

Home Health Value-Based Purchasing Frequently Asked Questions (FAQs)

June 2016

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FAQ Categories

Home Health Value-Based Purchasing (HHVBP) Model

Implementation

New or Revised	#	Originally Posted	Last Updated	FAQ
-	100	12/29/15	-	**What is the contact information of the Home Health Value-Based Purchasing (HHVBP) Helpdesk?** The HHVBP Helpdesk can be reached by email at HHVBPquestions@cms.hhs.gov (mailto: HHVBPquestions@cms.hhs.gov).
-	101	12/29/15	-	**Who will support the HHVBP Helpdesk?** The HHVBP Helpdesk is supported by the technical assistance contractor, The Lewin Group.
-	102	12/29/15	-	**Will HHAs have a project officer?** HHAs will not have a project officer, but will receive assistance through the Model's learning and diffusion website, *HHVBP Connect*, and the technical assistance contractor, The Lewin Group.
-	103	12/29/15	-	**I have read through the recently published Federal Register, CMS1625F, published November 5, 2015 regarding the Home Health PPS rates, and VBP for CY 2016. Even though I have read the section on Value-based purchasing a couple of times, I am a little confused as to when the actual VBP begins. Are all HHA's subject to the VBP adjustment beginning on January 1, 2016, or is only the nine selected states?** Starting January 1, 2016, CMS implemented the Home Health Value-Based Purchasing Model in nine states representing each geographic area in the nation. All Medicare-certified home health agencies that provide services in Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington, will compete on value in the HHVBP Model.
-	104	12/29/15	-	**If the branch office is in a state selected to be in the Model, but has a parent office in a non-selected state and the CCN is for the non-selected state are they required to participate for the patients out of the branch office?** No. Only Medicare certified home health agencies with a CCN that provide services in one of the nine selected states are required to participate.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	105.1	12/29/15	03/31/16	**How will this payment model impact newly certified agencies?** Newly certified agencies will be included in the Model. They will have access to the HHVBP Secure Portal to submit New Measure Data, the learning and diffusion website, and other resources but will not be subject to the payment adjustment until such time that they generate scores on five or more measures that are used to calculate the Total Performance Score for the HHVBP Model. In order to receive a score on a measure, the HHA must have a minimum of 20 home health episodes of care for the measure. For new market entries, under the model, the first full year of services will be used as baseline data for subsequent performance years.
-	106	12/29/15	-	**If you are Medicare certified, but provide very little services to Medicare (e.g., 10 cases/year), should you still sign up for this?** Yes. All Medicare certified HHAs that provide services in one of the selected states are required to participate in this Model. They will have access to the HHVBP Secure Portal to submit New Measure Data, the learning and diffusion website, and other resources but will not be subject to the payment adjustment until such time that they generate scores on five or more measures that are used to calculate the Total Performance Score for the HHVBP Model. In order to receive a score on a measure, the HHA must have a minimum of 20 home health episodes of care for the measure.
-	107	12/29/15	-	**Is hospice involved in HHVBP?** No. Hospice is not involved in HHVBP.
-	108	12/29/15	-	**What do you mean by a "same size cohort"?** Larger-volume cohort means the group of competing home health agencies within the boundaries of selected states that are participating in HHCAHPS in accordance with § 484.250. Smaller-volume cohort means the group of competing home health agencies within the boundaries of selected states that are exempt from participation in HHCAHPS in accordance with § 484.250. Those HHAs in the smaller-volume cohorts will compete with other HHAs that are in the smaller-volume cohort in their state with the exception of where there are too few HHAs in the smaller-volume cohort in each state to compete in a fair manner, these HHAs would be included in the larger-volume cohort for purposes of calculating the Total Performance Score and payment adjustment without being measured on HHCAHPS. HHAs in the larger-volume cohorts will only compete with other HHAs that are in the larger-volume cohort in their state.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	109	12/29/15	-	**What is a CCN?** A CCN is a six digit (all numeric) CMS Certification Number.
-	110	03/31/16	-	**For agencies in the 9 states selected, is the HHVBP Model mandatory or voluntary?** Inclusion in the HHVBP Model is mandatory for all Medicare-certified agencies with a CCN in the HHVBP select states. All Medicare-certified agencies with a CCN in the selected states are at risk for Medicare PPS payment adjustments regardless of their registration or active participation in the Model. Medicare-certified agencies that do not bill Medicare PPS and do not receive Medicare PPS payments are at no risk for Medicare PPS payment adjustments.
-	111	03/31/16	-	**Can you list the steps required to register for the Model and the HHVBP websites?** HHAs in the nine selected states should provide the HHVBP Help Desk, HHVBPquestions@cms.hhs.gov, with the name and email address of a primary point of contact (PPOC) for each CMS Certification Number (CCN). Please also include the agency name, agency address and agency phone number. The primary point of contact should be someone who understands the daily operations of the HHA and has the authority to delegate/assign tasks. PPOCs will be sent information about the *HHVBP Connect* site. Each PPOC must obtain a CMS Enterprise Identity Management (EIDM) User ID from the CMS Secure Portal (https://portal.cms.gov/wps/portal/unauthportal/home/) This is an important first step towards registration for the HHVBP Model Secure Portal, where HHAs will receive performance reports and enter data for new measures. PPOCs must email their EIDM User ID to the HHVBP Help Desk. Additional information about registering for the HHVBP Secure Portal can be found on the *HHVBP Connect* website.
-	112	03/31/16	-	**Are home health agencies that are not Medicare-certified required to participate in the HHVBP Model?** No. A competing HHA is defined as an agency that has a current Medicare certification and that is being paid by CMS for home health care delivered within any of the states selected in accordance with the HHVBP Model's selection methodology.

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-	113	03/31/16	-	**If an agency is in the process of changing ownership and the agency has a CCN in one of the HHVBP selected states, should the new owners follow the registration steps and participate in trainings?** If you have a CCN for the agency and the new owner will use the same CCN because they have accepted assignment of the CCN please follow registration steps and indicate in your emails to the HHVBP Help Desk the change of ownership effective date and CCN. If the new owner is not accepting assignment of the CCN, they should register once the new CCN is approved, and so state in the email to the HHVBP Help Desk.
-	114	03/31/16	-	**When does the HHVBP Model include all 50 states or additional states?** There are no plans at this time to add additional states to the current HHVBP Model.
-	115	4/30/16	-	**What payers are included in the Model?** The payment adjustments in the HHVBP Model apply to only Medicare PPS claims. The measures in the HHVBP Model include all payers that are currently included in the measure calculations: • OASIS-Based Measures – include Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care • Claims-Based Measures – include only Medicare fee-for-service • HHCAHPS Measures - include Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care • New Measures – o Herpes Zoster (Shingles) Vaccination - includes Medicare beneficiaries, including Medicare fee-for-service and Medicare Advantage (Medicare managed care) beneficiaries o Advance Care Plan - includes all payers
-	116	4/30/16	-	**Does the HHVBP Model include private duty patients?** HHVBP measures are not calculated for private duty patients. The HHVBP payment adjustments apply only to Medicare PPS claims.

Payments

New or Revised	#	Originally Posted	Last Updated	FAQ
-	200	12/29/15	-	**Are the payment adjustments only applied to a HHA's Medicare payments or will it also apply to Medicaid payments?** The HHVBP Model payment adjustments will only be applied to HH PPS claims for Medicare fee-for-service beneficiaries.
-	201	12/29/15	-	**Will our 2016 results affect payment in 2018, or will payment for 2016 be affected?** The first payment adjustments for HHVBP occur in January 2018 based on 2016 performance year scores.
-	202	03/31/16	-	**Our agency's address is not in a HHVBP Model state, but we see patients in a Model state. Do we need to participate?** The agency CCN will determine if the agency is included in the Model. Agencies with a CCN in one of the 9 select states will be included in the Model. In your example, if your CCN is not associated with a Model state, you would not be included in the Model even though you care for patients in a Model state.

Reports

New or Revised	#	Originally Posted	Last Updated	FAQ
Revised	301.1	12/29/15	6/30/16	**Please clarify if agencies have either 10 days or 30 days to review performance and payment adjustment reports for potential issues.** The HHAs will have 30 days to review the Interim Performance Reports[1] and the Annual TPS and Payment Adjustment Reports and submit a request for recalculation.
Revised	302.1	12/29/15	6/30/16	**Will we have a report prior to July 2016?** No. The first Interim Performance Reports[1] provided to HHAs will be in July of 2016.
Revised	303.4	12/29/15	6/30/16	**We were told CMS would be providing agencies with performance data from 2013 and 2014 in January. Is that for educational/informational purposes only, e.g., to get a sense of starting point?** Aggregate level Benchmarks and Achievement thresholds (by state) have been calculated using the 2014 data. This serves as a preview of how benchmark and achievement thresholds will be reported. This data can be found on the *HHVBP Connect* website. There are currently no plans to post 2013 values. The 2015 Benchmarks and Achievement Thresholds were posted on *HHVBP Connect* in April 2016. This resource provides the benchmarks and achievement thresholds for each measure included in the HHVBP Model, aggregated by state and then by cohort (larger-volume and smaller-volume). Note that benchmarks and achievement thresholds will be included in the Interim Performance Reports[1] which will first be available on the HHVBP Secure Portal in July 2016. HHA-specific Baseline Period Scores for each applicable measure will also be included in the Interim Performance Reports[1]. Agencies could review their Home Health Compare data for the individual measures to get an approximate rate that can be compared with the benchmark or achievement thresholds. Data periods for the calculation of the 2015 benchmark and achievement thresholds will not match the data periods currently displayed on Home Health Compare.

Scoring

New or Revised	#	Originally Posted	Last Updated	FAQ
-	400.1	12/29/15	4/30/16	**When will benchmarks and thresholds be available to competing HHAs?** Benchmarks and achievement thresholds for the OASIS measures using 2015 data will be available by the end of April 2016. Benchmarks and achievement thresholds for the HHCAHPS measures and the claims measures using 2015 data will be available by July 2016. However, because benchmarks and achievement thresholds of most measures are based on industry averages that do not vary significantly over a period of several years, we anticipate that the preliminary aggregate level benchmarks and achievement thresholds for the OASIS, HHCAHPS and Claims measures based on data for 2014 that was posted on *HHVBP Connect* will be comparable.
-	401	12/29/15	-	**While each individual measure is calculated to the third decimal point, will that also be the case for the TPS?** The Total Performance Scores will be calculated to the third decimal point. They will not be rounded to whole numbers. This was a change to the design of HHVBP that was described in the Final Rule that was published 11/5/2015 in the Federal Register https://www.federalregister.gov/articles/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home It states that "all achievement and improvement points will be rounded up or down to the third decimal point."
-	402	12/29/15	-	**Is there a threshold number of measures that an agency must have data on in order to participate across classifications? Or must agencies have at least one measure in each classification?** The HHAs must have a minimum of 20 episodes of care to be scored on any given measure. Only HHAs measured on a total of any five measures or more will receive a Total Performance Score and be subject to a payment adjustment regardless of how the measures are classified.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	403	12/29/15	-	**Please clarify which of the measures fall under the new classification of "Care Coordination and Efficiency."** Table 4a in the Final Rule that was published 11/5/2015 in the Federal Register describes both acute hospitalization and emergency room visits as efficiency measures. Care Coordination measures are advance care planning, care management, and discharge to community. Below is the link: https://www.federalregister.gov/articles/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home
-	404	12/29/15	-	**We are very small and will have some zeroes. How will that impact our score? What happens as we grow next year and those zeroes turn into numbers? Does that disadvantage our score?** Only measures that have values will be included in the TPS calculation. A minimum of five measures are need to calculate a TPS and a subsequent payment adjustment. As you grow, additional measures will be included in your TPS calculation if the measure has a minimum of 20 home health episodes of care. Having fewer measures will not have an advantage or disadvantage with respect to the TPS or the payment adjustment.
-	405	03/31/16	-	**Are the measures from Home Health Compare and the achievement score and improvement score used in the calculation of the Total Performance Score risk adjusted?** The risk-adjustment methodology uses the national predicted value to compute the HHA's risk-adjusted value. The achievement and/or improvement scoring (benchmarks) by measure for the Total Performance Score utilizes the risk-adjusted values for HHAs within each of the nine states to create state-specific achievement and/or improvement scores. The comparison of an HHA's performance is based on the HHA's performance relative to HHAs in the agency's state, using these achievement and/or improvement benchmarks.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	406	03/31/16	-	**Are the OASIS items used to calculate OASIS-based measures in the HHVBP Model and the Total Performance Score the same items as are used to calculate the measures in the CASPER Reports and on Home Health Compare?** Yes. All OASIS-based outcome measures utilized in the Total Performance Score computation are computed in accordance with the specifications listed in the Home Health Agency Quality Measures: Technical Documentation of OASIS Based Patient Outcome Measures, published in September 2014.
-	407.1	12/29/15	03/31/16	**Will the baseline data be individual, or based on all the other agencies in the nine states in the Model?** The baseline data consists of both individual HHA level data as well as aggregate HHA data. HHAs will have access to their own quality measure data from 2015. HHAs will also have access to the Benchmark (mean of top decile of 2015 within each state and cohort) and the Achievement Threshold (median of all the HHAs in 2015 in each state and cohort).
-	409	4/30/16	-	**Why on slide 32 of the Total Performance Score webinar is the second calculation 10x instead of 9x?** The calculations for Achievement and Improvement Points are based upon the methodology used by Hospital Value-Based Purchasing. The differences in their calculation stems from the distinction between achievement (scoring based on how well HHAs performed relative to other HHAs during the year) versus improvement (scoring based on how much the HHA has improved over time). The improvement score formula (using x 10) makes it so that you have to improve to get any points while the achievement score formula (using x 9) gives you points if you achieve the achievement threshold.
-	410	4/30/16	-	**Will a spreadsheet be provided with the formulas to estimate our scores using the correct calculations?** Currently, there is no downloadable spreadsheet containing formulas that HHAs can use to estimate scores. However, if a tool such as this would be useful to HHAs, we will consider providing one in the future.

New or Revised	#	Originally Posted	Last Updated	FAQ
Revised	411.1	4/30/16	6/30/16	**How can I find our individual HHA baseline and performance level data?** Individual HHA baseline and performance level data will be made available in the July 2016 Interim Performance Report[1] that will be posted on the HHVBP Secure Portal.
-	413	4/30/16	-	**Can you explain how the Total Performance Score is calculated and how agencies are scored?** The specifications for calculating the Total Performance Score were reviewed in detail in the February 18, 2016 webinar "Total Performance Score Calculation." The webinar slides with speaker notes and a recording of the webinar are available on the *HHVBP Connect* site.
-	414	4/30/16	-	**In reviewing the slides and presentation on HHVBP for TPS calculation, I noticed the following 5 items are the only being addressed as the "starter set". In attempt to establish our own calculator, we had included all the data sets for a total of 21 measures. Can you define the six "starter set" items?** There are 21 Starter Set Measures as listed in the rule (as noted in the slides from the 12/10/15 webinar). All of these measures were not included in the example shown in the February 18, 2016 webinar "Total Performance Score Calculations". That example illustrated a fictitious HHA which only had scores for five measures.

Measures

General Quality Measures

New or Revised	#	Originally Posted	Last Updated	FAQ
-	500	12/29/15	-	**What is CMS's plan to share risk adjustment data elements with partners to inform performance improvement efforts?** Risk adjustment elements are the same as what is currently reported on Home Health Compare for those measures that are currently being reported and are based on the OASIS data that are provided to CMS by the HHAs themselves. Technical specifications of calculated measures that are not currently on the CMS website will be provided in 2016.
-	501	12/29/15	-	**Could risk adjustment change with the implementation of ICD-10 and how will that be accounted for in the baseline performance year (Jan-Sep 2015 and Oct-Dec 2015) and subsequent performance years?** Currently, the transition to ICD-10 will not have any impact on HHVBP. Only one process measure uses ICD-9 based measures in its risk adjustment model, and this measure is not used in HHVBP. The risk-adjustment model for this measure has been updated for ICD-10 using the existing ICD-9 to ICD-10 crosswalk and will be re-estimated in 2017 once there is sufficient ICD-10 data.
	502	5/31/16	-	**Will patients that are discharged from a HHA to a home hospice program be included in the calculations for the measures that look at improvement in status?** Yes, patients discharged from home health to hospice are included in the calculations of measures for improved status. Discharge to hospice is not an exclusion for any of the Performance Year 1 HHVBP quality measures. The measure definitions including measure exclusions for the OASIS and claims-based measures in the HHVBP Model for Performance Year 1 are available in the Home Health Measures Tables found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html. Questions related to the Home Health Quality Measures may be submitted to the Home Health Quality Help Desk at homehealthqualityquestions@cms.hhs.gov.

New or Revised	#	Originally Posted	Last Updated	FAQ
New	503	6/30/16		**Patients who are recertified but not discharged are not included in the calculation of the outcome measures until their quality episode ends at transfer, discharge, or death. How will the patients that are only recertified (not discharged, transferred, or died during the reporting period) impact the Total Performance Score on the HHVBP Model as not all patients in the agency are included?** The calculation of outcome measures requires a completed quality episode. Patients who are not discharged, not transferred, or have not died within the reporting period will not be included in the calculation of the outcome measures as they do not have a completed quality episode. Patients who do not have a completed quality episode will not be included in the calculation of the Total Performance Score.

Claims-Based Measures

New or Revised	#	Originally Posted	Last Updated	FAQ
-	600	12/29/15	-	**Will the claims-based measures be based from all the beneficiaries that a HHA provides service or just the Medicare Fee-For-Service (FFS) population?** The claims-based measures are only based on the Medicare FFS population since the measures are only derived from Medicare claims. The claims-based measures are risk-adjusted that incorporate five categories of risk factors, including: 1. Prior care setting; 2. Demographic (i.e., age and gender) ; 3. Health status (i.e., based on hierarchical condition categories); 4. Medicare enrollment status; and, 5. Interaction terms.
-	601	12/29/15	-	**Where can we find the list of codes for the measures that we need to submit on the claims?** Measure data is not submitted on the claims. CMS will pull submitted claims data to use when calculating performance scores for the two claims-based measures, Acute Care Hospitalization; Unplanned Hospitalization during first 60 days of Home Health and Emergency Department Use without Hospitalization.

HHCAHPS Measures

New or Revised	#	Originally Posted	Last Updated	FAQ
-	700	12/29/15	-	**Will the HHCAHPS measures be calculated using HHCAPHS surveys from all the beneficiaries that a HHA provides service or just the Medicare FFS population?** HHCAHPS surveys from all the beneficiaries for which a HHA provides services are included in the model. This includes all patients 18 years old and older who are covered by Medicare or Medicaid who meet other survey criteria are eligible to be included in the HHCAHPS Survey. This includes patients who are enrolled in Medicare fee-for-service plans and those enrolled in Medicare Advantage (MA) plans or Medicaid managed care health plans. For more information on the HHCAHPS Survey visit: https://homehealthcahps.org/Portals/0/PandGManual_NOAPPS.pdf https://homehealthcahps.org/Home.aspx
-	701.1	12/29/15	03/31/16	**Will 'small' agencies have fewer total TPS points as they do not participate in HHCAHPS or will they not have scores available? How will these agencies be addressed?** The smaller-volume home health agencies are defined based on whether or not they are exempt from reporting HHCAHPS data. They will have a lower maximum Total Performance Score than larger-volume home health agencies, which are defined as those that are participating in HHCAHPS. The smaller-volume home health agencies will be competing with other smaller-volume home health agencies within their state except when there are too few HHAs in the smaller-volume cohort in each state to compete in a fair manner and these HHAs would be included in the larger-volume cohort for purposes of calculating the Total Performance Score and payment adjustment percentage without being measured on HHCAHPS. HHCAHPS measures will not be included in the calculation of the Total Performance Score for the smaller-volume cohort agencies. Smaller volume home health agencies will not have an advantage or disadvantage due to the exclusion on the HHCAHPS measures.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	702	12/29/15	-	**Will HHCAHPS scores be calculated the same way that they are for current public reporting? Or will they use the linear calculations as defined for stars?** The HHVBP Model will not alter the HHCAHPS current scoring methodology. HHCAHPS scores will be calculated as they are for public reporting on Home Health Compare. For calculating Total Performance Scores, we will compare agency performance by the following: (1) similar sized HHAs within their state and (2) the HHA's own past performance. We will use the scoring rules described in the Final Rule that was published 11/5/2015 in the Federal Register https://www.federalregister.gov/articles/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home

OASIS-Based Measures

New or Revised	#	Originally Posted	Last Updated	FAQ
-	800	12/29/15	-	**Will the OASIS-based measures be calculated using OASIS assessments from all the beneficiaries that a HHA provides service or just the Medicare FFS population?** The OASIS based-measures are calculated using assessments from the OASIS assessments from Medicare fee-for-service, Medicare Advantage, Medicaid fee-for-service, and Medicaid managed care. However, the measures are risk adjusted to include risk factor elements like the payer for the episode (Medicare/ Medicaid /Managed Care) as well as other risk factors selected using a rigorous, multistep process that includes clinical review of the scientifically identified risk factors.
-	801	12/29/15	-	**Are OASIS measures risk adjustment state-based or national?** OASIS measures are risk adjusted at the national level. The risk adjustment methodology compensates for differences in the patient population served by different home health agencies, using a predictive model developed specifically for each measure. The OASIS measures tables can be found at this link: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/Home-Health-Measures-Tables.zip
-	802.1	12/29/15	03/31/16	**There are two measures in the final PY1 measures for which HHA performance will have an impact on the TPS, but these measures have never been publicly reported. These are the measures for Communication and Care Coordination (M2102) and Prior Functioning ADL/IADL (M1900). In the final rule there is no numerator or denominator specified for the Communication and Care Coordination, and the full measure specifications have not been provided for both of these measures. What are the measure specifications for the coordination of care and prior function measures?** Not all measures selected for the HHVBP Model are currently publicly reported on Home Health Compare, and any additional public reporting of home health measures for this Model will be addressed in future rulemaking. Information about the measures utilized in the first year of the HHVBP Model will be presented through webinars planned for 2016. Webinar recordings and additional resources will be provided on the Model's learning and diffusion site, *HHVBP Connect*.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	803	12/29/15	-	**We proposed that data for the standardized quality measure would be collected using the OASIS-C1 with submission through the Quality improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system." Does this mean that the OASIS-C1 will contain all the measures to be included in the VBP system?** No. Although the majority of measures selected for the HHVBP Model rely on OASIS data, some rely on other data sources. Specifically, there are two measures that are claims-based, five measures from HHCAHPS, and three new measures reported by HHAs via the HHVBP Secure Portal.
-	805	03/31/16	-	**Is the Timely Initiation of Care measure included in the quality measures for performance year 1?** The quality measure of "Timely Initiation of Care" was included in the 2016 Home Health PPS Proposed Rule, but was not included in the 2016 Home Health PPS Final Rule and will not be used to calculate the Total Performance Score.

New Measures: General Questions

New or Revised	#	Originally Posted	Last Updated	FAQ
-	900	12/29/15	-	**Will New Measure data be based on six months of reporting only?** No. The New Measures will be reported quarterly.
-	901	12/29/15	-	**For the measures being reported through the HHVBP Secure Portal, i.e., flu vaccine taken by employees, when will the reporting of these measures begin? How often is it required to enter the information on the New Measures in the portal?** Data for New Measures should be entered in the HHVBP Secure Portal beginning on October 1, 2016, for the period covering July 1 - September 30 2016. New measure information should be submitted for each quarter throughout the Model.
-	902.1	12/29/15	03/31/16	**Can you give us the verbiage for the New Measures?** The numerator and denominator for each of the new measures can be found in the final rule that was published 11/5/2015 in the Federal Register https://www.federalregister.gov/articles/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home The data elements required for reporting on New Measures were provided to Model participants via webinar on January 28, 2016. The webinar recording and the New Measures templates can be found on the Model's learning and diffusion site, *HHVBP Connect*.
-	903	12/29/15	-	**Is there a minimum reporting requirement?** No. HHAs can elect to not report data on the New Measures. However, HHAs that do not report data on all three New Measures can only earn up to 90% of the total possible points for their Total Performance Score.
-	904	12/29/15	-	**Can my agency set up to start reporting on the New Measures if we are not in one of the nine mandated states for Value-Based Purchasing?** At this time, only Medicare certified HHAs that provide services in one of the nine selected states will be reporting data on the New Measures.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	905	03/31/16	-	**What payers are included for each of the New Measures?** The following payers are included in the measure calculations for the New Measures: 1) "Herpes Zoster (Shingles) Vaccination is calculated for Medicare beneficiaries, including Medicare fee-for-service and Medicare Advantage (Medicare managed care) beneficiaries; 2) Advance Care Plan is calculated for all payers; 3) Staff Influenza Vaccination Coverage for Home Healthcare Personnel is collected for staff and therefore the payer for the patient is not a consideration.
-	906.1	03/31/16	04/30/16	**As a software vendor, where can I find answers to specific data collection requirements for the New Measures?** Consultants and software vendors should obtain information from their agency partners that are competing in the Model if they so choose to provide it.
-	907	03/31/16	-	**Where can I find answers to specific data collection requirements for the New Measures?** Home health agencies were invited to participate in a webinar on the New Measures on January 28, 2016. At that time, agencies were provided with the New Measures Templates (an excel document with the data collection elements for each of the New Measures that replicated the data entry requirements for the HHVBP Secure Portal). The recorded webinar and the handouts from this webinar are available to HHAs on the *HHVBP Connect* site. Please refer to the handouts from this webinar. If your questions are not answered by reviewing webinar information, please submit detailed and specific questions to the HHVBP Help Desk.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	908	03/31/16	-	**Please explain the data collection periods and data entry process for the New Measures.** Data collection for all of the New Measures begins on July 1, 2016. Data collection is for a full quarter, therefore, the first data collection period begins on July 1, 2016 and ends on September 30, 2016. The second data collection period begins on October 1, 2016 and ends on December 31, 2016 and reporting is quarterly thereafter. Data entry into the HHVBP Secure Portal will be required to be completed by the 7th day of the month after the end of the quarter. For the first quarter of data collection, agencies will be able to enter data into the HHVBP Secure Portal from October 1, 2016 through October 7, 2016. For each quarter, agencies will be given 7 days after the end of the quarter to enter their New Measures data into the HHVBP Secure Portal.
-	909	03/31/16	-	**For the new measure denominators, the calculation is not based on actual patients served but on the number of patients that are discharged, transferred or died? For New Measures, if a patient is on service in Sept 2016 and is still on service on Oct 2016 does this same patient get counted both time points?** The New Measures Templates available on the *HHVBP Connect* website outline the specific data collection requirements for each of the 3 New Measures. For the Herpes Zoster Vaccination measure and the Advance Care Plan measure, data are collected for patients who were discharged from the HHA, transferred to an inpatient facility, or died during the reporting period. The term "during the reporting period" refers to the data collection quarter. For the first data collection period, this would include patients who were discharged from the HHA, transferred to an inpatient facility, or died during the period of July 1, 2016 through September 30, 2016. Related to your specific question for September and October (2 different reporting periods), an agency would include the same patient in multiple reporting periods if that patient experienced any of the events (discharge, transfer to inpatient facility, or death) during the reporting period. Patients are included in each reporting period that they have a qualifying event of discharge, transfer, or death, even if that means they are reported more than once in the same quarter, or if they are reported in more than one quarter.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	910	03/31/16	-	**Will we be submitting information at the aggregate level or at a patient/employee level for the three New Measures?** Data on the New Measures are submitted on the HHVBP Secure Portal at the aggregate level and not at the individual patient or staff level.
-	911	03/31/16	-	**We are a Medicare-certified pediatric home health agency. What data should we submit for each New Measure? We don't have patients that meet the age requirements for the Herpes Zoster Vaccination measure or the Advance Care Plan measure.** Agencies who wish to receive points on their Total Performance Score for New Measures should submit data each quarter. If your agency does not have patients who meet the criteria for one or more of the measures, you should enter zeroes.
-	912	03/31/16	-	**Regarding the New Measures Templates, is this the format we will be submitting through the HHVB Secure Portal? Will the metrics and breakout of metrics listed in the template need to be entered into the portal? For example, will we need to track/build into our system the exact verbiage for contraindications and reasons for not receiving shingles?** Yes. Data entry into the HHVBP Secure Portal will mirror the New Measures Templates. HHAs will need to develop data collection systems to accurately collect the information specified on the New Measures Templates.
-	913	03/31/16	-	**Which OASIS items are used to calculate New Measures?** OASIS items are not used to calculate any of the 3 New Measures. The New Measures are based on data submitted to the HHVBP Secure Portal. This data is not currently collected by OASIS or other data collection systems.
-	914	03/31/16	-	**As the New Measures of Herpes Zoster and Advance Care Plan both include data from start of care, do we need to begin data collection before July 1, 2016?** No. All data collection for the New Measures of Herpes Zoster Vaccination and Advance Care Plan will begin on July 1, 2016.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	915	03/31/16	-	**Is it required to submit data for both quarters in 2016 to receive points at all? Will half points be awarded if only one quarter is submitted?** Agencies who wish to receive full points on their Total Performance Score (TPS) for New Measures should submit data each quarter for each measure. Partial points will be included in the TPS calculation when data has been submitted for some, but not all, reporting periods. The amount of partial points will depend upon the number of reporting periods for which data were submitted.
	916	5/31/16	-	**For the measures that specify the patient's age (Advance Care Plan; Herpes Zoster Vaccination), could you clarify if this refers to the patient's age at SOC/ROC or Discharge/Transfer?** Home health agencies will report data based upon the patient's status at discharge, transfer to an inpatient facility, or death.

New Measures: Influenza Vaccination Coverage Home Health Care Personnel

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1000	03/31/16	-	**For the first submission of the New Measures in October 2016, will HHAs be exempt from submitting influenza data since the data collection period is outside of flu season?** No. Agencies who wish to receive the total number of available points on their Total Performance Score for New Measures should submit data each quarter for each measure. For the Influenza Vaccination Coverage for Home Healthcare Personnel measure only, data collection does not begin until October 1, 2016. Therefore, for this measure only, agencies should enter zeroes for the first data collection period submission. The data entry for the first data collection period will be completed on the HHVBP Secure Portal from October 1, 2016 through October 7, 2016.
-	1001	03/31/16	-	**For the New Measure, "Influenza Vaccination Coverage for Home Healthcare Personnel," should the denominator for the first data collection period of 7/1/16 - 09/30/16 include staff in the 2014-2015 flu season?** No. As data collection for the New Measures does not begin until July 1, 2016 and the measure of "Influenza Vaccination Coverage for Home Healthcare Personnel" denominator identifies personnel from October 1 through March 31, home health agencies will enter all zeroes in the HHVBP Secure Portal for this measure only for the first data collection period of July 1, 2016 through September 30, 2016.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1002.1	03/31/16	4/30/16	**For the Staff Influenza Vaccination measure, can you please expand on the definition of "affiliation" for licensed independent practitioners? Do you mean all referring physicians?** An affiliated practitioner refers to a specific practitioner (physician (MD, DO), advanced practice nurse, physician assistant) who has a contractual or legal relationship with the agency to provide services to either the agency staff or the agency patients. This does not include clinical service contracts for agency staff (such as employee assistance programs or work-related injury programs) in which a number of unspecified practitioners may be in contact with the agency staff as needed. This does not include practitioners who are merely ordering home health services or making referrals to the agency as their only relationship with the agency. This does not include other licensed personnel such as therapists, nurses, social workers, or dieticians/nutritionists. For agencies that have contractual relationships with Accountable Care Organizations (ACOs) or that have similar contractual arrangements, physicians, advanced practice nurses, and licensed physician assistants would not be considered an "affiliate" if their role is only to order home health services or make referrals to the agency. A physician who is not an employee of the agency, but provides services such as Medical Director, Board Member, or Clinical Consultant would be considered an affiliate.
-	1003	03/31/16	-	**For the Staff Influenza Vaccination measure, where do we count staff that are providing services through a contracting agency such as contracted therapists?** Contracted staff are not included in the measure calculations. Data are not collected for contracted staff. This is not to be confused with per diem or part time staff who are included in this measure in the "employee" denominator category if they receive a direct paycheck from the agency.

New or Revised	#	Originally Posted	Last Updated	FAQ
Revised	1004.2	03/31/16	6/30/16	**If a home health agency also has a hospice (one CCN for home health and a different CCN for hospice), but some employees work for both the home health agency and the hospice and are paid from a corporate payroll (not a separate payroll for each organization), which employees do we count for the Staff Influenza Vaccination measure?** For home health agencies that have employees that serve multiple CCNs, the "employee" denominator would include all staff who are paid by the organization and are serving a specific home health agency CCN. In your example, you would count only the employees that serve your home health CCN. This scenario also applies to an agency that is hospital-based. A hospital-based home health agency would report information on the personnel associated with the home health agency CCN.
-	1005	03/31/16	-	**For the Staff Influenza Vaccination measure, do we only count staff who visit patients?** No. HHAs will count all employees, licensed independent practitioners, and adult students/trainees and volunteers, even if the personnel have no encounters with patients.
-	1006	03/31/16	-	**Our HHA is hospital-based and is a department of the hospital. The hospital provides flu vaccines. Would we include employees who receive the vaccine from our hospital also (for answer "a-3" on the New Measures Templates)?** Yes. HHAs that are hospital-based or part of a healthcare system and personnel receive their influenza vaccination from the hospital or system can be included in "a-3" of the New Measures Templates ("How many of the HHA employees received the influenza vaccine from the HHA?"). Therefore, in this situation, the home healthcare worker would not need to provide written documentation of this vaccination.
-	1007	03/31/16	-	**For the Staff Influenza Vaccination measure, do we count employees only for October through December then report "NA" for the January through March quarter or will be penalized for not reporting the same data twice?** Data is reported for the flu season. It is possible that HHAs will enter the same information for multiple quarters if there is no change in their data from quarter to quarter. Agencies who wish to receive full points on their Total Performance Score for New Measures should submit data each quarter for each measure.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1008	03/31/16	-	**Can you please clarify whether agencies are required to report on flu vaccine for employees per flu season or per calendar year? It would seem that this should be done by flu season, which would technically require two different reports per employee per calendar year since one year's flu season ends at the beginning of a calendar year and the next flu season begins later that same calendar year.** Data is reported for the flu season. For each quarter, an agency will enter information related to their number of personnel (employees, licensed independent practitioners, and adult students/trainees and volunteers) in "a1", "b-1", or "c-1" of the New Measure Templates. From this information, they will then answer the remaining questions on the New Measures Templates for each denominator population (employees, licensed independent practitioners, and adult students/trainees and volunteers) related to what has occurred during the period of October 1, or when the vaccine first became available, through March 31).
-	1009	03/31/16	-	**I have a question about how the employee flu vaccine measure will be collected and reported. The denominator of the measure is listed as this: "The number of home health care employees who were working for the home health agency for at least 1 working day between October 1 and March 31. (Employees: All persons who receive a direct paycheck from the reporting HHA, that is, on the agency's payroll.)" However, as I understand it, agencies are to report this data quarterly. Consider the following example:** **Reporting period: 10/1 - 12/31** **Employees on payroll = 50,** **Employees offered vaccine = 50,** **Employees receiving vaccine = 49,** **Employees declining vaccine due to allergy = 1. Reporting period: 1/1 - 3/31** **I hired 2 new employees in January. (The 50 employees from the previous reporting period still work for me + 2 new employees in this reporting period.)**

New or Revised	#	Originally Posted	Last Updated	FAQ
-	“”	“”	-	**Question #1:** **Are my "Employees on payroll" for the second reporting period in my example equal to 2 or 52?** **Question #2:** **If the answer to question 1 is 52, do I repeat the vaccine data for those 50 employees in this reporting period, even though they were offered and got the vaccine during the last reporting period?** **Question #3:** **If the 50th employee from the previous reporting period got the vaccine from another source on 12/30, but didn't report that to me until 1/2, will that employee's data be reported in the 1/1-3/31 reporting period?** Question #1 Response: In your example, the number of employees for the second reporting period =52. Question #2 Response: You would count all employees that were offered and received the vaccine from October 1, or when the vaccine became available, through March 31, even if they received the vaccine in a previous data collection period. Question #3 Response: If an employee received a vaccine in one reporting period but did not REPORT receiving the vaccine until the next reporting period, you would report what you knew to be true for that employee for each reporting period. In your example, for field “a-4” of the New Measures Templates (“How many of the HHA employees provided documentation for receiving the influenza vaccine from a setting outside of the HHA?”) the employee would not be included for the first reporting period (10/1-12/31 in example), but would be included for the second reporting period (1/1-3/31 in example).

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1010	4/30/16	-	**What is an agency's responsibility related to "offering" an influenza vaccination? Are we required to offer the vaccine or pay for it?** There is no requirement for an agency to offer to administer or pay for the influenza vaccination; however, the Centers for Disease Control (CDC) recommends that healthcare providers offer the influenza vaccine to all healthcare personnel. When completing the New Measures templates and data entry into the HHVBP Secure Portal, field a-2, b-2, and c-d asks how many personnel ***were offered*** the influenza vaccine. To count personnel in these fields, the agency would need to offer to provide the vaccine to the personnel by either administering the vaccine, or assisting personnel to receive the vaccine through another source, or the employee could report that the vaccine was offered by another provider such as their PCP or specialist.
New	1011	5/31/16	-	**Our agency organizes an annual Influenza Vaccine Clinic at our agency and we offer the vaccine to all of our staff. However, the clinic is run by a local pharmacy and a pharmacist from the pharmacy administers the vaccine. Would an employee who received the vaccine at our clinic be counted in the employees who received the vaccine from the agency? Where do we include this information on the New Measures Templates?** If your agency organized the influenza vaccination clinic and then offered the influenza vaccine to your personnel, albeit administered by an external pharmacist, you would 1) note the number offered the vaccine in either field a-2, b-2, or c-2 on the New Measure Templates and 2) document the number that received the vaccine from this clinic in a-3, b-3, or c-3 on the New Measure Templates.
New	1012	6/30/16		**For the Staff Influenza Vaccination measure, if the corporate payroll/office has personnel who conduct administrative duties for the HHA CCN number in the model state but those employees are physically located in a different state, should they be included in the staff measure?** Corporate administrative employees who do not physically work at the agency and are therefore not physically in contact with the agency staff or patients would not be included in the denominator for the Staff Influenza Vaccination measure.

Herpes Zoster (Shingles)

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1101	03/31/16	-	**For the Herpes Zoster measure, does this only apply to patients that have been discharged, transferred or died during a stay with a Home Health Agency? The reason I ask is because of the verbiage "How many were then offered the vaccine by the HHA prior to home health discharge, transfer, or death..."** For the Herpes Zoster Vaccination measure, the denominator will include only patients who have been discharged, transferred to an inpatient facility, or died during the reporting period (quarter). This is listed as item "a" on the New Measures Template. As such, all data reported for this measure for the quarter (items "b-m" on the New Measures Templates) would be based upon this set of patients alone.
-	1102	4/30/16	-	**Regarding the reporting of the shingles vaccine, how would you treat a patient that was on service (and discharged) twice in the reporting period?** It is possible that a patient is on service more than one time during a reporting period. When this occurs, it is possible that a patient is "counted" more than one time during a single reporting period. If a patient had more than one event (discharge, transfer to an inpatient facility, or death) during the reporting period, each event would be counted for that reporting period. HHAs should report what is true for each discharge, transfer, or death during that reporting period.
-	1103	03/31/16	-	**What does it mean to "offer" the shingles vaccine? Does an agency need to actually administer the vaccine or can they offer it when another provider will administer the vaccine?** The New Measures Template for Herpes Zoster Vaccine, asks, "How many patients were then offered the vaccine by the HHA prior to home health discharge, transfer to an inpatient facility, or death during the reporting period?" In this question, "offered" includes agencies who offer to administer the vaccine and also agencies who offer to assist in coordinating the administration of the vaccine by another provider (e.g. the patient's physician or pharmacy).

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1104	4/30/16	-	**Can a patient report more than [one] reason for declining the shingles vaccine or should they just choose one or the best reason?** You may select more than one reason for declining the vaccine. If there is more than one reason for declining the vaccine, select all responses that apply.
	1105	5/31/16	-	**With regard to the new Herpes zoster vaccination measure, will there be an "Unknown" or "Not available" response option for the question "Has the patient ever received the shingles vaccination?" If not, how should an agency document if the patient does not know if he/she received the vaccination in the past?** If the herpes zoster (shingles) vaccination status cannot be confirmed and the patient did not report ever receiving the vaccine at start of care, this patient would not be included in the data field that asks, "At home health start of care, how many Medicare beneficiaries aged 60 years or older report ever receiving the shingles vaccine."

New Measures: Advance Care Plan

New or Revised	#	Originally Posted	Last Updated	FAQ
	1200.1	03/31/16	5/31/16	**What is an advance care plan and a surrogate decision maker?** Advance care planning encompasses communication and discussion regarding treatment preferences. It provides patients with an opportunity to consider, discuss, and plan their future care with health professionals. The advance care plan measure includes patients who have an advance care plan or surrogate decision maker documented in the medical record **AND** also patients in which the agency has had a discussion related to an advance care plan or surrogate decision maker documented in the medical record. For purposes of data collection for the Advance Care Plan measure, the following definitions will apply: • Medical Record – is the home health agency's clinical record or electronic medical record. • Advance Care Plan Document – is a legal directive specifying the patient's future healthcare decisions for a time when they are not able to make their own healthcare decisions. The advance care plan document is typically referred to as an advance directive. Examples of advance care plans/advance directives include a living will, durable power of attorney for health care, Physician Orders for Life-Sustaining Treatment (POLST), Medical Orders for Life-Sustaining Treatment (MOLST), Do-Not- Resuscitate (DNR) Orders, or other legally valid documents recognized under State law. • Surrogate Decision Maker - (also known as "Legal representative," "Agent," "Attorney in fact," "Proxy," "Substitute decision-maker") is a person designated and authorized by an advance directive or State law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.
	1201.1	03/31/16	5/31/16	**For advance care planning does the agency have to have a copy of those documents in their record?** Agencies should follow guidance in 42 CFR 489.102 which requires that a provider document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1202	03/31/16	-	**What is the difference between "a" and "b" in the denominator of the Advance Care Plan measure (New Measure Templates)?** On the New Measures Template for Advance Care Plan, "b" ("How many patients who are Medicare beneficiaries, including dually eligible beneficiaries, received services from the HHA during the reporting period?") is a subset of "a" ("How many patients 65 years or older received services from the agency during the reporting period? Calculated as the number of patients aged 65 or older discharged from the HHA, transferred to an inpatient facility, or died during the reporting period."). In other words, "a" includes patients aged 65 or over from ALL payers and "b" includes patients aged 65 or older that are Medicare beneficiaries (including Medicare fee-for-service and Medicare Advantage (Medicare managed care).
-	1203	03/31/16	-	**The Advance Care Plan New Measures Template, items "J – M" states, "How many patients with an advance care plan had the following information documented in the advance care plan" (Medical treatment preferences, mental health/behavioral treatment preferences, cultural/social, etc.). Question: Are these preferences, items that are expected to be in the advanced directives, DPOA (durable power of attorney), living will?** Items "J-M" in the New Measures Template for Advance Care Plan gather information on the types of information that may be found in an advance care plan document. All types of information (items "J-M" on the Advance Care Plan New Measures Template) are not required in all advance care plan documents. In an agency's data collection processes at the patient-level, it is possible to have "zero" for all of these fields for some individual patient advance care plan documents if their advance care plan document contains no preferences and simply provides a surrogate decision maker. However, it is required that HHAs collect information on items "J-M" and report this information quarterly via the HHVBP Secure Portal.
-	1204	03/31/16	-	**Our agency puts information on end of life planning in our Admission Packets, can we count this as "providing information on an advance care plan"?** No. The intent of this measure includes communication with the patient and/ or their caregiver. If, in addition to providing written information, you have a conversation with the patient and /or caregiver, this would meet the requirements for "providing information on advance care plan."

New or Revised	#	Originally Posted	Last Updated	FAQ
	1205.1	4/30/16	5/31/16	**If our system EMR has documentation of an Advance Care Plan would this serve as documentation?** Agencies should follow guidance in 42 CFR 489.102 which requires that a provider document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.
-	1206	4/30/16	-	**Can an Advance Care Plan document contain all of the categories listed (medical preferences, mental health/behavioral treatment preferences, cultural/social preferences, spiritual/religious preferences)?** Yes. An Advance Care Plan document can contain any or all of these categories.
	1207	5/31/16	-	**For the Advance Care Plan data collection, at start of care must you have a copy of the legal document in hand or just verbal acknowledgement of the existence of the forms to complete fields "c" and "d"?** **At discharge, questions e and f, do we include the items counted in c and d or is this strictly for documents received after SOC?** Agencies should follow guidance in 42 CFR 489.102 in collecting information related to the advance care plan measure. Fields "c" and "d" on the New Measures template collects information on an advance care plan or surrogate decision maker information that are present in the home health medical record at the start of care. A patient who does not have an advance care plan or surrogate decision maker at start of care but provides this information by the end of care (discharge, transfer to an inpatient facility, or death) would not be included in data collected for fields "c" or "d" but would be included in data collected for fields "e" or "f" on the New Measures Templates.

New or Revised	#	Originally Posted	Last Updated	FAQ
	1208	5/31/16	-	**For the Advance Care Plan measure, what is the difference between "did not wish" and "unable" to provide an advance care plan or name a surrogate decision maker?** Patients who "do not wish" to provide an advance care plan or surrogate decision maker have had a discussion with the agency staff related to an advance care plan or surrogate decision maker but chose to not pursue an advance care plan or surrogate decision maker. Patients who were "unable" to provide an advance care plan or surrogate decision maker may have no one they could name or have personal reasons for why they needed to delay pursuing establishing the advance care plan or surrogate naming by the time of home health discharge, transfer to an inpatient facility, or death.
	1209	5/31/16	-	**How do you calculate patients that you have had a discussion regarding advanced care and they refused to consider one?** In this example, assuming that the patient was 65 years of age or older, this patient would be captured in the data collection for the following fields on the Advance Care Plan New Measure templates: • At the start of care o How many patients aged 65 or older - Had an advance care plan documented in the home health medical record? NO – NOT INCLUDED o Had a surrogate decision maker documented in the home health medical record? NO – NOT INCLUDED • At discharge, transfer to an inpatient facility or death, how many patients aged 65 or older: o Had an advance care plan documented in the home health medical record? NO – NOT INCLUDED o Had a surrogate decision maker documented in the home health medical record? NO – NOT INCLUDED o Had a discussion with the HHA staff but did not wish to provide an advance care plan or name a surrogate decision maker? YES – INCLUDED o Had a discussion with the HHA staff but were unable to provide an advance care plan or name a surrogate decision maker? NO – NOT INCLUDED o Did not have any discussion with HHA staff related to an advance care plan or surrogate decision maker? NO – NOT INCLUDED

New or Revised	#	Originally Posted	Last Updated	FAQ
New	1210	6/30/16		**Are LPNs, COTAs, PTAs, and MSWs eligible to document a discussion with the patient about having an advance care plan or surrogate decision maker? Or is it restricted to just RNs, PTs, OTs, and SLPs?** The Advance Care Plan New Measure does not specify a discipline; therefore, any agency personnel could have the discussion related to the advance care plan or surrogate decision maker. Home health agencies are expected to follow their own policies and procedures that are consistent with their own State's laws in deciding who will provide information and discuss advance care planning.
New	1211	6/30/16		**Can we collect information and document based on a phone call with the patient/caregiver? Or must it occur on an actual visit?** Telephone conversations can be counted as a discussion with HHA staff about an advance care plan or surrogate decision maker, for the HHVBP Model measures. However, while the Advance Care Plan New Measure does not specify that the conversation must occur in person or via telephone, the regulations at 42 CFR 489.102 do state that this process can occur at any time prior to providing care, including the first visit. Since home health care is provided in-person, it is unclear why there would be a need or value of conducting this highly sensitive conversation other than in-person.

Quality Improvement

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1300	03/31/16	-	**Where can I find training material to improve on the quality measures for VBP?** Competing agencies are invited to join *HHVBP Connect*, the Model's learning and diffusion website. This site will include resources related to quality improvement and the quality measures in the Model. It will also include information found in literature including but not limited to information on tools, resources, and lessons learned. The site also supports sharing resources, success stories, and collaboration among competing agencies. Competing agencies will also be invited to attend a series of webinars which will include quality improvement topics. The webinars will be recorded and will be available on the *HHVBP Connect* site.
-	1301	4/30/16	-	**What are the Tally Reports and how do we use these for quality improvement?** The Certification and Survey Provider Enhanced Reporting (CASPER) system currently provides home health agencies with reports related to some quality measures. Although the CASPER system provides agencies with a suite of quality reports, a subset of these reports pertain to the quality measures identified for the HHVBP Model: 1) Risk Adjusted Outcome Report, 2) All Patients' Process Quality Measures Report, 3) Tally Outcome Report, and 4) Tally Process Report. The two Tally Reports drill-down to the patient-level to identify cases in which the measure was achieved or not achieved for each of the measures on either the Risk Adjusted Outcome Report or the All Patients' Process Quality Measures Report. Agencies may find the Tally Reports useful in investigating unfavorable OASIS-based outcome measures, determining best practices for each quality measure, and/or monitoring clinicians to assure that best practices are being implemented as planned.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1302	4/30/16	-	**What is the URL for the website to obtain our agency's CASPER Reports for outcome and process measures?** Information on requesting access to the CASPER system can be found at https://www.qtso.com/accesshha.html. Additional information on the CASPER quality reports can be found at https://www.qtso.com/hhatrain.html in the CASPER Reporting User's Manual, Section 6 – OASIS-C Quality Improvement Reports. Questions related to accessing the CASPER site or reports can be directed to the Technical Help Desk, E-mail: help@qtso.com, Phone: 1--877-201-4721.

Model Websites

Data Submission

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1400	12/29/15	-	**How do we submit the data? Or, do we use existing data?** For the majority of the measures, the data utilized are based on information already being reported by HHAs through OASIS. There are also two measures that are claims-based, five measures from HHCAHPS, and three New Measures to be reported by HHAs via the HHVBP Secure Portal. For the New Measures, HHAs will submit data on a quarterly basis beginning October 2016.
-	1401	12/29/15	-	**Will the data be entered in aggregate or per patient?** Data is entered as it is currently submitted to OASIS, which is patient level data.
-	1402	12/29/15	-	**How will the data be uploaded for the three New Measures?** HHAs will report data for the New Measures on a quarterly basis via the HHVBP Secure Portal.
-	1403	12/29/15	-	**What does the system look like to which we will be submitting data? Will we also get a demonstration of that portal?** Yes. CMS will provide HHAs with information about data collection and a demonstration of how to submit information to the HHVBP Secure Portal.
-	1404	12/29/15	-	**If our EMR software vender creates a data extract function like they have for OASIS and HHCAHPS, can the file created be sent via the portal instead of manual extraction and submission?** The implementation contractor who will be calculating each HHA's performance scores will have access to the OASIS and HHCAHPS data you have already submitted. The only data the HHA will submit via the HHVBP Secure Portal is for the New Measures.
-	1405	03/31/16	-	**Will the quality measures be submitted as they are currently or will agencies need to submit the measures by a separate submission process?** The HHCAHPS measures, the OASIS-based measures, and the claims-based measures will be submitted using the current data submission processes for these measures. Only the New Measures will require data submission by the agencies via the HHVBP Secure Portal.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1406	4/30/16	-	**When entering the New Measures data, will the HHVBP Secure Portal accept fractions or only whole numbers?** The system will only accept whole numbers.

EIDM (Enterprise Identity Management) Registration

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1500	12/29/15	-	**What is the website we should use to register our agency?** To obtain an Enterprise Identity Management (EIDM) User ID from the CMS Enterprise Portal, the url is https://portal.cms.gov/wps/portal/unauthportal/home/.
-	1502	12/29/15	-	**What is the first step to register on the site?** The first step to register on the EIDM site would be to agree to the terms and conditions. You will see this after clicking on the 'New User Registration' link on the landing page of the CMS Enterprise Portal.
-	1503.1	12/29/15	03/31/16	**Why is my SSN required to register for the HHVBP Secure Portal?** Identity Verification is important in the process of providing sufficient information (e.g., identity history, credentials, or documents) to a service provider for the purpose of proving that a person or object is the same person or object it claims to be. Individuals requesting electronic access to CMS protected information or systems must be identity proofed prior to being given access. The social security number will be used for verification purposes only. EIDM does not share SSNs with any other federal or private agency.
-	1504	12/29/15	-	**What is the format we must use when creating a password?** Below is the criteria needed when creating a password: 1) Must be a minimum of 8 and a maximum of 20 characters; 2) Must contain at least 1 number, 1 letter, 1 uppercase letter, and 1 lowercase letter; 3) It cannot contain your User ID; and, 4) Must differ from your previous 6 passwords.
Revised	1505.1	12/29/15	6/30/16	**If I want to access reports only, do I need to follow through with the Enterprise Identity Management (EIDM) registration?** Yes. In order to access reports, you will need to register with Enterprise Identify Management (EIDM) and obtain a User ID. This is the first step to gaining access to the HHVBP Secure Portal where interim[1] and annual performance reports and annual payment adjustment reports can be viewed.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1506.1	12/29/15	04/30/16	**Do we request access to all of the access catalog items? Which ones are required?** No, search for and request access to the Innovation Center. This is one of the following steps to register for the HHVBP Secure Portal: 1. Navigate to the CMS Enterprise Portal 2. Login using their EIDM User ID and password 3. Choose the "Request Access Now" button on the CMS Portal landing page 4. Search for the Innovation Center (IC) in the access catalog 5. Click the "Request Access" button in the IC webpage 6. Choose "IC Privileged User" role 7. Complete identity verification 8. Set up a multi-factor authentication device Additional details about the registration process were provided in the "Next Steps to Gaining Access to the HHVBP Secure Portal" webinar on Thursday, April 14, 2016. The webinar slides and a recording of the webinar are available on the *HHVBP Connect* site.
-	1507	12/29/15	-	**Is EIDM the same as the HHCAHPS portal?** The EIDM and HHCAHPS are separate systems, and each requires its own login. For the HHVBP Model, HHAs will need to register through the CMS Enterprise Portal.
-	1508	12/29/15	-	**We are awaiting our Provider Number (CCN). Can we register now?** You may obtain an EIDM User ID, but do not send it to the HHVBP Helpdesk until you have a CCN. After you have received the CCN, submit your EIDM User ID, and point of contact information along with your CCN.
-	1509	12/29/15	-	**As a Medicare Consultant for all agencies in our company, is there a way to get access to the system without being the primary point of contact?** Yes. You can request other roles in the Innovation Center when requesting access to the Secure Portal application. These roles include data entry and reviewer roles.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1510	12/29/15	-	**The main home health office is in Iowa with a non-manned office in Nebraska. Would the agency only have to register one time?** The agency only needs to register once if the offices share the same CCN. If each office has a separate CCN, they should register separately.
-	1511.1	12/29/15	03/31/16	**I have Enterprise Identity Management (EIDM) access and have emailed the Helpdesk. What should I do next?** Once you obtain your EIDM User ID, please make sure that the Helpdesk has your Point of Contact's (POC) name, email address, EIDM User ID, CCN(s), agency name, and address. CMS will inform you about next steps through a webinar in mid-April. A recording of the webinar will be made available on the Model's learning and diffusion site, *HHVBP Connect*.
-	1512	12/29/15	-	**Does each agency location leader register for their location or is this only by provider number?** HHAs should assign a Point of Contact (POC) for each CCN. It is acceptable for one person to be the POC for multiple CCNs.
-	1513	12/29/15	-	**I have registered as a user on the Enterprise Portal for the EIDM. My only concern is that we are in Virginia, not one of the designated states. The use of this information by non-designated states was unclear to me.** HHAs in states not selected to be in the Model will not need to register in EIDM or provide this information.
-	1514	03/31/16	-	**When registered for the HHVBP Secure Portal, I was asked personal information. Why is this needed and how will it be used?** Registration for the HHVBP Secure Portal requires uses to obtain an EIDM User ID. EIDM collects personal information to uniquely identify the user registering with the system. Your answers to the challenge questions and other personal information may also be used to identify you in case you forget or misplaced your User ID /Password. For security level information please visit: https://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/Privacy-Policy.html

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1515	4/30/16	-	**Is it just the POC that needs to obtain an EIDM? If someone who is not the POC and wants to join the *HHVBP Connect*, do they need to apply for an EIDM?** The EIDM User ID is needed for accessing the HHVBP Secure Portal, where agencies can access their HHVBP reports and submit New Measures data. Agencies may wish to have multiple staff access the HHVBP Secure Portal. An EIDM User ID is required for all HHVBP Secure Portal users. The EIDM User ID is not needed to access *HHVBP Connect*, the Model's learning and diffusion website.

Points of Contact (POC)

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1600	12/29/15	-	**For registration, for the single point of contact, do you recommend this be someone financial, clinical, or the executive director/administrator?** It is recommended that the primary point of contact should be someone who understands the daily operations of the HHA and has the authority to delegate/assign tasks. This person will also have the authority to submit measures and review financial reports on behalf of the HHA.
-	1601	12/29/15	-	**For registration, is it possible to set multiple points of contact for each CCN in case of absence or turnover?** It is recommended that there just be a single primary point of contact for each HHA with a CCN.
-	1602	12/29/15	-	**For registration, is the point of contact the only person who will be able to access the platform to view the results?** No. The primary point of contact can assign user roles to staff who will have access to the HHVBP Secure Portal. When the point of contact completes the second component of registration, to register for the Innovation Center Portal, they will be able to designate additional user roles. These include data entry and reviewer roles.
-	1603	12/29/15	-	**Regarding Outreach, can we dial in to the call or into HHVBP Model webinars from our corporate clinical department? Although none of us will be assigned as a specific point of contact, the department has responsibility for locations in all nine states of this pilot. We are working diligently with our performance improvement team to provide the training and support that will be necessary for our offices to excel and provide the highest value to our patients. Is it possible to register the corporate team for the call?** Yes, you may register as a Corporate Point of Contact. In order to do this, you will need to send your information along with the CCN for each agency for which you are responsible.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1604	12/29/15	-	**Can you please add me to the email distribution group for value-based based purchasing? Our company has 29 providers in 7 of the 9 states. As Vice President of Quality, I will be overseeing our improvement initiatives and would like to have all communications that are applicable.** A representative for each CCN in the HHVBP Model should complete the registration process. Once registered, participants will have access to communications and information regarding the Model. You may register as a Corporate Point of Contact. To do this you would send your contact information along with the CCN for each agency for which you are responsible.
-	1605	12/29/15	-	**I am not in one of the participating states. However, we would like to start the process. Can we register in the EIDM system? Is there any benefit to doing so?** Any HHA is able to register in the EIDM system. However, HHAs in states not selected to be in the Model will not need or be granted access to the HHVBP Secure Portal or *HHVBP Connect*.
-	1606.1	12/29/15	03/31/16	**Is it true that each provider number must register, however, one person can be the single point of contact (POC) for each provider, or there can be a different POC for each provider?** Each HHA must designate one POC for each of their CCNs and the POC needs to register with EIDM. The POC does not need to be the same for all CCNs for an agency with multiple CCNs, but the POC can be if the agency chooses.
-	1607	03/31/16	-	**I am responsible for multiple home health agencies with multiple CCNs. Is it possible for me to be the POC for all the CCNs and then be able to see multiple CCNs in the HHVBP Secure Portal?** Yes. When registering for the HHVBP Secure Portal, you will be able to select the role of "HHA Corporate POC." This will provide you with the ability to view all information of multiple CCNs under one User ID login in the HHVBP Secure Portal. However, having a role of "Primary Point of Contact" will provide you access to only the data for the CCNs in which you are the Primary POC. You may also consider the Corporate POC role if you are not the most directly involved POC for each CCN.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1608	4/30/16	-	**What is the process to add additional points of contact?** Agency staff that are requesting access to **HHVBP Secure Portal** should follow the process to register for an EIDM User ID and then register for the HHVBP Secure Portal. The primary point of contact (PPOC) will then approve the additional points of contact (POC) for their CCN. The exception to this is the Corporate POC as this role is approved by CMS. All requests for access to *HHVBP Connect* should be sent to the HHVBP Help Desk at hhvbpquestions@cms.hhs.gov.
-	1609	4/30/16	-	**When designating an HHVBP point of contact, is it just for each unique CCN or do branch office locations with different addresses need to be listed as well?** A primary point of contact (PPOC) is required for each CCN and each CCN can only have one PPOC. There is no requirement to have a point of contact (POC) for a branch office.
-	1610	4/30/16	-	**What are the steps to change the primary point of contact (PPOC) to another person in the agency?** Please email the HHVBP Help Desk, HHVBPquestions@cms.hhs.gov and request a PPOC replacement and include the following information: the new PPOC name, email address, CCN(s) they represent, and the old PPOCs name and email address.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1611	4/30/16	-	**Please explain the different roles in the HHVBP Secure Portal and which roles will be able to view reports and submit data?** There are 5 HHVBP Secure Portal roles, each with different functionality 1. **Primary Point of Contract (PPOC)** – This role can view all reports and submit data, will grant HHVBP Secure Portal access to the Secondary POC, Reviewer, and Data Entry roles, as well as initiate recalculation requests. It is required that someone at the agency hold this role for each CCN. This role is approved by CMS. 2. **Corporate Point of Contact (CPOC)** – This role has the ability to view all information for the corporate CCNs, but does not have the ability to approve access or to enter data. This role is approved by CMS. 3. **Secondary Point of Contact** – This role acts as a proxy for the PPOC and is able to review and submit New Measure Data. 4. **Reviewer** – This role acts as a quality check mechanism for the Data Entry role. 5. **Data Entry** – This role can enter New Measure Data on behalf of the HHA but cannot submit it. All roles require an EIDM User ID.
New	1612	6/30/16		**How many people can act under one role in the HHVBP Secure Portal? Do the Secondary POCs, Reviewer, and Data Entry Personnel roles have to be completely different individuals?** Each CCN must have one and only on PPOC. The Corporate and Secondary POC roles are optional and are limited to one per CCN. Multiple people may be assigned the roles of Reviewer and Data Entry. An individual should only have one role per CCN.

New or Revised	#	Originally Posted	Last Updated	FAQ
New	1613	6/30/16		**Is there a cut-off date with respect to setting up the roles for the agency in the HHVBP Secure Portal?** There is not a specific deadline for assigning roles for the HHAs. However, agencies should note that obtaining access and receiving an approved role in the HHVBP Secure Portal is not instantaneous and may take days or weeks. As agencies will be able to first submit data on the New Measures beginning on October 1, 2016 and ending on October 7, 2016, they are encouraged to assign roles as soon as possible to ensure they can meet this data submission deadline.

HHVBP Connect

New or Revised	#	Originally Posted	Last Updated	FAQ
	1700.1	03/31/16	5/31/16	**I have registered for the Model. When will I get access to *HHVBP Connect?*** The *HHVBP Connect* site was first available to home health agencies in early February 2016. Agencies that have provided the HHVBP helpdesk with a PPOC will receive an email with an invitation to the *HHVBP Connect* site within approximately 3 weeks. This email will come from cmmiconnectnotification@cms.hhs.gov; please be sure to add this email address to your safe sender list, or check your junk mail box for an email from cmmiconnectnotification@cms.hhs.gov. For additional help, the *HHVBP Connect* site Help Desk known as CMMI Salesforce Help Desk can be reached at 1-888-734-6433, option 5, or by sending an email to hhvbpquestions@cms.hhs.gov.
-	1701	4/30/16	-	**What is the URL for the HHVBP Connect website?** The URL for HHVBP Connect is https://app.innovation.cms.gov/HHVBPConnect/
	1702	4/30/16	5/31/16	**What are the steps to access *HHVBP Connect*?** Primary points of contact (PPOC), will be added in batches on a weekly basis to the *HHVBP Connect* website. For additional users, the PPOC should email the HHVBP Help Desk at hhvbpquestions@cms.hhs.gov and include names, emails, and CCN(s).
Revised	1703.1	4/30/16	6/30/16	**I am on the *HHVBP Connect* website but I do not see the upcoming webinars listed on that page.** All upcoming webinars and events can be found on the *HHVBP Connect* "calendar" tab.
-	1704	4/30/16	-	**I have not received any emails from cmmiconnectnotification@cms.hhs.gov. What should I do?** Please email the HHVBP Help Desk, HHVBPquestions@cms.hhs.gov with the issue, since they may have an incorrect email address. You should also check your junk email inbox for communications from them, and add the email address to your "safe sender" list.

HHVBP Secure Portal

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1800.1	12/29/15	3/31/16	**When will the reporting portal be available to HHAs?** The HHVBP Secure Portal will be available to the HHAs in April 2016.
-	1801	03/31/16	-	**How can we test the HHVBP Secure Portal for interoperability?** Home health agencies will submit aggregate data on the HHVBP Secure Portal as data are not reported on individual patients or staff. There is no need to test interoperability of the HHVBP Secure Portal as the data entry requires agencies to manually enter the results of their data collection for each measure as indicated on the New Measures Templates. The New Measures Templates were introduced to HHAs on the January 28, 2016 webinar on New Measures and are available on the *HHVBP Connect* site.
-	1802	03/31/16	-	**Can we upload data files into the HHVBP Secure Portal? Will the HHVBP Secure Portal support receipt of an export file of some type from a software vendor?** HHVBP Secure Portal does not support uploading data files and requires manual data entry for the submission of New Measure data. Agencies will be able to submit supporting documentation when requesting a recalculation of performance scores.
-	1803	4/30/16	-	**What are all the steps needed to access the HHVPB Secure Portal and to assign roles to myself and my staff after getting the EIDM User ID and password?** The following are the instructions for each part of the registration process: **Part A: Innovation Center** 1. Navigate to the CMS Enterprise Portal 2. Click the "Login to CMS Secure Portal" button 3. Accept the Terms and Conditions by clicking the "I agree" button 4. Login using your CMS Enterprise Identity Management (EIDM) User ID and password • Enter your EIDM user ID • Click the "Next: button • Enter your password • Click the "Log In" button 5. Click the "Request Access Now" button on the CMS Portal landing page (continued below)

New or Revised	#	Originally Posted	Last Updated	FAQ
-	“”	“”	-	**Part A: Innovation Center (cont’d)** 6. Search for the Innovation Center in the access catalog • Type in the access catalogue search box “IC” and press enter to find the IC widget 7. Click the “Request Access” button in the IC widget 8. Choose “IC Privileged User” role from the dropdown • All Home Health agency users should choose “IC Privileged User” regardless of the role they will play in the Secure Portal 9. Click the “Submit” button (continued below) **Complete Identity Verification** 10. Click “next” on the screen that says “Identity Verification” at the top 11. Agree to the Terms and Conditions. Check the “I agree” box • Then, click the “Next” button 12. Enter your name, email, address, social security, address, and phone number on this screen • Click the “Next” button 13. On the next screen, you will be asked a series of randomly selected questions to correctly prove you say who you say you are. These questions can include: • Date of opening a credit card • Current address • What town you live in • Lender of your mortgage • Instalments for an auto loan • It is very important that you answer these questions correctly. Please take the time to make your best informed choice. If you answer a question incorrectly, the Experian number (866-578-5409) will pop up on your screen and you will be able to continue with identity verification over the phone. • Click the “Next” button when you have answered the questions 14. If you answered all the questions correctly, a screen confirming you have completed remote identity proofing appears • Click the “Next” button (continued below)

New or Revised	#	Originally Posted	Last Updated	FAQ
-	“”	“”	-	**Set up a Multifactor Authentication Device** 15. A “Multifactor Authentication Information” screen appears • Click the “Next” button 16. On the next screen, you can select from 4 “Credential Types” • We recommend choosing either the “Email one-time pass-code” or “Text Message- Short Message Service (SMS)” option so that you get a unique code to your email each time you try to access the HHVBP Secure Portal • After you select your credential type, a text box will appear where you will enter your email or phone number where you want to receive the passcode • In the credential description, enter a description like “work email” • Then, click the “Next” button • A screen confirm that you have set up a device • Click the “OK” button 17. A screen appears that confirms your request and gives you your request ID. Store this for future reference 18. A CMS team member will approve access to your IC request. You will get an email confirming the approval **Part B: HHVBP Secure Portal** 1. Navigate to CMS Enterprise Portal 2. Accept the Terms and Conditions by clicking the “I Accept” button 3. Enter your EIDM user ID • Click the “Next” button 4. On the next screen, enter your password • Select the multifactor authentication device you setup in the Innovation Center step from the MFA Device Type dropdown • Click the “Send” button to receive a temporary passcode to the configured device • Enter the passcode into the Security Code field • Click the “Log In” button (continued below)

New or Revised	#	Originally Posted	Last Updated	FAQ
-	“”	“”	-	5. Click on the Innovation Center tab on the upper left-hand corner • From the dropdown, select the “Application Console” 6. On the Welcome to the Innovation Center screen, click the “Request New Access” button 7. In the CMMI Request Access section choose Home Health Value Based Purchasing (HHVBP) from the dropdown. 8. Choose the appropriate role from the next dropdown. The CMS team will approve of the Primary Points of Contact and Corporate Points of Contact • **Primary Point of Contact:** understands the daily operations of the HHA, has authority to delegate/assign tasks, submits data and reviews performance reports, grants HHVBP Secure Portal access to the Data Entry, Reviewer, and Secondary POC roles • **Corporate Point of Contact:** has the ability to view all information of the HHAs under the corporation • **Secondary POC:** acts as a proxy for the PPOC, reviewing and submitting HHA’s New Measure Data • **Data Entry:** can enter New Measure Data on behalf of the HHA but cannot submit it • **Reviewer**: acts as a quality check mechanism for the HHA Data Entry role 9. Enter a single CCN into the CCN text field 10. Enter the note “HHVBP Request” in the comments field 11. Click the “Submit Request” button 12. Repeat the process for each CCN you represent starting from step 5 • For Primary and/or Corporate Points of Contact that represent five or more CCNs, CMS can automatically approve you for the multiple agencies you represent 13. A pop-up notification will appear with your request ID 14. Save the request ID for your reference 15. Click “OK”, and you will return to the CMMI Request Access portlet, where a record of your request displays 16. The CMS Enterprise Portal will send an email when you are approved.

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1804	4/30/16	-	**I have access to other sites in the CMS Enterprise Portal. What do I need to do to get access to the HHVBP Secure Portal?** If you don't already have access to the Innovation Center, you will need to request the IC Privileged User role and complete the Remote Identity Proofing. Once you have been approved as an IC Privileged user, you will need to request access to the HHVBP Secure Portal from the access catalogue.
	1805	5/31/16		**I have registered for the HHVBP Secure Portal; however, I cannot enter it because I did not receive a security code sent to my email as requested. What do I do?** The first thing to do is check your SPAM and junk mail folders to ensure you did not receive an email from [state who it would be from]. Secondly, check to be sure you are using the type of Multi-factor Authentication (MFA) that you originally selected when you set up your account. For example, if you signed up for text messaging as the mode for MFA, you will receive a text message. Third, be sure you entered the email address or phone number correctly. If you are still having trouble, please contact the CMS Help Desk at HHVBPquestions@cms.hhs.gov.
	1806	5/31/16		**Does asking security questions for CMS registration for the HHVBP Secure Portal based on a person's credit report in any way at all effect their credit score?** The credit inquiry for HHVBP registration is a "soft" inquiry, and therefore does not impact your credit score.
	1807	5/31/16		**During the registration process my identity was not able to be verified as I do not have any credit cards and have no loans. What can I do?** There is a manual process for verifying your identity if you do not have any credit cards or loan information. To complete the manual identity verification process, please contact the CMS Help Desk at HHVBPquestions@cms.hhs.gov . Note that you will need a copy of your photo ID to complete this process.

Miscellaneous

New or Revised	#	Originally Posted	Last Updated	FAQ
-	1900	12/29/15	-	**How were the nine states included in the Model selected?** Clusters of states were formed that were geographically related and also were alike in terms of important HHA characteristics that were selected to ensure a robust evaluation. Then, we selected one state from each cluster at random. States, and the home health agencies within them, had a similar probability of being selected. See the Final Rule that was published 11/5/2015 in the Federal Register (https://www.federalregister.gov/articles/2015/11/05/2015-27931/medicare-and-medicaid-programs-cy-2016-home-health-prospective-payment-system-rate-update-home)(//www.cms.gov/AboutCMS/AgencyInformation/Aboutwebsite/ExternalLinkDisclaimer.html for a detailed explanation of how states were selected for inclusion in the HHVBP Model.
-	1901	12/29/15	-	**Will we receive a copy of webinar slides?** The slides from all webinars will be placed on *HHVBP Connect*, the learning and diffusion website established by CMS for HHAs in the nine states who have submitted point of contact information and their EIDM User ID.
-	1902	12/29/15	-	**Will webinars be repeated?** *No.* Webinars will not be repeated, but the recordings of the webinars will be available on *HHVBP Connect*.
-	1903	03/31/16	-	**I remember reading somewhere that there will be educators to assist the home health agencies with the HHVBP program. Will there be one assigned to each state? Will they be "certified"? How will this work?** CMS has contracted with The Lewin Group as the Technical Assistance Contractor for the HHVBP Model. This contract includes providing webinars and tools to the competing home health agencies. It does not provide one-on-one assistance to agencies and does not assign trainers to the individual states in the Model, but provides all available resources uniformly to all competing agencies through the *HHVBP Connect* site.

New or Revised	#	Originally Posted	Last Updated	FAQ
Revised	1904.1	03/31/16	6/30/16	**How and when will newly scheduled webinars be announced? Will consultants or software vendors be able to register for the webinars?** CMS will generally notify competing agencies of upcoming webinars a few weeks before the scheduled webinar date. Information will be posted on the *HHVBP Connect* site "calendar" tab and competing agencies will receive email updates. However, webinar dates and topics may change. If changes occur, competing agencies will be notified as soon as possible. Due to resource constraints, the primary audience for the webinars is competing HHAs. Agencies may choose to share information with their vendors and/or consultants.
-	1905	03/31/16	-	**Can agencies from states not included in the pilot participate in the upcoming webinar for informational purposes?** Agencies in states that are not participating in the HHVBP Model will not be invited to participate in the webinars and will not have access to the recorded webinars or resources on the *HHVBP Connect* site. *HHVBP Connect* is a collaborative platform designed to support the agencies competing in the Model equally.
-	1906	4/30/16	-	**How can new agencies or agencies that are not yet on HHVBP Connect register for the webinars?** New HHAs in the nine selected states should provide the agency's primary point of contact (PPOC) information to the HHVBP Help Desk, HHVBPquestions@cms.hhs.gov: name, email address, CCN, agency name, agency address, and phone number. Mention this is PPOC information for a new agency and your contact information will be noted in our records. You will begin receiving communications from the HHVBP Model Team, including emails inviting you to register for upcoming webinars.

[1] Prior to June 2016, the Interim Performance Reports were known as the Quarterly Performance Reports.