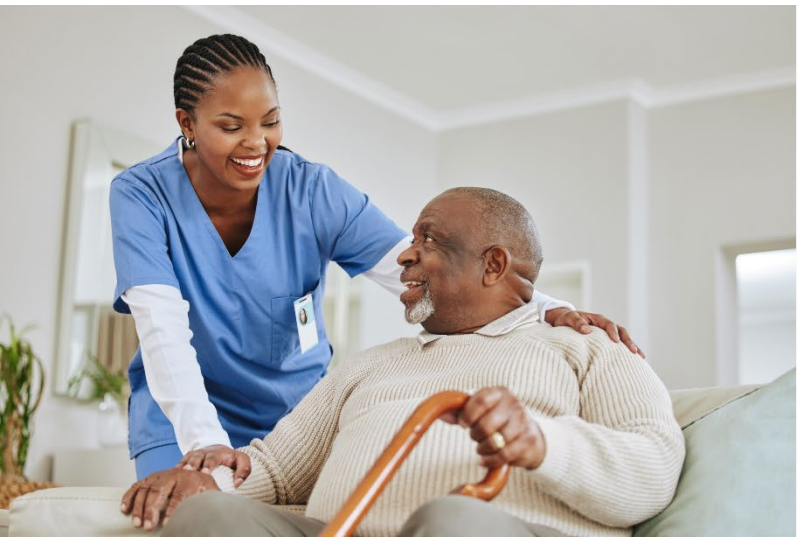
2024 Technical Expert Panel Meetings

Expanded Home Health Value-Based Purchasing Model Summary Report



February 2025

Prepared for:
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Glossary of Acronyms

ACH	Acute Care Hospitalization
ADI	Area Deprivation Index
APR	Annual Performance Report
HHCAHPS	Home Health Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DES	Dual eligible status
DC	Discharge
DTC	Discharge to Community
ED	Emergency department
FFS	Fee-for-service
GUIDE	Guiding an Improved Dementia Experience
HARP	Health Care Quality Information Systems (HCQIS) Access Roles and Profile
HHA	Home health agency
HHVBP	Home Health Value-Based Purchasing
IPR	Interim Performance Report
iQIES	Internet Quality Improvement & Evaluation System
MA	Medicare Advantage
MSPB	Medicare Spending Per Beneficiary
OASIS	Outcome and Assessment Information Set
PAC	Post-acute care
PDC	Provider Data Catalog
PPH	Potentially preventable hospitalization
QRP	Quality Reporting Program
REUP	Rewarding Excellent Care For Underserved Populations
SDOH	Social Determinants of Health
SNF	Skilled nursing facility
RUCA	Rural-Urban Community Area
SVI	Social Vulnerability Index
TEP	Technical Expert Panel
TPS	Total Performance Score
VBP	Value-Based Payment

1. Background

Introduction

The Centers for Medicare & Medicaid Services (CMS) contracted with Abt Associates (Abt) to support the implementation of the Home Health Value-Based Purchasing (HHVBP) Model, including the development of refinements to the measures and scoring methodology, first for the original Model, which ran from 2016-2020[1], and now for the expanded HHVBP Model, which started in calendar year (CY) 2022.[2] The original HHVBP Model operated in nine states (Arizona, Florida, Iowa, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington), while the expanded Model includes HHAs nationwide.

The contract name is Quality Reporting Program (QRP) and Value-Based Purchasing (VBP): Quality Measures and Assessment Instruments Development and Maintenance. The contract number is 75FCMC18D0014, Task Order number 75FCMC24F0011. The expanded HHVBP Model Technical Expert Panel (TEP) included experts from the home health setting specializing in quality assurance, patient advocacy, clinical work, and measure development. Abt convened the TEP for two virtual meetings in 2024, one on June 14 and the other on December 10. The virtual meetings covered potential future performance measures and public reporting of data from the expanded HHVBP Model. This report provides an overview of the topics discussed over these two meetings and a summary of feedback from the TEP members.

TEP Responsibilities

The TEP was convened to provide expert input regarding the needs of the home health populations, especially those that have traditionally been underserved in these settings. Specifically, the TEP was charged with the following:

- Review relevant materials (e.g., a summary of findings from analyses of measures, a summary of public comments in response to a Notice of Proposed Rulemaking).
- Provide input and advice to the implementation contractor on potential changes to the measures and scoring methodology used in the expanded HHVBP Model.
    - Discuss quality measure concerns, such as face validity and feasibility.
    - Provide input on measure concepts.
    - Provide input on potential changes to measure weights
- Collaboratively consider previously gathered relevant information and public comments to assess the validity and feasibility of proposed refinements to the expanded HHVBP Model.

[1] The original HHVBP Model ended one year early, as CMS did not use data from calendar year 2020 to calculate a payment adjustment for calendar year (CY) 2022.

[2] During CY 2022, CMS provided HHAs with resources and training, to allow HHAs time to prepare and learn about the expectations and requirements of the expanded HHVBP Model without risk to payments. The first full performance year for the expanded HHVBP Model is CY 2023.

- Ensure that refinements to the measures and scoring methodology used in the expanded HHVBP Model are meaningful for the home health populations and transparent to providers in these settings.

The TEP is expected to continue meeting in the future to provide input on potential refinements to the expanded HHVBP Model.

TEP Composition

Abt followed the Measures Management System Blueprint to form the TEP. Recruitment began in August 2023 with a 4-week call for potential members to submit nominations. CMS disseminated the call for TEP members through their webpage and various stakeholder listservs to solicit nominations from a diverse group of experts, including home health clinicians and staff, patient advocates, caregivers, methodologists, and researchers. Among the nominees, Abt selected 14 individuals from diverse backgrounds, reflecting a range of perspectives and expertise. All selected nominees agreed to serve on the TEP. The final TEP included members from 11 states and the District of Columbia. Members bring experience in clinical work, patient advocacy, quality improvement, and research. Five TEP members have current or past experience as a family caregiver to patients receiving home health. Additionally, at least one TEP member has personally received home health. Table 1 presents the name and a brief profile of each TEP member. For a detailed background of each TEP member, please see Appendix A.

Table 1: List of TEP Members

Name	State	Relevant Experience and Areas of Expertise	Current or Past Experience as a Family Caregiver
Alicia Arbaje, MD, MPH, PhD, FACP	Maryland	Geriatrician, professor, and health services researcher; collaborated with academic- and community-based HHAs for 20+ years (as a researcher and as a practicing clinician); currently serves as Medical Director for HHA	Yes
Dawnita Brown, MA, MS, CCC, CCE, CCF	Maryland	Family caregiver with extensive experience; founder of several organizations focused on caregiving	Yes
April Coxon, RN, CLHP	Texas	RN with 23 years of chronic disease management and performance improvement experience; Executive Vice President of Quality at HHA (Healing Hands Healthcare); Current Chair of the Education Committee for TAHC&H (Texas Association of Home Care & Hospice) and an active member of NAHC (National Association of Home Care & Hospice); PQM selected PRMR (Pre-Rulemaking Measure Review) Committee member for Post Acute Care	
Shekinah Fashaw-Walters, PhD, MSN	Pennsylvania	Health services researcher, professor, and consultant; expertise with health equity and structural racism in home health, post-acute, and long-term care	Yes
Kathleen Holt, MBA, JD	Connecticut	Acting Healthcare Advocate, State of Connecticut; former Associate Director of the Center for Medicare Advocacy; Medicare patient advocate; legal expertise in Medicare coverage	

Name	State	Relevant Experience and Areas of Expertise	Current or Past Experience as a Family Caregiver
Cindy Krafft, PT, MS, HCS-O	Georgia	PT with 25+ years of home health experience; educator on OASIS data collection; expertise on stabilization of function	
Terri Lindsey, RN, BSN, COS-C, CPHQ	Virginia	RN with 38 years' experience; Quality Outcomes Specialist at HHA (Bon Secours Mercy Health Home Health and Hospice, Richmond, VA)	Yes
Trudy Mallinson, PhD, OTR/L, FACRM, FAOTA, NZROT	Washington, DC	Occupational Therapist, professor, and health services researcher; expertise in quality measures development in post-acute care	Yes
Tracy Mroz, PhD, OTR/L, FAOTA	Washington	Occupational Therapist, professor, and health services researcher; expertise in access to and quality of home health care for Medicare beneficiaries, including in rural settings	
Dana Mukamel, PhD, MS	California	Distinguished Professor and health services researcher; expertise in QMs for long-term care providers and investigating the impact in terms of behavior, quality, and cost	
Eugene Nuccio, PhD	Colorado	Health services researcher and retired professor; expertise in OASIS and QM development	
Zainab Osakwe, PhD, MSN, NP, RN	New York	PhD-trained nurse, health services researcher, and professor; experienced as a home health nurse, administrator, and leader, with expertise in OASIS	
Steven Pamer, PT, MPA, CGS	Ohio	HHA Administrator & Director of Rehabilitation Services (Cleveland Clinic Home Health Care)	
Madeline Sterling, MD, MPH, MS	New York	General internist and health services researcher; expertise in improving patient outcomes in HH; Director, Home Care and Home Health Care Workers Initiative, Cornell University, Ithaca, NY	

The TEP convened for two virtual meetings during 2024. The subsequent sections of this report provide an overview of the topics discussed over the course of these meetings and a summary of feedback from the TEP members.

2. Performance Measures

Background

A comprehensive review conducted by ASPE identified several objectives for HHVBP measures.

- Broad measure set to captures the complexity of the HHA services
- Flexibility to use IMPACT Act cross-setting measures
- Develop second-generation measures of patient outcomes, health and functional status, shared decision making, and patient activation
- Include balance of process, outcome, and patient experience measures
- Advance the ability to measure cost and value
- Add measures for appropriateness or overuse
- Promote infrastructure investments.

The TEP were asked to consider these objectives during their discussion. The performance measure discussion focused on potential measures that CMS may wish to start using in HHVBP. The discussion included several potential future quality measures:

- ***Measures for Underserved Populations:*** CMS is considering refinements to the HHVBP model designed to reduce avoidable differences in health outcomes for people who are disadvantaged or underserved. The TEP discussed several possible ways of defining underserved populations, including dual eligible status (DES), the Area Deprivation Index (ADI), and whether Medicaid is the sole payor source for the patient. The TEP considered using CMS's Rewarding Excellent Care For Underserved Populations (REUP) for the HHVBP Expanded model to reward providers that deliver high quality care to high percentages of underserved populations.

- ***Caregiver Measures***: The TEP discussed the caregiver measure being developed for CMS's Guiding an Improved Dementia Experience (GUIDE) Model and whether a similar measure would be appropriate for HHVBP. The TEP discussed the potential use of the 22-item Zarit Burden Interview (ZBI-22). The TEP also discussed changes that would need to be made to the OASIS instrument to collect the information needed for an OASIS-based caregiver measure.

- ***Function Measures***: The TEP discussed several options for function measures to add to HHVBP to complement the existing Discharge Function Measure. Options that were discussed included adding the Improvement in Bathing (based on OASIS M1830), Improvement in Upper Body Dressing (based on OASIS M1810), and Improvement in Lower Body Dressing (based on OASIS M1820) measures starting in 2026, waiting until Section GG-based bathing and/or dressing items are available before adding new function measures to HHVBP, or not adding any additional functional measures to HHVBP.

- ***Medicare Spending Per Beneficiary (MSPB):*** The TEP also discussed potentially adding the Medicare Spending per Beneficiary measure to the HHVBP applicable measure set. MSPB is a risk-adjusted and payment-standardized measure of how much Medicare spends on an episode of care at an HHA compared to the national average. MSPB was identified as a potential metric of utilization and efficiency, helping to identify HHAs' ability to address patient care needs at lower costs. The potential benefits of a MSPB measure for HHVBP include filling a potential measure gap related to cost, value, and efficiency; using a measure that is familiar to providers; making it easier for providers to have sufficient data for five measures so they can receive a payment adjustment; and that the measure could be added to HHVBP as early as 2026. However, the TEP was asked to weigh these potential benefits against concerns that were previously raised in public feedback about the extent to which the MSPB measure is under HHA's control.

Summary of Feedback

The TEP provided feedback on potential development of measures targeted underserved populations, potential development of a family caregiver measure, the addition of function measures, and the potential addition of a Medicare spending per beneficiary (MSPB) measure the measure set for the expanded HHVBP Model.

Measures for underserved populations

The TEP generally supported including one or more measures based on performance for underserved patients although the TEP discussion was more focused on how to define and measure the underserved population than on the specific measures that would be used.

While dual-eligible status (DES) was presented as one way to define the underserved population, some TEP members expressed concern about using DES. Specifically, TEP members suggested that DES may not be sufficient on its own and may warrant supplementary characteristics to define the underserved population. Some TEP members pointed out potential data accuracy concerns, as DES may be based on enrollment in traditional Medicare and not include Medicare Advantage enrollees. The Area Deprivation Index (ADI) was presented as another possible metric for defining underserved populations. A few TEP members expressed concern about whether ADI adequately captures underserved groups in rural areas. We discussed some ways to potentially address these concerns, such as using only certain variables from the ADI that are most relevant to home health and/or using the Centers for Medicare and Innovation's version of the ADI (once it becomes available), which may be a better fit. TEP members encouraged CMS to consider including a regional factor in addition to the insurance payer and local ADI factors for defining the underserved population. One TEP member suggested a composite measure of underserved patients that would use DES, ADI, and select OASIS social determinants of health (SDOH) and cognitive items.

Some TEP members pointed out that we lack data on certain dimensions of underserved populations, such as which patients are being turned away from services or the percentages of placement of referrals. The TEP discussed the possibility of identifying potential barriers to receiving care, such as appropriate linguistic and cultural availability of home health providers.

Some TEP members expressed concerns about HHAs cherry-picking their patients to receive better TPS performance. They noted that based on Abt's presented data, HHAs with no Medicaid received higher average TPS than HHAs with those patients. Performance measures that focus only on the underserved populations might incentivize HHAs to select or reject patients in order to boost their measure performance. Additionally, some individuals on the TEP suggested distinguishing between HHAs that don't have any Medicaid patients because there aren't any in their service area and those that could provide care to Medicaid patients in their service area but are not. One related suggestion was to explore a 'home health referral region' measure, which would be similar to the hospital referral regions created by the Dartmouth Atlas of Health Care.

Some TEP members highlighted the importance of distinguishing between for profit, not-for-profit, and hospital-based agencies, which may differ with respect to their willingness to accept Medicaid and self-pay patients. They said that identifying differences between provider characteristics may help CMS to better define measures to incentivize the desired outcomes. Some TEP members suggested incorporating measures about the types of facilities or health systems that are referring underserved patients.

Caregiver measures

The TEP was broadly supportive of future development of a family caregiver measure. They provided multiple suggestions for how CMS could approach family caregiver measures for HHVBP.

TEP members generally felt that it would be important to collect data on caregiver burden and stress as part of a caregiver measure. Specifically, TEP members suggested that it would be valuable to measure caregiver burden beyond what is already measured by OASIS item M2102.

The TEP discussed the possibility of aligning with the GUIDE Model, which is considering using the 22-item Zarit Burden Interview (ZBI-22), either in whole or in part, to develop caregiver measures for GUIDE. However, TEP members cautioned against adding too many new items to the OASIS instrument, citing concerns about survey burden. They also pointed out that it takes time to add items to OASIS. Alternatively, TEP members suggested exploring using the caregiver item from HHCAHPS in HHVBP.[3] They observed that using the HHCAHPS caregiver item would circumvent potential issues with lengthy additions to OASIS.

TEP members also suggested measuring utilization of home health aides and social workers. They felt that home health aide and social worker utilization could be an important part of validating the caregiver measure, to help identify whether caregivers are being used as a substitute for home health aides.

Some TEP members felt that risk adjustment of a caregiver measure would be very important. They said that the kinds of care or the kinds of help that caregivers need depends on the type of patient they care for. They emphasized that we have insufficient data on cognitive conditions and that there might be other diagnoses or categories for which more data is needed.

Function measures

The TEP agreed that additional function measures to complement the DC Function Measure would be valuable. All of the TEP members that provided input on the topic supported CMS moving ahead as quickly as possible to add bathing and dressing function measures to complement the DC Function measure. This would mean using the existing M-based items while GG-based measures are being developed. Abt already has data for the M-based bathing and dressing measures, and could promptly use that data to incorporate those measures into HHVBP. Once GG-based measures have been developed, the TEP expressed that those GG-based measures would be even more useful than M-based measures.

Medicare Spending Per Beneficiary (MSPB)

TEP members were split on whether the expanded HHVBP Model should use the MSPB measure. Two TEP members voiced strong support, and several others expressed concerns with the measure. Supporters argued that MSPB would reward HHAs that efficiently manage patient needs. They also noted that the measure would be easy to add because it relies on Medicare claims data that are already collected.

TEP concerns about the MSPB measure included the extent to which the measure is under HHAs' control. Given the nature of the Home Health Patient-Driven Groupings Model, under which payments are based on measure of patient needs and characteristics rather than service utilization, there was concern about HHAs' ability to control Medicare spending levels by how they manage patient care needs within the episode of care. Some TEP members also voiced concerns about how CMS would define the "right" amount that should be spent per patient. They worried that if the MSPB measure incentivized HHAs to spend less per patient, it could become a "race to the bottom", with HHAs cutting care without

[3] "In the last 2 months of care, did home health staff from this agency provide your family or friends with information or instructions about your care as much as you wanted?"

considering beneficiary outcomes. One TEP member also pointed out that for-profit agencies already have strong incentives to spend efficiently, and therefore MSPB may not be necessary.

3. Public Reporting

Background

One of the goals of the expanded HHVBP Model is to enhance the current public reporting process. Through rulemaking, CMS finalized its proposal to publicly report data from the expanded HHVBP Model on or after December 1, 2024. Note that this date is after the Final Annual Performance Reports are made available to participating HHAs. The Rule specified that these data elements would be publicly reported on a "CMS website":

- Benchmarks and achievement thresholds
- For each HHA that qualified for a payment adjustment based on the data for the applicable performance year—
    - Applicable measure results and improvement thresholds;
    - The HHA's Total Performance Score (TPS)
    - The HHA's TPS Percentile Ranking
    - The HHA's payment adjustment for a given year
    - CMS finalized through rulemaking to publicly report this information on or after December 1, 2024.

Consistent with public reporting for other CMS value-based purchasing programs, CMS publicly reports 2023 performance year data from APRs for the 2023 performance year on the CMS Provider Data Catalog (PDC). The data were made available on the PDC in January 2025.

Summary of Feedback

The TEP discussion focused on potential reporting of data from the expanded HHVBP Model on CMS's Care Compare website. While Care Compare reports performance measure values, it does not report benchmarks, achievement thresholds, care points, or payment adjustment amounts for any value-based purchasing program. The TEP discussed the potential use of HHVBP-based icons on Care Compare. Icons could be used, for example, to identify HHAs with improvement or decline in performance (e.g., based on Improvement Points) or to identify HHAs with a positive payment adjustment. The use of icons would require addressing several technical issues, including the time period used to measure change in performance, the level of change required to identify HHAs with improvement or decline in performance, the minimum performance level required for HHAs that receive an improvement icon, and whether to measure change based on the TPS or individual performance measures.

For reporting data on Care Compare, several TEP members expressed concern about the timeframe reflected in the data. They noted that the data to be reported on the PDC in January 2025 is based on the 2023 performance year and may not be a reflection of their current level of quality. They suggested using data from the Interim Performance Reports, which present more current data, for Care Compare reporting. They expressed concern that the different time periods covered by the IPRs and the other quality measures reported on Care Compare might create confusion for consumers, potentially resulting in inconsistencies between 5-star ratings and HHVBP-based icons. They also noted that the 2025 changes to the measure set for the expanded HHVBP Model may also create confusion for consumers.

Additional feedback on the potential use of HHVBP-based icons on Care Compare was that the icons should be used to recognize positive achievements (e.g., improvement over time and/or a high level of performance). They expressed concern about using negative icons, for example to identify HHAs with declines in performance.

Some TEP members suggested the creation of an achievement-based "badge of excellence" to denote agencies that are already providing high-quality care and have little room to improve. They felt such a badge, combined with star ratings, would help consumers better understand HHA performance. They acknowledged that the criteria for a "badge of excellence" would need to be defined, which would require addressing a number of important technical details.

Appendix A: TEP Member Bios

- **Alicia Arbaje, MD, MPH, PhD, FACP** is a geriatrician, health services researcher, and Associate Professor of Medicine/Director of Transitional Care Research at the Johns Hopkins University School of Medicine. She is also Medical Director for Johns Hopkins Care at Home, the HHA affiliated with Johns Hopkins Medicine. She applied to the TEP to bring attention to issues relevant to the needs of older adults, their caregivers, and the home-based providers that serve them.
- **Dawnita Brown, MA, MS, CCC** is a family caregiver in Maryland, Founder/CEO of Hey Caregiver!, host of the Selfull Caregiver Podcast and Founder of the Binti Circle, a supportive network for Black women caring for their parents. She applied to the TEP because of her dedication to advancing home health, health equity, and quality of care.
- **April Coxon, RN, CLHP** is the Executive Vice President of Quality at an HHA, Healing Hands Healthcare, in Wichita Falls, Texas. She applied to the TEP because of her commitment to the improvement of healthcare payment models to ensure effective quality of patient care across all HHAs.
- **Shekinah Fashaw-Walters, PhD, MSPH** is an Assistant Professor in the Department of Medical Ethics and Health Policy at the Perelman School of Medicine at the University of Pennsylvania. She is a senior fellow at the Leonard Davis Institute of Health Economics and a research associate at the Penn Population Aging Research Center. As a health services researcher, she has a focus on equity in the home health setting. She applied to the TEP because it aligns with her goals to advance health equity for Medicare beneficiaries seeking services at home and in the community.
- **Kathleen Holt, MBA, JD** is the Acting Healthcare Advocate for the State of Connecticut, leading the Office of the Healthcare Advocate (OHA). She previously served as the Associate Director of the Center for Medicare Advocacy, a nonprofit law firm that works with Medicare beneficiaries. She has experience with several TEPs, including panels on the patient driven grouping and unified payment models and home and community-based services. She applied to the TEP because of her interest in fair implementation and monitoring of the HHVBP Model for patients living with chronic and longer-term impairments and advancing access to hospice and home health services for all Medicare beneficiaries.
- **Cindy Krafft, PT, MS, HCS-O** is a physical therapist with over 25 years of home health experience. She is the owner/founder of K&K Health Care Solutions. She applied to the TEP because of her interest in how functional outcomes are measured and supporting better alignment with patient performance for assessments of quality of care in home health.
- **Terri Lindsey, RN, BSN, COS-C, CPHQ** is an RN with 38 years of experience. She previously served as Quality Outcomes Specialist at Bon Secours Mercy Health Home Health and Hospice in Richmond, Virginia. She applied to the TEP because of her clinical and quality improvement experiences, as well as because of the firsthand family caregiver perspective that she brings.
- **Trudy Mallinson, PhD, OTR/L, FACRM, FAOTA, NZROT** is an occupational therapist, Professor with Tenure, and Director of Doctoral Research at the School of Medicine & Health Sciences at George Washington University. As a health services researcher, she has expertise in quality measures development in post-acute care. She applied to the TEP because of her involvement as a member of the TEP for the original HHVBP Model, relevant research focuses, and personal experiences with family caregiving.
- **Tracy Mroz, PhD, OTR/L, FAOTA** is an occupational therapist and Associate Professor in the Division of Occupational Therapy, Department of Rehabilitation Medicine, School of Medicine at the University of Washington. She applied to the TEP to contribute input on the expanded HHVBP Model, bringing perspectives from her research and as an occupational therapist.

- **Dana Mukamel, PhD, MS** is a Distinguished Professor of Medicine, Public Health and Nursing and the Director of the iTEQC Research Program (Program of Research in Translational Technology Enabling High Quality Care) at the University of California, Irvine. She has expertise in quality measures for long-term care providers and investigating the impact in terms of behavior, quality, and cost. She applied to the TEP because of her involvement as a member on the TEP for the original HHVBP Model, as well as on other relevant TEPs, and to contribute her expertise and experience.
- **Eugene Nuccio, PhD** is a health services researcher with extensive experience in QM development. He retired from his role as Assistant Professor at University of Colorado, Anschutz Medical Campus. He applied to the TEP to contribute his expertise and experience from working on refinements to the OASIS assessment instrument, development and maintenance of quality measures, risk adjustment, and participation in the implementation of the original HHVBP Model.
- **Zainab Osakwe, PhD, MSN, NP, RN** is a nurse practitioner and associate professor in the College of Nursing and Public Health at Adelphi University. Dr. Osakwe has an extensive background as a home healthcare nurse, and as the director of both a long-term home healthcare organization and a certified home healthcare program. Her research primarily focuses on developing clinical decision-support pathways that enable home healthcare nurses to improve the delivery of goal-concordant care. Her work is also dedicated to enhancing the care experiences of patients and caregivers. She applied to the TEP to provide input on potential refinements to the expanded HHVBP Model based on her background.
- **Steven Pamer, PT, MPA, CGS** is the Administrator and Director of Rehabilitation Services at Cleveland Clinic Home Health Care in Ohio. He applied to the TEP to provide input based on his experience with value-based care delivery, understanding of methods of evaluation of quality care, and exposure to health equity.
- **Madeline Sterling, MD, MPH, MS** is a general internist and Associate Professor of Medicine at Weill Cornell Medicine in New York, NY. She is also the Inaugural Director of the Initiative on Home Care Work at Cornell University in Ithaca, NY. She applied to the TEP to provide input based on her clinical experience in primary care, research expertise in home health care, and studies on HHVBP.