Navigating the Future of HHVBP: What's Changing in 2026 and Why It Matters

The Ripple Effect: Evolving Care at Home 2026

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Presenter

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HHVBP Changes

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Why is this important?

- Total Performance Score determines what +/- adjustment to payment you will get for the year
- Average TPS for Michigan was 32 (out of 100) in 2024
- CMS keeps on changing the rules of the game

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Matter of Clarification

2024	2025	2026
CY 2024 Performance	CY 2025 Performance	CY 2026 Performance
Called CY2025 APR	Changed from M1800s to DCF	First VBP reports out on OASIS outcomes not until July 2026
APR out this past fall	April IPR • 4 Quarters of 2025 OASIS outcomes • 3 quarters of 2025 claims based and HHCAHPS outcomes • Included 2026 data	First VBP reports out on other outcomes October 2026 New HHCAHPS in April but won't show up until 2028

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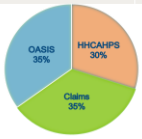
2025: Quality Measures Home Health VBP TPS

OASIS-based Measures	Weight
Discharge Function Self-Care and Mobility (based on GG)	20%
Oral Meds (M2020)	9%
Dyspnea (M1400)	6%
Total for OASIS-based Measures	**35.00%**



HHCAHPS Survey Measures	Weight
HHCAHPS Care of Patients	6.00%
HHCAHPS Communication	6.00%
HHCAHPS Specific Care Issues	6.00%
HHCAHPS Overall Rating	6.00%
HHCAHPS Willingness to Recommend	6.00%
Total for HHCAHPS Survey Measures	**30.00%**

Claims-based Measures	*Weight*
PPH	26%
DTC	9%
Total for claims-based Measures	***35.00%***

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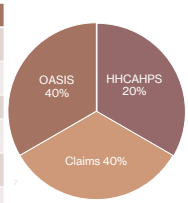
2026: Quality Measures Home Health VBP TPS

Measure	Weight
Improvement in Dyspnea	7%
Improvement in Oral Med Management	11%
Discharge Function	15%
Improvement in Bathing	3.5%
Improvement in Dressing Upper Body	1.75%
Improvement in Dressing Lower Body	1.75%



Measure	Weight
Willingness to Recommend	10%
Overall Rating	10%

Measure	Weigh t
PPH	15%
DTC-PAC	15%
MSPB	10%

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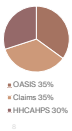
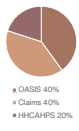
Changes in Measures

2025 Measures	Weight
Discharge Function Score	20%
Oral Meds (M2020)	9%
Dyspnea (M1400)	6%
PPH	26%
DTC-PAC	9%
HHCAHPS Care of Patients	6%
HHCAHPS Communication	6%
HHCAHPS Specific Care Issues	6%
HHCAHPS Overall Rating	6%
HHCAHPS Willingness to Recommend	6%



2026 Measures	Weight
Discharge Function Score	15%
Improvement in Oral Med Management	11%
Improvement in Dyspnea	7%
Improvement in Bathing	3.5%
Improvement in Dressing Upper Body	1.75%
Improvement in Dressing Lower Body	1.75%
PPH	15%
DTC-PAC	15%
MSPB	10%
Willingness to Recommend	10%
Overall Rating	10%



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2026 HHVBP Measure Weight Changes

Measure	Performance Year 2025	Performance Year 2026
Discharge Function	20	15
Oral Med Mgmt	9	11
Dyspnea	6	7
Bathing	--	3.5
Upper Body Dressing	--	1.75
Lower Body Dressing	--	1.75
PPH	26	15%
DTC-PAC	9	15%
MSPB	-	10%
Care of Patients, Communication, Specific Care Issues	6 x 3	--
Overall Rating	6	10
Willingness to Recommend	6	10

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Addition of OASIS-Based Function Measures to Supplement DC Function

- Improvement in Bathing (based on OASIS item M1830)
- Improvement in Upper Body Dressing (based on OASIS item M1810)
- Improvement in Lower Body Dressing (based on OASIS item M1820)

- Benchmarks, achievement thresholds, and improvement thresholds for the OASIS-based function measures are in the IPRs
- Found in iQIES (Bathing is found in STAR)

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Medicare Spending Per Beneficiary - Post-Acute Care (MSPB-PAC)

What It Measures

- Evaluates an HHA's Medicare spending per episode compared to the national median.
- Includes spending by the HHA and all other providers during the episode and the 30-day post-discharge services window.
- Risk-adjusted to allow fair comparison across agencies.

Why It Matters

- Identifies HHAs delivering high-quality care at lower cost.
- Encourages care coordination and efficient service delivery across the full episode of care.
- Directly impacts HHVBP scoring, with 10% weight in 2026.
- Reflects improvements over time – CMS includes **two years of data** and recognizes year-over-year performance gains.

Data Source & Reporting

- Based on Medicare Part A & B FFS claims and eligibility files.
- Uses a 6-month data lag, similar to other claims-based HHVBP measures.

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Measure Calculation

Measure Calculation

- The MSPB-PAC measure is calculated as the ratio of the payment-standardized, risk-adjusted MSPB-PAC Amount for each HHA divided by the episode-weighted median MSPB-PAC Amount across all HHAs. Mathematically, the MSPB-PAC measure for an individual PAC provider is:

Numerator (MSPB-PAC Amount)

- This is the average observed over expected (as predicted through risk adjustment) Medicare spending for a home health agency's MSPB-PAC HH's episodes, multiplied by the national average MSPB-PAC HH spending.

Denominator

- Episode-weighted national median of the MSPB-PAC amounts across all HHAs.

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MSPB-PAC Measure Results Meaning

< 1	• Indicates that the agency's resource use is less than that of the national median for HHAs during the performance period.
= 1	• Indicates that the agency's resource use is equal to that of the national median for HHAs during the performance period.
> 1	• Indicates that the agency's resource use is greater than that of the national median for HHAs during the performance period.

Example:
Actual cost: $1,000; Expected cost: $900 → ratio = 1.11
Average ratio across episodes = 1.10
National average spending $5,000 → agency's MSPB = $5,500

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MSPB-PAC Definitions

Episode

- Includes all Medicare Part A and Part B services with a start date in the **episode window**, except for services that are excluded for being clinically unrelated to PAC treatment.

Episode Window

- Consists of a **treatment period** and an **associated services period**.
- The episode window **begins** on the first day of the HH claim and **ends 30 days** after the **Treatment Period** ends.

Treatment Period

- Time which the pt receives care services from HHA, and includes claims for: The HHA, Physician/Supplier (Part B), Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
- Excludes services unrelated to PAC treatment
- End date is determined by the type of HH payment episode:
  - PEP – treatment period ends at HH discharge
  - Standard Payment Episode and LUPA – treatment period ends **60 days** after trigger

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MSPB-PAC Definitions

Associated Services Period

- Associated services are non-treatment services that are provided within the associated services period for a given MSPB-PAC episode.
- The associated services period is the time during which any Medicare Part A and Part B services other than those in the treatment period are counted towards the episode spending, except for a limited set of services that are clinically unrelated to PAC treatment.
- **The associated services period starts at the episode trigger and ends 30 days after the last day of the episode's treatment period.**

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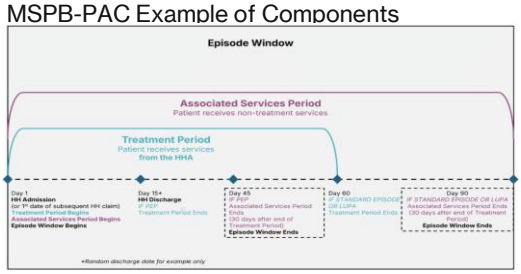
MSPB-PAC Example of Components



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Exclusions – Clinically Unrelated Services

Services that were determined by clinical consensus to be outside of the control of PAC providers include:

- Planned hospital admissions
- Routine management of certain preexisting chronic conditions (e.g., dialysis for end-stage renal disease (ESRD), enzyme treatments for genetic conditions, treatment for preexisting cancers, and treatment for organ transplants)
- Some routine screening and health care maintenance (e.g., colonoscopy and mammograms)
- Immune modulating medications (e.g., immunosuppressants for organ transplant or rheumatoid arthritis)

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Exclusions from Measure

- Episodes triggered by a PAC claim outside the 50 states, D.C., Puerto Rico, and U.S. territories.
- Episodes where the claim(s) constituting the attributed PAC provider's treatment have a standard allowed amount of zero or where the standard allowed amount cannot be calculated.
- Episodes in which a patient is not enrolled in Medicare FFS for the entirety of a 90-day lookback period (i.e., a 90-day period prior to the episode trigger) plus episode window (including where a beneficiary dies), or is enrolled in Part C for any part of the lookback period plus episode window.
- Episodes in which a patient has a primary payer other than Medicare for any part of the 90-day lookback period plus episode window.
- Episodes with outlier residuals below the 1st percentile or above the 99th percentile of the residual distribution.

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Changes to VBP based on HHCAHPS

Removed the following HHCAHPS Survey-based measures from the HHVBP applicable measure set starting with CY 2026:

- Care of Patients
- Communications between Providers and Patients
- Specific Care Issues

CMS needs a full year of data from new HHCAHPS items (CY2027). Needs achievement and improvement thresholds and benchmarks.

New rulemaking to add the revised items back into HHVBP.

What's left?

Overall Rating

Willingness to Recommend

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CY2026 Achievement and Improvement Thresholds and Benchmarks

CY 2026 Measure Set: Improvement Thresholds

Measure	Baseline Year Data Period [b]	Your HHA's Improvement Threshold	Your HHA's Percentile Ranking Within Your HHA's Cohort [c]	Your HHA's Cohort Statistics [d]			
				25th Percentile	50th Percentile	75th Percentile	90th Percentile
OASIS-based Measures							
Discharge Function (DC Function)	12-31-2023	72.350	≥75	51.180	62.350	70.090	83.179
Improvement in Dyspnea	12-31-2023	93.133	50-74	81.109	89.672	94.382	99.422
Improvement in Management of Oral Medications	12-31-2023	76.653	25-49	75.179	85.175	91.280	98.746
Improvement in Bathing	12-31-2023	91.910	50-74	82.710	89.627	94.024	99.259
Improvement in Upper Body Dressing	12-31-2023	87.488	25-49	82.519	88.966	93.014	98.570
Improvement in Lower Body Dressing	12-31-2023	84.905	25-49	80.378	87.189	92.184	98.207
Claims-based Measures							
Discharge to Community – Post Acute Care (DTC-PAC)	12-31-2023	90.578	≥75	78.036	85.161	89.907	95.089
Medicare Spending Per Beneficiary - Post-Acute Care (MSPB-PAC)	12-31-2023	0.911	≥75	1.050	0.987	0.922	0.784
Potentially Preventable Hospitalizations (PPH)	12-31-2023	8.520	50-74	11.997	10.003	8.356	6.302
HHCAHPS Survey-based Measures							
Overall Rating of Home Health Care	12-31-2023	92.142	≥75	82.336	86.128	89.659	94.687
Willingness to Recommend the Agency	12-31-2023	83.410	50-74	74.880	80.226	84.714	91.391

Found in the IPRs

Personal to your Agency

Achievement

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Compare

Measure	Baseline Year Data Period [b]	Your HHA's Improvement Threshold	Your HHA's Percentile Ranking Within Your HHA's Cohort [c]	25th Percentile	50th Percentile	75th Percentile	90th Percentile	99th Percentile	Current Ja
OASIS-based Measures		You 2023			Your peers 2023				
Discharge Function (DC Function)	12-31-2023	72.350	≥75	51.180	62.350	70.090	83.179	91.260	86.932
Improvement in Dyspnea	12-31-2023	93.133	50-74	81.109	89.672	94.382	99.422	100.000	98.426
Improvement in Management of Oral Medications	12-31-2023	76.653	25-49	75.179	85.175	91.280	98.746	100.000	
Improvement in Bathing	12-31-2023	91.910	50-74	82.710	89.627	94.024	99.259	100.000	99.70 CC
Improvement in Upper Body Dressing	12-31-2023	87.488	25-49	82.519	88.966	93.014	98.570	100.000	IQHS
Improvement in Lower Body Dressing	12-31-2023	84.905	25-49	80.378	87.189	92.184	98.207	100.000	IQHS
Claims-based Measures									
Discharge to Community – Post Acute Care (DTC-PAC)	12-31-2023	90.578	≥75	78.036	85.161	89.907	95.089	97.542	88.826
Medicare Spending Per Beneficiary - Post-Acute Care (MSPB-PAC)	12-31-2023	0.911	≥75	1.050	0.987	0.922	0.784	0.693	89 CC
Potentially Preventable Hospitalizations (PPH)	12-31-2023	8.520	50-74	11.997	10.003	8.356	6.302	5.295	8.212
HHCAHPS Survey-based Measures									
Overall Rating of Home Health Care	12-31-2023	92.142	≥75	82.336	86.128	89.659	94.687	97.805	91.300
Willingness to Recommend the Agency	12-31-2023	83.410	50-74	74.880	80.226	84.714	91.391	95.268	85.129

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Biggest Risks

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Some of the Biggest Risks (and Bigger Opportunities)

OASIS accuracy	Timely initiation of care	Functional outcomes
Discharge/transfer documentation	Rehospitalizations	Patient experience (HHCAHPS)

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OASIS Accuracy and Functional Outcomes

- If claims-based numbers are good, but OASIS is not
- Your Discharge Function could be good, but payment is not
- Struggles with Oral Med Management and Improvement with Dyspnea

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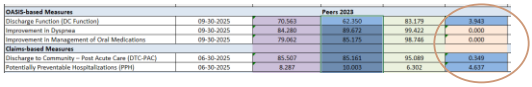
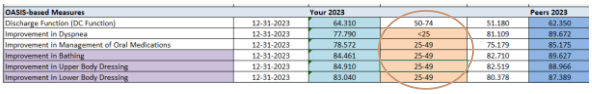
This agency has 12+ points on PPH



OASIS-based Measures			Peers 2023		
Discharge Function (DC Function)	09-30-2025	70.563	62.350	83.179	3.943
Improvement in Dyspnea	09-30-2025	84.180	89.672	99.422	0.000
Improvement in Management of Oral Medications	09-30-2025	79.062	85.175	98.786	0.000
Claims-based Measures					
Discharge to Community - Post Acute Care (DTC-PAC)	06-30-2025	85.507	85.161	95.089	0.349
Potentially Preventable Hospitalizations (PPH)	06-30-2025	8.287	10.003	6.302	4.637



OASIS-based Measures		Your 2023			Peers 2023
Discharge Function (DC Function)	12-31-2023	64.310	50-74	51.180	62.350
Improvement in Dyspnea	12-31-2023	77.790	<25	81.109	89.672
Improvement in Management of Oral Medications	12-31-2023	78.572	25-49	75.179	85.175
Improvement in Bathing	12-31-2023	84.461	25-49	82.710	89.627
Improvement in Upper Body Dressing	12-31-2023	84.910	25-49	82.519	88.966
Improvement in Lower Body Dressing	12-31-2023	83.040	25-49	80.378	87.389

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Example Revenue Difference (DCF was good)

- *Functional Level Opportunity – Do you have the correct primary?*

Percent Functional Low	66.67%	**Percent Functional Low**	30.17%
Percent Functional Medium	23.08%	**Percent Functional Medium**	31.73%
Percent Functional High	10.26%	**Percent Functional High**	38.10%

# of 30-day Claims	2400							
Agency Functional Impairment	Agency %	National Functional Impairment	National %	Difference %	% Multiplier	Number of cases	$ Multiplier	Additional Revenue
Low	66	Low	30				0	$0.00
Med	23	Med	32	9	0.09	216.00	$200	$43,200.00
High	10	High	38	28	0.28	672.00	$400	$268,800.00
High	10	4+ Star	45	35	0.35	840.00	$400	$336,000.00

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Timely Initiation of Care

- 48 hours from referral
- 48 hours from discharge
- Ordered SOC

- Patient at greatest risk within days 1-5 of DC from ACF

- What happens when the SOC date keeps moving?
- Is it really the patient?

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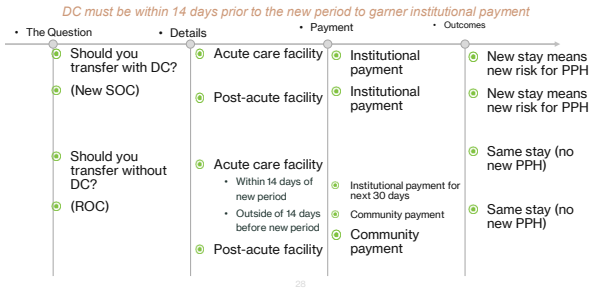
Discharge or Transfer – That is the question



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Rehospitalizations-PPH

- Potentially Preventable Hospitalizations
  - Risk adjustment completely different from that of ACH
  - Includes hospitalizations, ED and observation
- Strategies
  - 7 Touches in 7 Days
  - Tuck-in Thursdays
  - M1033 Screening
    - Mitigating risk
  - What does your data say?

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CoPs – Assess and Plan

- **Comprehensive Assessment (§484.55):**
  - ***Content of the Comprehensive Assessment:*** Agencies must ***evaluate*** the patient's current health, psychosocial, functional, and cognitive status. This includes identifying strengths, goals, care preferences, and any factors that may indicate a ***risk for hospitalization***.
- **Plan of Care (§484.60):**
  - ***Development of the Plan:*** Based on the comprehensive assessment, an individualized plan of care must be established. This plan should detail all pertinent diagnoses, mental and psychosocial status, types of services required, visit frequency, and other relevant information.
  - ***Mitigation:*** The plan must specifically include a description of the patient's risk for emergency department visits and hospital readmission, along with necessary interventions to address these underlying risk factors.

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Capturing Risk Factors for Hospitalization

- *Comprehensive Assessment & Plan Of Care*

Accuracy of OASIS item M1033	• Focus on more than reimbursement • Identifying Risk • Personalize POC
Identifying social determinants of health that place a patient at risk	• Early identification • Early intervention • Staff education of resources
Significant co-morbid conditions	• Assessment best practices for significant co-morbids • POC should not just address primary dx • Address comorbidities too

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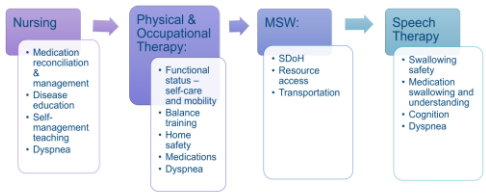
Who Owns Hospitalization Risk?



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mcbee part of Netsmart

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7 Touches in 7 Days

- Front loading
- On the days you don't visit, Call!
- Ask about:
  - Symptoms
  - Vital signs, blood sugar
  - Appointments
  - Pain
  - Meds
- Remind them when you are coming next
- Remind them to call you if they run into trouble
- Opportunity to identify:
  - Declines in status
  - Missing meds
  - Missing supplies
  - Need for additional visit or intervention
- Builds trust and rapport
- Improves communication and patient satisfaction
- Decreases hospitalizations!

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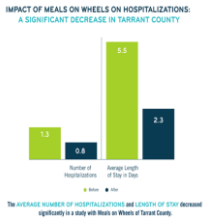
Meals- on- Wheels

- Over 38 studies done on the effect of MOW on outcomes!
- In a study with Meals on Wheels of Tarrant County, it was observed that among individuals recently discharged from the hospital, the average number of emergency department visits **decreased to less than a third** of the previous count (from 5.03 average emergency department visits in the six months before meals to an average of 1.45 emergency department visits after receiving meals).
- Research found that participants who received more meals over a 12-month period experienced fewer emergency department visits and hospitalizations, after controlling for demographic characteristics and levels of physical functioning.



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Meals- on- Wheels

- Receiving more than 11 home-delivered meals per month was associated with a 10% lower risk of hospital admissions in an analysis of Indiana Medicaid data.
- Receiving Meals on Wheels was associated with a lower risk of hospitalization for older adults who were partly homebound in a statistical analysis of national longitudinal survey data.
- Fewer individuals who received meals were hospitalized during the study period, compared to those who did not receive meals (14% vs. 20%) in the Meals on Wheels America More Than a Meal® study with eight local programs.
- The hospital readmissions rate declined (12% to 10%) after receiving meals services for 24 months as part of a community-based care transition program from the Maine Medical Center and the Southern Maine Agency on Aging.

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Rehospitalizations – DTC PAC

- Discharge to Community Post-Acute Care
  - Your discharge + 31 days
  - Hospice exclusions
  - DC AMA exclusions
- Strategies
  - Real DC planning
  - Set the patient up for success
    - Mobility
    - Medications
    - Follow-up provider appointments
  - Weekly calls after DC

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Against Medical Advice Discharges

3. Discharges against medical advice

- *Rationale:* Patients who discharge themselves against medical advice are excluded because their care plan may not have been fully implemented, and the discharge destination may not reflect the agency's discharge recommendation. Additionally, patients discharged against medical advice may potentially be at higher risk of post-discharge admissions or death, depending on their medical condition, or due to potential non-adherence or non-compliance with care recommendations.
- Disappears off the face of the Earth
- Refused further visits
- Discharge because of non-compliance
- Document discussion with the provider!!
- Patient's right to self-determination or autonomy while attempting to do what you think is best for the patient
- Inadequately treated medical problems can result in the need for readmission
- NOMNC

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Clinical Strategies

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OASIS-Based Measures

- Education, Education, Education!
- Educate staff on GG scoring accuracy and avoid "activity not attempted" defaults, as well as other OASIS items, PDGM, Star rating and HHVBP
- Regularly audit OASIS documentation to identify trends and inconsistencies. Evaluate internal processes for SOC/ROC assessments, clinician training, and QA feedback loops
- Outsource to certified experts for OASIS & Coding Review to ensure compliance, maximize outcomes and reimbursement
- Use performance dashboards to track improvement and motivate staff.
- Clinical Consulting to help identify documentation gaps, streamline workflows, and align practice with outcomes.
- Agencies investing in staff education, clinical QA partnerships, and real-time data feedback see measurable improvements in scores – and in revenue.

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Claims-Based Measures

- Avoiding unnecessary hospital stays can significantly boost outcomes and financial performance.
- Use predictive analytics to identify high-risk patients.
- Implement 7 Touches in 7 Days & Tuck-In Calls for early intervention.
- Provide patient & caregiver education on when to call the agency first.
- Track ER/Observation stays and address gaps in care planning.
- Conduct root cause analysis after hospitalizations to prevent recurrences.
- Embed risk assessments directly into care plans.
- Clinical Consulting to uncover root causes & optimize care management.
- Investing in proactive care planning and staff education leads to measurable gains in VBP performance, reduced hospitalization rates, and stronger patient outcomes.
- Real discharge planning

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HHCAHPS

- Train staff on new questions as of April 1.
- Willing to Recommend and Overall Rating counts in 2026.
- Agencies can use HHCAHPS feedback to identify areas for improvement in care delivery and patient interactions.
- Train staff in empathetic communication and customer service training at least annually.
- Use “Call Us First” campaigns to reinforce patient engagement.
- Touchbase calls during and after discharge
- Continuity of care
- Copy of envelope in SOC packet
- Look at return rates, consider increasing # surveys sent
- Monitor composite scores and address low-performing domains.

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Presenter Contact Information

Contact us via email LisaSelman-Holman@McBeeAssociates.com

Home Care & Hospice

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Resources

- https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-home-health-prospective-payment-system-proposed-rule-fact-sheet-cms-1828-p
- https://www.federalregister.gov/documents/2025/07/02/2025-12347/medicare-and-medicaid-programs-calendar-year-2026-home-health-prospective-payment-system-hh-pps-rate
- https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model

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