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CMS Releases Guidance on Expanded Home Health Value-Based Purchasing ("HHVBP") Model

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On November 2, 2021, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule ("Final Rule") that advances the shift from paying for Medicare home health services based on volume to a system that pays based on value. In addition to other matters, the Final Rule expands the HHVBP Model from 9 states to all 50.

The new rule stems from a decade of CMS Innovation Center experimenting with alternative home health payment models, all launched with the goal of incentivizing quality of care improvements for home health patients. The HHVBP Model was originally piloted in 9 states and resulted in reductions in acute hospitalizations and skilled nursing facility stays. Thus, CMS determined that expanding the model will further reduce Medicare spending and improve quality. Beginning on January 1, 2022, the HHVBP Model shall apply to all Medicare certified HHAs in the 50 States, Territories, and the District of Columbia. In this blog post, we highlight the key components of the expanded HHVBP Model.

Of note, CY 2022 will be a pre-implementation year with CMS providing HHAs with training and resources to prepare for success. CY 2023 will be the first performance year with payment adjustments occurring in CY 2025. Payment adjustments will be based on each HHA's performance on a set of quality measures in a given performance year relative to other HHAs grouped in the same cohort.

Cohorts are identified based on the unique nature of the HHAs beneficiaries served in the year prior to the performance year with assignment based on either nationwide large-volume or nationwide small-volume of similar size and quality performance HHAs. Adjustments will range from -5% to +5% of Medicare fee-for-service payments.

Specifically, payment adjustments are based on each HHA's Total Performance Score (TPS) in a given performance year, which is comprised of performance on: (1) A set of measures reported via the Outcome and Assessment Information Set (OASIS), (2) completed Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) surveys, and (3) claims-based measures (e.g., acute care or ER hospitalizations during the first 60 days of HHA use). Quality measures do not count: (i) for patients that were not responsive at the start of care or resumption of care, (ii) if the HHA has less than 20 eligible quality episodes and (iii) for any patients in Medicare Advantage or Medicaid.

The expanded Model will use benchmarks, achievement thresholds, and improvement thresholds based on CY 2019 data to assess achievement or improvement of HHA performance on applicable quality measures. Competing HHAs that demonstrate they can deliver higher quality of care in a given performance year when measured against a baseline year and relative to peers nationwide (as defined by larger- versus smaller-volume cohorts), will be eligible to have their HH PPS claims final payment amount adjusted higher than the amount that otherwise would be paid. Payment adjustments for a given year will be based on the TPS calculated for performance two years prior. All HHAs certified to participate in the Medicare program prior to January 1, 2022, will be required to participate and will be eligible to receive an annual TPS based on their CY 2023 performance.

Note that while the HHVBP Model does not apply to Medicaid or commercial patients, it does provide a path and format for use in these markets as most payors move toward paying for value instead of volume.

More information on the CMS HHVBP Model can be found at https://innovation.cms.gov/innovation-models/expanded-home-health-value-based-purchasing-model and as will be updated with further guidance in 2022.

Proskauer's Health Care team can help you strategize and consider alternative payment and value-based payment arrangements for home care and other healthcare services.

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