CMS Perspective:

Home Health Value Based Purchasing (HHVBP) Model Third Annual Evaluation Report

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For information on the model and to download the independent evaluation report discussed in this document, please visit
https://innovation.cms.gov/innovation-models/home-health-value-based-purchasing-model

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The Home Health Value Based Purchasing (HHVBP) Model presents an opportunity to improve the care of a vulnerable segment of Medicare beneficiaries in the home health setting. Under the Model, home health agencies (HHAs) receive payment adjustments based on their performance on a range of quality measures. CMS established payment adjustments based upon relative quality score rankings as incentives to HHAs to improve care. We based HHVBP largely on the findings and lessons learned from other CMS value-based purchasing programs and demonstrations, including the Hospital Value-Based Purchasing (HVBP) Program, the Home Health Pay-for-Performance (HHP4P) demonstration, and Nursing Home Value-Based Purchasing (NHVBP). Although similar in design to the hospital program, the HHAs under the HHVBP Model have significantly greater upward or downward payment adjustments to their home health prospective payment system payments. The incrementally stronger incentives in the HHVBP Model (three percent in 2018 and up to eight percent in 2022) will help us to understand if HHA providers will invest more meaningfully in the transformation of care. This third annual evaluation report describes the impact of these incentives in HHVBP on spending, health care resources, and patient experience, as well as how providers have responded to the Model during the initial three years.

With the maximum payment adjustment percentage set to three percent for 2018, we find continued savings to Medicare overall and improvements in performance across process and outcome measures. However, with this first payment adjustment applied in 2018, we did not find an appreciable difference in savings compared to the first two performance years, during which we applied no payment adjustments. Consistent with the Model's theory of action, unplanned hospitalizations and skilled nursing facility services were the main drivers of the overall savings. Interviews with HHAs cite practice changes, such as timely initiation of care, frequent home health visits early in the episode of care, and more remote monitoring of patients to reduce re-hospitalizations. Anticipated effects of increasing the weight of the unplanned hospitalization and ED use measures on agencies' TPS scores may also have contributed to these practice changes. As the maximum payment adjustment increased to five percent in 2019 (tied to 2017 performance year measures), CMS expects to see greater impacts to the savings and continued positive quality of care outcomes moving forward.

Since HHAs already participate in the Home Health Quality Reporting Program (HH QRP), under the HHVBP Model we are able to leverage the HH QRP's existing infrastructure for collecting and reporting on a core set of quality and patient experience metrics minimizing additional provider burden due to the Model. Interviews with HHA personnel in our evaluation corroborate with other HHVBP Model support activity feedback suggesting that HHVBP was not burdensome to implement and providers were able to focus on reinforcing existing quality improvement strategies and on areas for improvements rather than meeting many additional model requirements. Improvements in performance across process and outcome measures in each of the first three years of the Model strongly suggest that better performance results from continuously measuring quality, monitoring performance, and giving providers and HH organizations a way to understand how their efforts improve quality and increase payments.

The HHVBP Model's intervention has led to savings and quality improvements without evidence of adverse risks. Our monitoring and evaluation efforts have found no negative effects on access to care. Risks to quality and unintended consequences of the Model are high priority topics. CMS will continue to track them going forward, especially with the increases to the maximum adjustment percentage in subsequent payment years.

Since HHVBP aligns with the reporting requirements of HH QRP for the duration of the COVID-19 public health emergency, reporting exceptions due to the COVID-19 pandemic will affect the data we are able to obtain and may have implications for the payment adjustments in 2022. Any changes to payment

methodologies or public reporting resulting from limited or insufficient data would be addressed in the future as part of rulemaking and our evaluation would take these changes into consideration accordingly. In future years, the evaluation will also need to account for COVID-19 and other factors external to the model test, such as the effect of Patient-Driven Groupings Model (PDGM).

The HHVBP Model evaluation results in this third report are consistent with CMS goals to drive down cost and improve care without introducing significant provider burden and adverse effects on patient access or quality. CMS continues to rely on annual evaluation findings to inform future directions for the HHVBP Model as well as future value based models in the Innovation Center portfolio.