Evaluation of the Home Health Value-Based Purchasing (HHVBP) Model

First Annual Report: Qualitative Technical Appendix

Arbor Research Collaborative for Health
and L&M Policy Research

Prepared by:
Alyssa Pozniak, Marc Turenne, Purna Mukhopadhyay, Brant Morefield, Vladislav Slanchev, Kathryn Linehan, Lisa Green, Betsy Brigantti, Nicholas Byrd, Chad Cogan, Tony Cuttitta, Zach Dietrich, Julia Doherty, Diana Haggerty, Katherine Hanslits, Nan Ji, Yan Jin, Margaret Edder Johnson, Scott Liening, Kaden Milkovich, Danielle Norman, Jeffrey Pearson, Kaitlyn Repeck, Sarah Rosenblum, Jillian Schrager, Claudia Schur, Amanda Szymanski, and Lisa Tomai

Prepared for The Centers for Medicare & Medicaid Services (CMS)
Center for Medicare & Medicaid Innovation (CMMI)

July 2018

ARBOR RESEARCH COLLABORATIVE FOR HEALTH

Contract No. HHSM-500-2014-00029I, Task Order No. HHSM-500-T0001
Federal Contracting Officer's Representative: William Buczko, PhD

ACKNOWLEDGEMENT
The Evaluation Team wishes to acknowledge and thank the following CMS staff for their insightful review of the report: William Buczko, Ann Meadow, Shannon Flood, and Renee Mentnech.

NOTICE
The statements contained in this report are those of the authors and do not necessarily reflect the policies or views of the Centers for Medicare & Medicaid Services. Arbor Research Collaborative for Health assumes responsibility for the accuracy and completeness of the information contained in this report.

Table of Contents

Tables

1. HHA Interviews

We conducted interviews with 67 home health agencies (HHAs) in the nine Home Health Value-Based Purchasing (HHVBP) Model states as of September 1, 2017. The team integrated themes gathered from our interviews with national- and state-level home health stakeholders into semi-structured discussion guides designed to collect information about: (1) changes in agency structure and operations in response to HHVBP; (2) expected future impacts on patients and agencies as a result of HHVBP; and (3) challenges agencies have encountered while responding to HHVBP. The guides were reviewed and revised over multiple discussions with the qualitative research team and CMS. The evaluation team conducted these interviews between May and August 2017.[1]

1.1 Interview Allocation and Selection

For the first year of the HHVBP evaluation, we allocated all 72 of our interview slots in the nine intervention states to interviews with HHAs. When allocating these interviews across states, we attempted to approximately reflect the number of HHAs in each state, while still allowing sufficient interviews in each state to adequately understand any state-specific issues. Based on our discussions with national and state stakeholders, we identified other important characteristics to consider when selecting agencies to interview—including number of episodes, hospital-based/freestanding, and urban/rural status—that may influence HHAs' response to the demonstration and performance on the measures. Given the multiple HHA characteristics of interest, this approach allowed us to capture the greatest range of HHAs with different characteristics in each state. To balance the distribution of these characteristics across HHAs in HHVBP states and by state HHA differences, we allocated the 72 interviews as shown in Table 1.

[1] We began conducting a 68th interview with an agency in Massachusetts, but it concluded early after the participant requested to reschedule for another time and then fell out of contact with the interview team. This summary does not reflect any information gathered during the course of that partial interview.

Table 1. Allocation of HHA Interviews in Year 1 for each HHVBP State, by Select Characteristics

	AZ	FL	IA	MA	MD	NC	NE	TN	WA	Row Totals
Number of HHAs	122	889	131	148	52	167	63	130	59	1,771
Rural										
HB*<=Median			1				2			3
HB*>Median			1				1			2
FS*<=Median			2			2		2		6
FS*>Median			1							1
Urban										
HB*<=Median										
HB*>Median										
FS*<=Median	4	7	1	4	3	3	1	3	3	29
FS*>Median	4	7	2	4	3	3	2	3	3	31
Number of interviews	**8**	**14**	**8**	**8**	**6**	**8**	**6**	**8**	**6**	**72**
Share of all interviews	**11%**	**19%**	**11%**	**11%**	**8%**	**11%**	**8%**	**11%**	**8%**	**100%**

Source: HHAs in the October 2016 Interim Performance Report produced by Abt Associates, the HHVBP Implementation Contractor, and provided to Arbor Research.
*Notes: *FS=Freestanding, *HB=Hospital-Based; Median=Median per HHA episode count for all HHAs in HHVBP states, so it is a measure of size defined as the number of episodes.*

1.2 Outreach and Interviewing

Each selected HHA was assigned an interview team consisting of a lead interviewer and a note-taker, both of whom were trained on the discussion guide and outreach materials. The interview team drew initial contact names and information from the data compiled by Abt Associates, the HHVBP Implementation contractor, based on agencies that had registered in the HHVBP Web Portal as of October 2016, and contacted each HHA by email and/or telephone to schedule a 60-minute interview. During this outreach and scheduling process, we explained the topics to be covered and asked the HHA to make appropriate staff available for the interviews. We requested that key personnel engaged in the agency's response to HHVBP participate. Ultimately, the contacts at the HHA determined, based on the discussion topics, who was best positioned to answer the interview questions about HHVBP and facilitated their participation on the call. The interview team spoke with a wide variety of agency staff; while their titles varied across agencies, in general, we spoke to key informants who were the administrator for their agency (e.g., administrators and branch managers), who worked on clinical services (e.g., clinical directors), or who worked on the quality team (e.g., quality improvement managers). During the interviews, the interviewers asked about the person or persons who led the HHA's initial decision-making about HHVBP and confirmed that the majority of interviewees were involved in and/or led decision-making about HHVBP for their agency. Those who were not directly involved in the decision-making most often indicated that decision-making about HHVBP originated from a regional or national level, such as a corporate office, but that they were the best contact at the agency itself.

Some HHAs we had initially selected did not participate in interviews, for the following reasons:

- Declined to be interviewed;
- Failed to respond to multiple outreach attempts from the interview team;
- Closed between when they submitted their contact information to CMS and when the interview team attempted to contact them; and
- Failed to attend the scheduled interview times to which they had agreed.

When any of these issues arose, we replaced the agency in question with another agency in the same state that shared the same hospital-based/freestanding setting, urban/rural designation, and was of a similar size (based on whether they were above or below the median number of Medicare episodes for their state; Table 2). The proportions of urban, freestanding, and for-profit agencies interviewed mirrored those of all agencies in the HHVBP intervention states from which we drew our sample. When selecting replacements, we also considered, though did not include among our selection criteria, whether an agency was part of a chain that we had already interviewed within any of the Model states, and if the replacement agency was in a similar geographic area in the state to the agency being replaced.[2]

Table 2. Characteristics of Interviewed Agencies and Replaced Agencies

	Interviewed Agencies (n=67)	Replaced Agencies (n=78*)
Share: Urban (% of Total)	56 (83.6%)	68 (87.2%)
Share: Freestanding (% of Total)	62 (92.5%)	74 (94.9%)
Share: For-Profit (% of Total)	43 (64.2%)	58 (74.4%)
Mean Total Performance Score	43.472	43.223
Median Total Performance Score	41.543	38.554
Mean Payment Adjustment	-0.082%	-0.103%
Median Payment Adjustment	-0.220%	-0.401%

**Note: Although we replaced 79 agencies during the interview period, one agency did not appear in the August 2017 Preview Annual TPS and Payment Adjustment Report. This agency has been excluded from the table above as a result. Additionally, agencies that we did not interview but also did not replace before the end of the interview period are not included in this table.*

1.3 Data Collection and Analysis

The majority of interviews were audio recorded with permission of the interviewee, and teams produced transcript-style notes for each interview in a note-taking template that mirrored the discussion guide. The template helped to reinforce consistency in data collection across the HHAs and also kept the gathered information well-organized. Teams then summarized findings at the state level in a standardized debrief document. Raw notes and recordings were retained for back-up purposes, while the transcripts that had been put into the note-taking template were loaded into qualitative data analysis software (Dedoose), a secure, Web-based application that facilitates aggregation and storage of data by a broad team of users, allowing immediate access and real-time data sharing, with tight controls for access levels and version management. Each study document loaded into Dedoose was coded using a defined list of key topics. Before finalizing, the team tested the code tree multiple times across several interview transcripts documents, identifying and refining any codes that yielded inconsistent

[2] We completed 67 interviews, five short of our goal of 72, due to difficulty in recruiting and a compressed timeline.

applications or that required further disaggregation or consolidation to best serve the analysis. During testing, codes with lower agreement across coders were re-assessed to determine if they could be consolidated with other existing codes. Definitions of 34 codes were finalized prior to coding of all interview notes. Once all interviews were coded, excerpts for nine key topics were summarized by a team of three senior researchers and three research assistants. The team summarized excerpts by reviewing all of the coded text by each key topic area to identify categories and subcategories of responses. The summaries form the basis of the findings presented in the Annual Report. Quotations taken from the transcript-style notes were selected to demonstrate common themes or interesting insights and were reviewed by team members for quality and illustrative value.

2. HHVBP Connect

HHVBP Connect is an interactive web-based platform that allows HHAs in the nine HHVBP Model states to:

- "Find the latest updates for the HHVBP Model; download valuable resources to help [agencies] succeed in the model;
- View upcoming HHVBP events and key Model milestones;
- View the '2015 Benchmarks and Achievement Thresholds';
- Obtain the updated Frequently Asked Questions (FAQs);
- View past webinars and register for future webinars;
- Share best practices and chat with colleagues in the nine Model states; and,
- Understand when to submit New Measures data to the HHVBP Secure Portal and when and how to retrieve performance reports."[3]

It was launched in January 2016, coinciding with the beginning of the HHVBP Model. HHVBP Connect allows the HHVBP Technical Assistance staff and HHAs in the nine HHVBP states to securely login to the platform and communicate with each other and share best practices for improving performance and quality among competing HHAs. The resources available on the HHVBP Connect website include newsletters, FAQs, quality improvement tools, materials regarding HHVBP performance measures, and other information pertinent to the HHVBP Model. As part of our evaluation, we assess use of the HHVBP Connect website and its resources to answer the research question: To what extent did participants use the technical assistance provided?

2.1 Data Sources

We requested and obtained data regarding HHVBP Connect use and utilization during the calendar year 2016 from the HHVBP Technical Assistance contractor, The Lewin Group. This included data on user registration, logins, online posts, resource downloads, and webinar participation. A manual count of HHVBP Connect "Chatter" activity was also conducted to obtain data regarding posts and responses by HHAs versus non-HHAs.

[3] CMS (Centers for Medicare and Medicaid Services). (2016) Home Health Value-Based Purchasing Model. Accessed from the CMS website.

2.2 Analytic Approach

We assessed use of the HHVBP Connect site by reviewing 2016 data on user registration, logins, online posts, resource downloads, and webinar participation provided by the HHVBP Technical Assistance contractor. The data did not include information that allowed for identification of individual HHAs. However, the majority of available data regarding HHVBP Connect website use and participation included flags for HHA user type (including HHVBP Practice Users, HHVBP Administrator, and other non-HHA user types[4]) and organization name. This information allowed us to determine that between 97.8%–100% of users (depending on the resource) represent HHAs in the HHVBP intervention states. The 2.2% of HHVBP Connect users who are not HHA users include CMS staff, Technical Assistance contractor staff, and other CMS contractors. Table 3 below identifies the population that was used for analysis of each type of HHVBP Connect activity or resource. All data presented are for calendar year 2016.

Table 3. Population Analyzed for Each HHVBP Connect Activity/Resource

HHVBP Connect Activity/Resource	Description of Population
Registration	HHAs Only
Logins	All HHVBP Connect Users*
"Chatter" Activity	All HHVBP Connect Users*
Resource Downloads	All HHVBP Connect Users*
Webinar Participation	HHAs Only

**Approximately 97.8% of all HHVBP Connect users are HHAs (identified via the HHVBP Connect user profile name variable sent by the Technical Assistance contractor).*

[4] Primarily, CMS staff and its contractors.