Points." As with the Achievement Points, the Improvement Points increase as the agency's performance score on a measure gets closer to the Benchmark.

In summary, to improve on a measure, your agency needs to perform better than it did during the baseline period for a measure. If your performance score is higher than your Baseline Score, the Improvement Points

increase as your performance score gets closer to the Benchmark and reaches the maximum of “10” points (in Performance Years 1-3, and “9” points in Performance Years 4-5) when your performance score is equal to or greater than the Benchmark.

Again, the logic is reversed for the two claims-based measures as discussed in the Achievement Points section above. Your performance score must be lower than the Baseline Score to receive Improvement Points, which increase as the performance score gets closer to the Benchmark and reaches the maximum of “10” points (in Performance Years 1-3, and “9” points in Performance Years 4-5) when the performance score is equal to or less than the Benchmark.

Care Points Tab

The third tab, labeled “Care Points,” is shown in **Exhibit 28**. Care Points are important because they feed into the calculation of the Total Performance Score. Care Points are simply the greater value of either the Achievement or the Improvement Points.

Exhibit 28: Example of Care Points Tab in the Performance Year 3, CY 2019 Annual Report

NOTE: * Represents No Data Available for that time period

OASIS-Based Measures				
Measures	Sufficient Data for Measure Inclusion (0 = No; 1 = Yes)	Current Achievement Points	Current Improvement Points	Current Care Points [a]
Influenza Immunization Received for Current Flu Season	1	10	10	10
Pneumococcal Polysaccharide Vaccine Ever Received	1	10	10	10
Improvement in Bathing	1	7.488	7.265	7.488
Improvement in Bed Transferring	1	10	10	10
Improvement in Ambulation-Locomotion	1	10	10	10
Improvement in Management of Oral Medications	1	10	10	10
Improvement in Dyspnea	1	10	10	10
Improvement in Pain Interfering with Activity	1	10	10	10
Discharged to Community	1	3.225	3.33	3.33
Claims-Based Measures				
Measures	Sufficient Data for Measure Inclusion (0 = No; 1 = Yes)	Current Achievement Points	Current Improvement Points	Current Care Points [a]
Emergency Department Use Without Hospitalization	1	1.42	1.563	1.563
Acute Care Hospitalizations	1	3.217	2.501	3.217
HHCAHPS Measures				
Measures	Sufficient Data for Measure Inclusion (0 = No; 1 = Yes)	Current Achievement Points	Current Improvement Points	Current Care Points [a]
Care of Patients	1	0.586	0	0.586
Communications Between Providers and Patients	1	4.078	2.784	4.078
Specific Care Issues	1	2.863	0.595	2.863
Overall Rating of Home Health Care	1	0	0.185	0.185
Willingness to Recommend the Agency	1	2.277	2.551	2.551
Number of Applicable Measures (AM) used for TPS Calculation				16
Raw Total Points (RTP)				95.861

[a] Care Points are the higher of Achievement or Improvement Points.

1. Column 2, labeled "Sufficient Data for Measure Inclusion" identifies whether the measure had sufficient data available to receive Achievement, Improvement, and thus Care Points. If you see a "1" in this column, you submitted sufficient data for the measure. A measure with insufficient data available to calculate a performance score can earn neither Achievement nor Improvement Points and therefore shows a zero in Column 2 for a measure.
2. The second to last **row** in the Care Points tab, labeled "Number of Applicable Measures (AM) used for TPS Calculation" identifies the total number of applicable measures used for calculating the Raw Total Points (RTP). If your HHA had sufficient data for each of the measures you would receive Raw Total Points, as shown in **Exhibit 28**. The Raw Total Points will be referenced again in the Total Performance Score tab.
3. The Raw Total Points at the bottom of the tab comprises 90% of your Total Performance Score. The three New Measures account for the remaining 10%, as discussed in the next section.

New Measure Points Tab

The following three New Measures account for the remaining 10% of the Total Performance Score:

4. Influenza Vaccination Coverage for Home Health Care Personnel;
5. Herpes Zoster Vaccination; and
6. Advance Care Plan.

CMS does not evaluate your HHA on achievement or improvement for these measures. Instead, your agency receives points for submitting data.

As seen in Column 2 in **Exhibit 29**, labeled "Available Points," you can receive 10 points for each of the three New Measures. If you submitted all your data for a New Measure, you see a "1" in Column 3 and a "10" in Column 4.

Exhibit 29: Example of New Measures Tab in the Performance Year 3, CY 2019 Annual Report

NOTE: * Represents No Data Available for that time period

New Measures	Available Points	# Quarters Measures Reported [c]	New Measure Points [d]
Influenza Vaccination Coverage for Home Health Care Personnel [a]	10	0	0
Herpes Zoster Vaccination [b]	10	4	10
Advance Care Plan [b]	10	4	10
Total	30	8	20

[a] Data for the Staff Influenza Vaccination measure is only submitted once annually (in April of each year). This is so that the reported data can cover the entire flu season (October-March).

[b] New Measure Points for the Advance Care Plan and Herpes Zoster Vaccination measures are calculated from the prior submission period (three months earlier). For example, for the April 2017 IPR, New Measure Points are calculated using data from the January 2017 submission period.

[c] For Interim Performance Reports, a value of one indicates that the measure was reported for the relevant quarter. Values of zero indicate that the measure was not reported. For Annual Reports, this column reports the number of quarters that the measure was reported. This ranges from 0-4 for the Herpes Zoster Vaccination and Advance Care Plan measures and is either zero or one for the Staff Influenza Vaccination measure, since this measure is only reported once each year.

[d] For Interim Performance Reports, New Measure Points are calculated by multiplying the number of quarters the measures were reported (Column C) by 10 for each New Measure. In the Annual Report, New Measure Points are calculated by multiplying the number of quarters the measures were reported (Column C) by 10 for the Staff Influenza Vaccination measures, by 2.5 for the Herpes Zoster Vaccination, and by 2.5 for the Advance Care Plan measure.

In Performance Year 1, all agencies automatically received 2.5 points on each of the three New Measures for each of the first 2 quarters since no submission for these two submission periods was required. For the Influenza Vaccination Coverage for Home Health Care Personnel measure, agencies received a total of 10 points if they submitted data in October 2016. If they did not submit the Influenza Vaccination Coverage for Home Health Care Personnel data in October 2016, they received 5 points. Please refer to **Exhibit 22: Potential New Measure Points for Annual Performance Year 1 (CY 2016)** which displays the New Measure Points for Performance Year 1 (CY 2016).

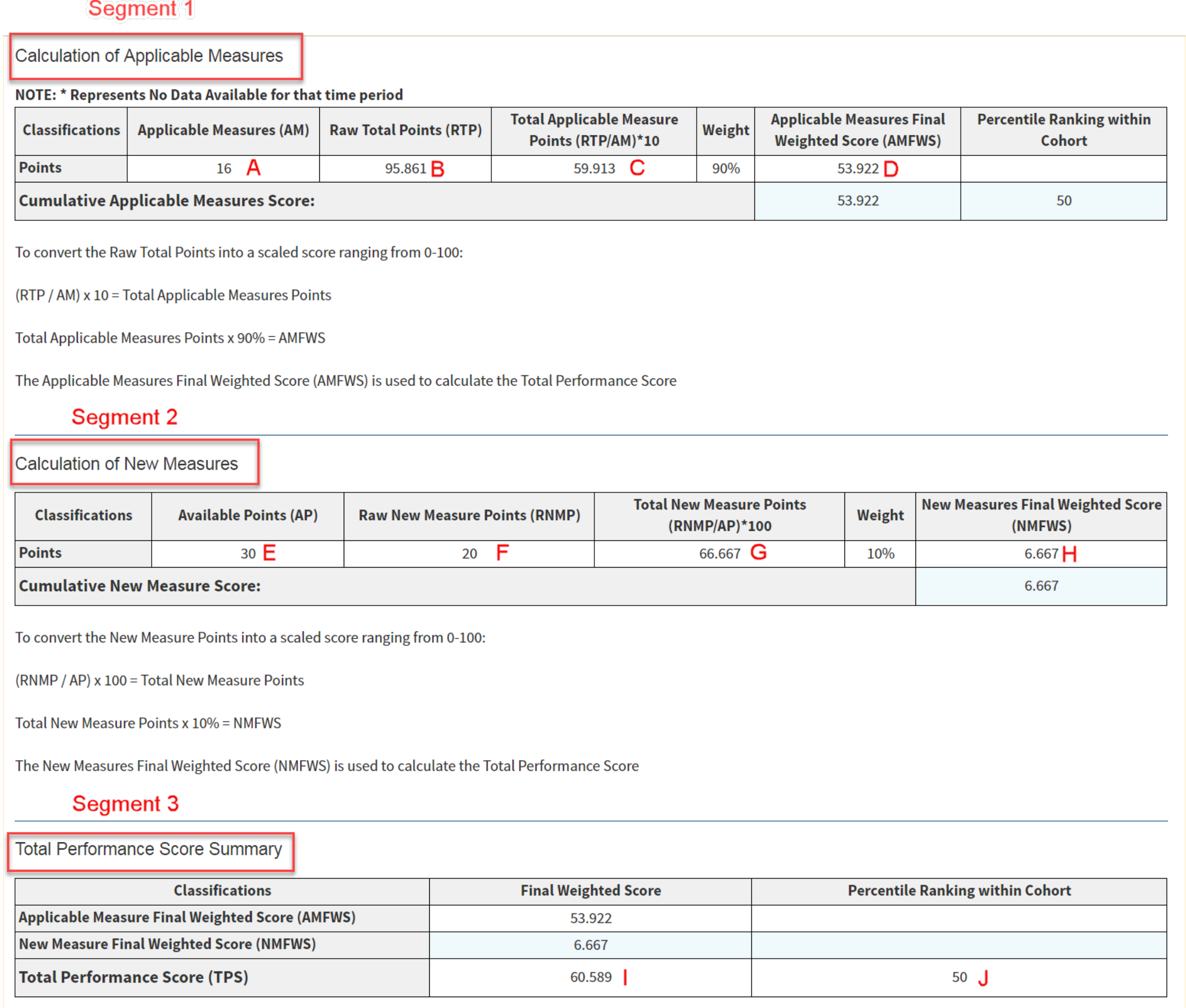
The minimum of 5 points per New Measure was unique to Performance Year 1. In Performance Year 2 (CY 2017), all agencies were expected to submit New Measures data for all applicable quarters. For subsequent performance years, the New Measures points will be based on the agency's submission activity for all 4 quarters for Herpes Zoster and Advance Care Plan and one quarter (that is, April 2017 in Performance Year 2) for Staff Influenza Vaccination. Please refer to **Exhibit 23: Potential New Measure Points Beginning Annual**

Performance Year 2 (CY 2017) and Subsequent Performance Years which displays the New Measure points available starting in Performance Year 2.

Total Performance Score Tab

The fifth tab is the Total Performance Score, or TPS, worksheet. **Exhibit 30** shows a TPS tab for a fictitious HHA. This tab is separated into three components, explained further below.

Exhibit 30: Example of Total Performance Score Tab in the Performance Year 3, CY 2019 Annual Report



Segment 1

Calculation of Applicable Measures

NOTE: * Represents No Data Available for that time period

Classifications	Applicable Measures (AM)	Raw Total Points (RTP)	Total Applicable Measure Points (RTP/AM)*10	Weight	Applicable Measures Final Weighted Score (AMFWS)	Percentile Ranking within Cohort
Points	16 A	95.861 B	59.913 C	90%	53.922 D	
Cumulative Applicable Measures Score:					53.922	50

To convert the Raw Total Points into a scaled score ranging from 0-100:

(RTP / AM) x 10 = Total Applicable Measures Points

Total Applicable Measures Points x 90% = AMFWS

The Applicable Measures Final Weighted Score (AMFWS) is used to calculate the Total Performance Score

Segment 2

Calculation of New Measures

Classifications	Available Points (AP)	Raw New Measure Points (RNMP)	Total New Measure Points (RNMP/AP)*100	Weight	New Measures Final Weighted Score (NMFWS)
Points	30 E	20 F	66.667 G	10%	6.667 H
Cumulative New Measure Score:					6.667

To convert the New Measure Points into a scaled score ranging from 0-100:

(RNMP / AP) x 100 = Total New Measure Points

Total New Measure Points x 10% = NMFWS

The New Measures Final Weighted Score (NMFWS) is used to calculate the Total Performance Score

Segment 3

Total Performance Score Summary

Classifications	Final Weighted Score	Percentile Ranking within Cohort
Applicable Measure Final Weighted Score (AMFWS)	53.922	
New Measure Final Weighted Score (NMFWS)	6.667	
Total Performance Score (TPS)	60.589 I	50 J

Segment 1: Calculation of Applicable Measures

1. **Cell A** shows this HHA has 16 applicable measures.
2. The Raw Total Points (**cell B)** originate from the Care Points tab. The Raw Total Points (RTP) are divided by the number of potential Applicable Measures (AM) and then multiplied by 10 to get the Total Applicable Measure Points (**cell C):** (RTP/AM)*10 = Total Applicable Measure Points.

3. The Total Applicable Measure Points are then multiplied by 0.9 as they are weighted at 90% of the TPS, as discussed in the Care Points section above. This results in the Applicable Measures Final Weighted Score (**cell D)**: Total Applicable Measure Points*0.9 = Applicable Measures Final Weighted Score

Segment 2: Calculation of New Measures

4. The Raw New Measure Points **(cell F)** are divided by the Available Points **(cell E)** and then multiplied by 100 to get to the Total New Measure Points **(cell G).**
5. The Total New Measure Points are then multiplied by 0.1, as the Total Applicable Measures for New Measures constitutes 10% of the TPS. This results in the New Measures Final Weighted Score (**cell H)**.

Segment 3: Total Performance Score Summary

6. This segment combines the Applicable Measures and New Measures Final Weighted Scores in the Total Performance Score Summary table. In **cell I**, you see the Total Performance Score. This is the sum of the Applicable Measures Final Weighted Score (**cell D)** and the New Measures Final Weighted Score (**cell H).**
7. Finally, the Percentile Ranking within the Cohort is shown in **cell J**. This enables each agency to gauge their performance relative to other agencies within the same state or cohort. Percentile ranks for the TPS and the Applicable Measures Final Weighted Score (AMFWS) are reported as 0, 10, 25, 50, 75, and 90.
8. The rankings on the Interim Performance Reports help an agency to understand if their HHA's "Total Applicable Measure Points" is "high" or "low" or "kind of in the middle," relative to other HHAs in their state or cohort, if applicable. If an agency has a TPS of equal to or greater than the 90th percentile TPS value for its state or cohort, if applicable, the ranking you will see is 90. Similarly, if an HHA has a TPS of equal to or greater than the 75th percentile TPS value AND less than the 90th percentile TPS value for its state and cohort, if applicable, the ranking you will see is 75. If an HHA has a TPS of less than the 10th percentile TPS value for its state and cohort, if applicable, the ranking you will see is 0. A higher percentile ranking indicates a higher level of performance.

"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?"

The TPS is adjusted to account for the number of measures available for an agency, so the maximum scores are the same for all agencies. HHCAHPS measures are not used for smaller volume agencies, and, in some states (i.e., states with at least 8 smaller volume agencies), smaller volume agencies are only competing against other smaller volume agencies. In states with fewer than eight smaller volume agencies, smaller and larger volume agencies are competing against each other, but the TPS for each agency is adjusted to account for the number of available measures.

Payment Adjustment Tab

The Annual Report contains a sixth and final tab, called the "Payment Adjustment" tab.

This tab provides you with three data components:

1. The Summary Information;
2. The Statistics for Your Cohort; and
3. The Payment Adjustment Calculation.

As seen in **Exhibit 31**, The Summary Information Table shows you which cohort you belong to, the TPS Performance Year, the Maximum Payment Adjustment Percentage (6% for Performance Year 3), the Payment Adjustment Application Year, and your agency's Final TPS-Adjusted Payment Percentage for Performance Year 3.

The agency in this example belongs to a cohort that includes all large HHAs within the agency's state and will receive a Final TPS-APP of 0.774%.

Exhibit 31: Example of Summary Information Table in the in the Performance Year 3, CY 2019 Annual Report

Your Cohort	All Large Volume HHAs in Your State
TPS Performance Year	CY 2018
Maximum Payment Adjustment Percentage	6%
Payment Adjustment Application Year	CY 2020
Your HHA's Final TPS- Adjusted Payment Percentage	0.774%

The Statistics for Your Cohort table, near the bottom of the Payment Adjustment tab, shows the relationship between the TPS and the TPS-Adjusted Payment Percentage for HHAs in your state or cohort.

As shown in **Exhibit 32**, this agency's cohort includes 104 large volume agencies with an average TPS value of 53.664 and a corresponding average Final TPS-APP of 0%. As a reminder, CMS will review your placement in a small or large cohort annually and update accordingly, if applicable.

Exhibit 32: Example of Statistics for Your Cohort Table in the in the Performance Year 3, CY 2019 Annual Report

Number Of HHAs in Your Cohort	104	
	TPS	Final TPS-Adjusted Payment Percentage
Mean	53.664	0%
25th Percentile	47.628	-0.675%
50th Percentile	54.548	0.099%
75th Percentile	63.512	1.101%
99th Percentile	78.691	2.798%

Finally, the Payment Adjustment Calculation table shows the steps involved to get you to your agency's Final TPS-Adjusted Payment Percentage. While **Exhibit 33** shows an example agency with an APP of 0.774%, your agency's percentage for Performance Year 3 (CY 2018) can be anywhere between -6% and +6% and will be

applied to all final fee-for-service home health claims for payment episodes ending in 2020. For more information, see **Exhibit 1: HHVBP Model Payment Adjustment Dates and Rates**.

Exhibit 33: Example of Payment Adjustment Calculation Table in the in the Performance Year 3, CY 2019 Annual Report

Steps	Step1 (C1)	Step2 (C2)	Step3 (C3)	Step4 (C4)	Step5 (C5)	Step6 (C6)	Step7 (C7)	Step8 (C8)
Total Performance	Total Performance Score (TPS)	Prior Year Payment	Unadjusted Payment Amount 6% x (C2)	TPS-Adjusted Payment Amount (C1/100) x (C3)	Linear Exchange Function (LEF)Ratio Total(C3) / Total(C4)	Final TPS-Adjusted Payment Amount (C4) x (C5)	TPS-Adjusted Payment Percentage (C6) / (C2)	Final TPS-Adjusted Payment Percentage (C7) - 6%
Your HHA	60.589	$2265848	$135951	$82371	1.863	$153495	6.774%	0.774%
Your Cohort (all HHAs):	53.664	$203556605	$12213396	$6554174	1.863	$12213397	6%	

Note that all dollar amounts in this table are rounded to the nearest dollar.

Step 1. Your HHA's final TPS for Performance Year 3 is shown in (C1). The average TPS for all HHAs in your cohort is shown below the value for your HHA.

Step 2. Your HHA's total Medicare FFS home health claims payments from the prior year is shown in (C2). The total amount of prior year Medicare FFS home health claims payments for HHAs in your cohort is shown below the value for your HHA.

Step 3. The Unadjusted Payment Amount in (C3) is calculated by multiplying the 6% maximum payment percentage for Performance Year 3 by your Prior Year Payments in (C2). The total Unadjusted Payment Amount for all HHAs in your cohort is below the value for your HHA.

Step 4. The TPS-Adjusted Payment Amount (C4) is calculated by dividing your HHA's TPS in (C1) by 100 and multiplying it by the Unadjusted Payment Amount in (C3). The total TPS-Adjusted Payment Amount across all HHAs in your cohort is shown below the value for your HHA. Note that this cohort-level value is obtained by applying the calculation to each HHA in the cohort separately and then summing across the individual values (and thus is not exactly the same as applying the calculation for Step 4 to the cohort values for (C1) and (C3)).

Step 5. The Linear Exchange Function (LEF) ratio in (C5) is calculated by dividing the total cohort-level Unadjusted Payment Amount (C3) by the total cohort-level TPS-Adjusted Payment Amount (C4). This ratio is needed to ensure that the total TPS-Adjusted Payment Amount is equal to the total Unadjusted Payment Amount across all HHAs in the cohort. The LEF ratio is the same for each HHA in the cohort.

Step 6. The Final TPS-Adjusted Payment Amount (C6) is calculated by multiplying the TPS-Adjusted Payment Amount (C4) by the LEF ratio (C5). The total Final TPS-Adjusted Payment Amount for all HHAs in your cohort is below the value for your HHA.

Step 7. The TPS-Adjusted Payment Percentage (C7) is calculated by dividing the Final TPS-Adjusted Payment Amount (C6) by your Prior Year Payment (C2). This represents the gross payment percentage applicable to your HHA without accounting for the 6% payment reduction.

Step 8. The Final TPS-Adjusted Payment Percentage (C8) is calculated by subtracting the 6% maximum payment adjustment percentage from the TPS-Adjusted Payment Percentage (C7). This percentage represents the overall payment adjustment percentage that will be applied to your CY2020 Medicare FFS home health claims payments. Positive values would result in additional payments made on your CY2020 Medicare FFS home health claims reimbursements. Negative Final TPS-Adjusted Payment Percentages would result in reductions to your CY2020 Medicare FFS home health claims reimbursements.

Your Final TPS-Adjusted Payment Percentage will be applied to your Medicare fee-for-service payments. If the payment percentage is positive, your agency's payment amount will increase. If the payment percentage is negative, your agency's payment amount will decrease.

Section 9: Adjusted Payment Percentage (APP)

This section provides background information on the annual calculation of the APP for HHAs in the HHVBP Model. Your agency's efforts to improve the quality of your HHA's performance in caring for your patients will affect your HHA's "bottom line," or annual APP. Your Final TPS-Adjusted Payment Percentage is applied to your Medicare fee-for-service (FFS) payments. If the payment percentage is positive, your agency's payment amount will increase according to your APP. If the payment percentage is negative, your agency's payment amount will decrease according to your APP.

"My agency had 57 completed HHCAHPS surveys for CY 2016– but my report indicates insufficient data for the HHCAHPS measures. Why does the report show insufficient data?"

The first criterion that must be met regarding HHCAHPS data used in the TPS calculation is that an HHA has to have at least 60 unique eligible patients in the year prior to the performance year. In the year prior to the performance year, your HHA did not have at least 60 unique eligible patients. This means that your agency would be in a smaller volume cohort for the HHVBP Model. The smaller volume cohort consists of agencies that have fewer than 60 eligible unique patients; the larger volume cohort includes agencies with 60 or more eligible unique patients. Only states with at least eight HHAs in the smaller volume cohort have a separate cohort; otherwise there is only one cohort in the state. HHAs with fewer than 60 unique patients are exempt from participation in HHCAHPS in accordance with § 484.250 (FAQ 104), and HHCAHPS data are not used in calculating small HHAs' TPS scores. This is the reason why your agency does not have HHCAHPS scores on your report.

The second criterion for receiving an HHCAHPS score, after having 60 or more unique eligible patients in the baseline year, is that an HHA must meet the minimum requirement for completed HHCAHPS surveys in both the baseline year and the performance year. The minimum requirement is 40 completed HHCAHPS surveys.

Eligibility Criteria for Adjusted Payment Percentage

The first adjusted payment percentages for HHVBP Model agencies were applied in January 2018 based on the 2016 performance year. This required that an HHA had Baseline data for the full 12 months of CY 2015. If your HHA began after January 1, 2015, your HHA did not have sufficient data and would not be eligible for the CY 2018 APP calculation. For eligible HHAs, the APP ranged from +3.0 to -3.0 percent and was applied to final Medicare FFS payments in CY 2018. To be eligible for the CY 2019 APP, an HHA must have had sufficient measure performance data on at least five measures for Performance Year 2017 and for the Baseline Year (2015 or 2016 depending on when the HHA began operations and if the HHA had sufficient data in a year). If an HHA began operations in CY 2016 or later, the agency was **not** eligible for the CY 2019 APP calculation. To be eligible for the CY 2020 APP, an HHA must have sufficient measure performance data on at least five measures for Performance Year 3 (CY 2018) and for the Baseline Year (2015, 2016, or 2017 depending on when the HHA began operations). HHAs that became Medicare-certified in CY 2017 or later are not eligible for Performance Year 3 (CY 2018) of the HHVBP Model, which determines the CY 2020 APP. Please refer to **Exhibit 1: HHVBP Model Payment Adjustment Dates and Rates** for more information. To receive an adjusted payment percentage, HHAs must have Achievement and Improvement scores on at least five of the same measures in the Baseline and Performance Years.

- For the OASIS and claims-based measures, HHAs must have at least 20 episodes of care in the Performance and Baseline years.
- For the HHCAHPS measures, a HHA needs a minimum of 40 completed HHCAHPS surveys in the Performance and Baseline years.

How the APP Is Applied to Claims

Once CMS calculates the APP for HHAs eligible for a payment adjustment, agencies will follow the three-step process below to apply the APP to claims:

1. The HHA submits a final claim as usual.
2. The Medicare claims processing system reviews the claim, calculates payment, and applies the APP to the claim.
3. The Medicare Administrative Contractor (MAC) pays the claims and returns the remittance advice with the claim. Please note that the adjustment amount is not separately identified on the remittance advice.

APP Calculation Examples

Calculation of the APP requires two steps:

1. Comparing your TPS with the average TPS for your cohort in your state; and
2. Calculating your payment and your cohort's prior year payment.

The following three examples review how to compute the Final TPS-APP and address broader questions regarding the relationship between a HHA's TPS value and the agency's APP, as well as the role of the cohorts in creating the Linear Exchange Function.

As you review the following three scenarios, keep the guidelines below in mind:

- The TPS value works as a multiplier. The higher the HHA's TPS is relative to others in their cohort, the larger the APP. As you will see in Step C4 in each of the computations, your agency's TPS value is part of the numerator in this calculation. The higher the TPS value, the bigger the boost the HHA receives in this step.
- Large HHAs have no advantage in APP when compared with small HHAs, but TPS performance counts. Scenario 3 shows that an

"In 2018, will HHVBP payment adjustments be applied to all aggregate Medicare home health revenue or only Medicare revenue from the first home health episode in a string of contiguous episodes?"

As stated in the CMS Home Health CY 2016 Final Rule, the Model will adjust the HH PPS *final* claim payment amount to an HHA for each claim in a calendar year by the applicable percentage. Medicare PPS payment adjustments are not made to aggregate revenue, but will occur for each *final* Medicare PPS claim an agency submits for claims with a payment episode "through date" in the HHVBP payment year. For example, if your final claim amount is $3,500.00 and your Adjusted Payment Percentage is 0.077%, your payment adjustment would be: 3500 multiplied by 0.00077 which equals an additional $2.70 included in the payment.

HHA that is 15 times larger than another HHA in its cohort does not have an advantage over the smaller HHA if the two HHAs are identical in their TPS values.

- The same HHA performance (i.e., TPS) but in different cohorts will produce different APP values. This is because the APP depends not only on an HHA's TPS but also on the performance of the other HHAs in its cohort. Cohort performance is the key factor in determining the Linear Exchange Function (Step C5) that works as another multiplier in arriving at the final APP.

Scenario 1: Same Cohort, Different TPS Values

Below is an example of the eight steps in the APP calculation for two HHAs in the same state and cohort with different TPS values. In **Exhibit 34**, the letter "a" indicates the "Cohort" values.

Exhibit 34: HHAs in the Same Cohort, Different TPS Values (CY 2015 Payments)

Calculation Elements	HHA #1	HHA #2
C1 – HHA's Total Performance Score (TPS)	38	50
C1a – Average TPS for Cohort	49.375	49.375
C2 – HHA's CY2015 Payment	$200,000	$190,000
C2a – Cohort Total CY2015 Payment	$3,507,222	$3,507,222
C3 – 3% at Risk [HHA 2015 Payment (C2) * 3%]	$6,000	$5,700
C3a – Sum of 3% at Risk for Cohort	$105,216.66	$105,216.66
C4 – Adjusted at Risk [HHA's TPS/100 (C1) * C3 value]	$2,280	$2,850
C4a – Sum Adjusted at Risk for Cohort	$53,515.16	$53,515.16
C5 – Linear Exchange Function (LEF) [C3a / C4a]	1.9661	1.9661
C6 – Final TPS Adjusted Amount [Adjusted at Risk (C4) * LEF (C5)]	$4,482.73	$5,603.41
C7 – TPS Adjusted Payment Percentage [C6 / C2]	2.241%	2.949%
C8 – Final TPS Adjusted Payment Percentage (APP) [C7 – 3%]	-0.759%	-0.051%

1. Step C1—Total Performance Score. This reports the TPS value from the Payment Adjustment Tab. In this example, HHA #1 (with the blue box) had a TPS value of 38 while HHA #2 (with the red box) had a much higher TPS value of 50. Based on this information, we would expect that HHA #2 would have a better APP score than HHA #1.
    a. Step C1a is the average TPS for the cohort of the HHA. Because each of these HHAs are in the same cohort, the values are the same for both HHAs. Notice that HHA #1's TPS value is quite a bit lower than the cohort average, while HHA #2's average is just slightly higher than average.
2. Step C2—Prior Year Payment—is the total dollar amount of the Fee-for-Service claims submitted by the agencies during CY 2015 for the first Annual Report. For the second Annual Report, the prior year will be 2016. This example shows the two HHAs have very similar Prior Year Payment amounts.
    a. Step C2a—Cohort Total CY 2015 Payment—this number is the total amount of FFS payments issued to your cohort during CY 2015.
3. Step C3 is specific to your agency. The following computational steps use HHA #1 as a concrete example of how to apply the formula. The Unadjusted Payment Amount is three percent of the amount of your agency's CY 2015 payment (found in C2). For HHA #1 this is $200,000 x 3% or $6,000.
    a. Step C3a is the sum of all C3 values for all of the agencies in your cohort.

4. Step C4—the TPS-Adjusted Payment Amount—is where your TPS value influences how much your agency can benefit from the HHVBP Model. Using HHA #1 values, the blue box computation divides the HHA's TPS value (38) by 100 and then multiplies that fraction by the Unadjusted Payment Amount of $6,000 that we computed in Step C3. The result of this computation for HHA #1 is $2,280. Again, we will be using this value later in our computations.
   a. Step C4a—Sum of TPS-Adjusted Payment Amount for Cohort—like Step C3a—is just the sum of these values for the other agencies in your cohort. Please remember that in our example, we have two agencies that have different TPS values, but they have the same cohort values with identical C3a and C4a values.
5. Step C5—the Linear Exchange Function (LEF). The LEF creates a ratio between two cohort values: the Unadjusted Payment Amount found in C3a and the TPS-Adjusted Payment Amount in C4a. In this example, the total cohort Unadjusted Payment Amount (C3a) = $105,216.66 and is divided by the cohort total TPS-Adjusted Payment Amount (C4a) of $53,515 to get an LEF of 1.9661. We use this value in the next step of the computation.
6. Step C6—Final TPS-Adjusted Payment Amount modifies your agency's C4 value by multiplying this value by the LEF. For HHA #1 in this example, we multiply $2,280 by 1.9661 to get a C6 value of $4,482.73. This dollar amount will be compared in the next step to the Prior Year Payment (back in Step C2) to create a percentage that CMS will compare with the target 3% for Performance Year 1.
7. Step C7—TPS-Adjusted Payment Percentage—is the ratio of your agency's Final TPS-Adjusted Payment Amount (C6) and your agency's Prior Year Payment (C2) expressed as a percentage. In this example, HHA #1's TPS-Adjusted Payment Percentage is $4,482.73 / $200,000 or 2.241%.
8. Step C8—Final TPS-APP –The last step in this computation is a simple subtraction: the C7 value minus 3%. For HHA #1 this means that each of their claims for CY 2018 will be reduced by 0.759%, whereas HHA #2 will have each of its claims reduced by 0.051% or about $1.02 on every $2,000 claim.

In summary, two HHAs in the same state and cohort with different TPS values end up with different APPs (-0.759% and -0.051%, respectively). In this example, even though HHA #2's TPS value was just slightly better than the average TPS for its state and cohort, it would still see a very slight reduction in CY 2018 in its payment amount, albeit less than the reduction of 0.759% experienced by HHA #1, which had a lower TPS.

Scenario 2: Different Cohorts, Same TPS

The second scenario shows how the same TPS value can have different results when the agencies are in different cohorts.

Exhibit 35 illustrates the eight-step APP calculation for two HHAs with the same TPS values and CY2015 payments, but from different states representing different groups (i.e. cohorts) of HHAs. The big picture question addressed in this scenario is: "What is the effect of different cohorts on an agency's Final TPS-APP?"

Exhibit 35: HHAs in Different Cohorts, Same TPS Values

Calculation Elements	HHA #1 in Cohort 1	HHA #2 in Cohort 2
C1—HHA's TPS	50	50
C1a—Avg. TPS for Cohort	49	43. 5
C2—HHA's CY2015 Payment	$190,000	$190,000
C2a—Cohort Total CY2015 Payment	$3,452,222	$4,507, 222
C3—3% at Risk (HHA 2015 payment (C2) * 3%)	$5,700	$5,700
C3a—Sum of 3% at Risk for Cohort	$103,567	$135,217
C4—Adjusted at Risk (HHA's TPS/100 (C1) * C3 value)	$2,850	$2,850
C4a—Sum Adjusted at Risk for Cohort	$52,927	$55,619
C5—Linear Exchange Function (LEF) (C3a / C4a)	1.987948	2. 431140
C6—Final TPS Adjusted Amount (Adjusted at Risk (C4) * LEF (C5))	$5,665. 65	$6,928.75
C7—Quality Adjusted Payment Rate (C6 / C2)	2.982%	3.647%
C8—Adjusted Payment Percentage (APP) (C7 – 3%)	-0.018%	0. 647%

The differences between these two HHAs are the different average TPS values (C1a), Total Payments (C2a), Total 3% at Risk (C3a), and Total Adjusted at Risk (C4a) of their respective cohorts. The latter two values are used to calculate the Linear Exchange Function (LEF) (C5) for HHAs in its respective cohort. When this LEF is applied to each HHA's performance, HHA #1 in Cohort 1 will see a very slight reduction of 0.018%, while HHA #2 in Cohort 2 will see about a 0.647% increase. This difference highlights how HHA performance is relative to the comparison cohort.

Both agencies have the same TPS value (50), but they are in different cohorts that have different average TPS values (49 and 43.5, respectively). While both agencies have the same TPS values, relative to its cohort, HHA #2 in Cohort 2 does better than HHA #1 in Cohort 1. Based on this information, we could assume that HHA #2 would do better than HHA #1 on its APP.

In Step C2, we show that both agencies also have the same Prior Year Payments, but their cohorts have different Cohort Total CY 2015 Payments (C2a), with the same pattern shown in Steps C3 and C3a and for Steps C4 and C4a. There are no differences between the agencies in Steps C1, C2, C3, and C4, but there are differences in their cohorts (i.e., C1a, C2a, C3a, and C4a). You may notice that some cohorts have a smaller swing in percentage impact than others do, which depends on the range of TPS values within a cohort, combined with the size (prior year payments) of HHAs.

In Step C5, the Linear Exchange Function (LEF) illustrates how cohorts affect the APP value. The LEF is the ratio of two cohort values—C3a (Sum of the Unadjusted Payment Amount) and C4a (Sum of the TPS-Adjusted Payment Amount), so these result in two different LEF values (1.988 for HHA #1 in Cohort 1 and 2.431 for HHA #2 in Cohort 2) and these values will affect later computations.

Step C6 displays how the C4 values ($2,850 for both agencies) are multiplied by the LEF values for each agency (i.e., 1.988 for HHA #1 in Cohort 1 and 2.431 for HHA #2 in Cohort 2). The result of these multiplications show a nearly $1,300 difference between the C6 values for these two "identical" agencies from different cohorts ($5,665.65 for HHA #1 in Cohort 1 vs. $6,928.75 for HHA #2 in Cohort 2). In Steps C5 and C6, you can see how the cohorts make a difference in payments.

Steps C7 and C8 complete the APP computation. The TPS-Adjusted Payment Percentage for HHA #1 in Cohort 1 is 2.982%, while this value for HHA #2 in Cohort 2 is higher at 3.647%. After subtracting 3% from each of

these C7 values, HHA #1 in Cohort 1 will have 0.018% reduction in FFS claims in CY 2018, while HHA #2 in Cohort 2 will have 0.647% increase in its FFS claims in CY 2018.

In summary, the cohort you are in does make a difference in your Final TPS-APP value.

Scenario 3: Same Cohort and TPS, Different CY 2015 Payments

The example below examines if the size of the agency (small vs. large based on prior year payments) makes a difference when the performance is the same, and the HHAs are in the same cohort. The big picture question addressed in this scenario is: "Does the size of an agency based on its total payments make a difference in the agency's Final TPS-APP when there is only one cohort in the state?"

Exhibit 36 illustrates the eight-step calculation for two HHAs with the same TPS values but substantially different CY 2015 payments who are in the same cohort of HHAs.

Exhibit 36: HHAs in the Same Cohorts, Same TPS Values, Different CY 2015 Payments

Calculation Elements	HHA #1 in Cohort 1	HHA #2 in Cohort 1
C1—HHA's TPS	55	55
C1a—Avg. TPS for Cohort	53.6	53.6
C2—HHA's CY2015 Payment	$100,000	$1,450,000
C2a—Cohort Total CY2015 Payment	$4,757,222	$4,757,222
C3—3% at Risk (HHA 2015 payment (C2) * 3%)	$3,000	$43,500
C3a—Sum of 3% at Risk for Cohort	$142,717	$142,717
C4—Adjusted at Risk (HHA's TPS/100 (C1) * C3 value)	$1,650	$23, 925
C4a—Sum Adjusted at Risk for Cohort	$76,510	$76,510
C5—Linear Exchange Function (LEF) (C3a / C4a)	1.86533	1.86533
C6—Final TPS Adjusted Amount (Adjusted at Risk (C4) * LEF (C5))	$3,077. 79	$44,628.01
C7—Quality Adjusted Payment Rate (C6 / C2)	3.08%	3.08%
C8—Adjusted Payment Percentage (APP) (C7 – 3%)	0.08%	0.08%

The differences between these two agencies are indicated in the blue and red boxes. The TPS values in C1 and C1a are identical. The big difference is the size of these two agencies as measured by their Prior Year Payments (C2), with HHA #2 being nearly 15 times larger than HHA #1. Note that their C2a cohort values are identical.

Similarly, these agencies' C3 values are more than $40,000 different, but their cohort totals (C3a) are identical. The C4 values are very different, and the cohort totals in C4a are identical.

Because the Linear Exchange Function (LEF) in Step C5 is based on cohort values and these values are the same in this scenario (i.e., C3a / C4a), the LEF values are also identical at 1.865.

In Step C6, the agency's individual TPS-Adjusted Payment Amount (i.e., $1,650 for HHA #1 and $23,925 for HHA #2) is multiplied by the LEF of 1.865 to arrive at its C6 value for HHA #2 of $44,628.01 while HHA #1's C6 value is a mere $3,077.79. Again, a difference of more than $40,000.

This example shows that large dollar amount differences do not make a difference in TPS-Adjusted Payment Percentages computed in Steps C7 and C8. Both HHAs performed identically and are in the same cohort so they have the same TPS-Adjusted Payment Percentage (3.08% in C7) and the same Final TPS-APP of 0.08% in C8. The size of the agency as measured by their Prior Payment does not make a difference when there is a single cohort in a state.

Section 10: Risk Adjustment and the HHVBP Model

Risk adjustment is a statistical process that takes into account the underlying health statuses and spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs. CMS conducts this statistical process in several steps. First, CMS creates a computer model to predict the probability that a home health patient will succeed on each of the publicly and privately reported home health outcomes. Second, CMS aggregates the observed and predicted rates for each outcome for each agency. Third, CMS adjusts the agency's observed rate by the difference between the national predicted and the agency's predicted rates. **Exhibit 37** illustrates the risk adjustment process.

Exhibit 37: The Risk Adustment Process

Step 1:
Build the Prediction Model

Step 2:
Aggregate the Results at the Agency Level

Step 3:
Apply the Risk Adjustment Algorithim

Every agency serves a different patient population. Some agencies have patients with more chronic needs, while other agencies serve primarily patients who are just recovering from orthopedic surgery. These patients have different expected improvement rates across different outcomes. Risk adjustment takes into account differences in the patient population served by different home health agencies and ensures that if an agency that serves more challenging patients (i.e., patients who are less likely to improve than the national average); the agency is not penalized for serving this patient population.

The prediction models identified for different outcomes account for these different probabilities for improvement based on patient risk factors (i.e., case mix). Agencies with more clinically complex patients have lower predicted rates of success on some outcomes compared to agencies with less acute patients. However, because CMS adjusts their observed score by the difference between the national and their predicted rates, the risk adjustment increases their observed score by this amount. As part of the CMS Home Health Quality Reporting Program (HHQRP), values for all OASIS and claims-based patient outcome measures are reported with risk adjustment to take into account differences in the characteristics of patients prior to admission to home health care. The patient outcome measures that are included in the HHVBP Model are also risk adjusted based on the HHQRP reporting conventions.

The risk-adjustment process for OASIS-based measures is conducted in three steps: (1) Building the prediction model, (2) Aggregating the results at the agency level, and (3) Applying the risk adjustment algorithm. Each step is described in the following paragraphs.

Step 1: Build the Prediction Model

The first step, building the prediction model, is the most complicated. The high level technical description is:

1. Randomly select a subset of episodes from the target population (develop sample);
2. Create and compute potential risk factors (approximately 300) that are related to one or more of the quality outcome measures;
3. Compute a series of ordinary least squares (OLS) and logistic regression calculations to identify those potential risk factors that are statistically related to a quality outcome measure (i.e., create a prediction model);
4. Repeat Step 3 for each quality outcome measure;
5. Complete a clinical review of (i.e., validate from a clinical perspective) the risk factors for each prediction model for each quality outcome measure;
6. Re-compute the prediction model (i.e., repeat Step 3) if any risk factor from a prediction model is rejected by the clinical review panel;
7. Randomly select another, non-duplicative one million episodes from the target population (validation sample);
8. Compute and compare the results of applying the prediction models for each outcome to both the development and validation samples;
9. Present analytic results for each prediction model to a Technical Expert Panel for an independent final review prior to implementation; and
10. Create and post the final set of technical specifications for each prediction model on the CMS Quality Measure Website.

Step 2: Aggregate the Results at the Agency Level

Once the prediction models for each quality outcome measure are finalized, they are applied to each episode of care nationally. For each improvement outcome, CMS calculates an observed value (i.e., was the patient more independent at the end of care than s/he was at the beginning of care;) and a predicted value based on the prediction model for that outcome for each episode of care where the patient is eligible for the outcome. As a reminder, if a patient is already completely independent for that outcome or otherwise excluded, we do not calculate the observed and predicted values for that outcome. However, the two HHVBP composite measures, TNC Change in Self-Care and TNC Change in Mobility, do not exclude patients who are independent at Start of Care (SOC) or Resumption of Care (ROC).

Once CMS calculates the observed and predicted values for all outcomes nationally, they aggregate the observed and predicted results to the agency level. Therefore, each agency receives two values for each quality outcome measure: an observed rate (i.e., average of all observed values from all eligible episodes of care); and a predicted rate (i.e., average of all predicted values from all eligible episodes of care).

Step 3: Apply the Risk Adjustment Algorithm

In Step 3, the two values calculated in Step 2 as well as the national predicted value for that outcome are used to risk adjust the agency's performance on the quality outcome measure. The formula used (which is also the value reported on Home Health Compare and on the CASPER Reports) is:

Risk Adjusted Outcome value = Agency's observed value + National predicted value – Agency's predicted value

The risk adjustment formula has two values specific to the agency (its observed and predicted values) and one national constant for all agencies (i.e., the national predicted value for that outcome). The biggest boost an agency can receive is if the agency's observed value is better than the agency's predicted value. That is, an

agency that has a better observed than predicted value does better with its patients than would be predicted based on the prediction model for the quality measure outcome.

Risk Adjustment Examples

Using the risk adjustment formula in Step 3 above, **Exhibit 38** illustrates three examples of how the risk adjustment calculation takes into account differences in agency performance and the patient population the agency serves:

Exhibit 38: Risk Adjustment Examples

Quality Outcome	HHA #1 ("Typical")	HHA #2 ("Complex")	HHA #3 ("Selective")
Agency Observed	68.5	65.3	70.4
National Predicted	70.2	70.2	70.2
Agency Predicted	69.1	63.5	71.5
Risk Adjusted Value	69.6	72.0	69.1

- **HHA #1** does slightly worse than the national predicted value with its observed rate, but their patients are also predicted to do less well than the national predicted rate. The risk adjustment equation gives this agency a small boost to its observed rate of 68.5 by creating a risk adjusted rate of 69.6.
- **HHA #2** performs much worse than the national predicted rate, but better than what the prediction model indicated for their very challenging patients. Hence, they get a big boost (risk adjustment) to their observed rate of 65.3 and have a publicly reported, risk adjusted rate of 72.0. This example illustrates that agencies who serve challenged patients can benefit from the risk adjustment process.
- **HHA #3** reports a strong observed rate, but notice that their predicted rate suggests that their performance should be even higher with their patient population. When the risk adjustment formula is applied, HHA #3's risk adjusted value is the lowest of the three agencies (69.1). This example illustrates that risk adjustment can reduce any advantage an agency might try to obtain by selectively choosing patients with less complex care needs.

Using Risk Adjustment to Improve HHVBP Performance

The OASIS-based HHVBP Model measures that are part of the TPS are risk adjusted. Additionally, the two claims-based measures also follow a very similar risk adjustment methodology, but they use information from the claims data as risk factors to create their prediction models. Additional information is in the *"Claims Based AC and ED Use Measures Technical Documentation and Risk Adjustment"* document located in the Downloads section of the CMS Home Health Quality Measures page.

The HHCAHPS measures included in the TPS are also risk adjusted. For information on the patient adjustment factors used in HHCAHPS, refer to the document called "Understanding HHCAHPS Public Reporting."

The OASIS process measures and the three New Measures are not risk adjusted.

As a reminder, the Achievement and/or Improvement Points earned by an HHA uses two comparable values—the Achievement Threshold and Benchmark. CMS derives the values for the OASIS-based measures and the claims-based measures from risk adjusted values; an agency's performance on these quality measures is risk adjusted. The risk adjustment algorithm helps make the comparison of an agency's performance to these two comparable values more balanced by accounting for the patient case mix served by an agency.

Does risk adjustment account for all patient case-mix differences that influence whether a patient achieves an outcome? No. The data collection burden to account for all case-mix differences would be overwhelming. However, accounting for at least some of these case differences through the risk adjustment process can recognize the challenges agencies have in serving the most needy home health patients by adjusting their publicly reported scores upward.

Section 11: Training Resources and Technical Support

The HHVBP Model includes several learning and support systems for HHAs who require technical support or guidance. This section of the guide will introduce you to the ongoing training resources and technical support available to HHAs in the Model. *HHVBP Connect* serves as the repository for all HHVBP resources. To ensure that you receive important HHVBP-related communications via email, please add cmslists@subscriptions.cms.hhs.gov to your safe senders list. Do not unsubscribe from receiving emails from CMS or mark the email as spam. You may also find it helpful to enable graphics in your inbox so that you are able to view email content in the enhanced format.

Learning Events

Learning events promote HHA understanding of the quality measures and other requirements of the HHVBP Model. The learning events allow for collaboration and encourage sharing of best practices and strategies to improve performance. Archived events allow for staff and Points of Contact in the HHVBP Model agencies to view previously disseminated information on-demand. The HHVBP Model TA Team produces three types of learning events:

1. **Model Operations**: These primarily didactic events emphasize sharing specific information related to the HHVBP Model, including HHVBP Secure Portal registration, collecting and submitting New Measures data, using *HHVBP Connect*, reviewing HHVBP reports, updates from CMS, and other topics related to HHVBP Model implementation.
2. **Bringing It Home: Patient Care Delivery**: These events support HHAs in implementing HHVBP and enhancing the quality of care delivery. These events focus on actionable strategies HHAs can use to improve HHVBP measures, support their QAPI efforts, and assist in organizational transformation to a value-based payment system.
3. **Critical Supports: Organizational Structure and Workforce**: These variables strongly influence an HHA's ability to implement QAPI, sustain effective processes, and enhance the delivery of patient care. Topics include use of QAPI to improve HHVBP outcomes, creating effective interdisciplinary teams (IDT), and conducting workforce model needs assessments.

HHAs can register for all HHVBP Model Learning Events through *HHVBP Connect* on the Calendar tab. Copy and paste the registration link into a web browser, and you will be automatically redirected to the registration page for that event.

Newsletters

The HHVBP Model Newsletter compiles critical information and highlights upcoming events. Newsletters provide an opportunity to summarize timely information, offer clarification on emergent issues, and provide quality improvement tips on an ongoing basis. The PPOC, CPOC, SPOC, Reviewer and Data Entry roles for each HHA receive newsletters via email, as well as staff who are registered for a *HHVBP Connect* account. You can access previous newsletters by searching the term "Newsletter" in the search bar embedded into the *HHVBP Connect* Libraries tab.

Frequently Asked Questions (FAQs)

FAQs aim to document valuable and useful responses to common questions submitted by HHAs on an ongoing basis through the HHVBP Help Desk and during Learning Events. FAQs reinforce information provided to HHAs and serve as a readily available knowledge database with up-to-date information. The *HHVBP Connect* Library and Knowledge tab contain all FAQs.

Environmental Scans

Each annual Environmental Scan provides a comprehensive review of the grey and academic home health literature published in the prior year. The scans include emerging trends within home health, an executive summary, and abstract summaries of academic and grey literature. You can access previous Environmental Scans by searching the term "Environmental Scan" in the search bar embedded into the *HHVBP Connect* Libraries tab.

HHVBP Communications

The HHVBP Model TA Team sends frequent emails alerting HHAs of Model milestones, learning event announcements, and important guidance from CMS, which is why it is important to update your email address with the HHVBP Help Desk if your information changes. PPOCs and CPOCs who have emailed their information to the Help Desk are included in the email distribution list. For emails that contain important information for individuals holding other user roles, we email the list of individuals who have been approved for those roles in the HHVBP Secure Portal. The HHVBP email distribution list primarily targets the PPOCs, CPOCs, SPOCs, Data Entry Personnel, and Reviewers, and those who are registered for *HHVBP Connect*. Emails regarding data submission periods may also be sent to individuals holding Data Entry and Reviewer roles. However, all important information is routinely posted to the *HHVBP Connect* site for who have registered for *HHVBP Connect* (regardless of their role in the HHVBP Secure Portal). To add or update the email addresses of a PPOC or CPOC, send an email to HHVBPquestions@cms.hhs.gov with the CCN, PPOC currently on file, and the new PPOC or CPOC contact information.

Other Resources

The *HHVBP Connect* Library contains additional tools and resources, which provide guidance to HHAs about various aspects of the HHVBP Model. Quick Reference Guides, Fact Sheets, Action Plans, and Action Checklists are some of the resources HHAs can find in the Library. Check the "*HHVBP Connect* Inventory" document for a current list of available resources.

Help Desk Contact Information

HHVBP Help Desk

The Help Desks assist HHAs with their inquiries related to the HHVBP Model. **Exhibit 39** provides an overview of HHVBP Help Desk services.

Exhibit 39: HHVBP Help Desks

Outlet	Type of Inquiry	Operating Hours
HHVBP Help Desk Email: HHVBPquestions@cms.hhs.gov	Contact for **program and registration questions**, including new PPOC or CPOC information and general Model questions about IPRs, New Measures, Scoring, data submission, etc.	Monday through Friday, except federal holidays. When sending an email to the Help Desk, include your name, phone number, and your organization's name, CCN(s), and Primary Point of Contact (PPOC). **Resolutions to your inquiries are not always immediate** and responses may take a few business days.
Collaboration Sites Business Operations Support Center (CBOSC) Phone: 1-844-280-5628	Contact for **technical issues** with gaining access to the HHVBP Secure Portal. Please stay on the line until your issue is resolved. Examples of technical inquiries are password resets, download errors, EIDM name or email address updates, etc.	Monday through Friday, 8:30 AM to 6:00 PM ET, except federal holidays. If you call outside of these hours, you may leave a voicemail message and your call will be returned on the next business day.
CMMI Connect Help Desk Email: CMMIConnectHelpDesk@cms.hhs.gov Phone: 1-888-734-6433, Option 4	Contact for ***HHVBP Connect*** **questions**, such as password resets and assistance getting a new account.	Monday through Friday, 8:30 AM to 6:00 PM ET, except federal holidays.

Other Help Desk Contact Information

Home Health Quality Help Desk

The Home Health Quality Help Desk should be used for questions related to any of the OASIS-based and claims-based measures and reports that are included in the Home Health Quality Reporting Program. These are the measures that exist for all HHAs, and not just agencies competing in the HHVBP Model. The Home Health Quality Help Desk may be contacted via email at homehealthqualityquestions@cms.hhs.gov.

HHCAHPS Help Desk

The HHCAHPS Help Desk is for all HHCAHPS survey and measure-related questions. The HHCAHPS Help Desk can be reached by email at HHCAHPS@rti.org or by phone at 1-866-354-0985.

For questions, corrections, or suggestions to this guide, please contact the HHVBP Help Desk (HHVBPquestions@cms.hhs.gov).

Appendix A: HHVBP Model Quality Performance Measures for Performance Year 4, Calendar Year 2019

Database	Measure
OASIS	Total Normalized Composite (TNC) Change in Self-Care
	Total Normalized Composite (TNC) Change in Mobility
	Improvement in dyspnea
	Discharged to community
	Improvement in pain interfering with activity
	Improvement in management of oral medications
Claims-Based	Acute care hospitalization: Unplanned hospitalization during first 60 days of home health
	Emergency Department use without hospitalization
HHCAHPS	Care of patients
	Communication between providers and patients
	Specific care issues
	Overall rating of home health care
	Willingness to recommend the agency
New Measures	Advance Care Plan
	Herpes Zoster (Shingles) Vaccination
	Influenza vaccination coverage for home health care personnel (Staff Influenza Vaccination)

Appendix B: HHVBP Model Glossary of Terms, Acronyms, and Defintions

Terminology	Definition
Achievement Points	Achievement Points on the Interim Performance Report (IPR) and the Annual TPS & Payment Adjustment Report are awarded based on an agency's actual performance on each measure compared to the Achievement Threshold and Benchmark for that measure. Specifically, an agency receives Achievement Points for a measure if its value during the Performance Year is equal to or better than the Achievement Threshold, and the Achievement Points increase as the measure value gets closer to the Benchmark. An HHA may receive up to 10 Achievement Points for each measure, with the exception of the composite measures, TNC Change in Self-Care and TNC Change in Mobility, in which an HHA may receive up to 15 Achievement Points.
Achievement Threshold	The Achievement Threshold on the Interim Performance Report (IPR) and Annual TPS and Payment Adjustment Report establishes an attainable standard for HHAs in measuring performance. For each measure, the Achievement Threshold is calculated as the median quality measure score for HHAs with sufficient data within a state in CY 2015, with the exception of the Total Normalized Composite Change in Self-Care and Total Normalized Composite Change in Mobility measures in which CY 2017 data are calculated. HHAs must reach the Achievement Threshold for that specific measure to receive Achievement Points for that measure.
Adjusted Payment Percentage (APP)	The percentage determined annually and applied to an HHA's Medicare fee-for-service (FFS) payments for the corresponding payment year. If the payment percentage is positive, the agency's payment amount will increase. If the payment percentage is negative, the agency's payment amount will decrease.
Advance Care Plan Document	The Advance Care Plan Document is a legal directive specifying the patient's future healthcare decisions for a time when they are not able to make their own healthcare decisions. The advance care plan document is typically referred to as an advance directive. Examples of advance care plan documents/advance directives include a living will, durable power of attorney for health care, Physician Orders for Life-Sustaining Treatment (POLST), Medical Orders for Life-Sustaining Treatment (MOLST), Do-Not- Resuscitate (DNR) Orders, or other legally valid documents recognized under State law.
Annual Report	The TPS and Payment Adjustment Report made available to agencies annually beginning in August of each year, starting in 2017. It contains the HHA's TPS based on complete performance year data (CY 2016 for Performance Year 1, CY 2017 for Performance Year 2, CY 2018 for Performance Year 3, CY 2019 for Performance Year 4, and CY 2020 for Performance Year 5). It also contains the APP that will be applied in the corresponding payment adjustment year.

Terminology	Definition
Baseline Score	For Medicare-certified HHAs participating in Medicare before January 1, 2015, the Baseline Score on the Interim Performance Report (IPR) and Annual TPS and Payment Adjustment Report is the agency's score on a measure during the baseline year which is typically calendar year 2015. • If the HHA does not have enough episodes to calculate a measure in 2015, data for the next available calendar year are used. • For agencies new in 2015, the first potential baseline year is calendar year 2016. Note that the OASIS-based outcome measures and claims-based measures in the HHVBP Model are risk-adjusted to account for differences in your agency as compared to other agencies.
Baseline Year	The reference year against which measure performance will be compared. The baseline year is determined for each measure. For most HHAs, Calendar Year (CY) 2015 is the baseline year for all performance years. The baseline year remains the same once established for a given measure. • For HHAs that are new to the Model (i.e., initially certified in 2015 through 2018), the baseline year is their first full calendar year of data that meets the minimum requirements to generate scores on five or more measures. o To receive a score on an OASIS-based or claims-based measure, the HHA must have a minimum of 20 home health quality episodes of care for the measure. o To receive a score on HHCAHPS measures, the HHA must have 60 or more unique eligible patients in the baseline year and a minimum of 40 completed HHCAHPS surveys • For the two measures added in the CY 2019 Final Rule, Total Normalized Composite (TNC) Change in Self-Care and TNC Change in Mobility, the first possible baseline year is CY 2017.
Benchmark	The performance measurement goal for HHAs. A measure's Benchmark is calculated as the mean of the best 10% (90th percentile) of all HHAs with sufficient data within a state in CY 2015, with the exception of the Total Normalized Composite (TNC) Change in Self-Care and TNC Change in Mobility measures in which CY 2017 data are used.
Care Points	As the TPS is calculated by using the greater of either the Achievement Points or Improvement Points for each measure, the "Care Points" on the IPR and Annual TPS and Payment Adjustment Report indicate whether Achievement Points or Improvement Points are greater for the measure.
CCN	A six-digit (all numeric) CMS Certification Number.
Cohort	A cohort is based on state and HHA size and is the group in which the individual HHA competes. If an HHA has fewer than 60 eligible unique HHCAHPS patients annually, then the HHA is identified as a "small" HHA. If a state has 8+ "small" HHAs, then two cohorts (i.e., one for small HHAs and one for large HHAs) are formed for each of these states. However, if a state has fewer than 8 HHAs that are identified as "small," then all HHAs in that state are assigned to a single cohort, (i.e. a single cohort that includes all HHAs in that state).

Terminology	Definition
Composite Measure	A measure based on combining different underlying data items.
CPOC	Corporate Point of Contact. This HHVBP Secure Portal role can view all information of the HHAs under the corporation.
CY	Calendar Year
Data Collection Period	The data collection period includes the dates in which HHAs collect data on the New Measures in the Model. Data collection periods are either quarterly or annually based upon the specific measure.
Data Entry Role	This **HHVBP Secure Portal** role can enter New Measure Data on behalf of the HHA but cannot submit data.
Data Submission Period	The New Measures in the HHVBP Model are submitted by HHAs via the **HHVBP Secure Portal** quarterly or annually based upon the specific measure. The data submission period extends for fifteen days after the end of each data collection period.
Experience of Care (HHCAHPS) Measures	Based on patient reporting and evaluation of health care experience; derived from Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey data.
HHA Performance Score	The HHA Performance Score on the Interim Performance Report (IPR) and Annual TPS and Payment Adjustment Report is the individual value for each measure for an agency's OASIS-based measures, HHCAHPS measures, and claims-based measures for the specific time period. Note that the OASIS-based and claims-based outcome measures are risk-adjusted to account for differences in your agency as compared to other agencies.
HH PPS	Home Health Prospective Payment System
HHA	Home Health Agency
HHVBP	Home Health Value-Based Purchasing
HHVBP Connect	The collaborative learning site where ongoing communication occurs among HHAs and training resources and event registration links are found.
HHVBP Secure Portal	HHAs must register for this site to submit New Measures data to CMS and to access the IPRs and Annual Reports.

Terminology	Definition
Improvement Points	Improvement Points on the Interim Performance Report (IPR) and the Annual TPS and Payment Adjustment Report are calculated for each agency's measures by comparing the agency's measure value in the performance year to its value in the baseline year and to the Benchmark value. The agency receives Improvement Points for a measure if the measure has improved since the baseline year, per the formula used to calculate Improvement Points (see the CY 2016 HH PPS Final Rule). The greater the improvement, the more improvement points are earned, up to a maximum of ten points for Performance Year 1 (CY 2016), Performance Year 2 (CY 2017), and Performance Year 3 (CY 2018). Beginning in Performance Year 4 (CY 2019), HHAs can earn up to a maximum of nine Improvement Points, with the exception of the Total Normalized Composite Change in Self-Care and Total Normalized Composite Change in Mobility measures, in which an HHA can earn up to 13.5 Improvement Points. The formula used to calculate Improvement Points for Performance Year 4 can be found in the CY 2019 HH PPS Final Rule. The maximum number of Improvement Points is earned if performance improves to the Benchmark or better. Agencies receive zero points for a measure if their performance on the measure is equal to or worse than their Baseline performance for that measure.
IPR	Interim Performance Report. Quarterly reports with Preliminary and Final versions based on the most recently available rolling 12-month data periods.
Medical Record	The home health agency's clinical record or electronic medical record.
New Measures	Measures not currently reported by Medicare-certified HHAs to CMS, but that may fill gaps in the National Quality Strategy (NQS) Domains not completely covered by existing measures in the home health setting. The three new quality measures, which HHAs now collect and submit, are Influenza Vaccination Coverage for Home Health Care Personnel, Herpes Zoster Vaccine, and Advance Care Plan.
Outcome Measures	Based on changes in patient health status between two time points that can be attributed to the health care provided; measurements derived from OASIS data or Medicare fee-for-service claims data.
Payer	Health care insurance coverage such as Medicare, Medicaid, managed care, etc.

<table>
<tr><th>Terminology</th><th>Definition</th></tr>
<tr><td>Percentile Ranking</td><td>
The percentile rankings reported on the Interim Performance Report (IPR) and Annual TPS and Payment Adjustment Report, enable HHAs to know how their performance compares to other HHAs within the same state and size cohort (if applicable). There are two types of percentile rank variables using the categories listed in the two tables below: 1) For the Total Performance Score and the Applicable Measures Final Weighted Score (AMFWS); 2) For the individual performance measures used in the Model. Note that for states with fewer than 8 small HHAs, the percentile ranking is based on how performance compares to other HHAs in the state, as there are not separate cohorts for small and large agencies.
Percentile Ranking reported for the Total Performance Score (TPS) and the Applicable Measures Final Weighted Score (AMFWS)
<table>
<tr><th>For Your State and Size Cohort, If Your HHA’s TPS Is:</th><th>Your HHA’s Percentile Ranking will be:</th></tr>
<tr><td>Equal to or greater than the 90th percentile score</td><td>90</td></tr>
<tr><td>Equal to or greater than the 75th percentile score AND less than the 90th percentile score</td><td>75</td></tr>
<tr><td>Equal to or greater than the 50th percentile score AND less than the 75th percentile score</td><td>50</td></tr>
<tr><td>Equal to or greater than the 25th percentile score AND less than the 50th percentile score</td><td>25</td></tr>
<tr><td>Equal to or greater than the 10th percentile score AND less than the 25th percentile score</td><td>10</td></tr>
<tr><td>Less than the 10th percentile score</td><td>0</td></tr>
</table>
Percentile Ranking Reported for the Individual Performance Measures
<table>
<tr><th>Interpretation</th><th>Percentile Ranking for Care Points</th></tr>
<tr><td>Indicates that your HHA is performing in the highest quartile for all HHAs in your cohort</td><td>75-99</td></tr>
<tr><td>Indicates that your HHA is performing in the second highest quartile for all HHAs in your cohort</td><td>50-74</td></tr>
<tr><td>Indicates that your HHA is performing in the second lowest quartile for all HHAs in your cohort</td><td>25-49</td></tr>
<tr><td>Indicates that your HHA is performing in the lowest quartile for all HHAs in your cohort</td><td>1-24</td></tr>
</table>
</td></tr>
<tr><td>Performance Year</td><td>A calendar year subsequent to the baseline year in which an HHA’s performance is reported.</td></tr>
<tr><td>POC</td><td>Point of Contact</td></tr>
<tr><td>PPOC</td><td>Primary Point of Contact. This HHVBP Secure Portal role understands the daily operations of the HHA; submits data and reviews performance reports; has authority to delegate/assign tasks; grants HHVBP Secure Portal access to the Data Entry, Reviewer and Secondary POC roles; has authority to submit recalculation and reconsideration requests.</td></tr>
</table>

Terminology	Definition
Process Measures	Evaluate the rate of HHAs' use of specific evidence-based processes of care. Measures are derived from OASIS data.
Quality Episode	In the calculation of OASIS-based measures, a quality episode begins with either a Start of Care (SOC) or Resumption of Care (ROC) and ends with a Transfer, Death, or Discharge for a patient regardless of the length of time between the start and ending events. OASIS quality episodes are not the same as payment or Prospective Payment System (PPS) episodes.
Raw Total Points (RTP)	Total of all Care Points for an individual HHA during the reporting period.
Recalculation Request	An agency may submit a recalculation request related to their Preliminary Interim Performance Report and Annual TPS & Payment Adjustment Report Preview Report. This request may be submitted if the HHA has proof that their agency's data are inaccurate. Recalculation requests may only be submitted via the **HHVBP Secure Portal**, and must be submitted within 15 days of when CMS publishes the report to the **HHVBP Secure Portal**.
Reconsideration Request	An agency may submit a reconsideration request if they have proof that their data on the Annual TPS & Payment Adjustment Report Preliminary Report are inaccurate. The reconsideration request must be submitted within 15 days of when CMS publishes the Preliminary Report to the HHVBP Secure Portal. An agency may request a reconsideration following a decision on that HHA's request for recalculation. Note that the Annual TPS & Payment Adjustment Report will have three versions. HHAs will first receive a *Preview Report*, then a *Preliminary Report*, and then a *Final Report* each year.
Reviewer	This **HHVBP Secure Portal** role acts as a quality check mechanism for the Data Entry role.
SPOC	Secondary Point of Contact. This HHVBP Secure Portal role acts as a proxy for the PPOC, reviewing and submitting HHA's New Measure data, and accessing and submitting recalculation requests for Interim Performance Reports (IPRs). The SPOC is unable to view the Annual TPS and Payment Adjustment Report.
Surrogate Decision Maker	A surrogate decision maker (also known as "Legal representative," "Agent," "Attorney in fact," "Proxy," "Substitute decision-maker") is a person designated and authorized by an advance directive or State law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.
Total Normalized Composite (TNC) Change in Mobility Measure	Measures the magnitude of change based on normalized total possible change across three OASIS-based Activities of Daily Living (ADL) items (M1840 Toilet Transferring, M1850 Bed Transferring, and M1870 Ambulation/Locomotion). This measure is calculated using episodes of care that begin with a SOC/ROC and end with a Discharge. Episodes of care that begin with a SOC/ROC and end with a Transfer are not included in the calculations since the Transfer does not include the M-items used in the measures.
Total Normalized Composite (TNC) Change in Self-Care Measure	Measures the magnitude of change based on normalized total possible change across six OASIS-based Activities of Daily Living (ADL) items (M1800 Grooming, M1810 Upper Body Dressing, M1820 Lower Body Dressing, M1830 Bathing, M1845 Toileting Hygiene, and M1870 Eating). This measure is calculated using episodes of care that begin with a SOC/ROC and end with a Discharge. Episodes of care that begin with a SOC/ROC and end with a Transfer are not included in the calculations since the Transfer does not include the M-items used in the measures. For more information, please refer to the *"HHVBP Technical Specification Resource for Composite Outcome Measures."*

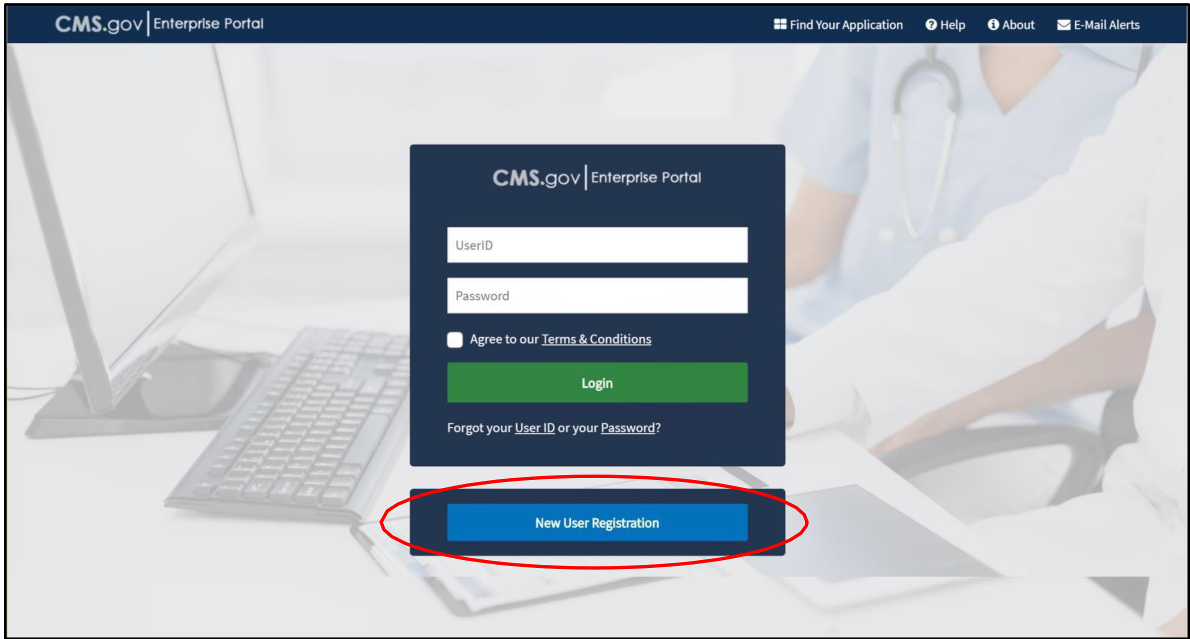
Terminology	Definition
Total Performance Score (TPS)	Score based on quality of care compared to others in their state AND their own past performance. TPS is determined using the higher of an HHA's Achievement or Improvement Points for each measure and calculated by summing the points for each measure and adjusting for number of measures available.

Appendix C: Screenshots for Creating an EIDM User ID and Requesting Access to the Innovation Center

This section provides information on how to register and create an EIDM User ID and password and request access to the Innovation Center. The following are the step-by-step instructions.

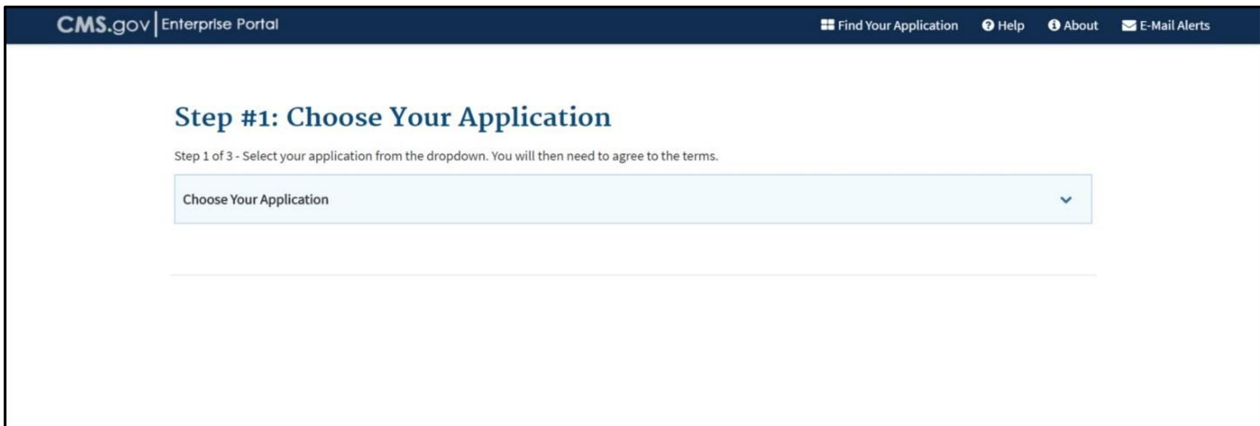
1. On the CMS Enterprise Portal landing page, click the **New User Registration** button.

Figure 1: New User Registration Button on Landing Page



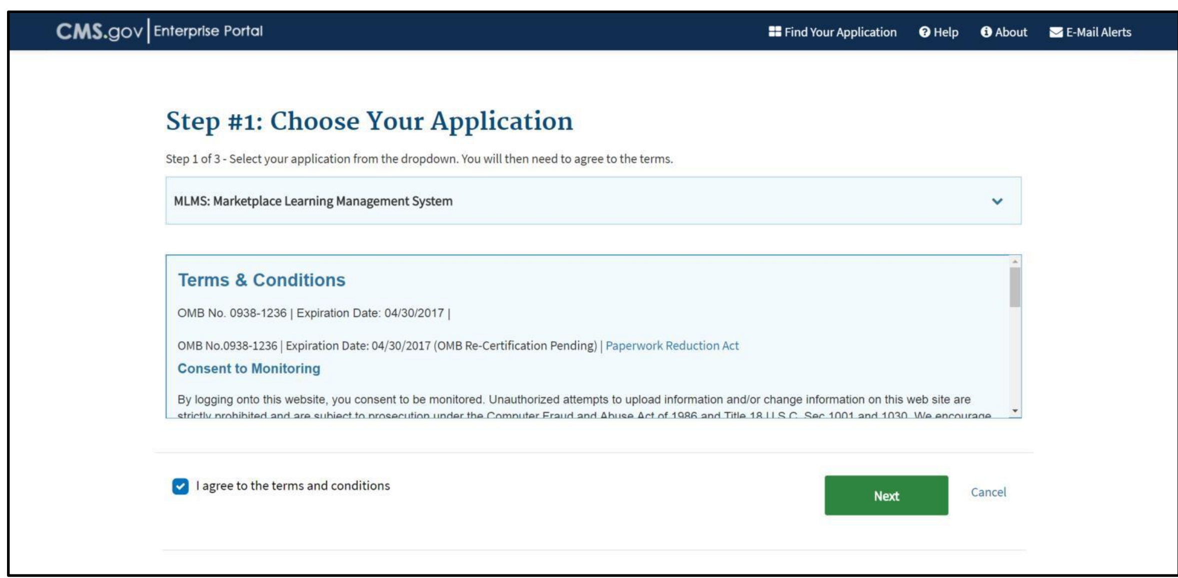
2. On **Step #1: Choose Your Application** page, select your application (IC – Innovation Center) from the **Choose Your Application** drop-down list

Figure 2: Step 1 of New User Registration – Choose Your Application



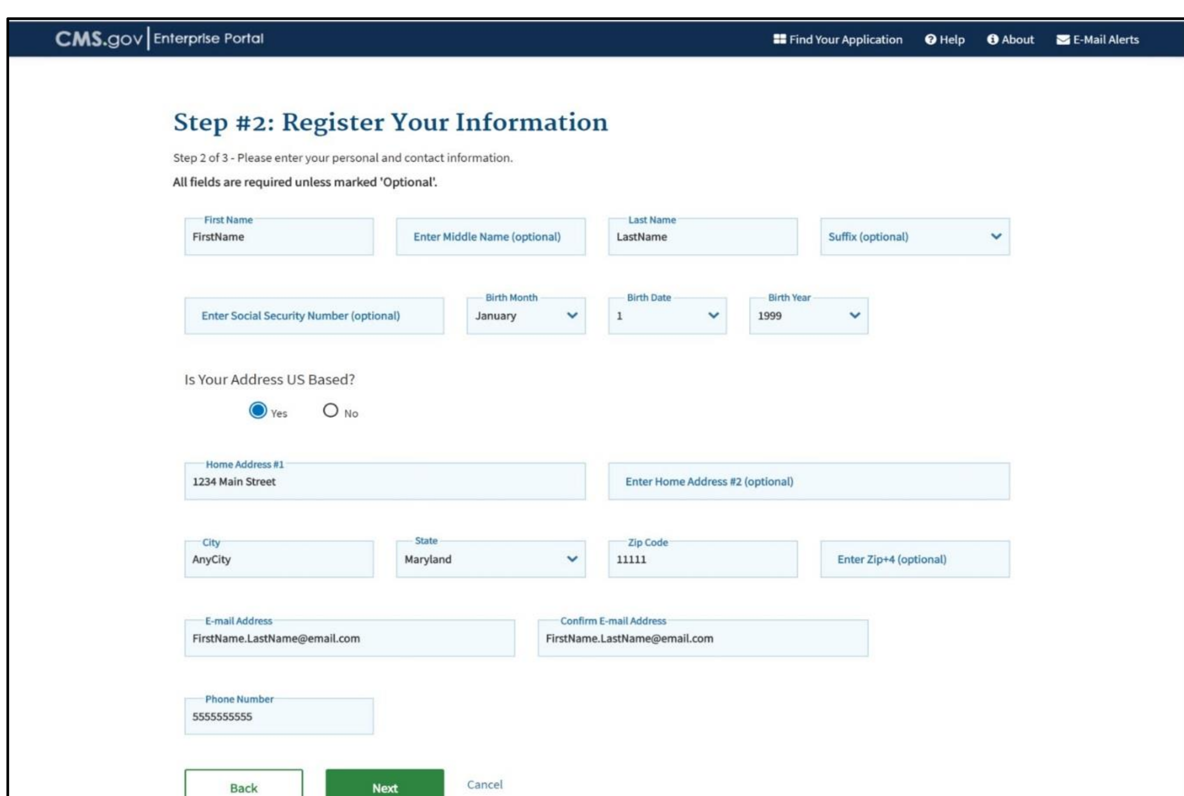
3. Read the Terms & Conditions, select **I agree to the terms and conditions**, and then click **Next** to continue with the registration process

Figure 3: Agree to Terms and Conditions



4. The **Step #2: Register Your Information** page displays. Provide the information requested on the **Step #2: Register Your Information** page. All fields are required and must be completed unless marked "Optional." After all required information has been provided, click **Next** to continue.

Figure 4: Step 2 of New User Registration - Register Your Information (Completed)

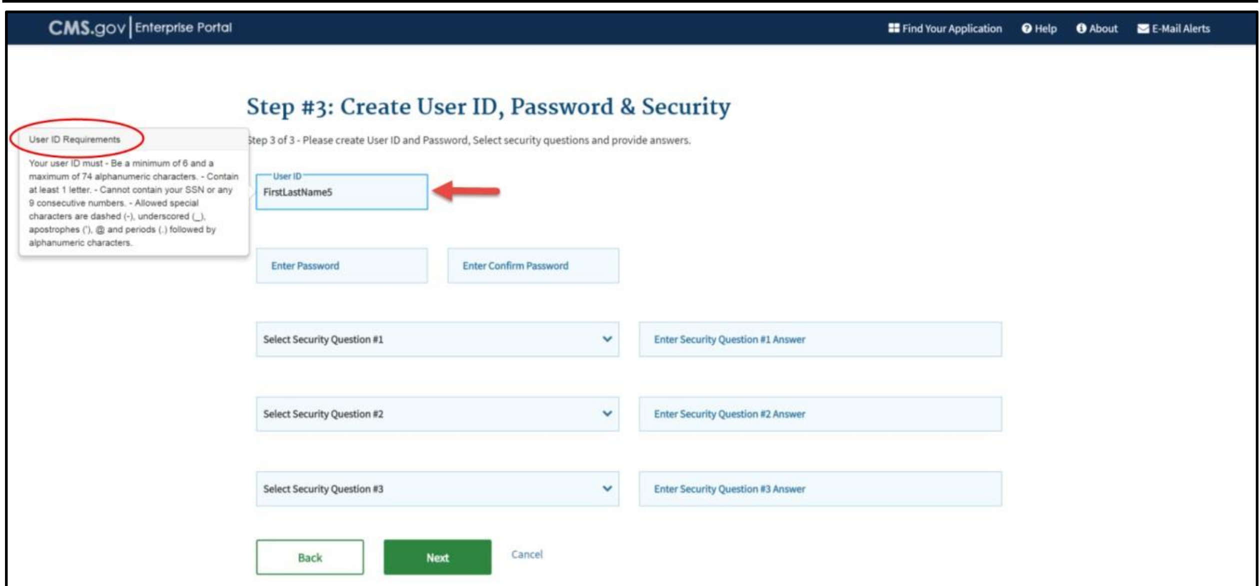


> ***Note:*** You may click **Cancel** at any time to exit out of the registration process. Changes entered will not be saved. To go to the previous step, click the **Back** button.

5. The **Step #3: Create User ID, Password & Security** page displays Create and enter a User ID in the **Enter User ID** field based on the requirements for creating a User ID.

Figure 5: Step 3 of New User Registration – User ID Entered

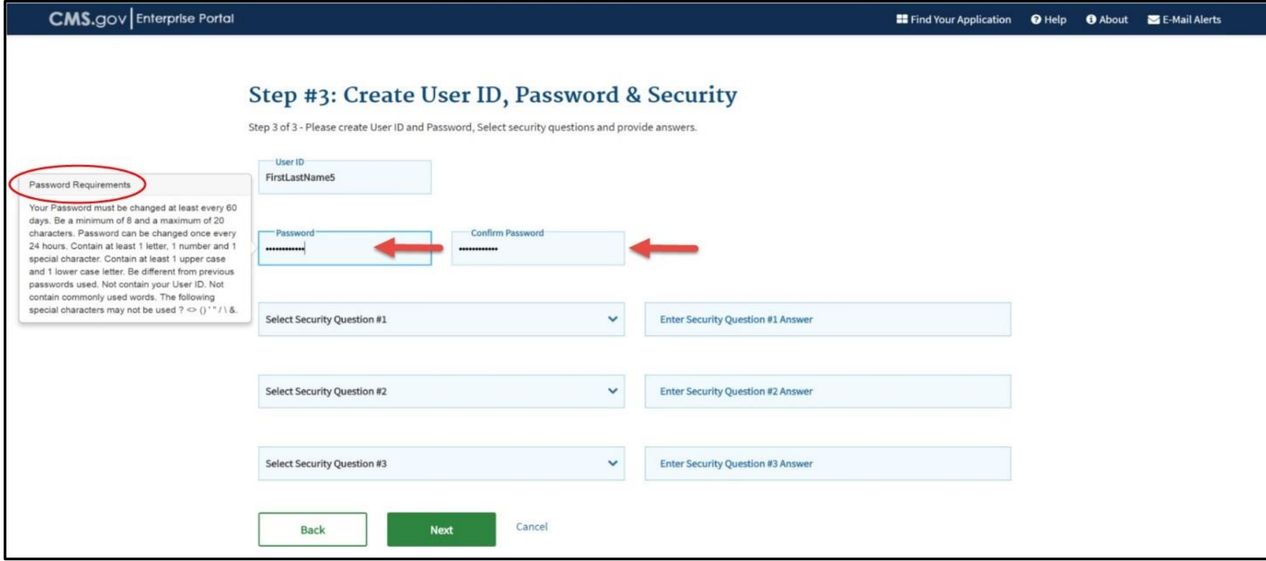
Note: Instructions are displayed, in the form of tool tip, on what you are required to include in your User ID.



6. Create and enter a password in the **Enter Password** field based on the requirements for creating a password. Enter the same password in the **Enter Confirm Password** field

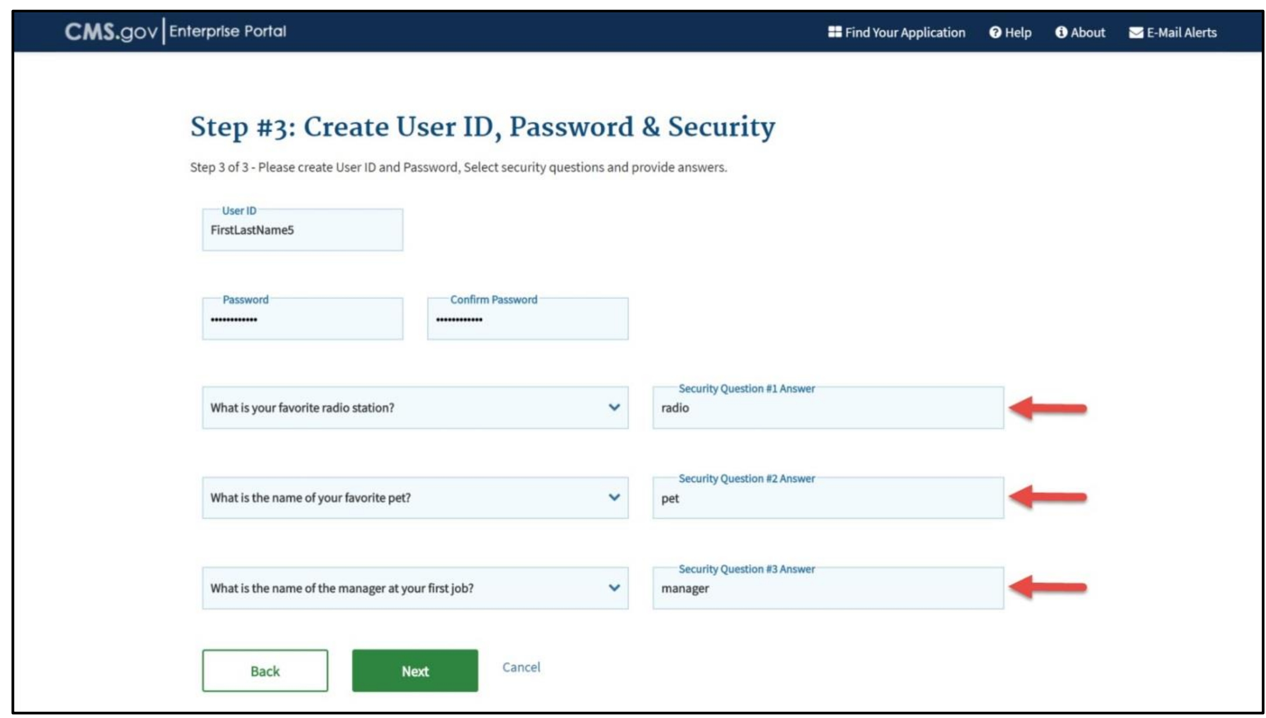
Figure 6: Step 3 of New User Registration – Password Entered

Note: Instructions are displayed, in the form of tool tip, on what you are required to include in your password.



7. After entering the user ID and password, select a question in the **Select Security Question #1** drop-down list and enter the answer you want to be saved with the question. Continue to select a question and enter an answer for Question #2 and Question #3. Click **Next** to complete the registration process.

Figure 7: Step 3 of New User Registration – Create User ID, Password & Security (Completed)


CMS.gov | Enterprise Portal
Find Your Application
Help
About
E-Mail Alerts
Step #3: Create User ID, Password & Security
Step 3 of 3 - Please create User ID and Password, Select security questions and provide answers.
User ID
FirstLastName5
Password
Confirm Password
What is your favorite radio station?
Security Question #1 Answer
radio
What is the name of your favorite pet?
Security Question #2 Answer
pet
What is the name of the manager at your first job?
Security Question #3 Answer
manager
Back
Next
Cancel

8. The **Registration Summary** page displays Review the information you entered, make any necessary changes and then click the **Submit User** button.

Figure 8: New User Registration – Registration Summary

CMS.gov | Enterprise Portal

Find Your Application | Help | About | E-Mail Alerts

Registration Summary

Please review your information and make any necessary changes before submitting.

All fields are required unless marked 'Optional'.

First Name: FirstName
Enter Middle Name (optional)
Last Name: LastName
Suffix (optional)

Enter Social Security Number (optional)
Birth Month: January
Birth Date: 1
Birth Year: 1999

Home Address #1: 1234 Main Street
Enter Home Address #2 (optional)

City: AnyCity
State: Maryland
Zip Code: 11111
Enter Zip+4 (optional)

E-mail Address: FirstName.LastName@email.com
Confirm E-mail Address: FirstName.LastName@email.com

Phone Number: 5555555555

User ID: FirstLastName5

Password: ••••••••••••
Confirm Password: ••••••••••••

What is your favorite radio station?
Security Question #1 Answer: radio

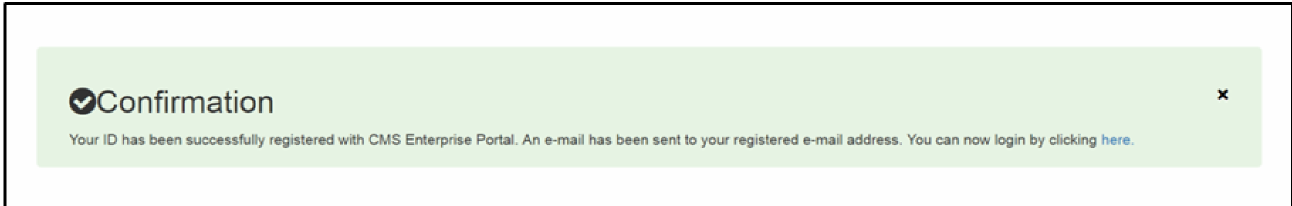
What is the name of your favorite pet?
Security Question #2 Answer: pet

What is the name of the manager at your first job?
Security Question #3 Answer: manager

Submit User | Cancel

9. The Confirmation page is displayed acknowledging your successful registration and informs you that you should receive an email with your User ID.

Figure 9: New User Registration – Confirmation



Appendix D: Screenshots for Requesting Access to the HHVBP Secure Portal Application

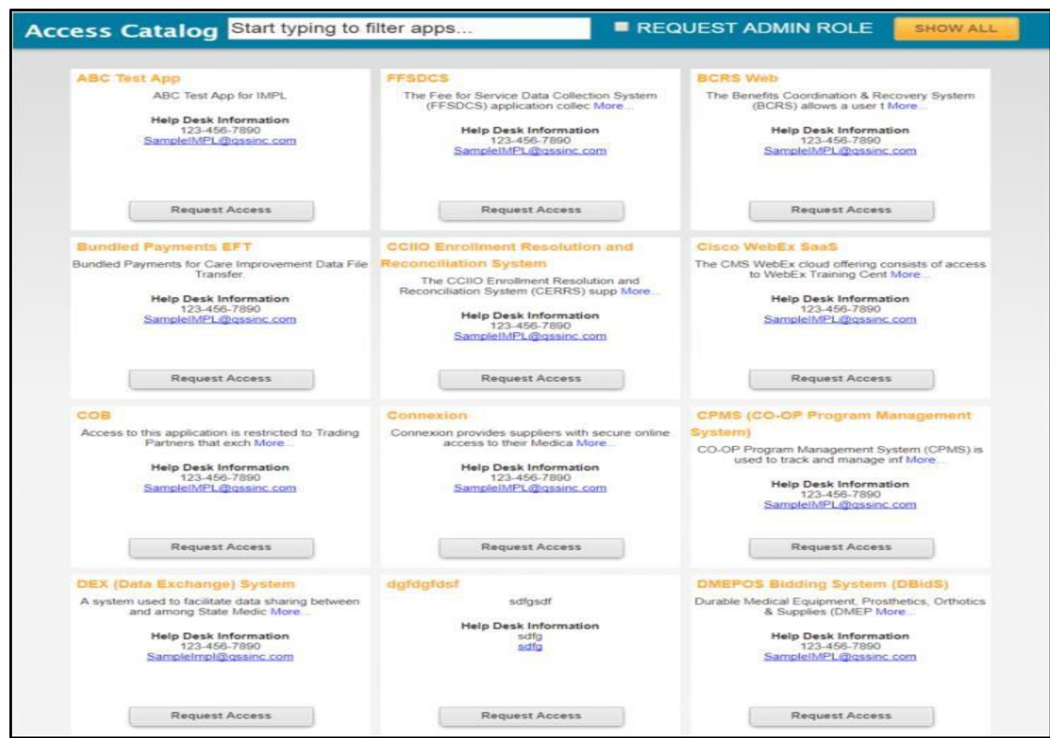
This section provides instructions on how to request access to the HHVBP Secure Portal application and a HHA role. Registered users can use the application Access Catalog to request access to CMS applications.

The catalog is accessed by selecting the **My Access** option from the Welcome drop-down list in the top navigation bar or by clicking the **Request/Add Apps** tile on the **My Portal** page.

Figure 1: Accessing the Application Catalog

The application **Access Catalog** displays all the CMS applications that use EIDM services.

Figure 2: Access Catalog Page



The features listed below refer to the numbered image shown in *Figure 3: Features of Access Catalog.*

1. **Request Access** – Request access to a particular application by clicking on the **Request Access** button on the application's tile.
2. **Search** – Search for a particular application by typing the name of the application in the search box on the **Access Catalog** title bar.
3. **My Access** – This panel displays information for each application for which the user has access including:
    a. Contact information for the application Help Desk.
    b. The existing roles the user has been granted for the application.
4. **Available Actions** – This panel appears for each application for which the user has access. The user can select from the following options:
    a. Add a Role – Directs the user to the **Request Additional Role** screen to request an additional role for the application.
    b. Remove a Role – Directs the user to the **View and Manage My Access** screen to remove a role from the application.
    c. Other Actions – Directs the user to the **View and Manage My Access** screen to select other options.
5. **My Pending Requests** – This section lists the pending requests for which the user has requested access.

Figure 3: Features of Access Catalog

Access Catalog | Start typing to filter apps... | REQUEST ADMIN ROLE | SHOW ALL

ABC Test — ABC Test App for IMPL — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

FFSDCS — The Fee for Service Data Collection System (FFSDCS) application collec More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

BCRS Web — The Benefits Coordination & Recovery System (BCRS) allows a user t More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

Bundled Payments EFT — Bundled Payments for Care Improvement Data File Transfer — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

CCIIO Enrollment Resolution and Reconciliation System — The CCIIO Enrollment Resolution and Reconciliation System (CERRS) supp More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

Cisco WebEx SaaS — The CMS WebEx cloud offering consists of access to WebEx Training Cent More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

COB — Access to this application is restricted to Trading Partners that exch More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

Connexion — Connexion provides suppliers with secure online access to their Medica More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

CPMS (CO-OP Program Management System) — CO-OP Program Management System (CPMS) is used to track and manage inf More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

DEX (Data Exchange) System — A system used to facilitate data sharing between and among State Medic More... — Help Desk Information 123-456-7890 Sampleimpl@qssinc.com — Request Access

dgfdgfdsf — sdfgsdf — Help Desk Information sdfg sdfg — Request Access

DMEPOS Bidding System (DBidS) — Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEP More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

EIDM — EIDM Application — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

EIDM Reports — The EIDM Reports application provides access to various EIDM reports w More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

EIDM Weblogic System Access(EWLSA) — EWLSA Application will provide EIDM Weblogic console access for OIM, O More... — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Request Access

My Access

FFM/Training – Agents/Brokers/Assisters — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Check Agent Broker Registration Status — Existing Roles: Training Access — Available Actions: Add Role, Remove Role, Other Actions

HIOS — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Existing Roles: HIOS User — Available Actions: Add Role, Remove Role, Other Actions

IC — Help Desk Information More... — Existing Roles: Innovation Center Privileged User, Innovation Center Report User, Innovation Center User, Innovation Center Application Approver — Available Actions: Add Role, Remove Role, Other Actions

Open Payments — Help Desk Information 123-456-7890 SampleIMPL@qssinc.com — Existing Roles: Applicable Manufacturer, GPO, Physician or Teaching Hospital; DMSTR (for use by government staff only); AMSTR (for use by government staff only) — Available Actions: Add Role, Remove Role, Other Actions

My Pending Requests

You do not have any pending requests at this time.

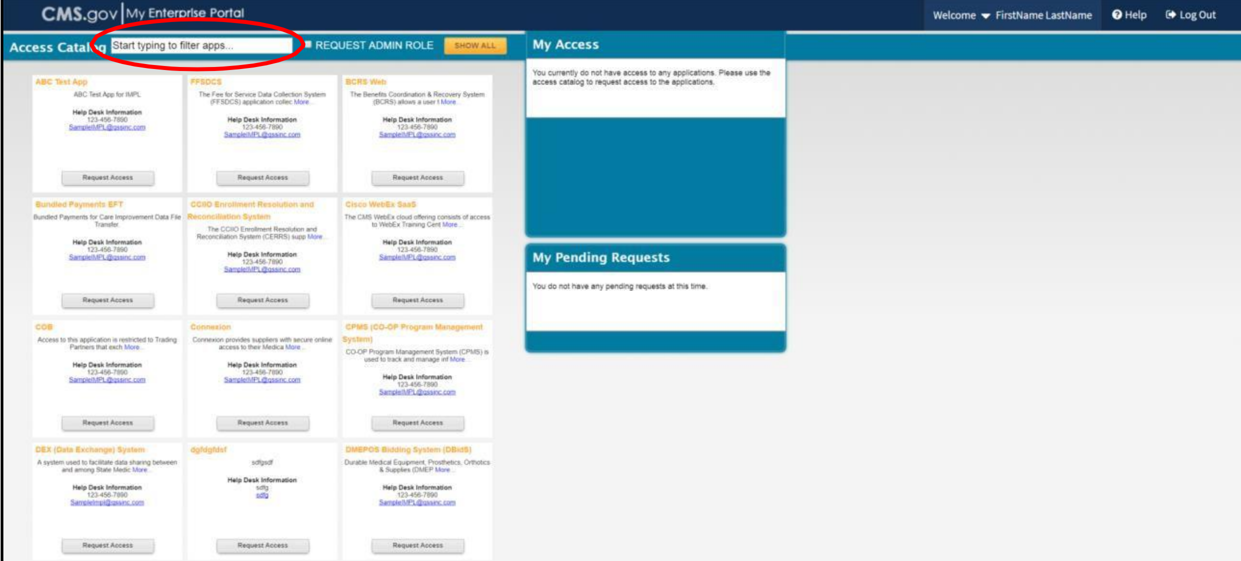
Appendix E: Screenshots for Requesting Access to a Role on the HHVBP Secure Portal

The following are the instructions on how to request access to an application and a role when you currently do not have a role in the application.

1. Navigate to the CMS Enterprise Portal landing page.
2. Login using your User ID and password.
3. On the **My Portal** page, as shown in *Appendix D*, *Figure 1: Accessing the Application Catalog*, select the **My Access** option from the Welcome drop-down list in the top navigation bar. Alternatively, click **Request/Add Apps** to continue.
4. On the **Application Catalog** page, scroll down to locate the application you need. Alternatively, enter the first few letters of the application in the Search section and all of the applications beginning with those letters will display, as shown in *Figure 1: Searching for an Application.*

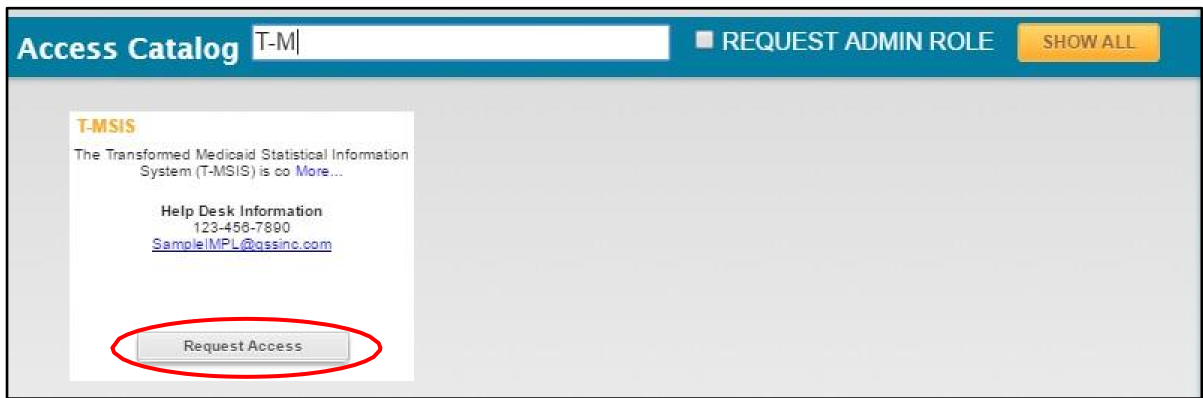
Note: If you currently have access to one or more applications, they display in the My Access panel. If you have pending requests, they display in the **My Pending Requests** panel.

Figure 1: Searching for an Application



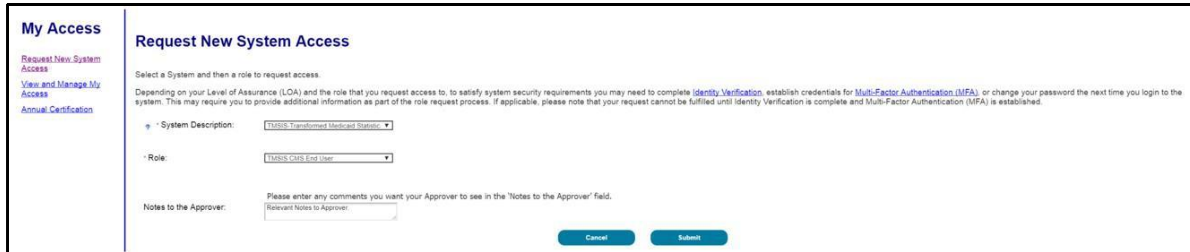
5. Click **Request Access** for the IC – Innovation Center application.

Figure 2: Requesting Access for an Application



6. The **Request New System Access** page displays. Click **Submit** to submit the request for approval. If you select a role that requires identity verification, the Identify Verification page is displayed.

Figure 3: Request New System Access Page



Appendix F: Step by Step Guide to Download Your Reports

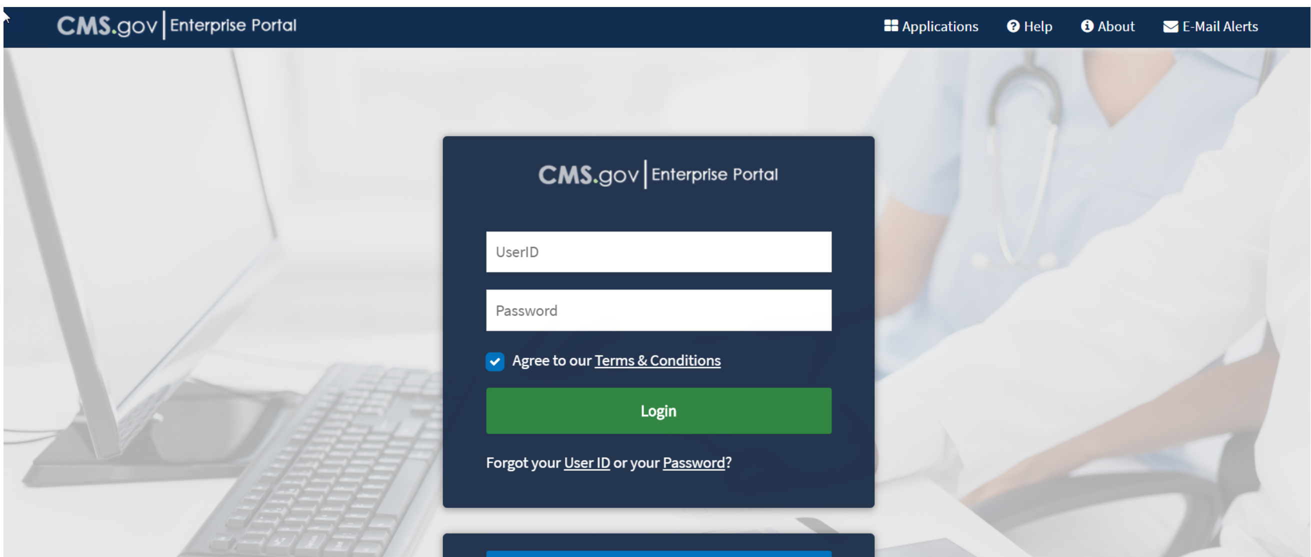
To access your Interim and Annual Performance Reports, you must have access to the HHVBP Secure Portal as a PPOC, CPOC, or Secondary POC. To access your Annual Reports, you must have access to the HHVBP Secure Portal as a PPOC or CPOC.

If you experience difficulty downloading your report, contact the HHVBP Technical Support Help Desk at 1-844-280-5628. The Collaboration Sites Business Operations Support Center (CBOSC) is available to answer your questions Monday through Friday, 8:30 AM to 6 PM ET, except federal holidays.

Part 1: Downloading Your Report

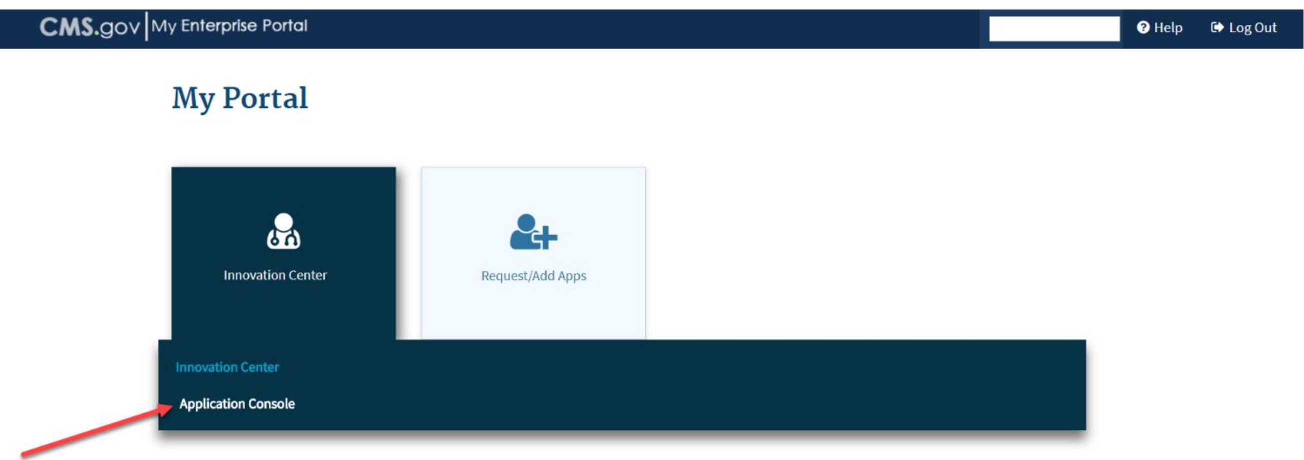
1. Log into the CMS Enterprise Portal.

Figure 1: CMS Enterprise Portal Login Screen



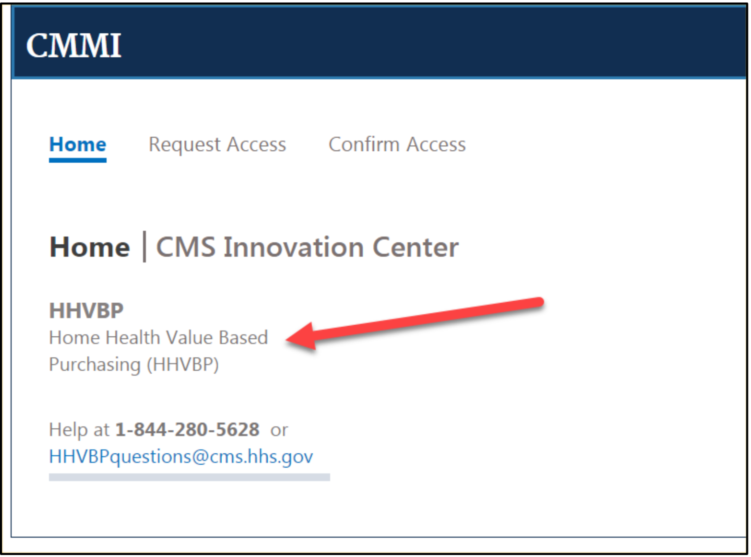
2. Select “Application Console” under Innovation Center dropdown menu.

Figure 2: Innovation Center Menu



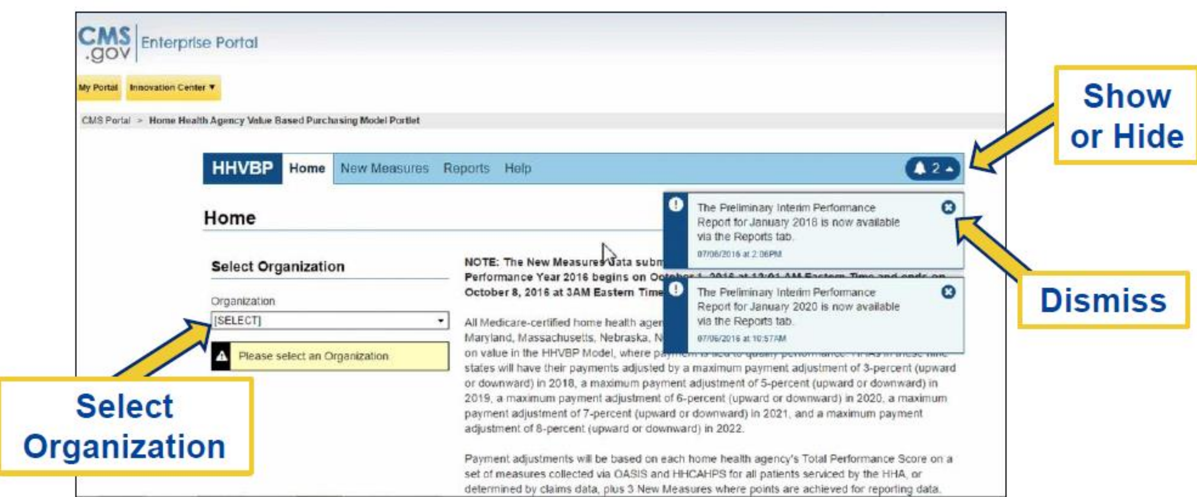
3. Click “HHVBP” to enter the HHVBP Secure Portal.

Figure 3: HHVBP Application



4. When you start the application, you will land on the Home screen. Any notifications will display on the right, which you can hide or show by clicking the Bell icon in the upper right hand corner of the screen. Select your organization from the drop down menu on the left.

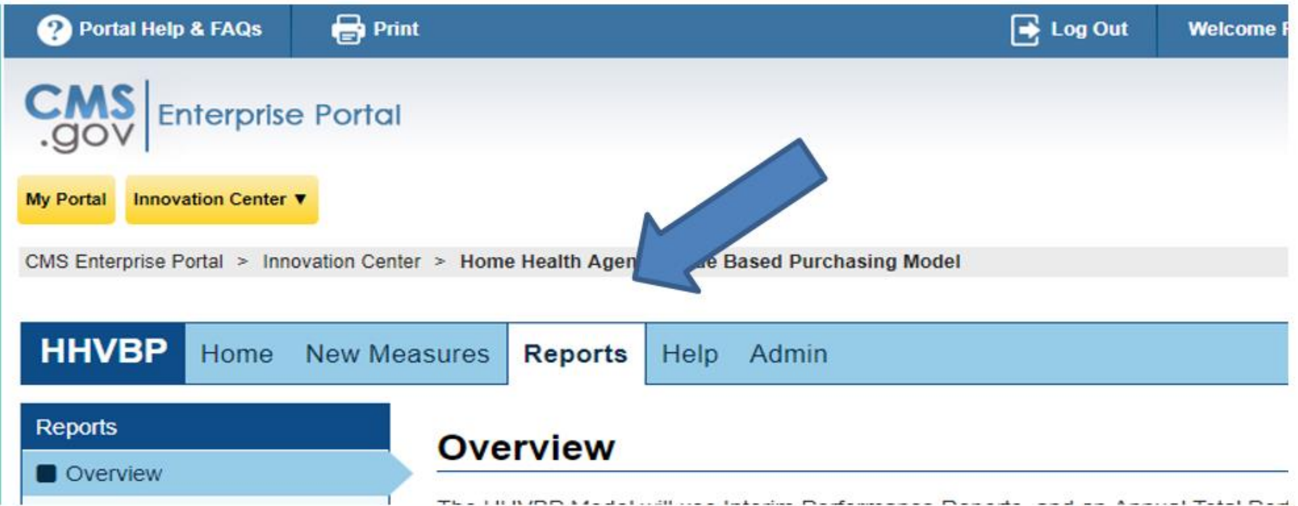
Figure 4: HHVBP Application Home Screen



Tip: Hide and show your notifications by clicking on the arrow next to the Bell icon in the upper right of your screen

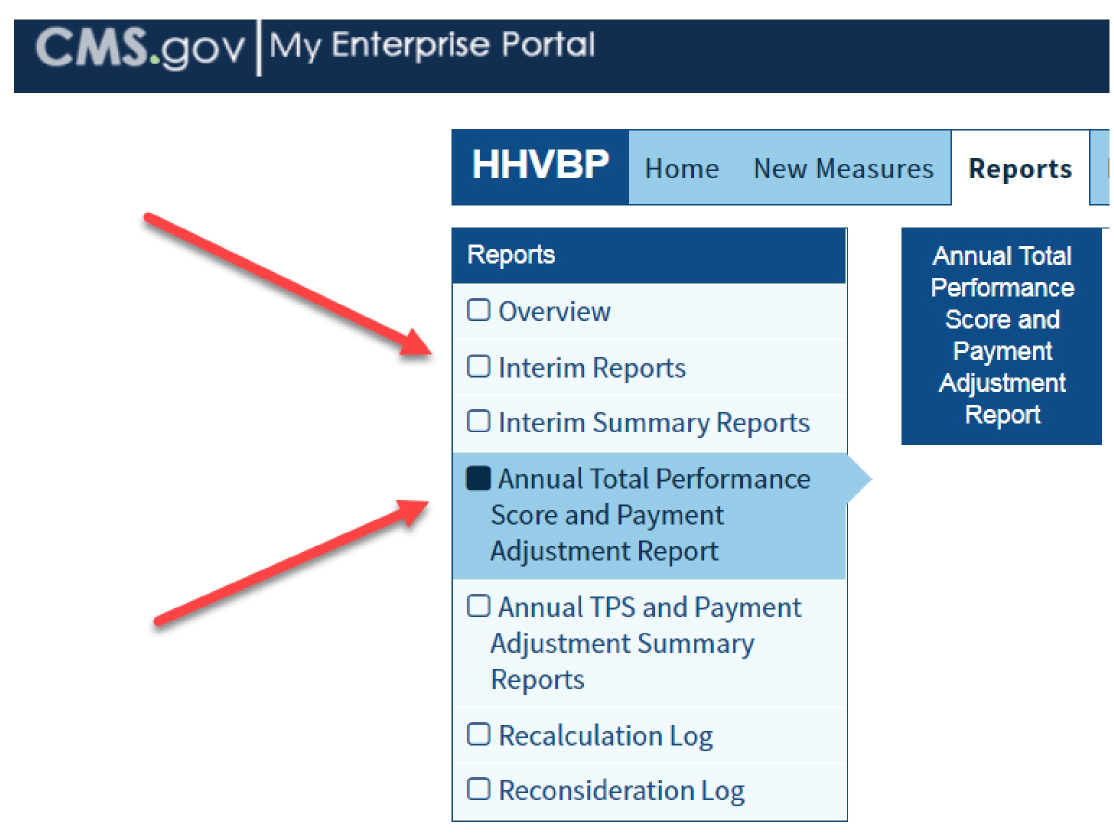
5. Navigate to the “Reports” tab.

Figure 5: Reports Tab



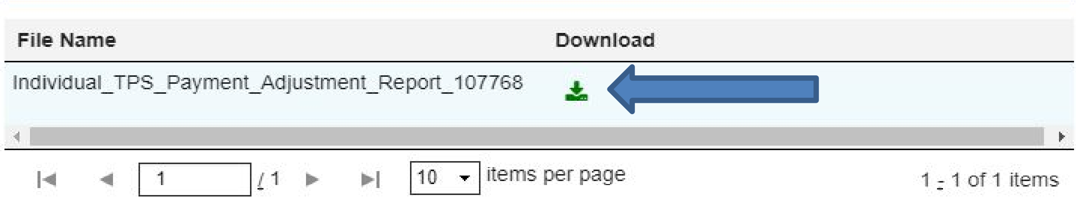
6. Select the report you want to view:
   a. To view your IPR, select **“Interim Reports”**
   b. To view your Annual Report, select “Annual Total Performance Score and Payment Adjustment Report”

Figure 6: Reports Tab (Cont.)



7. Scroll to the bottom of the Achievement Points page and click on the green "Download" icon.

Figure 7: Downloading Your Report



8. Open downloaded file in Excel.

Part 2: Printing Your Report

Follow the steps below if you would like to print each worksheet (tab) individually. This ensures that all the worksheet's data is on a single page. Please note that screenshots are taken from Microsoft Excel 2017. Your reader may look different, but the print settings should apply.

1. Navigate to the worksheet (tab) you wish to print.

Figure 1: Choose the Report Tab

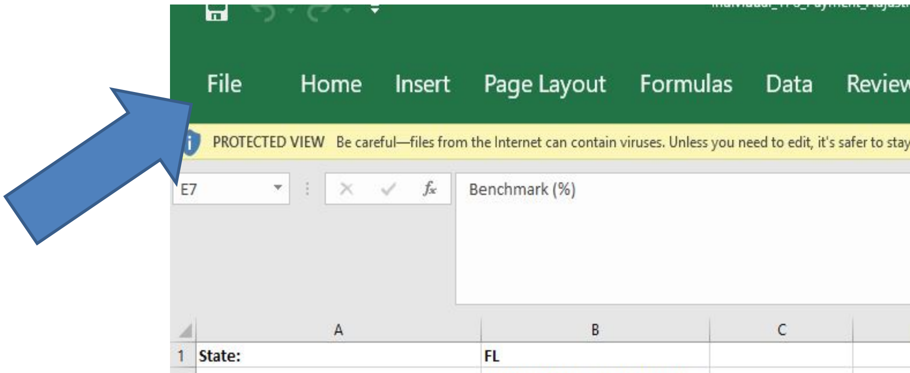
12	Adjusted Payment Percentage	-0.1%			
13					
14			Payment Adjustment Calc		
15		Step 1 (C1)	Step 2 (C2)	Step 3 (C3)	Step 4 (C4)
16		Total Performance Score (TPS)	Prior Year Payment	Unadjusted Payment Amount 3% x (C2)	TPS-Adjusted Payment Amount (C1/100) x (C3)

... Improvement | Care Points | New Measures | TPS | Payment Adjustment

Enter

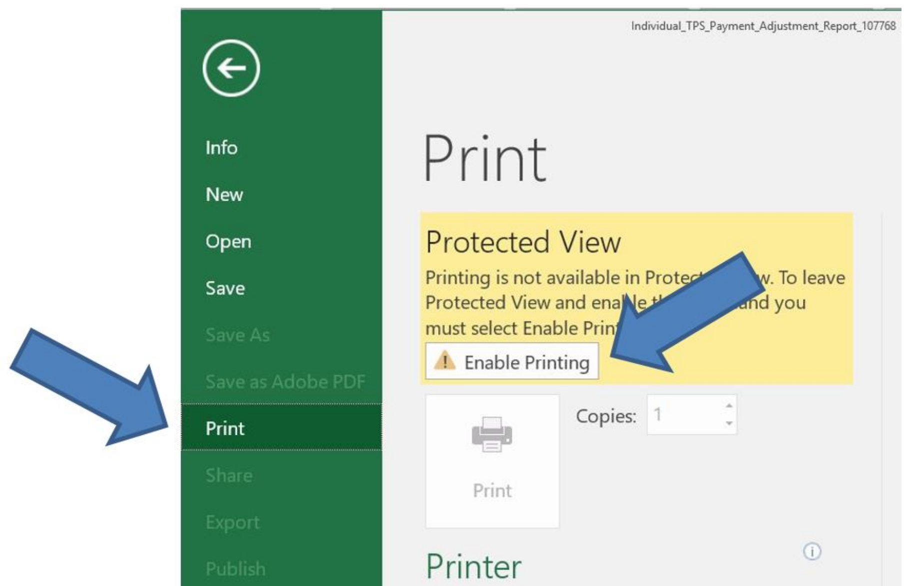
2. Click "File" to navigate to settings

Figure 2: Navigate to the File Tab



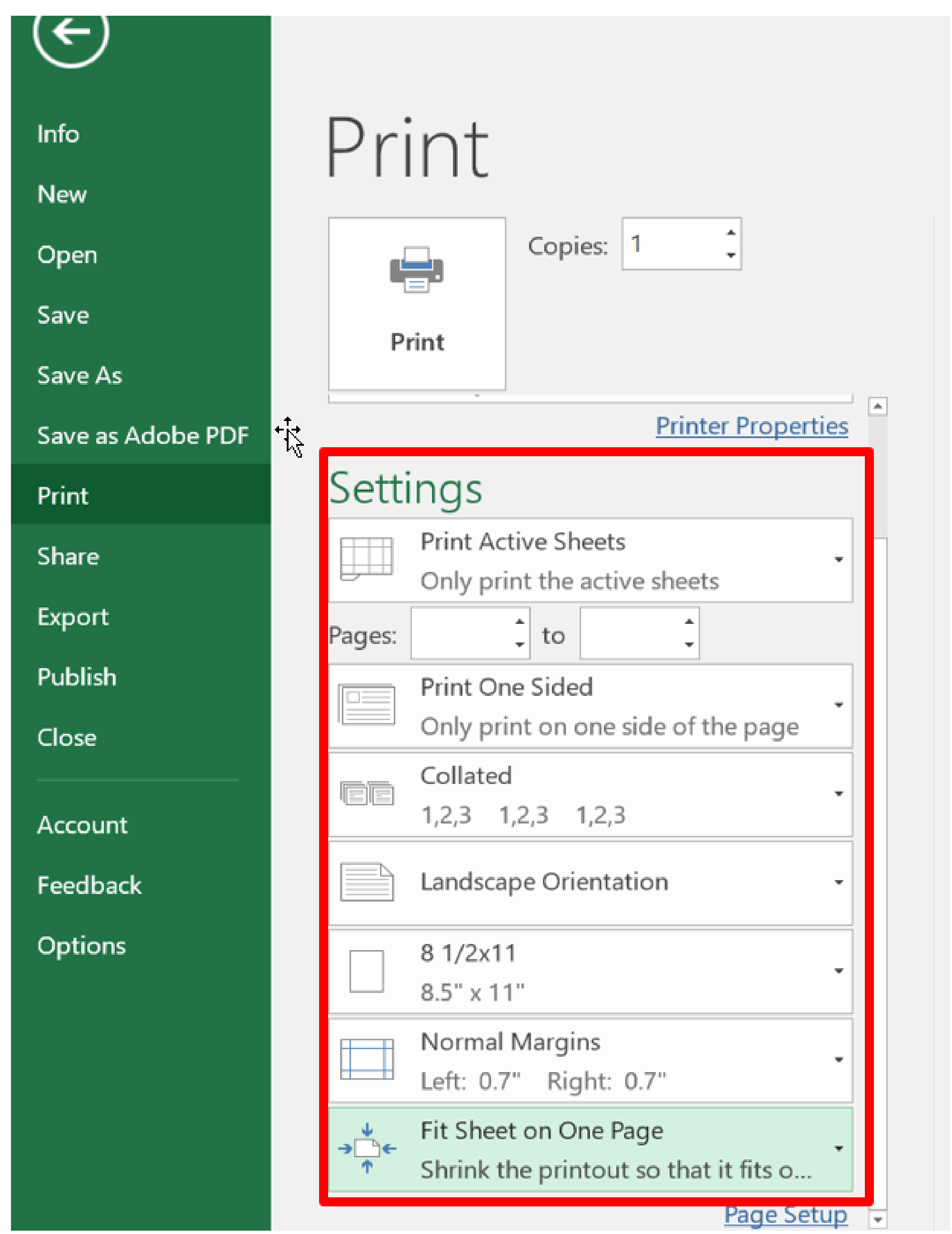
3. Click "Print" to navigate to printer settings. If your document is in Protected View, click "Enable Printing."

Figure 3: Click Printer Settings



4. Ensure the following print settings are selected:
    a. Print Active Sheets
    b. Print One Sided
    c. Collated
    d. Landscape Orientation
    e. Letter
    f. Normal Margins
    g. Fit Sheet on One Page

Figure 4: Select Your Printer Settings



5. Click "Print"

Appendix G(a): Applicable Measure Set Beginning Performance Year 4

NQS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Clinical Quality of Care	Improvement in Dyspnea	Outcome	NA	OASIS (M1400)	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.
Communication & Care Coordination	Discharged to Community	Outcome	NA	OASIS (M2420)	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.
Efficiency & Cost Reduction	Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health	Outcome	NQF0171	CCW (Claims)	Number of home health stays for patients who have a Medicare claim for an unplanned 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.
Efficiency & Cost Reduction	Emergency Department Use without Hospitalization	Outcome	NQF0173	CCW (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.
Patient Safety	Improvement in Pain Interfering with Activity	Outcome	NQF0177	OASIS (M1242)	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.

NQS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Patient Safety	Improvement in Management of Oral Medications	Outcome	NQF0176	OASIS (M2020)	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.
Patient & Caregiver-Centered Experience	Care of Patients	Outcome		CAHPS	NA	NA
Patient & Caregiver-Centered Experience	Communications between Providers and Patients	Outcome		CAHPS	NA	NA
Patient & Caregiver-Centered Experience	Specific Care Issues	Outcome		CAHPS	NA	NA
Patient & Caregiver-Centered Experience	Overall rating of home health care	Outcome		CAHPS	NA	NA
Patient & Caregiver-Centered Experience	Willingness to recommend the agency	Outcome		CAHPS	NA	NA

NQS Domains	Measure Title	Measure Type	Identifier	Data Source	Numerator	Denominator
Population/ Community Health	Influenza Vaccination Coverage for Home Health Care Personnel	Process	NQF0431 (Used in other care settings, not Home Health)	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 previously 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.
Population/ Community Health	Herpes zoster (Shingles) vaccination: Has the patient ever received the shingles vaccination?	Process	NA	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.
Communication & Care Coordination	Advance Care Plan	Process	NQF0326	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 G(b): Applicable Measure Set Beginning Performance Year 4

NQS Domains	Measure Title	Measure Type	Identifier	Data Source	Measure Computation**	Risk Adjustment**
Patient and Family Engagement	Total Normalized Composite Change in Self-Care	Composite Outcome	NA	OASIS (M1800) (M1810) (M1820) (M1830) (M1845) (M1870)	The total normalized change in self-care functioning across six OASIS items (grooming, bathing, upper & lower body dressing, toilet hygiene, and eating)	A prediction model is computed at the episode level. The predicted value for the HHA and the national value of the predicted values are calculated and are used to calculate the risk-adjusted rate for the HHA, which is calculated using this formula: HHA Risk Adjusted = HHA Observed + National Predicted – HHA Predicted.
Patient and Family Engagement	Total Normalized Composite Change in Mobility	Composite Outcome	NA	OASIS (M1840) (M1850) (M1860)	The total normalized change in mobility functioning across three OASIS items (toilet transferring, bed transferring, and ambulation/locomotion)	A prediction model is computed at the episode level. The predicted value for the HHA and the national value of the predicted values are calculated and are used to calculate the risk-adjusted rate for the HHA, which is calculated using this formula: HHA Risk Adjusted = HHA Observed + National Predicted – HHA Predicted.

*NOTES: For more detailed information on the measures using OASIS refer to the OASIS-C2 Guidance Manual effective January 1, 2017 available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-C2-Guidance-Manual-6-29-16.pdf. Please also refer to the CMS website for guidance on the OASIS dataset, available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.html.

For NQF endorsed measures see The NQF Quality Positioning System available at http://www.qualityforum.org/QPS. For non-NQF measures using OASIS see links for data tables related to OASIS measures at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/index.html. For information on HHCAHPS measures see https://homehealthcahps.org/SurveyandProtocols/SurveyMaterials.aspx.

** Because the Total Normalized Composite Change in Self-Care and Mobility measures are composite measures rather than simply outcome measures, the terms “Numerator” and “Denominator” do not apply.

Appendix H: HHVBP Performance Years 1-3 Measure Weights vs. Performance Years 4-5 Measure Weights, effective January 1, 2019[123]

	Performance Years 1 – 3 Measure Weights				Performance Years 4-5: Measure Weights			
	All Measures (n=1,026)	No HHCAHPS (n=465)	No claims (n=20)	No claims or HHCAHPS (n=99)	All Measures (n=1,026)	No HHCAHPS (n=460)	No claims (n=20)	No claims or HHCAHPS (n=73)
OASIS-Based Measures								
Flu vaccine ever received	6.25%	9.09%	7.14%	11.11%	0.00%	0.00%	0.00%	0.00%
Pneumococcal vaccine	6.25%	9.09%	7.14%	11.11%	0.00%	0.00%	0.00%	0.00%
Improvement in bathing	6.25%	9.09%	7.14%	11.11%	0.00%	0.00%	0.00%	0.00%
Improvement in bed transfer	6.25%	9.09%	7.14%	11.11%	0.00%	0.00%	0.00%	0.00%
Improvement in ambulation	6.25%	9.09%	7.14%	11.11%	0.00%	0.00%	0.00%	0.00%
Improve oral meds	6.25%	9.09%	7.14%	11.11%	5.00%	7.14%	7.69%	14.28%
Improve Dyspnea	6.25%	9.09%	7.14%	11.11%	5.00%	7.14%	7.69%	14.28%
Improve Pain	6.25%	9.09%	7.14%	11.11%	5.00%	7.14%	7.69%	14.28%
Discharged to community	6.25%	9.09%	7.14%	11.11%	5.00%	7.14%	7.69%	14.28%
TNC Change in Self-Care	0.00%	0.00%	0.00%	0.00%	7.50%	10.71%	11.53%	21.42%
TNC Change in Mobility	0.00%	0.00%	0.00%	0.00%	7.50%	10.71%	11.53%	21.42%
Total weight for OASIS measures	**56.25%**	81.82%	64.26%	100.00%	**35.00%**	49.98%	53.82%	99.96%
Claims-Based Measures								
Hospitalizations	6.25%	9.09%	0.00%	0.00%	26.25%	37.50%	0.00%	0.00%
Outpatient ED	6.25%	9.09%	0.00%	0.00%	8.75%	12.50%	0.00%	0.00%
Total weight for claims measures	**12.50%**	18.18%	0.00%	0.00%	**35.00%**	50.00%	0.00%	0.00%
HHCAHPS Measures								
Care of patients	6.25%	0.00%	7.14%	0.00%	6.00%	0.00%	9.23%	0.00%
Communication between provider and patient	6.25%	0.00%	7.14%	0.00%	6.00%	0.00%	9.23%	0.00%
Discussion of specific care Issues	6.25%	0.00%	7.14%	0.00%	6.00%	0.00%	9.23%	0.00%
Overall rating of care	6.25%	0.00%	7.14%	0.00%	6.00%	0.00%	9.23%	0.00%
Willingness to recommend HHA to family or friends	6.25%	0.00%	7.14%	0.00%	6.00%	0.00%	9.23%	0.00%
Total weight for HHCAHPS measures	**31.25%**	0.00%	35.70%	0.00%	**30.00%**	0.00%	46.15%	0.00%

[1] Under the weights for PYs 4-5, the weights of the measure categories, when one category is removed, are based on the relative weight of each category when all measures are used. For example, if the two measure categories, Claims and OASIS, are expressed then each category represents 50% because each of these categories has the same weight (35%) when all 3 categories are represented (the OASIS percentage is shown as 49.98% in Table 49 due to rounding). However, if only OASIS and HHCAHPS are expressed, OASIS represents 53.82% while HHCAHPS represents 46.15%, which represents the same relative proportion as 35% and 30%, the OASIS and HHCAHPS weights, respectively, when all three categories are present.

[2] The flu vaccine ever received and pneumococcal polysaccharide vaccine measures are finalized to be removed from the applicable measure set beginning in CY 2019/Performance Year 4.

[3] The Improvement in Bathing, Improvement in Bed Transfer and Improvement in Ambulation measures are finalized to be removed from the applicable measure set and replaced with the two new composite measures beginning in CY 2019/PY4. These new composite measures (TNC Change in Self-Care and TNC Change in Mobility) will be weighted 1.5 times more than the other OASIS-based measures so that the total weight for the functional-based OASIS measures is unchanged.

Appendix I: Data Included in the 2018 HHVBP Reports

Report (Date First Reported)	OASIS-Based Measures	Utilization and HHCAHPS-Based Measures	New Measures: Advance Care Plan and Herpes Zoster Vaccination	New Measure: Staff Influenza Vaccination
January 2018 IPR	12 months ending **9/30/2017**	12 months ending **6/30/2017**	Quarter ending **9/30/2017** (Data Submitted: October 2017)	**10/1/2016-3/31/2017** (Data Submitted: April 2017)
April 2018 IPR	12 months ending **12/31/2017**	12 months ending **9/30/2017**	Quarter ending **12/31/2017** (Data Submitted: January 2018)	**10/1/2016-3/31/2017** (Data Submitted: April 2017)
July 2018 IPR (July 2018)	12 months ending **3/31/2018**	12 months ending **12/31/2017**	Quarter ending **3/31/2018** (Data Submitted: April 2018)	**10/1/2017-3/31/2018** (Data Submitted: April 2018)
Annual TPS and Payment Adjustment Report (Aug 2018)	12 months ending **12/31/2017**	12 months ending **12/31/2017**	12 months ending **12/31/2017**	**10/1/2016-3/31/2017** (Data Submitted: April 2017)
Oct 2018 IPR (Oct 2018)	12 months ending **6/30/2018**	12 months ending **3/31/2018**	Quarter ending **6/30/2018** (Data Submitted July 2018)	**10/1/2017-3/31/2018** (Data Submitted: April 2018)