Home Health Value-Based Purchasing (HHVBP)

Quality Improvement: Utilization Measures

June 9, 2016

As prepared by the Centers for Medicare & Medicaid Services HHVBP Technical Assistance contract number HHSM-500-2014-00031.

Today's Objectives

Attendees will gain an understanding of:

1) The 3 utilization measures in Performance Year 1 of the HHVBP Model:
   - Acute Care Hospitalization: Unplanned Hospitalization during first 60 days of Home Health (claims-based)
   - Emergency Department Use without Hospitalization (claims-based)
   - Discharge to Community (OASIS-based)
2) Sample best practice tools and quality improvement strategies for the utilization measures
3) Tips for implementing best practices

Handouts & Questions

- **Handouts**
  - » Presentation Slides (PDF)
  - » Best Practice Tools
    - Call Me First Poster (MS Word)
    - My Emergency Care Plan (MS Word)
    - Zone Tools (MS Word)
    - Patient Friendly Medication Schedule (PDF)
    - Medication Simplification Tool (PDF)
    - Medication Reconciliation Process (PDF)

- **Questions**
  - » Questions may be submitted privately through the Q&A feature on your screen OR
  - » HHVBP Help Desk at HHVBPquestions@cms.hhs.gov

Webinar Console Overview

Polling Question

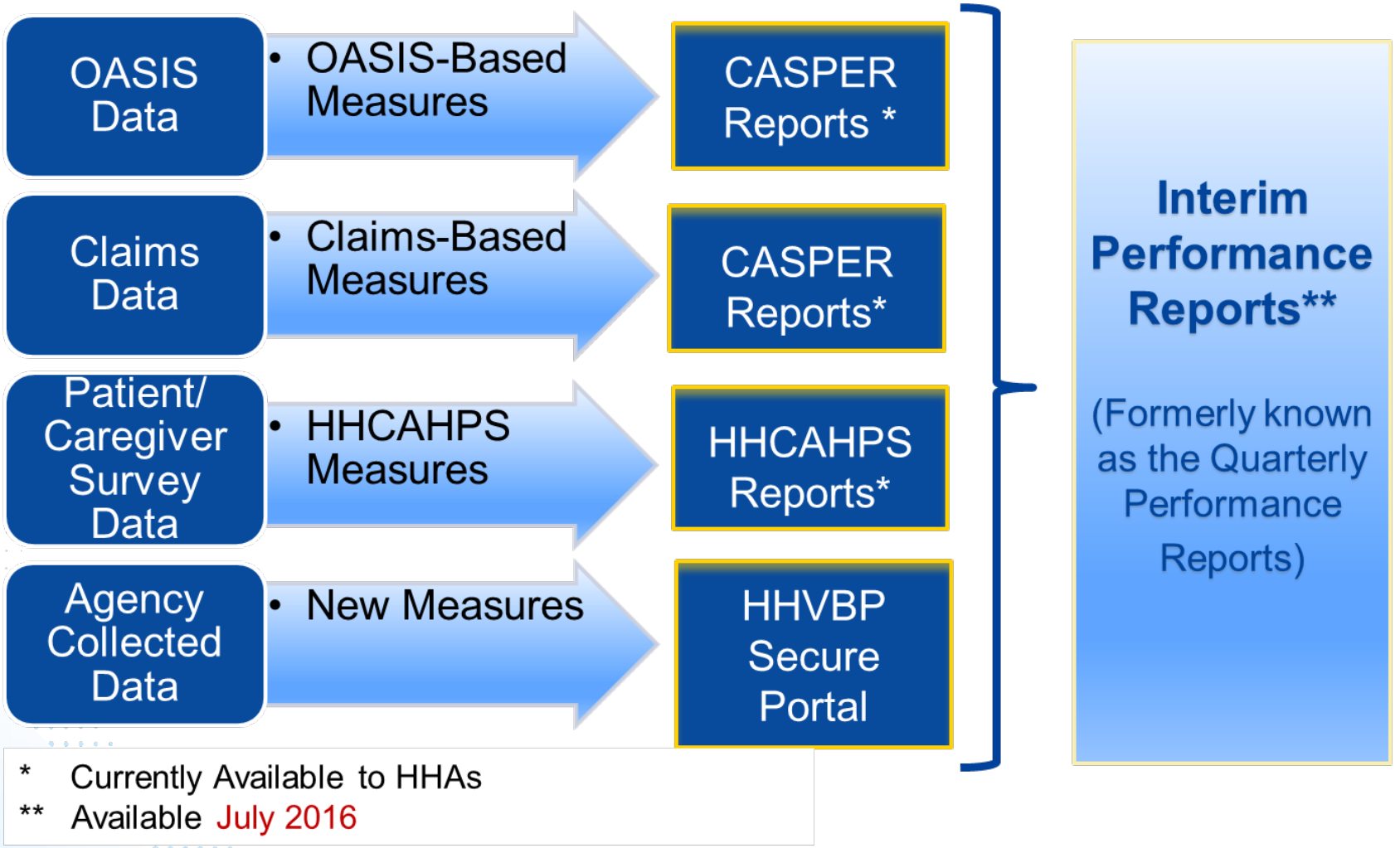
Have you registered and accessed the HHVBP Secure Portal yet?

A. Yes

B. No

TYPES OF MEASURES IN THE MODEL

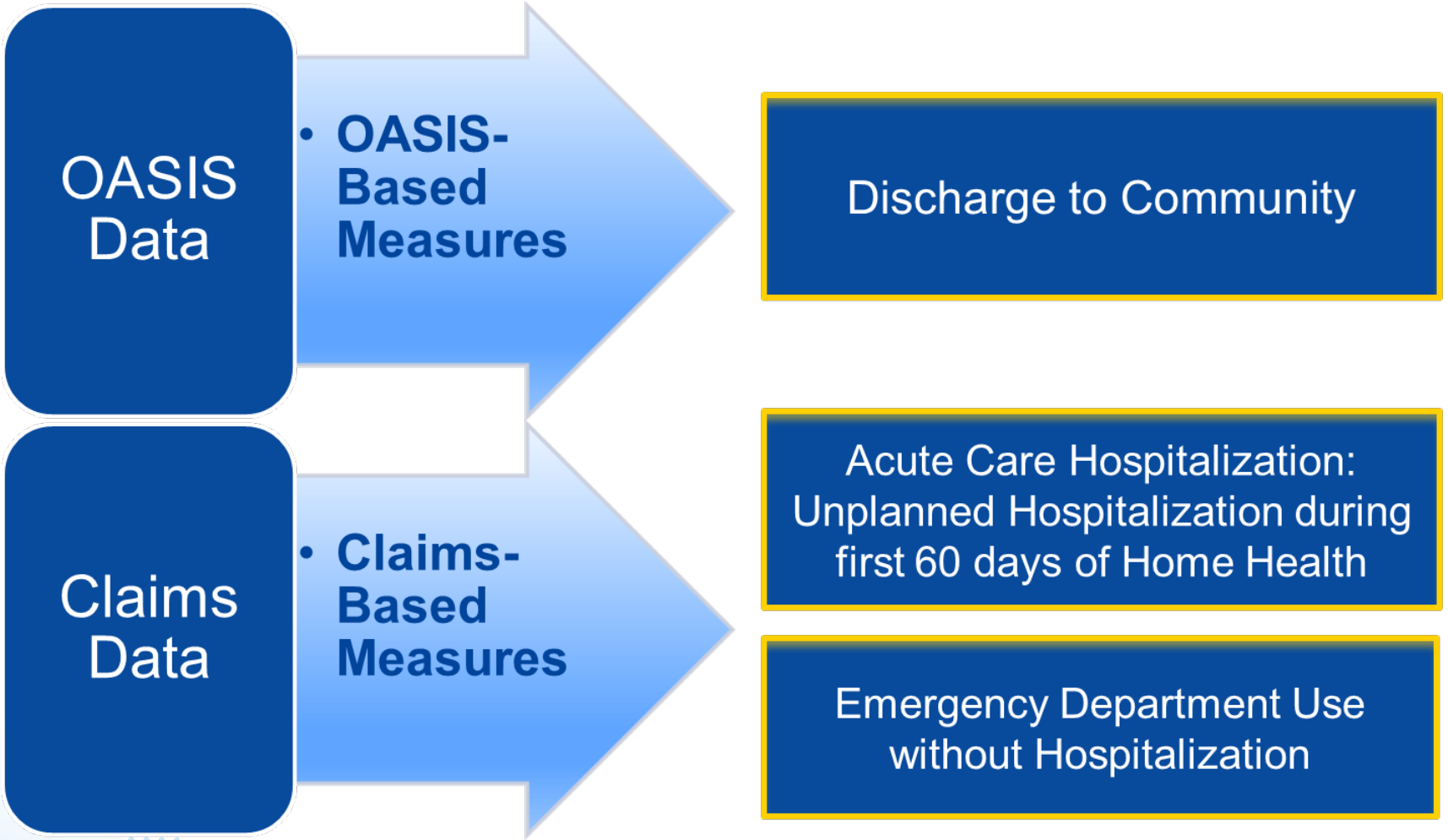
Quality Measures



* Currently Available to HHAs

** Available July 2016

3 Utilization Measures – HHVBP PY1



UNDERSTANDING MEASURE CALCULATIONS

Measure Calculation Terminology

Term	Definition
Denominator	The group of patients for which the measure applies
Numerator	The subset of patients from the denominator who meet the measure specified clinical requirements
Exclusions	Specifications that would remove a patient from the denominator of a specific quality measure
Measurement Period	The time frame for which the measures will be calculated
Quality Episode	OASIS-based outcome measures - a matched pair of OASIS assessments consisting of a start of care (SOC) or resumption of care (ROC) assessment and the corresponding discharge, transfer, or death assessment Claims-based measures - defined by the begin and end date of a claim or sequence of claims, matched, if applicable, with any inpatient admission or emergency department utilization claims

Applying Terminology: Example

The **gold box**[1] depicts all patients in a home health agency with a **quality episode** during the **reporting period**.

HOME HEALTH AGENCY PATIENTS[1]
with a Quality Episode

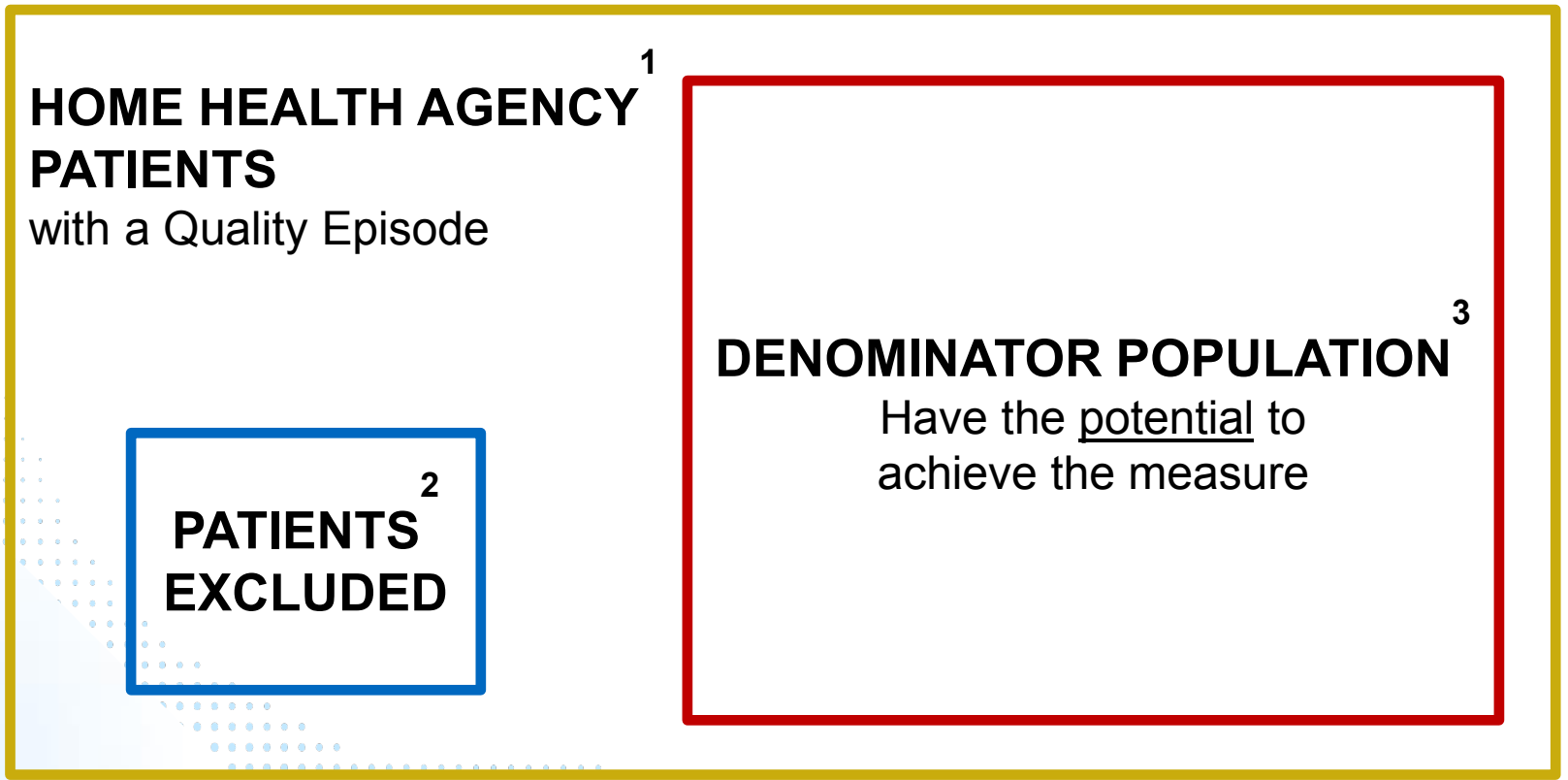
Applying Terminology: EXCLUSIONS

The **blue box**[2] depicts patients who are in the home health agency's population during the reporting period but are **excluded** from the measure.

Some patients may be excluded from the measure if they don't meet certain criteria for that measure (e.g. age, payer, etc.).

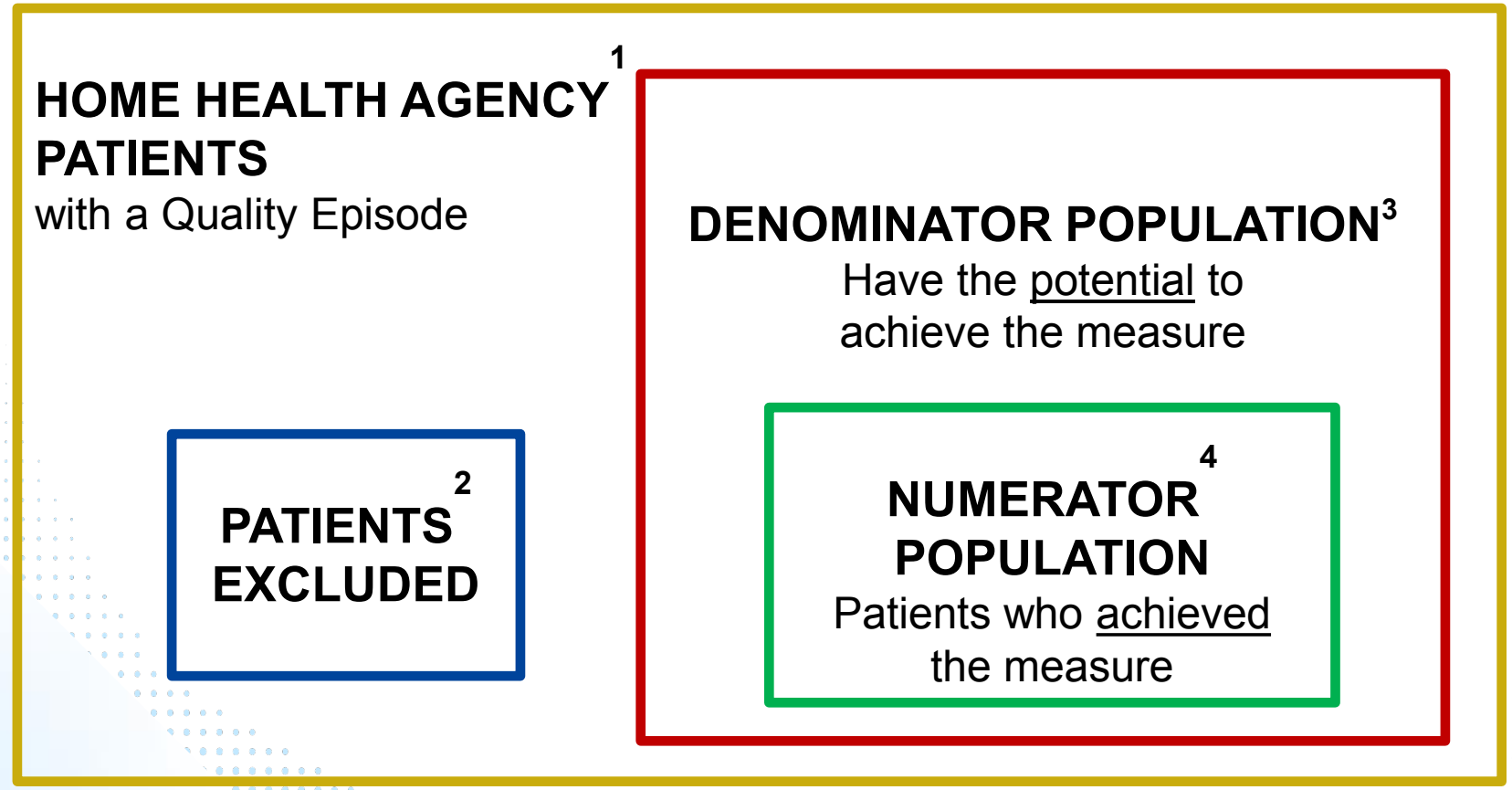
Applying Terminology: DENOMINATOR

The **red box**[3] depicts the **denominator population** and includes those patients in the home health agency with a quality episode in the reporting period that are not excluded from the measure and **have the potential to achieve the measure** (e.g. patients who have the potential to improve in a measure).



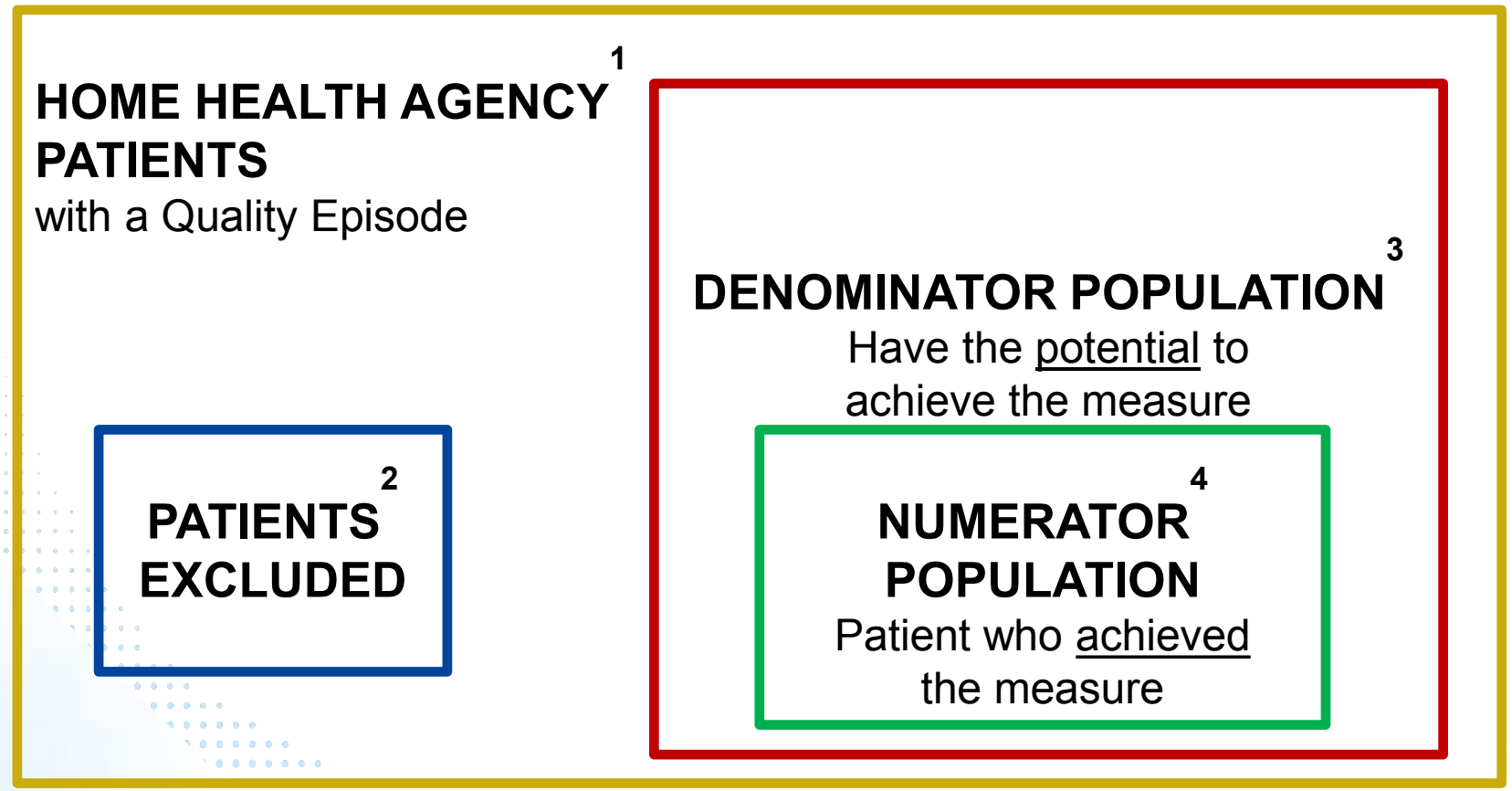
Applying Terminology: NUMERATOR

The **green box** depicts the **numerator population** which includes patients in the denominator population and **achieved the measure** (e.g. patients who improved in a measure).



Applying Terminology: Quality Measure Rate (%)

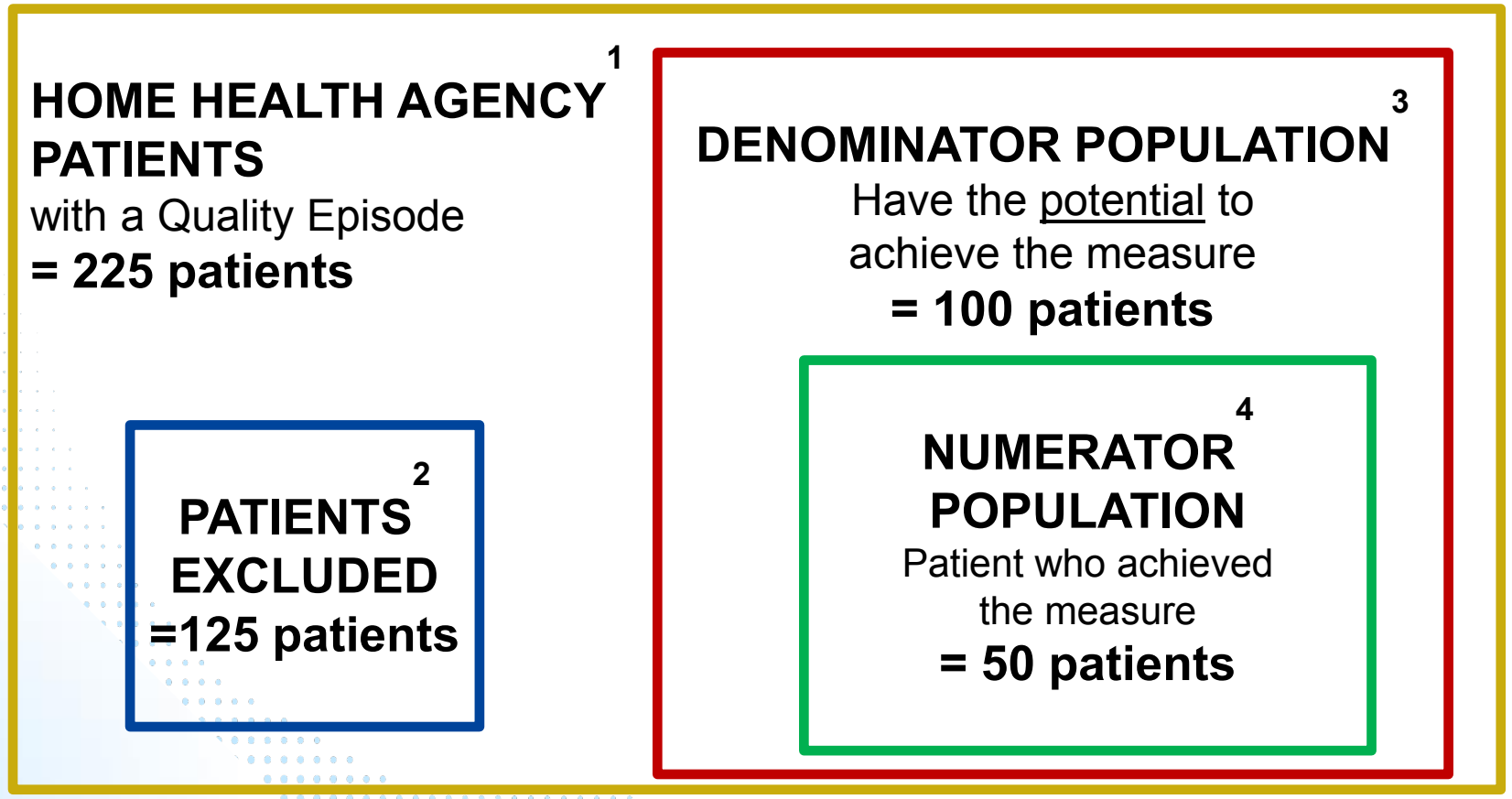
Quality Measure Rate (%) = Numerator ÷ Denominator



Applying Terminology: Quality Measure Rate

Quality Measure Rate (%) = Numerator ÷ Denominator

0.50 or 50% = 50 ÷ 100



UTILIZATION MEASURES: MEASURE DEFINITIONS

Discharge to Community Measure Definitions

Term	Definition
Description	Percentage of home health episode after which patients remained at home.
Numerator	Number of home health episodes where the assessment completed at the discharge indicates the patient remained in the community after discharge.
Denominator	Number of home health episodes of care ending with a discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.
Exclusions	Home health episodes of care that end in death.
OASIS Item(s) Used	(M0100) Reason for Assessment (M2420) Discharge Disposition

Acute Care Hospitalization Measure Definitions

Term	Definition
Description	Percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay.
Numerator	Number of home health stays for patients who have a Medicare claim for an admission to an acute care hospital in the 60 days following the start of the home health stay.
Denominator	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
	(CONTINUED ON NEXT SLIDE)

Acute Care Hospitalization Measure Definitions (continued)

Term	Definition
Exclusions	• Home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim. • Home health stays in which the patient receives service from multiple HHAs during the first 60 days. • Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to and the 60 days following the start of the home health stay or until death. • Planned hospitalizations are excluded from the numerator.
OASIS Item(s) Used	None – based on Medicare fee-for-service claims
	NOTE: A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

ED Use Without Hospitalization Measure Definitions

Term	Definition
Description	Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.
Numerator	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay.
Denominator	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
	(CONTINUED ON NEXT SLIDE)

ED Use Without Hospitalization Measure Definitions (continued)

Term	Definition
Exclusions	• Home health stays that begin with a Low Utilization Payment Adjustment (LUPA) claim. • Home health stays in which the patient receives service from multiple agencies during the first 60 days. • Home health stays for patients who are not continuously enrolled in fee-for-service Medicare for the 6 months prior to and the 60 days following the start of the home health stay or until death.
OASIS Item(s) Used	None – based on Medicare fee-for-service claims
	NOTE: A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

DATA COLLECTION

Data Collection Accuracy

Measure	Source	Agency Data Collection
Discharge to Community	OASIS	Item Used to Compute Change: (M2420) Discharge Disposition Item Used to Compute Exclusions: (M0100) Reason for Assessment
Acute Care Hospitalization	Medicare fee-for-service claims	None
Emergency Department Use without Hospitalization	Medicare fee-for-service claims	None

OASIS C1-ICD-10 Guidance Manual: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html

OASIS Q&As and Quarterly Q&As: https://www.qtso.com/hhatrain.html

Discharge to Community OASIS Item: M2420

(M2420) Discharge Disposition: Where is the patient after discharge from your agency? **(Choose only one answer.)**

- ❑ 1 - Patient remained in the community (without formal assistive services)
- ❑ 2 - Patient remained in the community (with formal assistive services)
- ❑ 3 - Patient transferred to a non-institutional hospice
- ❑ 4 - Unknown because patient moved to a geographic location not served by this agency
- ❑ UK - Other unknown [Go to M0903]

Discharge to Community OASIS Item: M2420

OASIS Data Collection Guidance

- Patients who are in assisted living or board and care housing are considered to be living in the community with formal assistive services.
- Formal assistive services refers to community-based services provided through organizations or by paid helpers.
  - » Examples: homemaking services under Medicaid waiver programs, personal care services provided by a home health agency, paid assistance provided by an individual, home-delivered meals provided by organizations like Meals-on-Wheels.
  - » Therapy services provided in an outpatient setting would not be considered formal assistive services

OASIS C-1/ICD-10 Guidance Manual, Chapter 3: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html

Discharge to Community OASIS Item: M2420

OASIS Data Collection Guidance (continued)

- Informal services are provided by friends, family, neighbors, or other individuals in the community for which no financial compensation is provided.
  - » Examples: assistance with ADLs provided by a family member, transportation provided by a friend, meals provided by church members (specifically, meals not provided by the church organization itself, but by individual volunteers).
- Non-institutional hospice is defined as the patient receiving hospice care at home or a caregiver's home, not in an inpatient hospice facility.

OASIS C-1/ICD-10 Guidance Manual, Chapter 3: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html

QUALITY IMPROVEMENT

Quality Improvement (QI) Process Overview

Quality Improvement Cycle

Quality Improvement Activities

1. Review and interpret data
2. Select measures for improvement or reinforcement
3. Investigate care and processes resulting in the individual measure results
4. Determine your best practices/process improvements (for each measure)
5. Document your plan (for each measure)
   a. Targeted measure
   b. Best practices/process improvements
   c. Strategies and plan to implement best practices/process improvements
   d. Plan to monitor the best practices/process improvements

Key Points:
Utilization Measures & Quality Improvement

- Many best practices can impact all 3 utilization measures
- Many resources are available as there are tools, resources, lessons learned available from many current and past quality initiatives, including:
  - CMS Quality Improvement Organizations: Home Health Quality Improvement National Campaign
  - CMS Quality Improvement Organizations: Care Transitions
  - Visiting Nurse Association of America Blueprint for Excellence
  - CHAMP – Advancing Homecare Excellence
  - Transitional Care Model, University of Pennsylvania
  - Visiting Nurse Service of New York ReACH Collaborative

Sample Best Practice Tools

1. Call Me First Poster - Patient Support Tool
2. My Emergency Care Plan – Patient Support Tool
3. Zone Tools - Patient Support Tools
   Condition- Specific Tools for:
   - COPD
   - Depression
   - Diabetes
   - Heart Disease
   - Heart Failure
   - Hypertension
   - Pain
   - Urinary Catheter

Sample Best Practice Tools

4. Patient-Friendly Medication Schedule – Patient Support Tool
5. Medication Simplification Tool – Staff Education Tool
6. Clinician Medication Reconciliation Process – Staff Education Tool
7. SBAR Communication Tool – Staff Education Tool


CALL ME
FIRST
because we care!
Stay safe and well at home. Avoid unnecessary trips to the hospital.
Call me when you:
• Get sick
• Just don't feel right
• Find it harder to stand up from a chair
We can help if we know you're in need.
[Insert AGENCY LOGO]
[Insert phone number]
Anytime: 24 Hours a Day/7 Days a Week
In the Case of Emergency, Call 9-1-1
This material was prepared by Quality Insights, the Medicare Quality Innovation Network-Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Adapted from Girling Health Care. Publication number 11SOW-WV-HH-MMD-063015A

Polling

- I am familiar with the Call Me First Poster (or a similar tool)
- I am not familiar with the Call Me First Poster

Polling

- My agency:
  - Currently uses the Call Me First Poster (or a similar tool)
  - Will consider using the Call Me First Poster
  - Will not consider using the Call Me First Poster
  - Unsure

Agency Name: _____ _____

Agency Phone Number: _____ Patient Name

MY EMERGENCY PLAN

WHAT'S WRONG?	CALL MY HOME HEALTH AGENCY WHEN:	CALL 911 WHEN:
 **I hurt**	• New pain OR pain is worse than usual • Unusual bad headache • Ears are ringing • My blood pressure is above: _____/_____ • Unusual low back pain • Chest pain or tightness of chest RELIEVED by rest or medication	• Severe or prolonged pain • Pain/discomfort in neck, jaw, back, one or both arms, or stomach • Chest discomfort with sweating/nausea • Sudden severe unusual headache • Sudden chest pain or pressure & medications don't help (e.g. Nitroglycerin as ordered by physician), OR • Chest pain went away & came back
 **I have trouble breathing**	• Cough is worse • Harder to breathe when I lie flat • Chest tightness RELIEVED by rest or medication • My inhalers don't work • Changed color, thickness, odor of sputum (spit)	• I can't breathe! • My skin is gray OR fingers/lips are blue • Fainting • Frothy sputum (spit)
 **I have fever or chills**	• Fever is above _____ F • Chills/can't get warm	• Fever is above _____ F with chills, confusion or difficulty concentrating
 **I fell**	• Dizziness or trouble with balance • Fell and hurt myself • Fell but didn't hurt myself	• Fell and have severe pain

This plan is a guide only and may not apply to all patients and/or situations. This plan is not intended to override patient/family decisions in seeking care. 1

This material was developed by Quality Insights of Pennsylvania in conjunction with Carol Siebert, MS, OTR/L, FAOTA, American Occupational Therapy Association and Karen Vance, OTR/L, BKD Healthcare Group and American Occupational Therapy Association. Based on My Emergency Plan created by Delmarva in conjunction with OASIS Answers, Inc. This material was provided by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication number: 9SOW-WV-HH-BBK-012710B App. 01/10.

Polling

- I am familiar with the My Emergency Care Plan Tool (or a similar tool)
- I am not familiar with the My Emergency Care Plan Tool

Polling

- My agency:
  - Currently uses a My Emergency Care Plan Tool (or a similar tool)
  - Will consider using a My Emergency Care Plan Tool
  - Will not consider using a My Emergency Care Plan Tool
  - Unsure

Depression Management ZONES

Insert Agency's Logo

GREEN ZONE	**ALL CLEAR (GOAL)**
	• Feeling hopeful
	• Not sad or gloomy
	• Able to concentrate
	• No trouble sleeping
	• Good appetite
		Doing Great!
		• Your symptoms are under control
		• Actions:
		  ○ Take medicines as ordered
		  ○ Do fun and interesting activities
		  ○ Keep regular sleep habits
		  ○ Keep all doctor appointments

YELLOW ZONE	**WARNING**
	If you have <u>any</u> of the following:
	• Sad mood most of the time
	• More anxious, irritable, angry, and/or feeling empty
	• Less interested in doing daily activities
	• Trouble sleeping
	• Unable to have fun or pleasure
	• Hard to concentrate
	• Less interested in food
	• Missing or not taking medications
	• Missing health appointments
		Act Today!
		• You may need your medicines changed
		• Actions:
		  ○ Set small goals
		  ○ Try to exercise
		  ○ Be around people who care about you
		  ○ Call **your home health nurse**
		  _____
		  (agency's phone number)
		  ○ Or call **your doctor**
		  _____
		  (doctor's phone number)

RED ZONE	**EMERGENCY**
	• Overwhelmed by anxious, irritable, angry, or empty feelings
	• Hopeless or helpless feelings
	• Thoughts to hurt self or others
	• Unable to get out of bed
	• Unable to sleep
	• Not eating at all
	• Unable to take medications or keep doctor appointments
		Act NOW!
		• You need to be seen <u>right away</u>
		• Actions:
		  ○ **Call your home health nurse**
		  _____
		  (agency's phone number)
		  ○ **Or call your doctor**
		  _____
		  (doctor's phone number)
		  ○ **Or go to the Emergency Department**

References: (National Institute of Mental Health, n.d.; A.D.A.M. Medical Encyclopedia, 2013; Kroenke, Spitzer, & Williams, 2001)

HHQI Home Health Quality Improvement

This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The views presented do not necessarily reflect CMS policy. Publication Number: 10SOW-WV-HH-MMD-072414A1

Polling

- I am familiar with the Zone Tools (or a similar tool)
- I am not familiar with the Zone Tools

Polling

- My agency:
  - Currently uses the Zone Tools (or a similar tool)
  - Will consider using the Zone Tools
  - Will not consider using the Zone Tools
  - Unsure

Medicine schedule for: _____

Medicine name, strength	Morning dose 	Noon dose 	Evening dose 	Bedtime dose 	As needed dose	Notes:

Schedule was last updated on _____ Page _____ of _____

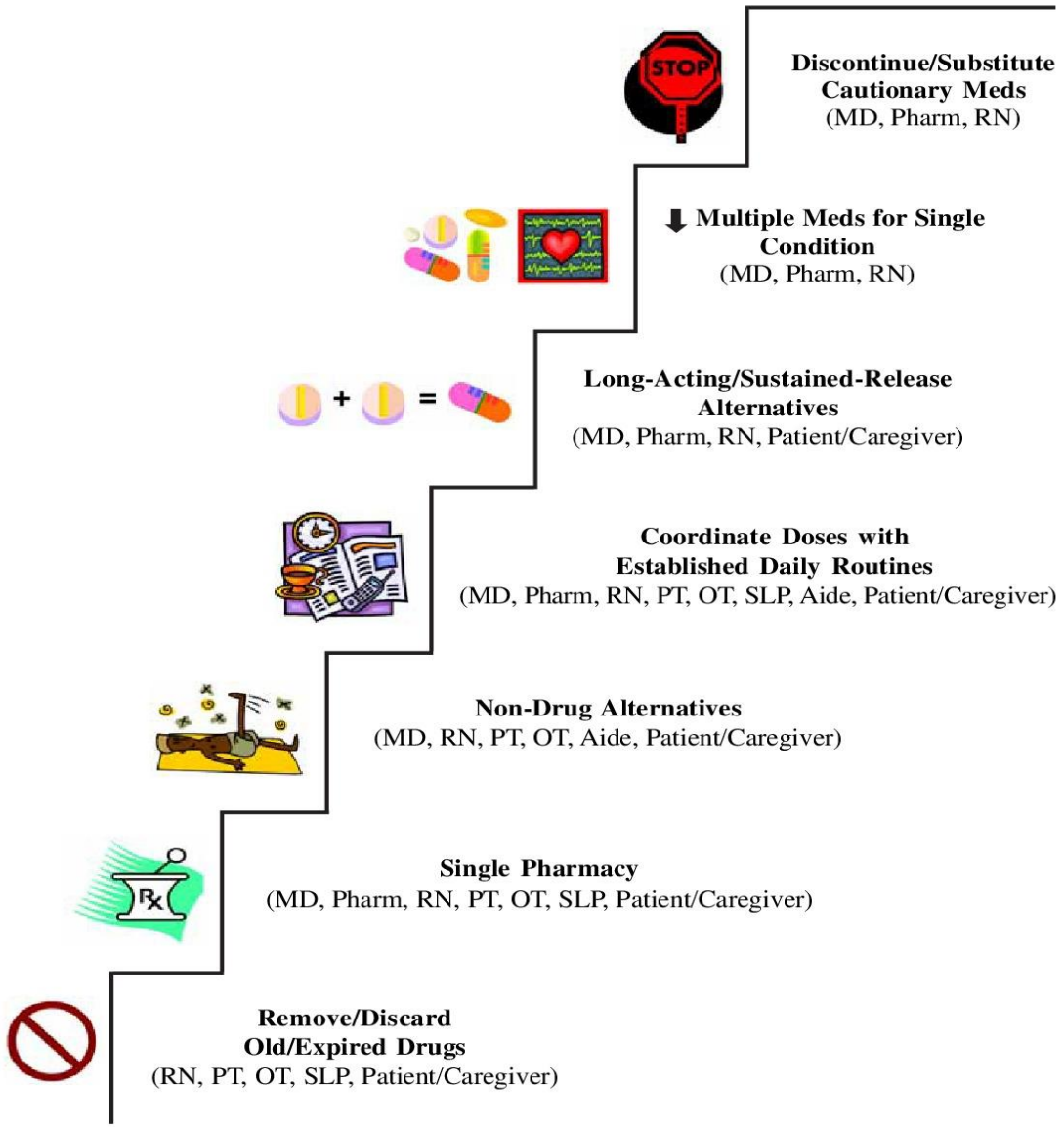
Polling

- I am familiar with the Patient-Friendly Medication Schedule (or a similar tool)
- I am not familiar with Patient-Friendly Medication Schedule

Polling

- My agency:
  - Currently uses the Patient-Friendly Medication Schedule (or a similar tool)
  - Will consider using the Patient-Friendly Medication Schedule
  - Will not consider using the Patient-Friendly Medication Schedule
  - Unsure

STEPS to MEDICATION SIMPLIFICATION



Discontinue/Substitute Cautionary Meds
(MD, Pharm, RN)

⬇ Multiple Meds for Single Condition
(MD, Pharm, RN)

Long-Acting/Sustained-Release Alternatives
(MD, Pharm, RN, Patient/Caregiver)

Coordinate Doses with Established Daily Routines
(MD, Pharm, RN, PT, OT, SLP, Aide, Patient/Caregiver)

Non-Drug Alternatives
(MD, RN, PT, OT, Aide, Patient/Caregiver)

Single Pharmacy
(MD, Pharm, RN, PT, OT, SLP, Patient/Caregiver)

Remove/Discard Old/Expired Drugs
(RN, PT, OT, SLP, Patient/Caregiver)

This material was developed by Linda Krulish, PT, MHS, and Stephanie Mello Gaskell, MS, MBA, RN, COS-C, and distributed by Quality Insights of Pennsylvania, the Medicare Quality Improvement Organization for Pennsylvania, under contract with the Centers for Medicare & Medicaid Services (CMS). The views presented do not necessarily reflect those of CMS. Publication number 7SOW-PA-HH05.125

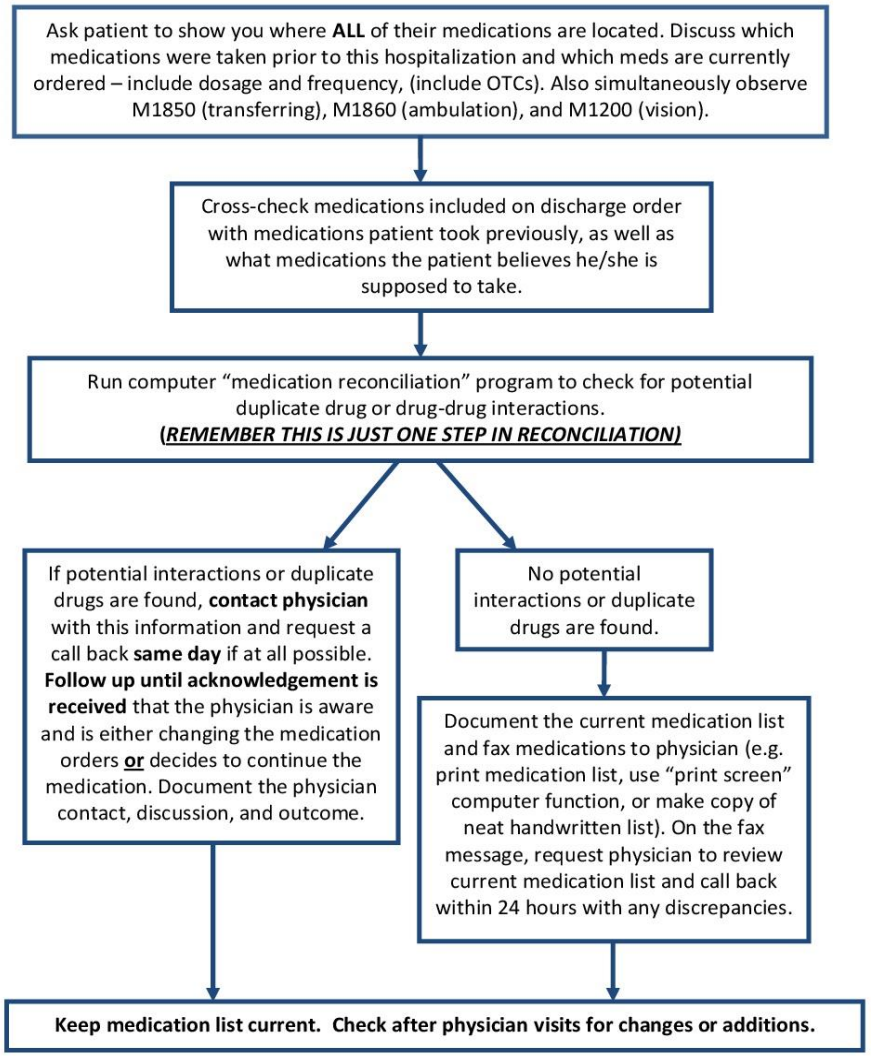
Polling

- I am familiar with the Medication Simplification Tool (or a similar tool)
- I am not familiar with the Medication Simplification Tool

Polling

- My agency:
  - Currently uses the Medication Simplification Tool (or a similar tool)
  - Will consider using the Medication Simplification Tool
  - Will not consider using the Medication Simplification Tool
  - Unsure

Clinician Medication Reconciliation Process



Developed by Lynda Laff, RN, BSN, COS-C, www.laffassociates.com

Polling

- I am familiar with the Medication Reconciliation Process (or a similar tool)
- I am not familiar with the Medication Reconciliation Process

Polling

- My agency:
  - Currently uses the Medication Reconciliation Process (or a similar tool)
  - Will consider using the Medication Reconciliation Process
  - Will not consider using the Medication Reconciliation Process
  - Unsure

SBAR

A structured communication technique designed to convey a great deal of information in a succinct and brief manner. This is important as we all have different styles of communicating, varying by profession, culture, and gender.

S Situation
A concise statement of the problem

What is going on now

B Background
Pertinent and brief information related to the situation

What has happened

A Assessment
Analysis and considerations of options

What you found/think is going on

R Recommendation
Request/recommend action

What you want done

KAISER PERMANENTE®

[Agency Logo]

Patient Name: _____
Record #: _____

SBAR
(Physician Communication)

Have ALL information AVAILABLE when reporting:
chart, allergies, medication list, pharmacy number, pertinent lab results

S SITUATION
I am calling about: _____ (**patient's name**)
The **problem** I am calling about is: _____

B BACKGROUND
State the **primary diagnosis & reason patient is being seen** for home care: _____
State the pertinent **medical history**: _____
Most recent **findings**: _____
Mental status _____ Neuro changes _____ Temp _____
BP _____ Pulse rate/quality/rhythm _____ Resp rate/quality _____
Lung sounds _____ Pulse Oximetery _____% Oxygen _____ L/min via _____
GI/GU changes (nausea/vomiting/diarrhea/impaction/hydration) _____
Weight _____ (actual) Loss or Gain Skin color _____ Blood Glucose _____
Wound status (drainage, wound bed, treatment) _____
Pain level/location/status _____
Musculoskeletal changes (weakness) _____
DNR Status _____
Other _____

A ASSESSMENT
(What do you think is going on with the patient?)
I think that the patient is: _____
or
I am not sure of what the problem is, but the patient's status is deteriorating.

R RECOMMENDATION
I suggest or request:
☐ PRN visit or referral: ☐ Nurse ☐ PT ☐ ST ☐ OT ☐ HH Aide ☐ MSW ☐ Dietician
☐ Visits frequency change
☐ Schedule for a physician office visit
☐ Physician, Nurse Practitioner or Physician Assistant home visit
☐ Pulse Oximetery ☐ Lab work _____
☐ Urinalysis, C & S ☐ X-rays ☐ EKG
☐ Medication changes _____
☐ Wound care changes _____
☐ Nutrition or fluid restriction changes _____
☐ Other _____
☐ Call physician with: _____

Staff Name _____ Date & Time _____

Physician's Name _____

SBAR Communication Tool

- The complete SBAR communication tool package can be accessed here:
  - » http://champ-program.org/static/Entire_SBAR_Package.pdf

Polling

- I am familiar with the SBAR Communication Tool (or a similar tool)
- I am not familiar with the SBAR Communication Tool

Polling

- My agency:
  - Currently uses the SBAR Communication Tool (or a similar tool)
  - Will consider using the SBAR Communication Tool
  - Will not consider using the SBAR Communication Tool
  - Unsure

RESOURCES

Help Desk Resources

1. **Home Health Quality Help Desk**:
   - homehealthqualityquestions@cms.hhs.gov
   - Questions related to: previously existing home health quality measures (OASIS and claims-based) and reports
2. **OASIS Q&A Help Desk:**
   - cmsoasisquestions@oasisanswers.com
   - Questions related to: OASIS data collection (scoring convention, time points, patient populations, item-specific guidance)
3. **HHCAHPS**
   - hhcahps@rti.org; Phone: 1-866-354-0985
   - Questions related to: the Home Health CAHPS survey or measures
4. **HHVBP Help Desk:**
   - hhvbpquestions@cms.hhs.gov
   - Questions related to HHVBP-specific content

References

- Centers for Medicare & Medicaid Services (2016). Home Health Measure Tables.
- Centers for Medicare & Medicaid Services (2015). OASIS-C/ICD-10 Guidance Manual October 2015.
- Centers for Medicare & Medicaid Services (2012). Outcome-Based Quality Improvement Manual.
- Health Insight. Medication Simplification Protocol. Accessed 5/13/16.
- Home Health Quality Campaign/Quality Insights (2010). Clinician Medication Reconciliation Process.
- Home Health Quality Campaign/Quality Insights (2010). Fundamentals of Reducing Acute Care Hospitalization.
- Home Health Quality Campaign/Quality Insights. Zone Tools Accessed 5/13/16.
- VNAA Blueprint for Excellence Tools and Critical Interventions: Exacerbation of Condition. Accessed 5/13/16.

Upcoming Events

Event Title	Date	Time
HHVBP QI Chat: Quality Improvement & Utilization Measures	June 16, 2016	2:00 PM (ET)
Journey to Improvement: 6 Month Check Up: HHVBP Planning, Implementation, and Monitoring	July 14, 2016	2:00 PM (ET)
Understanding Your HHVBP Interim Performance Report	July 28, 2016	2:00 PM (ET)

You're invited to our first HHVBP QI Chat !!!!

When: June 16th at 2:00 (ET)
Where: *HHVBP Connect* (under "Chatter")

HHVBP QI Chat

- **What's HHVBP QI Chat?**
  - An interactive discussion (in text only) on *HHVBP Connect*
- **How can I attend the chat?**
  - Log onto the *HHVBP Connect* site at https://app.innovation.cms.gov/HHVBPConnect/
  - Then go to the "Chatter" page on the site
  - Find the question/discussions related to today's presentation
  - You can either post a question or comment or add to a question or comment that has been posted
- **Do I have to be online the entire time?**
  - No. Being online for the entire chat is not necessary as all discussions will be available to all *HHVBP Connect* users
  - We encourage your attendance at the beginning of the chat to be sure your questions are addressed

Questions

If you have questions about the Model, contact the

HHVBP Model Helpdesk at:

HHVBPquestions@cms.hhs.gov

If you are experiencing issues with gaining access to the HHVBP Secure Portal or *HHVBP Connect*, please call:

(844) 280-5628

Thank you!

As prepared by the Centers for Medicare & Medicaid Services HHVBP Technical Assistance contract number HHSM-500-2014-00031.