

## Chapter 29

## Section 6

# Home Health Value-Based Purchasing (HHVBP) Demonstration

Revision: C-71, September 8, 2020

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### 1.0 PURPOSE

**1.1** As a result of Section 705 of National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017, which authorizes the Defense Health Agency (DHA) to adopt value-based incentive programs conducted by the Centers for Medicare and Medicaid Services (CMS) or any other Federal, State, or commercial health care programs, the DHA issued a notice in the Federal Register on September 25, 2019, to adopt Medicare's HHVBP model as a demonstration under the TRICARE program.

**1.2** The purpose of this demonstration is to improve the quality and delivery of home healthcare, and incentivize those Home Health Agencies (HHAs) that provide higher quality, more efficient care, as well as evaluate the administrative feasibility of adopting HHVBP adjustments under the TRICARE program. It is expected that TRICARE's adoption of the HHVBP model will strengthen the impact of the incentives included within the model by adding TRICARE's market share to Medicare's.

### 2.0 BACKGROUND

**2.1** As finalized in the Medicare Calendar Year (CY) 2016 Home Health Prospective Payment System (HH PPS) final rule (80 FR 68624), CMS began testing the HHVBP Model in January 2016. This program outlined goals to: 1) incentivize better quality care with greater efficiency; 2) study potential quality and efficiency measure for use in the HH setting; and 3) enhance the public reporting process. It is expected that tying quality to payment through a system of Value-Based Purchasing (VBP) for all Medicare-certified Home Health Agencies (HHAs) providing services in the states of Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington will improve the beneficiaries' experience and outcomes.

**2.2** In Medicare's HHVBP model, CMS determines a payment adjustment up to the maximum percentage, upward or downward, based upon the HHA Total Performance Score (TPS). The distribution of payment adjustments under this HHVBP Model are based upon quality performance, as measured by both achievement and improvement, across a set of quality measures constructed to minimize the burden as much as possible and improve care. The degree of the payment adjustment is dependent upon the level of quality achieved or improved from the base year, with the highest upward performance adjustment going to competing HHAs with the highest overall level of performance based upon either achievement or improvement in quality.

**2.3** A payment adjustment report is provided once a year to each of the HHAs by CMS. The annual report from CMS provides the HHA's payment adjustment percentage and explains how the adjustment was determined relative to its performance scores. This is the document that HHAs in the selected states shall be required to submit to TRICARE contractors prior to the beginning of each CY,

upon adoption of the HHVBP by TRICARE. For additional information on quality measures and methodologies used for calculating the HHVBP payment adjustment factor, refer to the CMS Innovation Center website at <https://innovation.cms.gov/initiatives/home-health-value-based-purchasing-model>.

**2.4** Due to the complexity of the multiple reporting systems and methodology used in the calculation of TPSs and final payment adjustment factors, DHA's approach to mirroring these HHVBP adjustment factors is to require each HHA to submit their current payment adjustment report to the TRICARE contractor. See [paragraph 2.3](#). Failure to submit the required payment adjustment report shall result in full application of the negative adjustment factor for the CY, as described in [paragraph 4.1.2](#).

### **3.0 APPLICABILITY**

**3.1** Participation in the demonstration is mandatory for all TRICARE-authorized HHAs (network and non-network) that are Medicare-certified and provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington. This demonstration is applicable to the East and West Regional Managed Care Support Contracts (MCSCs), and does not apply to the Uniformed Services Family Health Plan (USFHP), TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC), or any other contracts.

**3.2** The demonstration is effective January 1, 2020, and will run through December 31, 2022. However, if Medicare decides to terminate early or expand the demonstration beyond December 31, 2022, TRICARE will follow suit as well as adopt future modifications made to the HHVBP model by Medicare, as practicable.

### **4.0 POLICY**

#### **4.1 Reimbursement**

**4.1.1** The HHVBP payment adjustment shall apply to all TRICARE HHA PPS claims, which includes the Patient-Driven Groupings Model (PDGM) (see TRICARE Reimbursement Manual (TRM), [Chapter 12](#)), based upon the location where services were rendered, and contractors shall use the same adjustment factor calculated by Medicare for each HHA. An annual TPS and Payment Adjustment Report is released by Medicare which contains payment adjustment percentages, an explanation of when the adjustment will be applied, and how the adjustment was calculated. This report is specific to each HHA and accessible only to that HHA.

**4.1.2** Since DHA will not have access to the TPS and Payment Adjustment Report, each HHA shall provide a current copy of this report to TRICARE contractors every calendar year, and contractors shall adjust claim payments in accordance with this report. The HHA is responsible for ensuring that the appropriate TRICARE contractor who is responsible for processing the beneficiary's claim has a current copy of the TPS and Payment Adjustment Report.

**4.1.3** Providers shall have 90 days to submit their TPS to the contractor after publication of this policy. During this time contractors shall continue to process claims with a TPS adjustment factor of 1.0. At the end of the 90 days, or upon receipt of the TPS, the contractor shall reprocess all claims with a "Through" date ending on or after January 1, 2020, with the TPS factor (if received) or the full negative adjustment of 6% (if not received).

**4.1.4** For claims received 90 days after publication of this policy, failure to submit the required payment adjustment documentation with the claim or prior to the first claim submission shall result in full application of the negative adjustment factor as follows:

- Six percent (6%) for episodes or periods of care ending on or after January 1, 2020, and before January 1, 2021;
- Seven percent (7%) for periods of care ending on or after January 1, 2021, and before January 1, 2022; and
- Eight percent (8%) for periods of care ending on or after January 1, 2022, and before January 1, 2023.

Reconsideration requests shall be considered, if the provider submits the TPS Report within 90 days from the date of the initial remittance advice listing the claim as paid. Claims that are reprocessed under [paragraph 4.2](#), the reconsideration request shall be considered, if the TPS Report is received within 90 days of the new remittance advice.

**4.1.5** The HHA PPS payment amount that is due to an HHA on each claim, shall be increased or decreased by the applicable HHVBP payment adjustment percentage, after all other payment adjustments are applied. The claim payment amount that is made to an HHA by the TRICARE contractor, shall include the HHVBP incentive amount (negative or positive) that was calculated for that HHA PPS claim. Therefore, any negative incentives, if applicable, shall not be withheld from future claim payments, except for reprocessed claims described in [paragraph 4.2](#).

**4.1.6** Revisions have been made to the HH Pricer program to accept the necessary adjustment factor to apply the appropriate adjustment percentage and to capture the adjusted amount on the claim record. The HHVBP adjustment amount shall be placed on the claim as a value code **QV** amount, which may be a positive or a negative amount.

**4.1.7** All normal home health benefits and conditions for coverage requirements as outlined in TRM, [Chapter 12](#) and other TRICARE manuals shall continue to apply. This also includes those requirements related to (not an all-inclusive list):

- Beneficiary cost-share amounts
- Assessment process
- Prior authorization
- Claims and billing submission
- Medical review requirements
- Consolidated billing
- Primary provider status

## **4.2 Special Processing Code (SPC)**

**4.2.1** The contractor shall for all HHVBP claims, submit a non-underwritten TRICARE Encounter Data (TED) records citing SPC **HH** "Home Health Value-Based Purchasing". Since this demonstration shall be implemented in the contractors' systems after January 1, 2020, contractors shall search for previously processed HHA PPS claims with "Through" dates ending on or after January 1, 2020, that are eligible for the HHVBP payment adjustment (positive or negative) and adjust those claims and TED

records to reflect SPC **HH** and the new payment amount. If any of the previously submitted claims were submitted as underwritten claims, the contractor shall cancel the underwritten TED record (returning the underwritten funds to the contract) and submit the new TED record as non-underwritten citing SPC **HH**.

**4.2.2** Providers shall have 90 days to submit their TPS to the contractor after publication of this policy. At the end of the 90 days, or upon receipt of the TPS, the contractor shall reprocess these claims with the TPS (if received) or the full negative adjustment of 6% (if not received).

### **4.3 Contractor Responsibilities**

**4.3.1** The contractor shall educate HHVBP participating providers regarding the goals, terms, and conditions of the initiative.

**4.3.2** The contractor shall continually monitor access to care for participating providers according to existing TRICARE requirements. The contractor shall contact DHA within five calendar days if it is determined that HHVBP participation is adversely impacting access to care.

## **5.0 EVALUATION AND REPORTS**

### **5.1 Evaluation**

**5.1.1** This demonstration project will assist the Department of Defense (DoD) in evaluating the feasibility of incorporating the HHVBP model in the TRICARE program. The hypothesis is that payments that are linked to quality outcomes will:

- Be administratively feasible, meaning that the demonstration is successfully implemented and administered within a reasonable margin of the DHA's estimate of this demonstration;
- Improve the quality of care delivered over time; and
- Be cost-neutral or result in modest long-term cost savings.

**5.1.2** Success is defined as:

- Implementation and ongoing maintenance costs do not exceed 2% of the annual TRICARE total spent on home health care in the HHVBP demonstration states, and a high percentage of TRICARE HHAs provide their TPS scores.
- Measurable improvements in HHA quality of care measures for HHA patients in HHVBP states as compared to non-HHVBP states as reported in the Medicare HHVBP evaluation reports.
- The average acuity-adjusted home health cost per TRICARE beneficiary or episode in the HHVBP states increases at a slower rate or at the same rate compared to the same measure in the non-HHVBP states.

## **5.2 Quarterly Reports**

**5.2.1** The contractor shall submit the first quarterly reports and subsequent quarterly reports through the DHA e-Commerce Extranet, in accordance with [Chapter 14, Section 1](#).

**5.2.2** The contractor shall provide quarterly written reports to DHA. Details for reporting are identified in DD Form 1423, Contract Data Requirements List (CDRL), located in Section J of the applicable contract. The quarterly written reports summarize all of the following:

- Total dollar amount of HHVBP incentives paid to providers;
- Total dollar amount of HHVBP incentives paid to providers by State (based upon where HH services were furnished);
- Total number of claims paid under the demonstration;
- Total number of unique beneficiaries receiving HH services under the HHVBP model;
- Total number of new TPS reports received from HHAs;
- Summary of any access to care issues; and
- Summary of any provider feedback (positive or negative) received, specifically related to the demonstration.

**5.2.3** These quarterly written reports shall be provided to DHA within 15 calendar days after the end of the reporting period. Reporting periods are every April 1, July 1, October 1, and January 1. The report shall be based upon claims that were completed during the prior three months. For example, the report that is due in October, shall provide information on claims completed and issues reported during the months of July, August, and September.

**5.2.4** In addition to the written reports, contractors shall also provide quarterly claims data on each claim that was paid under the HHVBP model. These reports shall be provided to DHA within 15 calendar days after the end of the reporting period. Reporting periods are every April 1, July 1, October 1, and January 1, and is separate from the written report. The report shall be based upon claims completed during the prior three months, as described in [paragraph 5.2.3](#). Details for reporting are identified in DD Form 1423, CDRL, located in Section J of the applicable contract.

## **5.3 Annual Reports**

**5.3.1** The contractor shall submit the first annual written report and subsequent annual written reports through the DHA e-Commerce Extranet, in accordance with [Chapter 14, Section 1](#). Details for reporting are identified in DD Form 1423, CDRL, located in Section J of the applicable contract.

**5.3.2** The contractor shall provide annual written reports to DHA that summarize the following:

- Total dollar amount of HHVBP incentives paid to providers by State (based upon where HH services were furnished);

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- Total number of claims paid under the demonstration;
- Total number of unique beneficiaries receiving HH services under the HHVBP model;
- Total number of new TPS reports received from HHAs;
- Summary of any access to care issues;
- Summary of any provider feedback (positive or negative) received, specifically related to the demonstration;
- Analysis in emergency department utilization for beneficiaries who received HH services in HHVBP states; and
- Analysis in spending and utilization of HH services in the nine states.

**5.3.3** These annual written reports shall be provided to DHA within 20 calendar days after the end of the calendar year, and is in addition to the quarterly reports. The report shall be based upon claims completed during the prior year. For example, the annual report that is due in January 2021, shall provide an analysis and summary of all HHVBP claims completed during CY 2020.

## **6.0 EXCLUSIONS**

**6.1** Any claims where home health services are furnished outside of the nine selected states listed in [paragraph 3.1](#).

**6.2** Any Medicare-certified HHA that provides services in the nine selected states, and has a CMS exemption letter stating that the HHA is exempt from participating in the Medicare HHVBP Model.

**6.3** Any claims for TRICARE beneficiaries with Other Health Insurance (OHI), where TRICARE is not the primary payer.

**6.4** Beneficiaries enrolled in TRICARE For Life (TFL).

**6.5** Beneficiaries who have dual eligibility under both TRICARE and Medicare and whose claims are not processed under the East or West Regional MCSC.

**6.6** Beneficiaries enrolled in the TRICARE Overseas Program (TOP).

**6.7** Beneficiaries enrolled in the Continued Health Care Benefit Program (CHCBP).

## **7.0 EFFECTIVE DATE**

The HHVBP Model is effective January 1, 2020.

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