Home Health Medicare Regulation Update: Today, Tomorrow and Beyond

by Annette Lee, Provider Insights, Inc.

Timeline for HH Payment

- 1965- Medicare begins and HH is a part of the benefit
  - Part A if a three day qualifying hospital stay
  - Part B if no qualifying stay
  - 100 day max
- 1970s Expanded HH- no longer needed three day stay
  - 100 day maximum was discontinued and continued to pay per visit
- 1980s saw explosion in utilization, Begin hospital DRGs
- 1990s Congress takes aim to contain costs in PAC
  - Operation Restore Trust
  - Balanced Budget Act of 1997
  - Interim Perspective Payment 1999

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Timeline for HH Payment

- 2000 PPS- (initially therapy adjustment for 10 visits)
  - Case mix evaluated and adjusted yearly
- 2008 PPS Update with therapy intervals, 6, 14, 20 (and between!)
- 2015 HHVBP Pilot
- 2016 Pre-Claim Review
- 2017 HHGM (Home Health Grouping Model) introduced, then put on hold, Claims/OASIS Matching edits
- 2018 PDGM (Patient Driven Grouping Model) Proposed for 2020

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HHGM and PDGM Models

- HHGM Proposed in 2017 for 2019= NOT in Final Rule
- PDGM Proposed in 2018 for 2020= ?? In Final Rule
  - Two changes from HHGM to PDGM
  - Budget Neutral (BIG WIN for HH!)
  - Additional Comorbidity impact
- CMS originally introduced idea in December 2016 to HH industry
- Moves to a 30 day payment system
  - Reflective of average LOS

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Admission Source/Timing

- Community Early (FIRST 30 days)
- Institutional Early (FIRST 30 days)
- Community Late (All subsequent)
- Institutional Late (All subsequent)

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Clinical Grouping (Primary Dx)

- Wound
- Neuro Rehab
- Musculoskeletal Rehab
- Complex Nursing Interventions
- Behavioral Health
- Medication Management, Teaching, Assessment.

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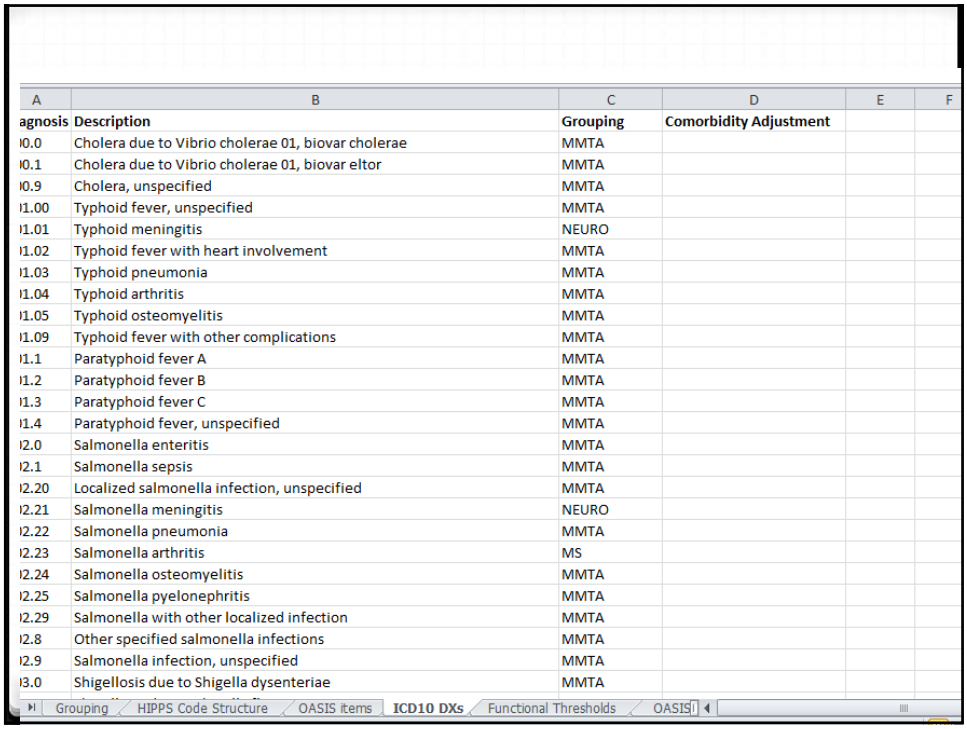
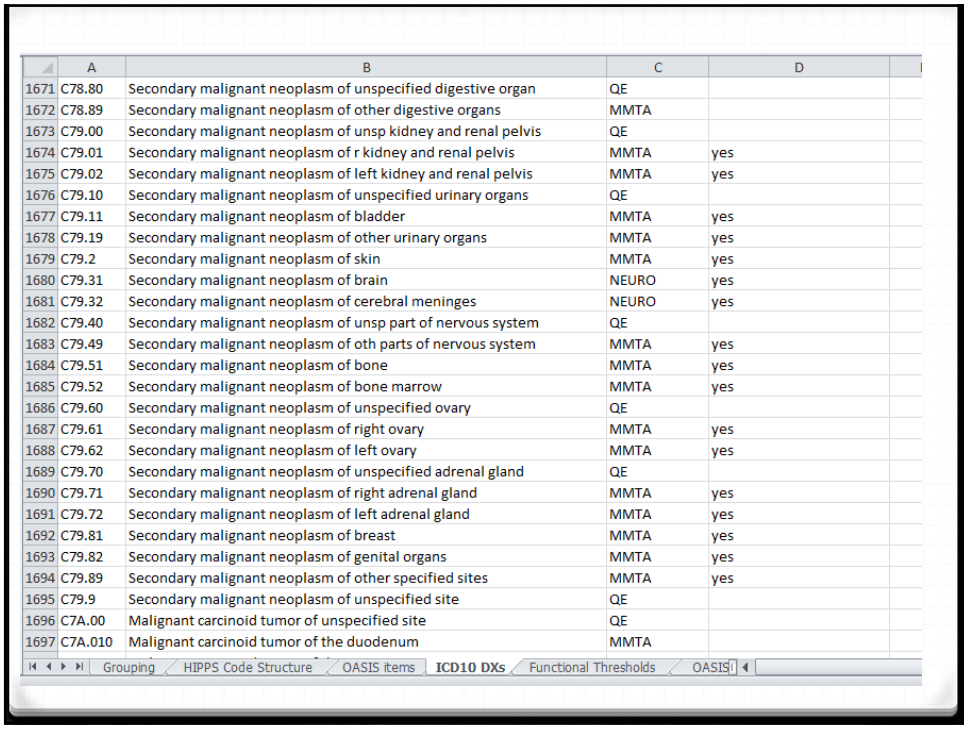


A	B	C	D	E	F
agnosis	Description	Grouping	Comorbidity Adjustment		
0.0	Cholera due to Vibrio cholerae 01, biovar cholerae	MMTA			
0.1	Cholera due to Vibrio cholerae 01, biovar eltor	MMTA			
0.9	Cholera, unspecified	MMTA			
1.00	Typhoid fever, unspecified	MMTA			
1.01	Typhoid meningitis	NEURO			
1.02	Typhoid fever with heart involvement	MMTA			
1.03	Typhoid pneumonia	MMTA			
1.04	Typhoid arthritis	MMTA			
1.05	Typhoid osteomyelitis	MMTA			
1.09	Typhoid fever with other complications	MMTA			
1.1	Paratyphoid fever A	MMTA			
1.2	Paratyphoid fever B	MMTA			
1.3	Paratyphoid fever C	MMTA			
1.4	Paratyphoid fever, unspecified	MMTA			
2.0	Salmonella enteritis	MMTA			
2.1	Salmonella sepsis	MMTA			
2.20	Localized salmonella infection, unspecified	MMTA			
2.21	Salmonella meningitis	NEURO			
2.22	Salmonella pneumonia	MMTA			
2.23	Salmonella arthritis	MS			
2.24	Salmonella osteomyelitis	MMTA			
2.25	Salmonella pyelonephritis	MMTA			
2.29	Salmonella with other localized infection	MMTA			
2.8	Other specified salmonella infections	MMTA			
2.9	Salmonella infection, unspecified	MMTA			
3.0	Shigellosis due to Shigella dysenteriae	MMTA			

Grouping | HIPPS Code Structure | OASIS items | ICD10 DXs | Functional Thresholds | OASIS

Comorbidity Adjustment

- The user can enter up to twenty-four secondary diagnosis codes that are used to determine if a comorbidity exists relative to the primary diagnosis entered previously.



	A	B	C	D
1671	C78.80	Secondary malignant neoplasm of unspecified digestive organ	QE	
1672	C78.89	Secondary malignant neoplasm of other digestive organs	MMTA	
1673	C79.00	Secondary malignant neoplasm of unsp kidney and renal pelvis	QE	
1674	C79.01	Secondary malignant neoplasm of r kidney and renal pelvis	MMTA	yes
1675	C79.02	Secondary malignant neoplasm of left kidney and renal pelvis	MMTA	yes
1676	C79.10	Secondary malignant neoplasm of unspecified urinary organs	QE	
1677	C79.11	Secondary malignant neoplasm of bladder	MMTA	yes
1678	C79.19	Secondary malignant neoplasm of other urinary organs	MMTA	yes
1679	C79.2	Secondary malignant neoplasm of skin	MMTA	yes
1680	C79.31	Secondary malignant neoplasm of brain	NEURO	yes
1681	C79.32	Secondary malignant neoplasm of cerebral meninges	NEURO	yes
1682	C79.40	Secondary malignant neoplasm of unsp part of nervous system	QE	
1683	C79.49	Secondary malignant neoplasm of oth parts of nervous system	MMTA	yes
1684	C79.51	Secondary malignant neoplasm of bone	MMTA	yes
1685	C79.52	Secondary malignant neoplasm of bone marrow	MMTA	yes
1686	C79.60	Secondary malignant neoplasm of unspecified ovary	QE	
1687	C79.61	Secondary malignant neoplasm of right ovary	MMTA	yes
1688	C79.62	Secondary malignant neoplasm of left ovary	MMTA	yes
1689	C79.70	Secondary malignant neoplasm of unspecified adrenal gland	QE	
1690	C79.71	Secondary malignant neoplasm of right adrenal gland	MMTA	yes
1691	C79.72	Secondary malignant neoplasm of left adrenal gland	MMTA	yes
1692	C79.81	Secondary malignant neoplasm of breast	MMTA	yes
1693	C79.82	Secondary malignant neoplasm of genital organs	MMTA	yes
1694	C79.89	Secondary malignant neoplasm of other specified sites	MMTA	yes
1695	C79.9	Secondary malignant neoplasm of unspecified site	QE	
1696	C7A.00	Malignant carcinoid tumor of unspecified site	QE	
1697	C7A.010	Malignant carcinoid tumor of the duodenum	MMTA	

Grouping | HIPPS Code Structure | OASIS items | **ICD10 DXs** | Functional Thresholds | OASIS

Functional OASIS Items

- M1033 Risk for Hospitalization (4 or more)
- M1800 Grooming
- M1810 Current Ability to Dress Upper Body,
- M1820 Current Ability to Dress Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1850 Transferring
- M1860 Ambulation/Locomotion

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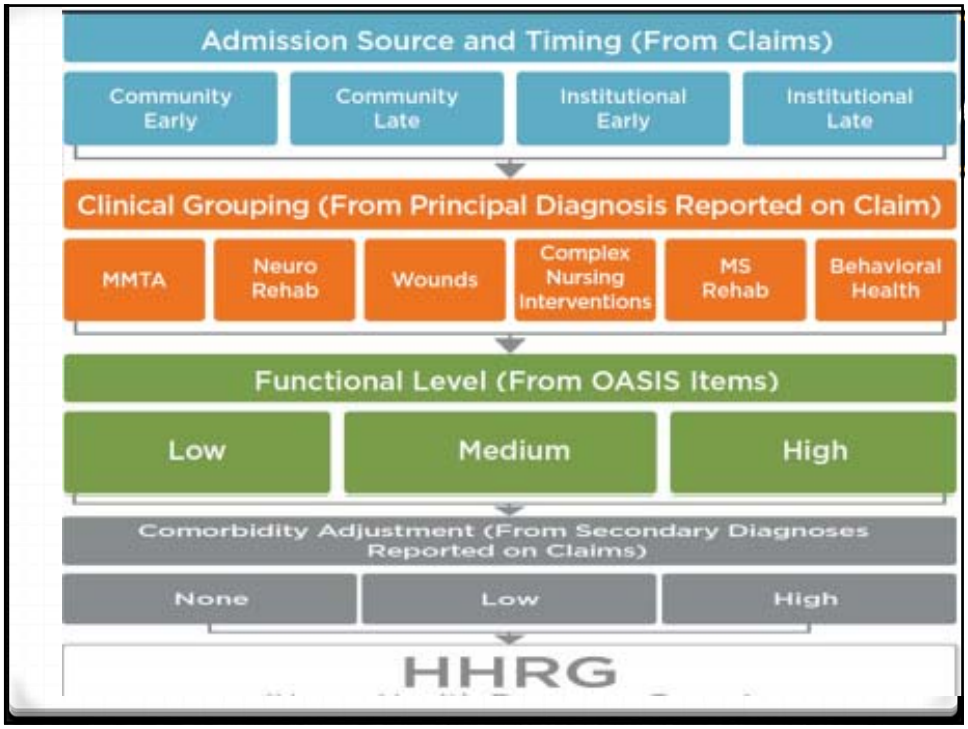

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	Clinical Group	Functional Level	Co-Morbidity	Placeholder
1	A	A	N	1
Community Early	MMTA	Low	No	
2	B	B	Y	
Institutional Early	Neuro Rehab	Medium	Low/High	
3	C	C		
Community Late	Wounds	High		
4	D			
Institutional Late	Complex Nursing			
	E			
	MS Rehab			
	F			
	Behavioral Health			

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Standard Rate PDGM

- $1,873.91 is standard non-weighted rate
- Controversy- CMS is planning on behavioral changes by HHAs and adjusting rate to lower based on projection of changes to number of visits, "upcoding", etc.
  - Updated standard rate proposed at a 4% decrease
    - $1,786.54

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RAPS?

- No RAPs for new HHAs
- Current HHAs will continue to receive RAPs at this time...

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Let's Look: Case Weight

PDGM CASE MIX WEIGHTS FOR EACH HHRG PAYMENT GROUP

HIPPS	Clinical Group and Functional Level	Timing and Admission Source	Comorbidity Adjustment	Proposed CY 2019 Weight
1AA11	MMTA - Low	Early - Community	0	0.9934
1AA21	MMTA - Low	Early - Community	1	1.0523
1AA31	MMTA - Low	Early - Community	2	1.2132
1AB11	MMTA - Medium	Early - Community	0	1.1449
1AB21	MMTA - Medium	Early - Community	1	1.2037
1AB31	MMTA - Medium	Early - Community	2	1.3646
1AC11	MMTA - High	Early - Community	0	1.2588
1AC21	MMTA - High	Early - Community	1	1.3176
1AC31	MMTA - High	Early - Community	2	1.4785
1BA11	Neuro - Low	Early - Community	0	1.203
1BA21	Neuro - Low	Early - Community	1	1.2619
1BA31	Neuro - Low	Early - Community	2	1.4228
1BB11	Neuro - Medium	Early - Community	0	1.3716
1BB21	Neuro - Medium	Early - Community	1	1.4305

Let's Look: LUPA

PROPOSED LUPA THRESHOLDS FOR THE PDGM PAYMENT GROUPS

HIPPS	Clinical Group and Functional Level	Timing and Admission Source	Comorbidity Adj (0 = none, 1 = single comorbidity, 2 = interaction)	Visit Threshold (10th percentile or 2 - whichever is higher)
1AA11	MMTA - Low	Early - Community	0	4
1AA21	MMTA - Low	Early - Community	1	4
1AA31	MMTA - Low	Early - Community	2	4
1AB11	MMTA - Medium	Early - Community	0	4
1AB21	MMTA - Medium	Early - Community	1	4
1AB31	MMTA - Medium	Early - Community	2	5
1AC11	MMTA - High	Early - Community	0	4
1AC21	MMTA - High	Early - Community	1	4
1AC31	MMTA - High	Early - Community	2	4
1BA11	Neuro - Low	Early - Community	0	4
1BA21	Neuro - Low	Early - Community	1	5
1BA31	Neuro - Low	Early - Community	2	5
1BB11	Neuro - Medium	Early - Community	0	5
1BB21	Neuro - Medium	Early - Community	1	5

Let's Look: Impact to YOU!!!

CCN	City	State	Facility Type	Ownership	Location	Census division	Nursing/Therapy Visits Ratio	30-day periods	60-day episodes	Total $, 153-group current system	Total $, PDGM
437003	Rapid City	SD	Freestanding	Non-Profit	Urban		1st Quartile (Lowest 25% Nursing)	843	516	$1,777,303	$1,599,445
437004	Sioux Falls	SD	Freestanding	Non-Profit	Urban		1st Quartile (Lowest 25% Nursing)	818	554	$1,570,119	$1,445,748
437006	Yankton	SD	Freestanding	Non-Profit	Rural		1st Quartile (Lowest 25% Nursing)	395	348	$665,037	$646,162
437008	Huron	SD	Facility-Based	Non-Profit	Rural		2nd Quartile	217	168	$422,150	$372,353
437009	Winner	SD	Facility-Based	Non-Profit	Rural		1st Quartile (Lowest 25% Nursing)	106	68	$190,925	$170,888
437019	Watertown	SD	Facility-Based	Non-Profit	Rural		3rd Quartile	820	541	$1,317,832	$1,318,052
437020	Miller	SD	Freestanding	Non-Profit	Rural		2nd Quartile	32	18	$48,548	$48,410
437024	Aberdeen	SD	Freestanding	Non-Profit	Rural		2nd Quartile	588	489	$1,022,419	$984,812
437030	Brookings	SD	Facility-Based	Gov't-Owned	Rural		2nd Quartile	337	249	$515,724	$517,567
437037	Spearfish	SD	Facility-Based	Non-Profit	Rural		1st Quartile (Lowest 25% Nursing)	462	300	$898,740	$772,510
437039	Rapid City	SD	Freestanding	Non-Profit	Urban		1st Quartile (Lowest 25% Nursing)	133	109	$305,659	$249,511
437040	Martin	SD	Facility-Based	Non-Profit	Rural		4th Quartile (Top 25% Nursing)	2	1	$1,568	$2,735

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What Do the Quartiles Mean?

QUARTILE	
1	Lowest quartile of SN to therapy visits– Least proportion of nursing and highest proportion of therapy
2	Second highest quartile of aggregate nursing to therapy visits for the agency
3	Third highest quartile of aggregate nursing to therapy visits for the agency
4	Greatest quartile of aggregate nursing to therapy visits for the agency; highest proportion of nursing visits and least of therapy visits

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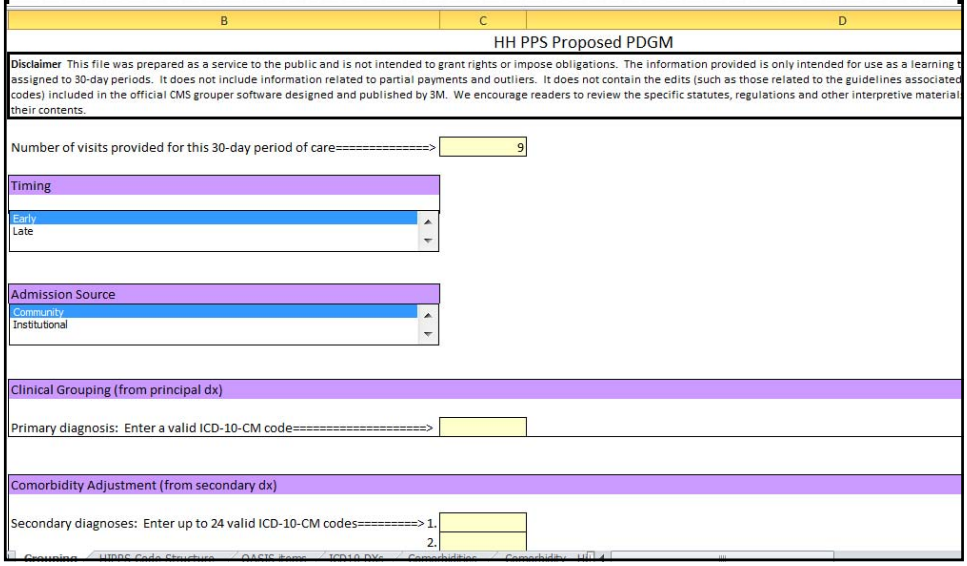
Let's Look: Patient Impact



B C D

HH PPS Proposed PDGM

Disclaimer This file was prepared as a service to the public and is not intended to grant rights or impose obligations. The information provided is only intended for use as a learning t assigned to 30-day periods. It does not include information related to partial payments and outliers. It does not contain the edits (such as those related to the guidelines associated codes) included in the official CMS grouper software designed and published by 3M. We encourage readers to review the specific statutes, regulations and other interpretive material their contents.

Number of visits provided for this 30-day period of care==========> 9

Timing

Early
Late

Admission Source

Community
Institutional

Clinical Grouping (from principal dx)

Primary diagnosis: Enter a valid ICD-10-CM code==========>

Comorbidity Adjustment (from secondary dx)

Secondary diagnoses: Enter up to 24 valid ICD-10-CM codes==========> 1.
2.

Grouping | HIPPS Code Structure | OASIS Items | ICD10 DXs | Comorbidities | Comorbidity H

What is an ADR?

- Additional Development Request
- Means to audit Medicare claims by Medicare Administrative Contractor (MAC) prior to payment
  - Small percentage of claims have ADR- most paid through automated system

Quality vs Payment Standards

Quality

- Conditions of Participation (CoPs)
- State regulations
- Agency policies

Payment

- Medicare Benefit Policy Manuals (100-2)
  - Chapter 7- Home Health
- Local Coverage Determinations (LCDs)
- CMS Program Integrity Manual CMS 100-8

How are ADRs Decided?

- How edits are determined
  - Outlined in PIM (Program Integrity Manual 100-8) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
  - Three primary types of edits:
    - Widespread or Topic
    - Provider Specific
    - Beneficiary Specific

    Plus– the addition of the FTF Probe!

Issues to be Posted

- CR 8690 states MACs and SMRCs (Supplemental Medical Review Contractors) must post all topic driven edits
  - Prior to edits
  - Current edits
  - May post past edits

Why an ADR?

- Widespread or provider specific vulnerabilities
- Focused on proven problem areas
- Focus on payment
- Provides feedback, and education for provider community

Widespread Edits

- Begins with data or vulnerability identified
- Widespread probe completed
  - 100 claims total
- If effective, will continue as widespread edit
- Evaluated Quarterly
- Current examples of Widespread Edits

Widespread Edits for HH

- At this time, MACs are primarily focusing on TPE
  - More on next step later!
- Data is currently being reviewed
- May implement at anytime
- NGS and Palmetto currently have no widespread edits
- CGS currently has three HH, several Hospice edits

CGS Widespread Edits

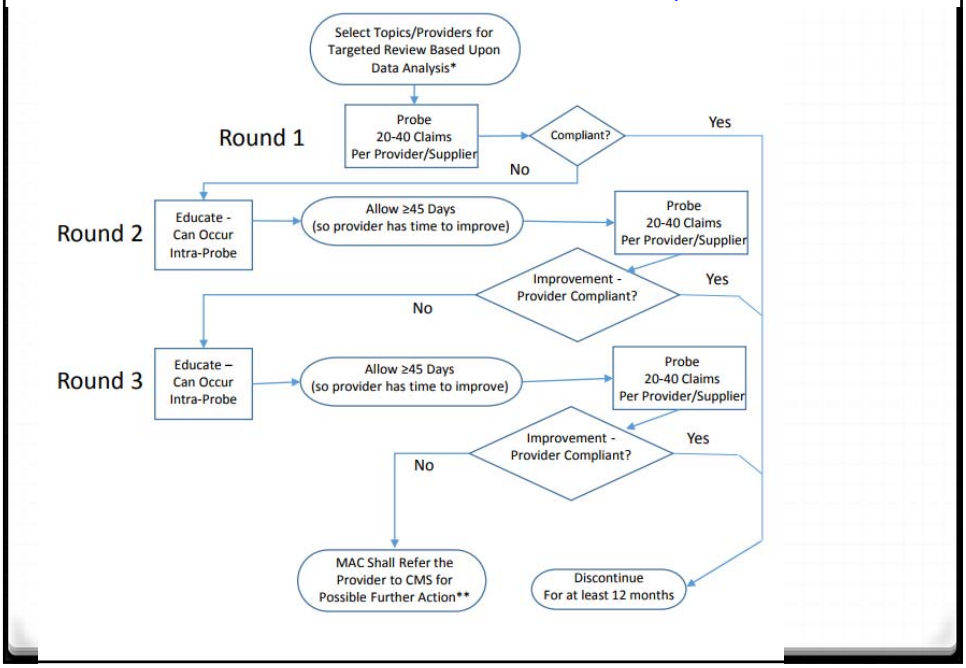
Review Topic	Description	Review Type	Status
Home Health Eligibility and Medical Necessity	This edit selects providers who submitted home health claims with errors as identified in HH probe and educate round 2.	Targeted Probe and Educate Prepayment Review	Active
LOS with Hypertension	This edit selects home health claims for providers who submitted diagnosis Hypertension and a length of stay greater than 120 days.	Targeted Probe and Educate Prepayment Review	Active
No response to ADR	This edit selects providers who fail to respond to ADRs (additional documentation requests)	Targeted Probe and Educate Prepayment Review	Active

Targeted Probe and Educate Provider Specific Probes

- Began October 1, 2017
- Agencies "Putting Medicare Trust Fund at risk"
  - No thresholds/parameters published
- Agencies chosen will receive a letter
- 20-40 claims

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1919OTN.pdf



MACs to Publish TPE Results

https://cgsmedicare.com/hhh/medreview/tpe_process.html

September 4, 2018

Targeted Probe and Educate Progress Update

The Centers for Medicare & Medicaid Services (CMS) Change Request 10249 PDF implemented the Targeted Probe & Educate (TPE) process, effective October 1, 2017. The following provides progress of TPE from October 1, 2017 – June 30, 2018.

Findings

Medical Review initiated complex review edits for specific providers identified through data analysis demonstrating high risk for improper payment. Education has been offered to providers throughout and upon completion of Round 1 of TPE review. Currently not enough Hospice providers have completed Round 1 to report Hospice progress. Current Round 1 Home Health Results are as follows:

Home Health

Probes completed October 1, 2017 – June 30, 2018

Eligibility and Medical Necessity edit 5A000

Results	Home Health
Probes Completed	45
Providers Compliant after Round 1 Completion	4

High Incidence of Additional Rounds of TPE

- **Probes completed April 1, 2018 – June 30, 2018**
- **Eligibility and Medical Necessity edit 5A000**
- Probes Completed 30
- Providers Compliant after Round 1 Completion 1
- Providers Non-compliant after Round 1 Completion *(advancing to Round 2)* 29
- Providers with Non-Reponses to ADRs for Round 1= 9

- **No response to ADR edit 5A004**
- Probes Completed 12
- Providers Compliant after Round 1 Completion 1
- Providers Non-compliant after Round 1 Completion *(advancing to Round 2)* 11
- Providers with Non-Reponses to ADRs for Round 1= 2

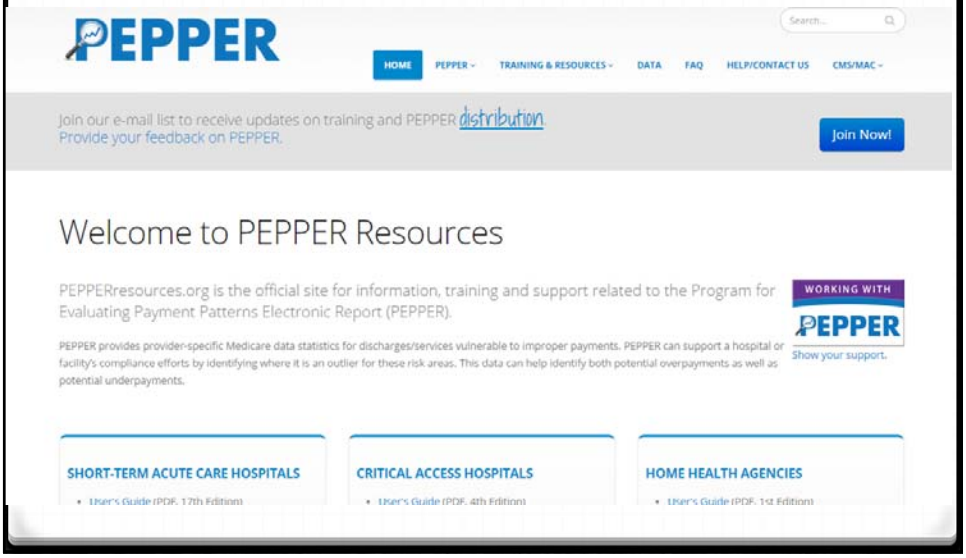
Are You an Outlier?

- You want to be outstanding in your field for excellence and quality– but average in your data percentages
  - Industry association benchmarks
  - Your own agency benchmarks
  - Data warehouse benchmarks and peers

PEPPER Reports

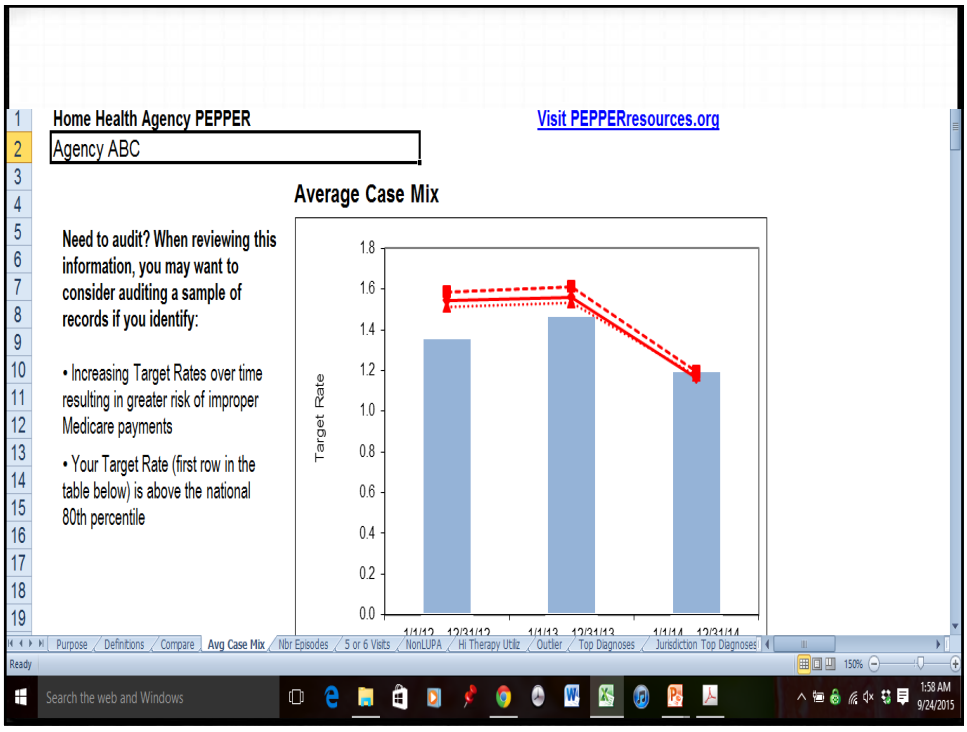
- Program for Evaluating Payment Patterns Electronic Report (PEPPER).
- Focus of all PEPPER reports (HH and Hospice!) is looking at billing – not necessarily quality
- Focuses on areas that are "vulnerabilities" in the payment systems
- Review your own from www.pepperresources.org

Obtain Report Yearly July 18th



Percentiles View

- The target area percent or rate lets the HHA know its billing patterns.
- More useful information comes from knowing how it compares to other HHAs, which is why we calculate percentiles.
- The percentile identifies the percentage of HHAs that have a lower target area percent or rate.



Average Case Mix

- *Numerator (N):* sum of case mix weight for all episodes paid to the
- HHA during the report period, excluding LUPAs (identified by Part A NCH HHA LUPA code) and PEPs (identified as patient discharge status code equal to '06')
- *Denominator (D):* count of episodes paid to the HHA during the report period, excluding LUPAs and PEPs
- Note: reported as a rate, not a percent

Average Number of Episodes

- Average Number of Episodes
- *N*: count of episodes paid to the HHA
- *D*: count of unique beneficiaries served by the HHA
- Note: reported as a rate, not a percent

Episodes/5-6 Visits

- Episodes with 5 or 6 Visits
- *N*: count of episodes with 5 or 6 visits paid to the HHA
- *D*: count of episodes paid to the HHA

- Non-LUPA Payments
- *N*: count of episodes paid to the HHA that did not have a LUPA payment
- *D*: count of episodes paid to the HHA

High Therapy

- *N*: count of episodes with 20+ therapy visits paid to the HHA (first digit of HHRG equal to '5')
- *D*: count of episodes paid to the HHA

- A known HHA has been issued a Targeted Probe and Educate due to over 80 percentile High Therapy, plus five of five errors on FTF probe and educate

High Outlier Payments

- *N:* dollar amount of outlier payments (identified by the amount where Value Code equal to '17') for episodes paid to the HHA
- *D:* dollar amount of total payments for episodes paid to the HHA
- Outliers can Not be paid over 10% of total payment

New On RADAR:

- Home Health agencies with more RAPs than final claims
- 30% more RAPs- will receive warning letter
- May face 50% RAP supression

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Beneficiary Specific Edit

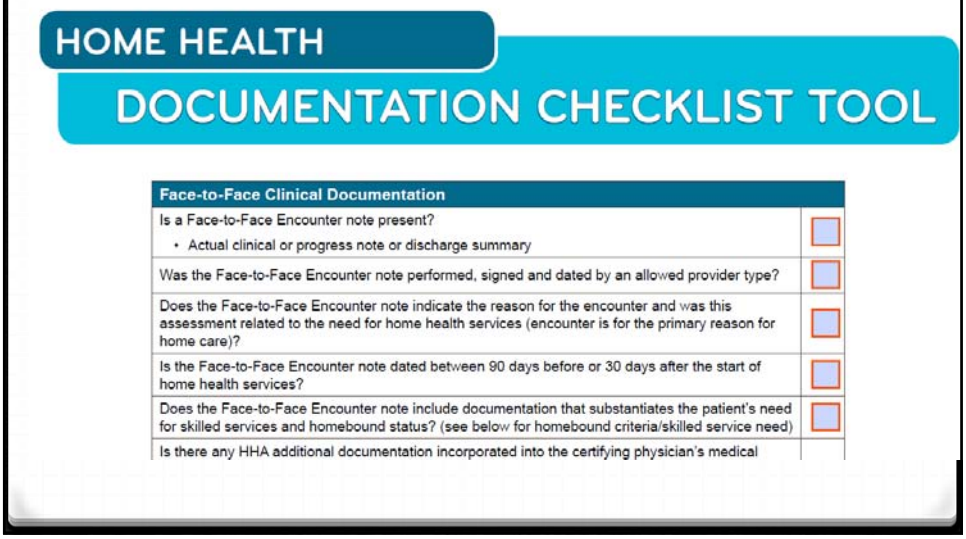
- Used when service previously determined to be a non-covered service upon medical review
- May have been previously reviewed from widespread or provider specific edit
- Claim suspended for medical review based on identification of beneficiary

Who ADRs Impact

- You!
- Everyone at your agency and in the home health/hospice industry…
- "We've always done it this way…"
- No news is not always good news
- When ADRs hit- everyone at the agency is involved

MACs Checklists

https://cgsmedicare.com/hhh/education/materials/pdf/hh_documentation_checklist_tool.pdf



HOME HEALTH

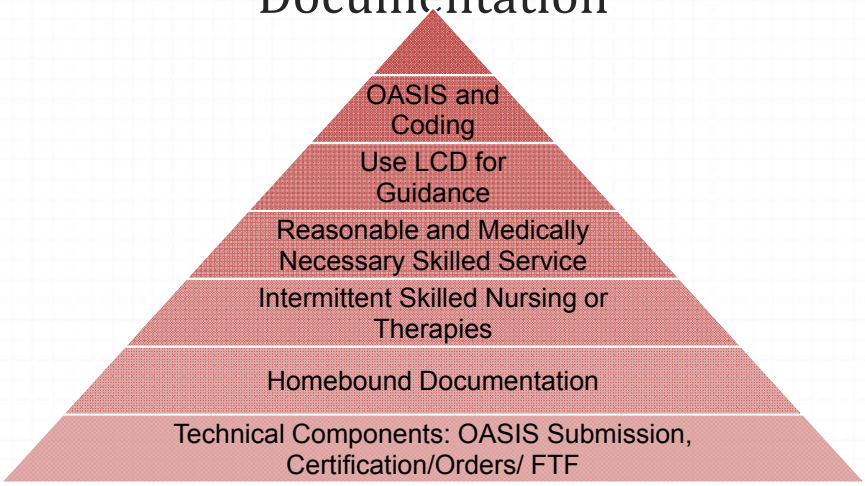
DOCUMENTATION CHECKLIST TOOL

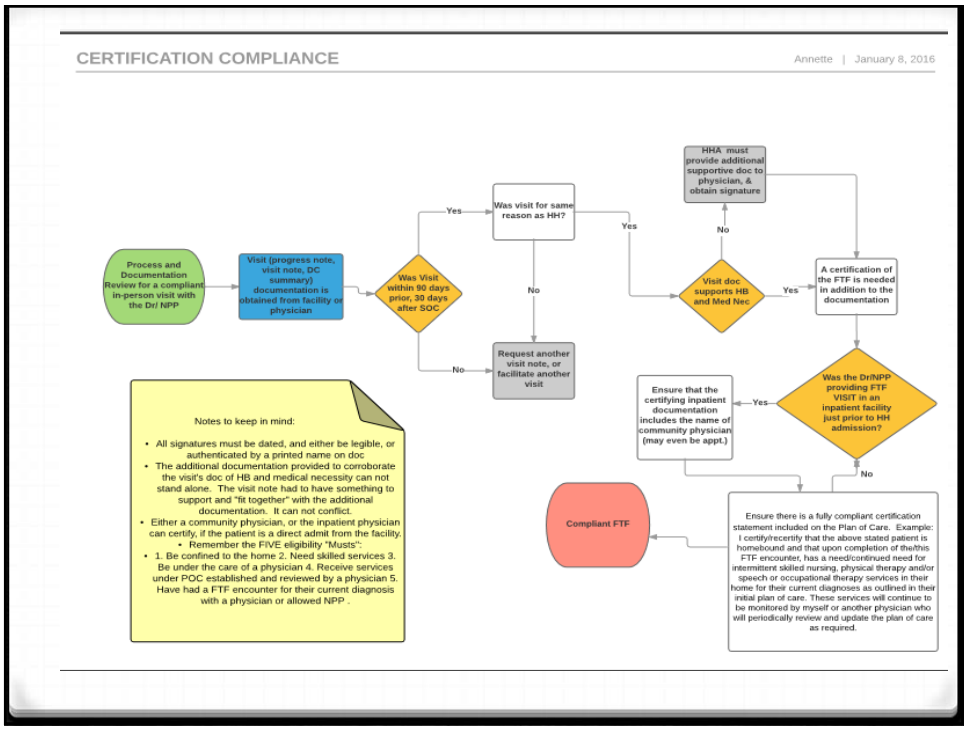
Face-to-Face Clinical Documentation	
Is a Face-to-Face Encounter note present? • Actual clinical or progress note or discharge summary	☐
Was the Face-to-Face Encounter note performed, signed and dated by an allowed provider type?	☐
Does the Face-to-Face Encounter note indicate the reason for the encounter and was this assessment related to the need for home health services (encounter is for the primary reason for home care)?	☐
Is the Face-to-Face Encounter note dated between 90 days before or 30 days after the start of home health services?	☐
Does the Face-to-Face Encounter note include documentation that substantiates the patient's need for skilled services and homebound status? (see below for homebound criteria/skilled service need)	☐
Is there any HHA additional documentation incorporated into the certifying physician's medical	

Top Medical Review Denials

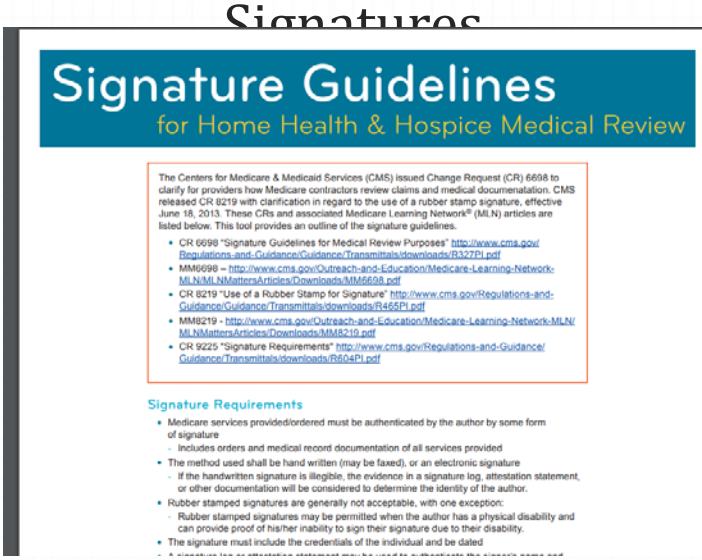
- **CGS and NGS Top Denial Reasons April 1 2018 – June 30, 2018**
- 1. Face-to-Face missing/incomplete/untimely
- 2. Therapy visits not medically necessary
- 3. Initial certification invalid
- 4. Recertification estimate missing/invalid
- 5. Plan of care missing/invalid

Essential Home Health Documentation





MAC Quick Reference Tool for Signatures



Signature Guidelines
for Home Health & Hospice Medical Review

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6698 to clarify for providers how Medicare contractors review claims and medical documentation. CMS released CR 8219 with clarification in regard to the use of a rubber stamp signature, effective June 18, 2013. These CRs and associated Medicare Learning Network® (MLN) articles are listed below. This tool provides an outline of the signature guidelines.

- CR 6698 "Signature Guidelines for Medical Review Purposes" http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R327PI.pdf
- MM6698 – http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf
- CR 8219 "Use of a Rubber Stamp for Signature" http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R465PI.pdf
- MM8219 - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf
- CR 9225 "Signature Requirements" http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R604PI.pdf

Signature Requirements

- Medicare services provided/ordered must be authenticated by the author by some form of signature
  - Includes orders and medical record documentation of all services provided
- The method used shall be hand written (may be faxed), or an electronic signature
  - If the handwritten signature is illegible, the evidence in a signature log, attestation statement, or other documentation will be considered to determine the identity of the author.
- Rubber stamped signatures are generally not acceptable, with one exception:
  - Rubber stamped signatures may be permitted when the author has a physical disability and can provide proof of his/her inability to sign their signature due to their disability.
- The signature must include the credentials of the individual and be dated

Showing the Need through Documentation

Clinical Indications that Support Need for Home Health

- Patient has a new diagnosis of _____
- Patient recently had an exacerbation of symptoms related to _____
- Patient recently had the following changes in medications and/or treatments _____
- Patient recently hospitalized for _____
- Patient has a wound _____
- Patient has an infection requiring antibiotics _____
- Patient recently had a decline in function related to _____
- Patient recently had a decline in safe ability to perform ADLs _____
- Patient recently had a change in speech and/or swallowing _____

Supporting Skill through Documentation

Interventions for skilled services

- Skilled nursing for assessment of symptoms related to recent changes in condition and treatments (defined)
- Skilled nursing for wound care, IV medication administration, Disease Management and Teaching on new medications, Pain Management, Ostomy/Foley Catheter/Tracheal Care
- Physical Therapy for Gait, Strength, Endurance Training, Therapeutic Exercise, Caregiver Training
- Occupational Therapy for ADL Re-training, Caregiver Training, Environmental Assessment
- Speech Therapy for Swallow Assessment, Speech Assessment and training
- Home Health Aide for Bathing, Dressing, Grooming
- Social Worker for Resources Assessment, Placement, Counseling

Medical Necessity Documentation

- Documentation should answer question "Why Home Health, Why Now?"
  - Objective clinical evidence of patient's individual need for care- What's new, exacerbated, high risks or hands on skill?
  - Progress or lack of progress
  - Medical condition
  - Functional losses
  - Treatment goals

HHVBP Proposed Changes

- Quality Measures
- Remove **two** OASIS-based process measures:
  - Influenza Immunization Received for Current Flu Season and Pneumococcal Polysaccharide Vaccine Ever Received, from the set of applicable measures
- Replace **three** individual OASIS measures:
  - Improvement in Bathing, Improvement in Bed Transferring, and Improvement in Ambulation-Locomotion with **two** composite measures: Total Normalized Composite Change in **Self-Care** and Total Normalized Composite Change in **Mobility**
  - The baseline year for these two composite measures would be calendar year 2017
  - Each of the two composite measures would have a maximum score of 15 points

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HHVBP Proposed Changes

- Weighting the measure categories so that the **OASIS-based** measure category and the **claims-based** measure category would each count for **35 percent** and the **HHCAHPS** measure category would count for **30 percent** of the 90 percent of the TPS that is based on performance of the Clinical Quality of Care, Care Coordination and Efficiency, and Person and Caregiver-Centered Experience measures
  - **Weight of the Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health claims-based measure would be increased so that it has three times the weight of the Emergency Department Use without Hospitalization claims-based measure**

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HHVBP Proposed Changes

- Reduce the maximum amount of improvement points, from 10 points to 9 points, for PY4 (2019) and subsequent performance years for all measures except for, if finalized, the Total Normalized Composite Change in Self-Care and Total Normalized Composite Change in Mobility measures, for which the maximum improvement points would be 13.5.

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QUESTIONS?

THANK YOU!!!!

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