Expanded Home Health Value-Based Purchasing (HHVBP) Model

Frequently Asked Questions (FAQs)

September 2024

Contents

List of Exhibits

Technical Assistance and Help Desks

The Centers for Medicare & Medicaid Services' (CMS) provides support, information, and resources to all home health agencies (HHAs) competing in the expanded HHVBP Model. Resources to assist HHAs with implementation of the expanded HHVBP Model are available on the Expanded HHVBP Model webpage. For a list of resources that are available on the webpage, by topic, please see the Expanded HHVBP Model Resource Index.

Help desks are available to support HHAs with implementation of the expanded HHVBP Model, as shown in **Exhibit 1**. The CMS HHVBP Model Help Desk, HHVBPquestions@cms.hhs.gov, is for programmatic questions. To support HHAs with registration and access to reports, the Internet Quality Improvement and Evaluation System (iQIES) help desk is available at iQIES@cms.hhs.gov. In addition, there are other help desks available to support HHAs with questions, including questions about the Home Health Quality Reporting Program (HH QRP) (**Exhibit 2**). For information about other help desks available to support HHAs, please refer to the Guide to Home Health Help Desks.

When sending an email to help desks, please do not send any identifiable patient information through email. This includes medical record numbers, dates of birth, service dates, or any other information considered identified or Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). However, including the CMS Certification Number (CCN) for your agency would be helpful.

Exhibit 1. CMS HHVBP Model and iQIES Help Desks' Contact Information

CMS HHVBP Model Help Desk	iQIES Help Desk
Questions related to the expanded Model requirements, technical assistance and learning resources, and technical questions pertaining to the Total Normalized Composite (TNC) measures and performance reports. Email: HHVBPquestions@cms.hhs.gov	Technical questions related to Internet Quality Improvement and Evaluation System (iQIES) registration, navigation, or assistance with accessing reports. Email: iQIES@cms.hhs.gov Phone: 1 (800) 339-9313 Webpage: iQIES Help
When sending an email to either help desk, please include the following information: • Your first and last name • Email address • CMS Certification Number (CCN) (do not include Taxpayer Identification Number (TIN)) • Provider name and address • If CCN is unknown, please include provider name and zip code	

Exhibit 2: HH QRP and HHCAHPS Help Desks' Contact Information

Home Health Quality Reporting Program (HH QRP) Help Desks	
Home Health Quality Help Desk	**Home Health CAHPS**
Questions related to Home Health Quality Measures including but not limited to questions related to OASIS coding and OASIS documentation, quality reporting requirements and deadlines, data reported in quality reports (excluding HHVBP), measure calculations, Quality of Patient Care Star Rating (excluding suppression requests), public reporting/Care Compare (excluding HHCAHPS), risk adjustment (excluding HHVBP), Quality Assessment Only (QAO)/Pay for Reporting (P4R). Email: homehealthqualityquestions@cms.hhs.gov	Questions related to the Home Health Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Survey or the Patient Survey Star Ratings Email: hhcahps@rti.org Phone: 1 (866) 354-0985

Introduction

About the Frequently Asked Questions (FAQs)

The FAQs assist HHAs in understanding common terms used in the expanded HHVBP Model and requirements under the Home Health Prospective Payment System (HH PPS) final rules[1][1], available on **Expanded HHVBP Model webpage** under "Regulations & Notices." CMS provides updates to the FAQs as needed and notifies HHAs that have signed up to receive communications when an updated version is available on the **Expanded HHVBP Model webpage**.

To receive email updates about expansion, please subscribe to the **Expanded HHVBP Model listserv**. Enter your email address in the contact form, then select "Home Health Value-Based Purchasing (HHVBP) Expanded Model" from the Innovations list. To ensure you receive HHVBP Expanded Model communications via email, please add "cmslists@subscriptions.cms.hhs.gov" to your email safe sender list. For assistance with the subscription service, please contact **Subscriber Help**.

FAQ Numbering System

The FAQs are grouped by topic and assigned a range of numbers (1000's, 2000's, etc.). When there are revisions to original FAQs, the number will include a decimal point. For example, Q1001.1 would be a revision of Q1001. With each revision, the decimal increases by 0.1. If there is another revision to Q1001.1, the number would become Q1001.2.

When an updated version of the FAQ document is available on the Expanded HHVBP Model webpage, there will be an email announcement sent to HHAs that have signed up for the listserv.

[1] HH PPS final rules impacting the expanded HHVBP Model are: 1) CY 2022 HH PPS final rule; 2) CY 2023 HH PPS final rule; and 3) CY 2024 HH PPS final rule.

New and Updated FAQs

New and/or newly revised questions appear in this section. The next FAQ publication will incorporate these new and updated questions under their respective sections. The first digit in the question number identifies which section the FAQ will appear in the next publication – e.g., 1010 will be available in **I. General Information**.

New FAQs

Q4018. For a newly certified HHA, when will their OASIS data begin to be used in the expanded HHVBP model and reported on HHVBP reports?

For a newly Medicare-certified HHA, OASIS data from the first full calendar year after the agency received Medicare-certification are used to calculate the agency's **HHA baseline** for each of the OASIS-based measures in the Model. OASIS data from the second calendar year after Medicare-certification are used to calculate the agency's performance on the OASIS-based measures included in the Model. For example:

- **Anytime in 2024** – HHA is Medicare-certified
- **1/1/2025 – 12/31/2025** -This agency's OASIS data are used to calculate the **HHA baseline** for each of the OASIS-based measures in the Model (if at least 20 eligible episodes are available in that year).
- **1/1/2026 – 12/31/2026** – The agency's OASIS data are used to calculate their **performance** on each of the OASIS-based measures in the Model. CY 2026 is this agency's **1st Performance Year** in the Model.
- **July 2026** – The agency receives their first IPR.
- **August 2027** – The agency receives their first APR.
- **1/1/2028 – 12/31/2028 –** Measure results from the CY 2026 data will be used to calculate a **Total Performance Score (TPS).** The TPS will determine the agency's payment on all their Medicare Fee-for-Service (FFS) claims in calendar year 2028. CY 2028 is this agency's **1st Payment Year** in the Model.

Note: For an agency's baseline (HHA baseline) to be established for an applicable measure, they must have sufficient data in the baseline year. See Q4001.1 for more information on sufficient data requirements.

Q3024. When will the expanded HHVBP Model include data from non-Medicare and non-Medicaid patients for the OASIS-based measures included in the Model?

As finalized in the CY2023 HH Final Rule, CMS is ending the suspension of OASIS data collection as part of the comprehensive assessment requirement for patients with non-Medicare and non-Medicaid payers. The CY2023 rule specifies that starting July 1, 2025, OASIS data must be collected on all patients, regardless of payer, with some exceptions: patients under the age of 18, patients receiving maternity services, patients receiving only personal care, housekeeping services, or chore services. At this time, the OASIS-based measures used in the expanded HHVBP Model will continue to be calculated using only data from skilled Medicare and Medicaid patients that includes Medicare fee-for-service (FFS), Medicare Advantage, Medicaid, and Medicaid Managed Care.

Q6030. Our HHA was certified in 2022. Why did our first IPR in July 2024 show zero improvement points for claims-based and HHCAHPS Survey-based measures?

For claims-based and HHCAHPS Survey-based measures, an HHA certified in CY 2022 can receive only achievement points and not improvement points in the **July 2024 IPR.** This is because the data collection period for claims-based and HHCAHPS measures is the same as the HHA's baseline year (01/01/2023-12/31/2023). Since no improvement could be calculated, zero (0) improvement points are reported on the HHA's July 2024 IPR for the claims-based and HHCAHPS measures.

For the **October 2024 IPR**, the HHA baseline year will remain CY 2023 for the entire CY 2024 performance year, and the performance year data period for the claims-based and HHCAHPS Survey-based measures is 04/01/2023 – 03/31/2024. Since the 12-month performance period on the October IPR is not the same as the HHA baseline period (they differ by one quarter), HHAs will have their first opportunity to receive improvement points if the measure value is better than their improvement threshold for the measure.

Q6031. Why is our HHA's performance report displaying dashes (-) for the HHCAHPS Survey-based measures if we are in the larger-volume cohort and think we have enough HHCAHPS data for the measures?

An HHA must have sufficient data for both the baseline year **AND** the performance year for an applicable measure's achievement points, improvement points, and care points to be calculated in the expanded HHVBP Model. A dash (-) on a report means that no or insufficient data are available. Therefore, if your HHA does not have sufficient data to establish an HHA baseline score (despite having sufficient data to calculate a performance year measure score) for an applicable measure, no care points can be earned for the measure.

Updated FAQs

Q8001. What information will CMS publicly report for the expanded HHVBP Model?

Public reporting of performance data for the expanded HHVBP Model will begin with the calendar year (CY) 2023 performance year/CY 2025 payment year. As finalized in the HH CY2023 Final Rule, CMS will publicly report the following information for the expanded HHVBP Model:

- Applicable measure benchmarks and achievement thresholds for each smaller volume and larger volume cohort.
- For each HHA that qualified for a payment adjustment based on the data for the applicable performance year –
  - Applicable measure results and improvement thresholds
  - The HHA's Total Performance Score (TPS)
  - The HHA's TPS percentile ranking
  - The HHA's payment adjustment for a given year

Q8002. When will CMS publicly report HHA performance in the expanded HHVBP Model?

As finalized in the HH CY2023 Final Rule, CMS will publicly report information for the expanded HHVBP Model on or after December 1, 2024. CMS plans to first publicly report HHVBP data in January 2025 on the Provider Data Catalog.

Q8003. Where will CMS make information for the expanded HHVBP Model available to the public?

The Provider Data Catalog (PDC) is a CMS website that is a companion to the Care Compare website. While the Care Compare website has consumer-focused content, the PDC is designed for innovators and stakeholders who are interested in detailed CMS data. Those looking for data related to the expanded HHVBP Model are encouraged to review the interactive and downloadable datasets for Home Health agencies, which CMS is planning to initially make available in January 2025 on the PDC.

Q8004. Why is CMS publicly reporting HHA performance in the expanded HHVBP Model?

Publicly reporting performance data under the expanded Model will enhance the current home health public reporting processes, as it will better inform the public when choosing an HHA, while also incentivizing HHAs to improve performance. Publicly reporting performance data under the expanded Model is also consistent with the CMS practice of publicly reporting performance data under other value-based initiatives such as the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) (42 CFR 413.338) and Hospital Value-Based Purchasing (HVBP) Programs (42 CFR 412.163).

Section One: Expanded HHVBP Model Glossary of Terms, Acronyms, & Definitions

Exhibit 4 contains the list of common terms, acronyms, and definitions used specifically in the expanded HHVBP Model and referenced throughout this document.

Exhibit 4 Expanded HHVBP Model Glossary of Terms, Acronyms, and Definitions

Terminology	Definition
Achievement Score (Also referred to as achievement points)	During the performance year data period for each applicable measure, an HHA will receive an achievement score, quantifying the HHA's performance relative to other HHAs within the respective volume-based cohort in the Model baseline year. An HHA can earn between zero (0) and 10 achievement points for each measure. Achievement points are calculated for each measure by dividing the difference between an HHA's performance score and the achievement threshold by the difference between the benchmark and the achievement threshold, multiplying the resulting quotient by 10, and rounding to the third decimal point. The formula for calculating an HHA's achievement score is: $\text{Achievement Score} = 10 \times \left(\frac{\textit{HHA Performance Score} - \textit{Achievement Threshold}}{\textit{Benchmark} - \textit{Achievement Threshold}} \right)$ The following rules apply to the OASIS-based and HHCAHPS Survey-based measure achievement score calculations to ensure the achievement score falls within the range of zero (0) to 10 points. • An HHA with an HHA performance score **greater than or equal** to the benchmark receives the maximum of 10 points for achievement. • An HHA with an HHA performance score greater than the achievement threshold (but below the benchmark) receives greater than zero (0) but less than 10 points for achievement (prior to rounding to the third decimal point), by applying the achievement score formula. • An HHA with an HHA performance score that is less than or equal to the achievement threshold receives zero (0) points for achievement. For claims-based measures, lower scores reflect better performance, therefore an HHA with a performance score for a claims-based measure that is: • Less than or equal to the benchmark receives the maximum of 10 achievement points. • Less than the achievement threshold but greater than the benchmark, receives greater than zero (0) but less than 10 achievement points. • Greater than or equal to the achievement threshold receives zero (0) points for achievement. (Note that for one of the claims-based measures to be added to the Model measure set beginning with the CY 2025 performance year, Discharge to Community, higher scores reflect better performance.) The achievement score for each measure with sufficient data will be available on the Interim Performance Report (IPR) and the Annual Performance Report (APR).
Achievement Range	A scale between the achievement threshold and the designated benchmark, along which an HHA will receive achievement points for a given measure.
Achievement Threshold	The median (50th percentile) of Medicare-certified HHAs' performance scores on each quality measure during the designated Model baseline year, calculated separately for the larger and smaller-volume cohorts. CMS uses the achievement threshold for calculating the achievement score.
Annual Performance Report (APR)	A performance feedback report available to HHAs in iQIES only. The APR focuses primarily on the HHA's payment adjustment percentage for the following payment year and includes an explanation of when CMS will apply the adjustment and how CMS determined this adjustment relative to the HHA's performance scores.

Terminology	Definition
Adjusted Payment Percentage (also referred to as the payment adjustment percentage)	The percentage by which an HHA's final claim payment amount under the HH PPS changes in accordance with the methodology described in § 484.370. CMS reports the payment adjustment percentage in the HHA's Annual Performance Report and applies the percentage to an HHA's payment for each final Medicare fee-for-service (FFS) claim submitted with a payment episode "through date" in the corresponding expanded Model payment year.
Baseline Years	HHA Baseline Year: The year used by CMS to compare an HHA's reporting period performance score for each applicable performance measure to its own performance in the specified measure during the HHA Baseline Year. CMS uses the HHA baseline year to calculate an HHA's improvement threshold for each quality measure. An HHA's baseline year for each quality measure is determined by: Sufficient data to establish a baseline year for a particular quality measure, and The HHA's Medicare-certification date: • HHAs with a Date of Medicare Certification prior to January 1, 2022: The HHA's baseline year is CY 2022 (January 1, 2022 - December 31, 2022). • HHAs with a Date of Medicare Certification on or after January 1, 2022: The HHA's baseline year is the first full calendar year of services beginning after the date of Medicare certification. CMS uses the HHA's Medicare-certification date and the year in which the HHA has sufficient data for a specific quality measure to establish the HHA's baseline year for a particular quality measure and to calculate the HHA's unique improvement threshold for each quality measure. If an HHA does not have sufficient data to create a measure score in the first possible baseline year, the following year(s) may qualify to become the HHA baseline year if the HHA has sufficient data.
	Model Baseline Year: The year against which CMS calculates the achievement thresholds and benchmarks values for each quality measure by cohort.
Benchmark	The mean of the top decile (90th percentile) of all Medicare-certified HHAs' performance scores on the specified quality measure during the Model baseline year, calculated separately for the larger and smaller-volume cohorts. CMS uses the benchmark for calculating both the achievement score and the improvement score.
Care Points	The higher of achievement points or improvement points for each measure with sufficient data reported in the Interim Performance Report and Annual Performance Report.
CCN	An HHA's six (6)-digit (all numeric) CMS Certification Number.
Claims-based Measures	For the expanded HHVBP Model, the utilization measures calculated using Medicare fee-for-service (FFS) claims data. Claims-based utilization measures provide information related to the use of health care services (e.g., hospitals, emergency departments, etc.) resulting from a change in patient health status. Calculations may include • Negative events such as unplanned hospitalizations, potentially avoidable hospitalizations, potentially preventable observation stays, emergency department care, or • Positive events such as remaining in the community after home health discharge. These measures use healthcare utilization data to indicate whether patients achieved a successful outcome of care or, instead, whether they have unresolved care needs.
Cohort	The group in which an HHA competes. HHAs compete nationally in one (1) of two (2) volume-based cohorts, as defined by the number of unique HHCAHPS Survey-eligible beneficiaries for each HHA in the year prior to the performance year. • Smaller-volume cohort: the group of competing HHAs that had fewer than 60 unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year. • Larger-volume cohort: the group of competing HHAs that had 60 or more unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year.

Terminology	Definition
Competing Home Health Agency (HHA)	A home health agency that has a current Medicare certification and is receiving payment for home health care services from CMS.
Composite Measure	A combination of two (2) or more individual measures that results in a single measure and score. For information on the expanded HHVBP Model composite measures, please refer to Total Normalized Composite (TNC) Change in Mobility and Total Normalized Composite (TNC) Change in Self-Care in this glossary.
CY	Calendar year. The period from January 1 through December 31.
Home Health Prospective Payment System (HH PPS)	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount, specific to home health agencies. The payment amount for a particular service is derived based on the classification system of that service. More information on the HH PPS is available on CMS.gov.
HHA	A home health agency.
HHA Performance Score	The risk adjusted value for an applicable measure based on the HHA's performance in a given performance year data period.
Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)	A publicly reported survey that measures the experiences of people receiving home health care from Medicare-certified home health agencies. For the HHCAHPS Survey-based measure category, there are five (5) individual components that each serves as single measure under the expanded Model. Details on the HHCAHPS Survey scoring methodology are available on the HHCAHPS website. See Appendix B: Measure Weighting and Re-Weighting for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years and the CY 2024 HH PPS final rule for the HHCAHPS Survey-based measures in the expanded HHVBP Model.
Improvement Range	A scale between an HHA's performance during the HHA baseline year and the benchmark along which an HHA will receive improvement points for a given measure.
Improvement Score (Also referred to as improvement points)	During the performance year for each applicable measure, an HHA will receive an improvement score, quantifying the HHA's performance relative to its own performance in the HHA baseline year. An HHA can earn between zero (0) and nine (9) improvement points for each applicable measure. An HHA's performance score on each applicable quality measure during the HHA baseline year is also known as the improvement threshold. The improvement score is calculated for a given quality measure by dividing the difference between an HHA's performance score and the improvement threshold by the difference between the designated benchmark and the improvement threshold and multiplying the resulting quotient by nine (9). The formula for calculating the improvement score is: $\text{Improvement Score} = 9 \times \left(\frac{\textit{HHA Performance Score} - \textit{HHA Improvement Threshold}}{\textit{Benchmark} - \textit{HHA Improvement Threshold}} \right)$ The following rules apply to the OASIS-based and HHCAHPS Survey-based measures improvement score calculations to ensure the improvement score falls within the range of zero (0) to nine (9) points. • An HHA with an HHA performance score greater than or equal to the designated benchmark receives the maximum of nine (9) points for improvement. • An HHA with an HHA performance score greater than the improvement threshold (but below the benchmark) receives greater than zero (0) but less than nine (9) points for improvement (prior to rounding to the third decimal point), by applying the improvement score formula. • An HHA with an HHA performance score that is less than or equal to the improvement threshold receives zero (0) points for improvement. For claims-based measures, lower scores reflect better performance, therefore an HHA with a performance score for a claims-based measure that is: • Less than or equal to the benchmark receives the maximum of 9 improvement points.

Terminology	Definition
	• Less than the improvement threshold but greater than the benchmark, receives greater than zero (0) but less than 9 improvement points. • Greater than or equal to the improvement threshold receives zero (0) points for improvement. (Note that for one of the claims-based measures to be added to the Model measure set beginning with the CY 2025 performance year, Discharge to Community, higher scores reflect better performance.) The Interim Performance Report (IPR) and the Annual Performance Report (APR) will include an HHA's improvement points for each measure with sufficient data.
Improvement Threshold (Also referred to as the baseline year score)	An individual competing HHA's performance on an applicable measure during the HHA baseline year.
Internet Quality Improvement Evaluation System (iQIES)	iQIES serves as the only access site for all HHVBP performance feedback reports for the expanded HHVBP Model. Only iQIES users authorized to view an HHA's OASIS Quality report can access HHVBP reports. If an HHA needs to register a user or experiences trouble locating or downloading reports, please contact the QIES/iQIES Service Center at (800) 339-9313 or by email at iqies@cms.hhs.gov .
Interim Performance Report (IPR)	A performance feedback report is available to HHAs in iQIES only. These quarterly reports contain information on the quality measure performance based on the 12 most recent months of data available. The IPR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. The IPR provides HHAs with the opportunity to assess and track their performance relative to peers in their respective cohort.
Linear Exchange Function (LEF)	The equation used to translate an HHA's Total Performance Score (TPS) into a payment adjustment percentage. For more information about the LEF, see Section 8 (Payment Adjustment Methodology) in the CY 2022 HH PPS final rule.
Measure Weight	The Interim Performance Report (IPR) and the Annual Performance Report (APR) include an HHA's measure weights on the Measure Scorecard tab. The weight applied to each measure may vary depending on the availability of measures within each measure category. For more information on within-category measure weights, refer to Appendix C: Within-Category Measure Weights for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years.
Outcome and Assessment Information Set (OASIS)	A data collection instrument incorporated within a home health patient comprehensive assessment. Serves as the data source for calculating OASIS-based measures. See Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years for the OASIS-based measures used in the expanded HHVBP Model.
Payer	Health care coverage such as Medicare, Medicaid, managed care, etc.
Payment Year	The calendar year in which the adjusted payment percentage for a designated performance year applies.
Percentile Ranking	A percentile ranking compares competing HHA's performance to those of other HHAs within the same cohort.
Performance Year	The calendar year during which OASIS-based, claims-based, and HHCAHPS Survey-based measure data are used for the purpose of calculating an HHA's Total Performance Score (TPS).
Pre-Implementation Year	CY 2022 was the pre-implementation year to allow HHAs time to prepare for implementation of the expanded HHVBP Model. During this time, CMS provided education and support to competing HHAs. HHAs used this time to assess their performance on the set of quality measures used in the expanded Model.

Terminology	Definition
Quality Episode	Used in the calculation of the quality measures. Quality episodes are different from payment episodes. A quality episode begins with either a SOC (start of care) or ROC (resumption of care) and ends with an End of Care (EOC) assessment (transfer, death, or discharge) for a patient
	regardless of the length of time between the start and ending events. This is relevant for OASIS-based measures.
Quality Measure Set	The quality measures included in the expanded HHVBP Model consist of OASIS-based, claims-based, and HHCAHPS Survey-based measures. There are 12 quality measures in the expanded Model measure set, including five (5) OASIS-based measures, two (2) claims-based measures, and five (5) HHCAHPS Survey-based measures. See Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years for the current list of measures.
Recalculation Request	An HHA may submit this request if it wishes to dispute the calculation of the following: (i) interim performance scores, (ii) annual performance scores, or (iii) application of the formula to calculate annual payment adjustment percentages. Recalculation requests are available for each quarterly Preliminary IPR and for the Preview APR using instructions provided by CMS. An HHA may only submit a recalculation request within 15 calendar days after CMS publishes the HHA-specific Preliminary IPR or Preview APR to iQIES, if the HHA has evidence there may be an error in the calculation.
Reconsideration Request	An HHA may request a reconsideration of the Preliminary APR if it disagrees with the results of a recalculation request presented in the Preliminary APR. HHAs can submit a reconsideration request and supporting documentation via instructions provided by CMS within 15 calendar days after CMS issues the Preliminary APR. Only HHAs that submit a recalculation request may submit a reconsideration request. Per the CY 2024 HH PPS final rule, an HHA may request an Administrator review of a reconsideration decision within seven (7) calendar days from CMS' notification of the outcome of the reconsideration request.
Total Normalized Composite (TNC) Change in Mobility	This measure captures the magnitude of change (positive change, no change, or negative change) in home health patients' mobility between the Start or Resumption of Care (SOC/ROC) and the End of Care (EOC). It is a composite of three (3) OASIS items related to mobility (i.e., M1840, M1850, and M1860). CMS calculates the risk-adjusted Total Normalized Composite (TNC) Change in Mobility measure from the observed difference in patient mobility between SOC/ROC and EOC in eligible home health quality episodes ending with a discharge from the agency during the reporting period, except for those meeting the exclusion criteria. For more information, please refer to the "Technical Specifications for the Total Normalized Composite Change Measures – October 2021" and "Technical Specifications for the Total Normalized Composite Change Measures – April 2023" and the "Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures" document, available on the Expanded HHVBP Model webpage.
Total Normalized Composite (TNC) Change in Self-Care	This measure captures the magnitude of change (positive change, no change, or negative change) in home health patients' self-care between the Start or Resumption of Care (SOC/ROC) and the End of Care (EOC). It is a composite of six (6) OASIS items related to self-care (i.e., M1800, M1810, M1820, M1830, M1845, and M1870). CMS calculates the risk-adjusted Total Normalized Composite (TNC) Change in Self-Care measure from the observed difference in patient self-care between SOC/ROC and EOC in eligible home health quality episodes ending with a discharge from the agency during the reporting period, except for those meeting the exclusion criteria. For more information, please refer to the "Technical Specifications for the Total Normalized Composite Change Measures – October 2021", "Technical Specifications for the Total Normalized Composite Change Measures – April 2023", and "Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures" documents,

Terminology	Definition
	available on the Expanded HHVBP Model webpage.
Total Performance Score (TPS)	The numeric score awarded to each qualifying HHA based on the performance scores for each applicable measure. CMS determines the TPS by multiplying the care points by the applicable measure weight and summing the weighted measure points. A qualifying HHA will receive a numeric score ranging from zero (0) to 100. An HHA must have sufficient data to allow calculation of at least five (5) applicable measures in the expanded Model measure set in the baseline year and performance year. The following is the minimum threshold of data an HHA must have for each applicable measure to receive a measure score: • For OASIS-based measures, 20 home health quality episodes per reporting period. • For claims-based measures, 20 home health stays per reporting period. • For the HHCAHPS Survey-based measures, 40 completed surveys per reporting period
Weighted Measure Points	The Interim Performance Report (IPR) and the Annual Performance Report (APR) include an HHA's weighted measure points on the Measure Scorecard tab. The Total Performance Score (TPS) is the sum of the weighted measure points.

Exhibit 5. Common Expanded HHVBP Model Acronyms

Acronym	Term
ACH	Acute Care Hospitalization
ADL	Activity of Daily Living
APP	Adjusted Payment Percentage
APR	Annual Performance Report
AT	Achievement Threshold
BM	Benchmark
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBE	Consensus-based entity
CCN	CMS Certification Number
CHOW	Change in Ownership
CMIT	CMS Measures Inventory Tool
CMMI	CMS Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CoPs	Conditions of Participation
CY	Calendar Year
DTC-PAC	Discharge to Community – Post-Acute Care (claims-based measure)
ED Use	Emergency Department Use
EOC	End of Care
FAQ	Frequently Asked Question
FFS	Fee-for-Service
HH	Home Health
HH PPS	Home Health Prospective Payment System
HH QRP	Home Health Quality Reporting Program
HHA	Home Health Agency
HHCAHPS	Home Health Consumer Assessment of Healthcare Providers and Systems
HHVBP	Home Health Value-Based Purchasing
HIPAA	Health Insurance Portability and Accountability Act
IPR	Interim Performance Report

Acronym	Term
iQIES	Internet Quality Improvement and Evaluation System
LEF	Linear Exchange Function
NPRM	Notice of Proposed Rulemaking
NQS	National Quality Strategy
OASIS	Outcome and Assessment Information Set
P4P	Pay for Performance
PHE	Public Health Emergency
PHI	Protected Health Information
PII	Personal Identifiable Information
PIPR	Pre-Implementation Performance Report
PPH	Potentially Preventable Hospitalization
PPS	Prospective Payment System
QAO	Quality Assessment Only
QAPI	Quality Assurance and Performance Improvement
QoPC	Quality of Patient Care
QTSO	QIES Technical Support Office
ROC	Resumption of Care
SNF	Skilled Nursing Facility
SOC	Start of Care
TA	Technical Assistance
TIN	Taxpayer Identification Number
TNC	Total Normalized Composite
TPS	Total Performance Score
VBP	Value-Based Purchasing

A list of resources are available in the *"Expanded HHVBP Model Resource Index,"* located on the Expanded HHVBP Model webpage.

Section Two: Frequently Asked Questions (FAQs)

I. General Information

On January 1, 2022, the Centers for Medicare & Medicaid Services (CMS) launched the expanded HHVBP Model, designating calendar year (CY) 2022 as a pre-implementation year to allow HHAs time to prepare and learn about the expectations and requirements. CMS did not apply a payment adjustment to HHAs for their performance in CY 2022.

Participation in the expanded Model is mandatory for all Medicare-certified home health agencies (HHAs) with a CMS Certification Number (CCN) in the 50 States, District of Columbia, and U.S. territories. HHAs that are Medicare-certified are eligible for Medicare Prospective Payment System (PPS) payment adjustments. These HHAs compete on a set of quality measures related to the care that HHAs provide.

Under the expanded Model, CMS will apply a reduction or increase of up to 5% to an HHA's Medicare fee-for-service (FFS) payments starting in 2025, based on their performance against a set of quality measures relative to peer performance in the same cohort starting with CY 2023. Performance on these quality measures in a specified year (performance year) impacts payment adjustments in a later year (payment year). See **Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years** for the list of quality measures.

The first performance year for the expanded Model is CY 2023, beginning January 1, 2023. HHA performance during CY 2023 will determine payment adjustment amounts CMS will apply during the first payment year, CY 2025.

Participation in the expanded HHVBP Model is mandatory for all Medicare-certified HHAs with a CCN in the 50 States, District of Columbia, and U.S. territories. HHAs that are Medicare-certified are eligible for Medicare Prospective Payment System (PPS) payment adjustments

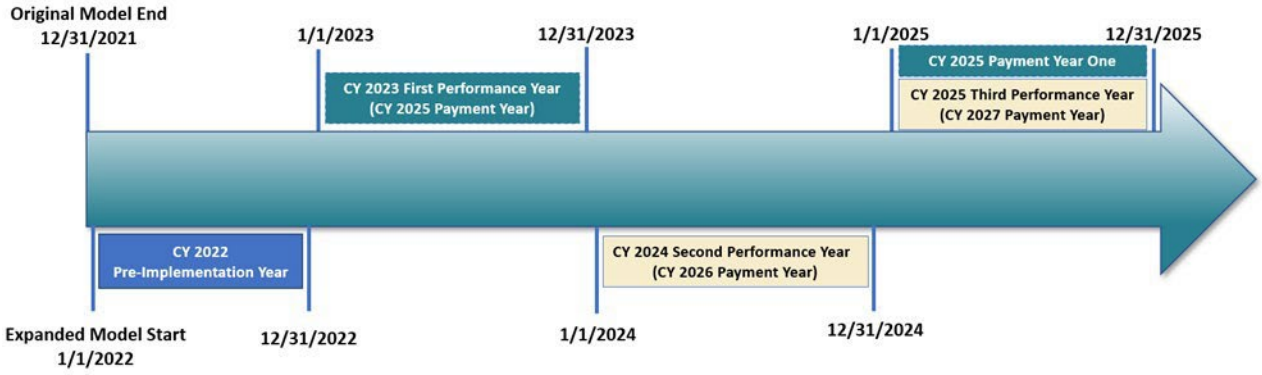
Q1001. When did the expanded HHVBP Model begin?

The expanded HHVBP Model began on January 1, 2022.

Calendar year (CY) 2022 was designated a pre-implementation year to allow home health agencies (HHAs) time to learn about the expanded Model without risk to payments. HHAs used this time to assess their performance on the set of quality measures used in the expanded Model in CY 2022.

The first performance year for the expanded Model is CY 2023, beginning January 1, 2023, which will determine payment adjustment amounts during the first payment year, CY 2025. **Exhibit 6** illustrates the timeline for the rollout of the expanded Model.

Exhibit 6. Timeline for initial rollout of the expanded HHVBP Model



Q1002. Where can I find information about the expanded HHVBP Model and resources to support implementation?

All expanded HHVBP Model resources are publicly available and located on the **Expanded HHVBP Model webpage**.

To receive updates on the expanded Model via email, please subscribe to the **Expanded HHVBP Model listserv** by entering your email address on the contact form, then selecting "Home Health Value-Based Purchasing (HHVBP) Expanded Model" from the *Innovations* list. To ensure receipt of email communications, please add "cmslists@subscriptions.cms.hhs.gov" to your email safe sender list.

Q1003. Is participation in the expanded HHVBP Model mandatory or voluntary?

Participation in the expanded HHVBP Model is mandatory. CMS requires all Medicare-certified home health agencies (HHAs) that provide services in the 50 States, District of Columbia, and U.S. territories to compete in the expanded Model. A "competing HHA" has a current Medicare certification (identified by a CMS Certification Number, or CCN) and receives payment from CMS for home health care services.

Q1004. Are HHAs that are not Medicare-certified required to participate in the expanded HHVBP Model?

No. Home health agencies (HHAs) that are not Medicare-certified are not required to participate in the expanded HHVBP Model.

Q1005. When did the original HHVBP Model, that began in 2016, end?

The original HHVBP Model ended one (1) year early for the home health agencies (HHAs) in the nine (9) original Model States (i.e., Arizona, Florida, Iowa, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington), such that CMS did not use calendar year (CY) 2020 performance data to calculate a payment adjustment for CY 2022, under the original Model.

Q1006. Are small HHAs required to participate? How does the expanded HHVBP Model impact agencies that provide services to a small number of Medicare patients (e.g., 10 cases/year)?

Participation in the expanded HHVBP Model is mandatory for all Medicare-certified home health agencies (HHAs) with a CMS Certification Number (CCN) in the in the 50 States, District of Columbia, and U.S. territories that receive payment from CMS for home health care services.

For the expanded Model, CMS established cohorts prospectively, determined by the number of unique HHCAHPS Survey-eligible beneficiaries for each HHA in the year prior to the performance year. HHAs will compete in either a nationwide larger-volume cohort or nationwide smaller-volume cohort. This approach allows for grouping of HHAs that are of similar size and more likely to receive scores on the same set of measures, for purposes of setting benchmarks and achievement thresholds and determining payment adjustments. The smaller-volume cohort is the group of competing HHAs that had fewer than 60 unique HHCAHPS-Survey eligible beneficiaries in the calendar year prior to the performance year.

For HHAs that provide services to a small number of patients, the number of patients they serve may affect the number of applicable measures with sufficient data to create a baseline year score or performance score. HHAs must have sufficient data to allow calculation of at least five (5) of the

12 measures to receive a Total Performance Score (TPS). Therefore, some small HHAs may not receive a TPS and a corresponding payment adjustment. See **Q3004**.

Q1007. Which payers does CMS include in the expanded HHVBP Model?

For calculating performance scores and public reporting, the expanded HHVBP Model includes the following payers for each measure category:

Exhibit 7: Payers Included in the Expanded HHVBP Model

Measure Category	Payer			
	Medicare FFS	Medicare Advantage	Medicaid FFS	Medicaid Managed Care
OASIS-based	X	X	X	X
Claims-based	X			
HHCAHPS Survey-based	X	X	X	X

Q1009.3 What can HHAs do to further understand the expanded HHVBP Model and stay up to date with expanded Model requirements?

Home health agencies (HHAs) can take the following actions:

- Review the HH PPS final rules for: CY 2022; CY 2023; and CY 2024. See the table of contents for each rule to locate information specific to the expanded HHVBP Model.
- Visit and bookmark the Expanded HHVBP Model webpage.

- Review each resource on the Expanded HHVBP Model webpage, starting with the *"Expanded HHVBP Model Guide" and the "Resource Index."*
- Subscribe to the Expanded HHVBP Model listserv by entering your email address on the contact form, then selecting "Home Health Value-Based Purchasing (HHVBP) Expanded Model" from the *Innovations* list. To ensure you receive expanded Model communications via email, please add "cmslists@subscriptions.cms.hhs.gov" to your email safe sender list.
- Confirm agency access to Internet Quality Improvement Evaluation System (iQIES). Review all identifying agency information (e.g., name, address, CCN) in the expanded HHVBP Model reports for accuracy. If information is incorrect, please contact the iQIES Help Desk: iQIES@cms.hhs.gov or 1 (800) 339-9313. For more information, please review the QIES Technical Support Office webpage for HHA Providers.
- Access and review the reports available in iQIES in the "HHA Provider Preview Reports" folder.
- Review the quality measures in the expanded HHVBP Model. See **Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years**.
- Contact the CMS HHVBP Model Help Desk**,** HHVBPquestions@cms.hhs.gov, with questions.

Q1010. Are there exclusions to participation for an HHA, such as excluding patients that are dual beneficiaries (Medicare skilled nursing, Medicaid personal care) from expanded HHVBP quality measures?

Participation in the expanded HHVBP Model is mandatory for all Medicare-certified home health agencies (HHAs) with a CMS Certification Number (CCN) in the in the 50 States, District of Columbia, and U.S. territories that receive payment from CMS for home health care services. Services include those provided to individuals who are dually eligible.

CMS does not have evidence to suggest that HHAs that care for beneficiaries with more significant social risk factors would receive decreased fee-for-service payments under the expanded Model.

Q1011. How will CMS differentiate between public reporting under the expanded HHVBP Model and public reporting under the Home Health Quality Reporting Program (HH QRP)?

Publicly reporting performance data under the expanded HHVBP Model will enhance the current home health public reporting processes, as it will better inform the public when choosing a home health agency (HHA), while also incentivizing HHAs to improve performance. Publicly reporting performance data under the expanded Model is also consistent with the CMS practice of publicly reporting performance data under other value-based initiatives such as the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) and Hospital Value-Based Purchasing (HVBP) Programs.

Public reporting of performance data for the expanded Model will begin with the calendar year (CY) 2023 performance year/CY 2025 payment adjustment. CMS anticipates making this information available to the public on a CMS website on or after December 1, 2024, the date by which CMS intends to complete the CY 2024 Annual Performance Report (APR) appeals process and issuance of the Final APR to each competing HHA.

CMS will provide definitions for the Total Performance Score (TPS) and the TPS Percentile Ranking methodology, as well as descriptions of the scoring and payment adjustment methodology, on the CMS website to ensure the public understands the relevance of these data points and the calculations.

HHA performance data for the expanded Model is separate from the Home Health Quality of Patient Care and Patient Survey Star Ratings.

Q1012. How are payment adjustment percentages applied in the expanded HHVBP Model?

The expanded HHVBP Model payment adjustment percentage is applied based on the quality of the home health agency's (HHA's) performance represented by the quality measure scores for all Medicare and Medicaid patients. CMS applies the payment adjustment percentage to Home Health Prospective Payment System (HH PPS) Medicare claims, which are only available for Medicare fee-for-service (FFS) beneficiaries. The Home Health Quality Reporting Program (HH QRP) collects quality measure data from the same payer sources as the expanded Model, including Medicaid. Please see **Q1007** for the payers included in each expanded Model measure category.

To minimize provider documentation burden and improve care, the expanded Model quality measure set aligns with data already submitted via the OASIS Instrument, Medicare FFS claims, and HHCAHPS

Surveys. Quality measures used in the expanded Model are calculated using data from all Medicare and Medicaid payers (health care insurances).

The expanded Model is one (1) of CMS' value-based payment programs, which incentivizes health care providers for the quality of care they give to Medicare beneficiaries. These programs are part of a larger CMS quality strategy, which seeks to reform how health care is delivered and paid for to ensure that all persons receive equitable, high-quality, and value-based care. Consistent with this strategy, where it is practical and appropriate, CMS seeks to include all patients regardless of payment source in quality measurement and promotes the adoption of value-based payment models by other payers.

Q1013. What steps should an HHA take in the case of an extraordinary circumstance, i.e., a natural or man-made disaster?

CMS provides home health agencies (HHAs) an opportunity to request an exception or extension from the Home Health Quality Reporting Program (HH QRP) reporting requirements in the event they are unable to submit quality data due to extraordinary circumstances beyond their control. HHAs affected by a natural or man-made disaster, or other extraordinary circumstances may request an exception or extension by filing a Request for Reconsideration Due to Disaster or Extraordinary Circumstance.

For additional assistance, HHAs may submit questions related to HH QRP exception and extension requests to: **HHAPUReconsiderations@cms.hhs.gov**.

Q1015. Do HHAs need to contract with a vendor to support the HHA's expanded HHVBP Model activities?

There are no requirements specific to the expanded Model that require home health agencies (HHAs) to contract with external vendors outside of those required for HHCAHPS Surveys.

The expanded Model quality measure set aligns with data already submitted via the OASIS Instrument, Medicare fee-for-service claims, and HHCAHPS Surveys. There are no additional data submission requirements for the expanded HHVBP Model

Q1016.1. Where can I find more information about expanded HHVBP Model changes that were finalized in the CY 2024 Home Health Prospective Payment System (HH PPS) final rule?

The recording, slides, and two written resources (CY 2024 Written Resource, CY 2025 Written Resource) from the webinar, "Expanded HHVBP Model: Preparing for Calendar Year (CY) 2024 and CY 2025", November 9, 2023, are available for download and are located on the CMS Expanded HHVBP Model webpage in the Model Overview section.

All information regarding changes to the expanded HHVBP Model in the calendar year (CY) 2024 Home Health Prospective Payment System (HH PPS) final rule is available in the Federal Register at https://www.federalregister.gov/documents/2023/11/13/2023-24455/medicare-program-calendar-year-cy-2024-home-health-hh-prospective-payment-system-rate-update-hh

Q1017. What is the impact of the expanded HHVBP Model on Medicare-certified HHAs?

Participation in the expanded HHVBP Model is mandatory for all Medicare-certified home health agencies (HHAs) with a CMS Certification Number (CCN) in the 50 States, District of Columbia, and U.S. territories. HHAs that are Medicare-certified are eligible for Medicare Prospective Payment System (PPS) payment adjustments.

Under the expanded HHVBP Model, Medicare-certified HHAs receive adjustments to their Medicare fee-for-service payments based on their performance on a set of quality measures, relative to their peers' performance. Performance on these quality measures in a specified year (performance year) would impact payment adjustments in a later year (payment year). Information and resources designed to support implementation of the expanded Model are available on the Expanded HHVBP Model webpage.

Requirements under the expanded Model do not waive or modify home health benefits or requirements for Medicare-certified HHAs defined by other CMS regulations, programs, and policies – such as Home Health Conditions of Participation, the Home Health Prospective Payment System, and the Home Health Quality Reporting Program.

Q1018. If our HHA's location changes, how should we update our HHA's information for the expanded HHVBP Model?

Information on how to update an HHA's demographic data can be found on the Home Health Quality Reporting web page CMS's How to Update Home Health Demographic Data and additional instructions can be found in the download section.

Historically, provider demographic data have been maintained in the Automated Survey Processing Environment or ASPEN software; however, CMS will be transitioning to use the demographic information from Provider Enrollment, Chain and Ownership System (PECOS). While this transition is underway, a final date when all demographic data will be obtained from PECOS has not been identified. During this transition, all PAC providers will be responsible to ensure their latest demographic data are updated and available in both the iQIES and PECOS systems.

1. Complete form CMS-855A in PECOS with the updated demographic information, url: https://pecos.cms.hhs.gov/pecos/login.do#headingLv1. If you need assistance, contact your Medicare Administrative Contractor (MAC).
2. Contact your State OASIS Automation Coordinator (OAC) or State OASIS Education Coordinator (OEC) and request an update of your demographic data in iQIES. A list of OAC/OECs and their contact information can be found here: CMS Quality, safety, and oversight-General information, OASIS Coordinators webpage.

Updates to home health provider demographic information do not happen in real time and can take up to 6-months to appear on Care Compare. Updates to home health provider demographic information do not happen in real time and can take up to 6-months for updates to occur.

Should you have questions regarding this process, please contact the iQIES help desk by email at iQIES@cms.hhs.gov or by phone at (800) 339-9313.

II. Cohorts

Under the expanded HHVBP Model, cohorts are the group in which an HHA competes. HHAs compete nationally in one (1) of two (2) volume-based cohorts, as defined by the number of unique HHCAHPS Survey-eligible beneficiaries for each HHA in the year prior to the performance year. This approach allows for the grouping of HHAs that are of similar size and more likely to receive scores on the same set of measures, for purposes of setting benchmarks and achievement thresholds and determining payment adjustments.

Q2001. How are cohorts determined?

Cohorts are determined prospectively, based on each home health agency's (HHA's) unique beneficiary count in the prior calendar year, as defined below:

- Smaller-volume cohort: the group of competing HHAs that had fewer than 60 unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year.
- Larger-volume cohort: the group of competing HHAs that had 60 or more unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year.

HHAs can identify their cohort assignment through the expanded HHVBP Model performance feedback reports available on iQIES.

The smaller-volume cohort is the group of competing HHAs that had fewer than 60 unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year.

The larger-volume cohort is the group of competing HHAs that had 60 or more unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year.

Q2002.3 How will HHAs identify their cohort assignment? When will cohort assignments be available?

Interim Performance Reports (IPRs) include a home health agency's (HHA's) cohort assignment for the current performance year. Only active HHAs that were Medicare-certified in the calendar year prior to the performance year and meet the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year receive an IPR. Updated cohort assignments will be recalculated annually and made available in the July IPR.

Q2004.1 Will cohort assignments change during a performance year?

A home health agency's (HHA's) cohort assignment is based on the number of its unique beneficiaries in the year prior to the performance year. The smaller-volume cohort is the group of competing HHAs that had fewer than 60 unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year. The larger-volume cohort is the group of competing HHAs that had 60 or more unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year.

For the calendar year (CY) 2023 performance year, cohort assignment is based on CY 2022 beneficiary counts. For the CY 2024 performance year, the cohort assignment will be based on CY 2023 beneficiary counts. Because the beneficiary counts can change year to year, so can the cohort assignment.

The HHA cohort assignment in the July 2023 Interim Performance Reports (IPR) will be the same as in the CY 2024 Annual Performance Report (APR), which will cover the CY 2023 performance year. The cohort assignment is updated every July based on the most recent full calendar year.

It is possible that the assigned cohort for an HHA will change depending on the beneficiary count during the applicable CY. For example, an HHA with a beneficiary count less than 60 during CY 2022, will be assigned to the smaller-volume cohort for the CY 2023 performance year. If this same HHA experiences an increase to more than 60 beneficiaries in CY 2023, the HHA will be assigned to the larger-volume cohort for the CY 2024 performance year.

Q2005. How did CMS determine the number of cohorts and the definition of each?

CMS believes that separating smaller and larger-volume home health agencies (HHAs) into cohorts under the expanded HHVBP Model will group HHAs that are of similar size and are more likely to receive scores on the same set of measures for purposes of setting benchmarks and achievement thresholds and determining payment adjustments. To allow for a sufficient number of HHAs in each volume-based cohort, CMS assigns cohorts based on all HHAs nationwide, rather than by state, as under the original HHVBP Model. Using nationwide, rather than state/territory-based cohorts, in performance comparisons is consistent with the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) and Hospital Value-Based Purchasing (HVBP) Programs, in addition to the Home Health Compare Five-Star Ratings.

A valid cohort must have a sufficient number of HHAs to 1) create a robust distribution of Total Performance Scores (TPS), which allows meaningful and reasonable translation into payment adjustments using the linear exchange function (LEF); 2) set stable, reliable benchmarks and achievement thresholds that are not heavily skewed by outliers. However, when only a small number of HHAs fall within a cohort, one HHA's outlier TPS could skew the payment adjustments and deviate from the intended design

of the LEF payment methodology. As a result, a key consideration in defining the cohorts is ensuring sufficient HHA counts within each cohort.

For the expanded Model, CMS proposed and finalized to establish cohorts prospectively and with sufficient HHA counts to prevent the need to combine multiple cohorts retrospectively. To reliably define cohorts prospectively and to avoid regrouping multiple states, territories, or the District of Columbia into a single cohort retrospectively based solely on their lower HHA counts, CMS estimated that a minimum of 20 HHAs in each cohort is necessary to ensure that attrition and variation in episode counts do not lead to insufficient HHA counts at the end of the performance year.

Q2007. If an HHA's beneficiary count changes each calendar year so that an HHA's cohort size changes, how is the improvement threshold determined?

Home health agencies (HHAs) compete nationally in one (1) of two (2) volume-based cohorts, as defined by the number of unique HHCAHPS Survey-eligible beneficiaries for each HHA in the year prior to the performance year. For questions about changes in beneficiary count, please see **Q2004.1**.

For applicable measures, cohort assignment does not determine an HHA's improvement threshold. CMS uses the HHA's Medicare-certification date and the year in which the HHA has sufficient data for a specific quality measure to establish the HHA baseline year for a particular quality measure and to calculate the HHA's unique improvement threshold for each quality measure.

For more information about the improvement threshold, please see **Q4002.3** and **Q4004.2**.

III. Quality Measures

The expanded HHVBP Model measure set currently uses data already reported by HHAs through the Home Health Quality Reporting Program (HH QRP) requirements, or Medicare claims, and HHCAHPS surveys.

For the CY 2023, CY 2024, and beginning with CY 2025, applicable measures, please refer to

- **Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years and**
- **Appendix D: Applicable Measure Sets: CY 2023 and 2024 Performance Years vs CY 2025 Performance Year for the Expanded** HHVBP Model

CMS may consider changes to the quality measure set for the expanded Model through future rulemaking.

Q3001. How do HHAs submit the measure data required under the expanded HHVBP Model?

To reduce reporting burden, there are no additional data submission requirements for the expanded HHVBP Model. The expanded Model quality measure set aligns with data already submitted via the OASIS Instrument, Medicare fee-for-service claims, and HHCAHPS Surveys.

For applicable OASIS measures, home health agencies (HHAs) must electronically report all OASIS data collected in accordance with § 484.45, in order to meet the Medicare Conditions of Participation (CoPs), and as a condition for payment at § 484.205(c). HHAs submit the OASIS assessments in iQIES.

For the Home Health Quality Reporting Program (HH QRP), HHAs are required to contract with an approved, independent HHCAHPS Survey vendor to administer the HHCAHPS on its behalf, in accordance with § 484.355(a)(1)(ii)(A).

In addition, the measure set for calendar year (CY) 2023 and CY 2024 performance years includes the following two (2) claims-based measures derived from claims data submitted to CMS for payment purposes:

- Acute Care Hospitalization During the First 60 Days of Home Health (ACH)
- Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (ED Use)

Q3002. Under the expanded HHVBP Model, will HHAs need to submit the self-reported "New Measures" that were part of the original HHVBP Model?

No. New Measures as defined for the original HHVBP Model are not included in the expanded HHVBP Model measure set.

Q3004. What are the minimum data requirements for an HHA to receive a performance score for each applicable measure?

An HHA must have sufficient data to receive a performance score for OASIS-based, claims-based, and HHCAHPS Survey-based measures, as identified below:

- OASIS-based measures, 20 home health quality episodes per reporting period.
- Claims-based measures, 20 home health stays per reporting period.
- HHCAHPS Survey-based measures, 40 completed surveys per reporting period for home health agencies (HHAs) in the larger-volume cohort. *HHCAHPS Survey-based measures are not reported or included in TPS calculations for the smaller-volume cohort so that HHAs in this cohort are more likely to receive scores on the same set of measures.*

For additional information about the Total Performance Score, please refer to **Section IV. Total Performance Scoring Methodology**.

Q3005.1 Do all the measures have the same weight when calculating each HHA's Total Performance Score (TPS) for the calendar year (CY) 2023 and CY 2024 performance years?

For the CY 2023 and CY 2024 performance years, the OASIS-based, claims-based, and HHCAHPS Survey-based measures categories are weighted 35%, 35%, and 30%, respectively, for the larger-volume cohort, accounting for 100% of the Total Performance Score (TPS). For the smaller-volume cohort, the OASIS-based and claims-based measure categories each have a weight of 50%. For more information on weighting, please refer to:

- **Appendix B: Measure Weighting and Re-Weighting for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years; and**
- **Appendix C: Within-Category Measure Weights for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years.**

Q3006.1 Why are the data in the expanded HHVBP Model performance feedback reports different from other home health reports available on the Internet Quality Improvement Evaluation System (iQIES)?

While there are similarities in the measures used in the expanded HHVBP Model, the Home Health Quality Reporting Program (HH QRP) and the Quality of Patient Care (QoPC) Star Rating use a specific measure set. The expanded Model includes 12 quality measures (See **Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years**). Of these 12, two (2) of these measures, Total Normalized Composite (TNC) Change in Self-Care and the Total Normalized Composite (TNC) Change in Mobility, are unique to the expanded Model and therefore do not appear in the HH QRP nor QoPC Star Rating.

Additionally, while measures in the HH QRP, QoPC Star Rating, and expanded Model use the same measure specifications, each may use different data collection time periods for the measures. Differences in individual quality measure scores between the HH QRP and the expanded Model performance feedback reports are most likely due to differences in the time periods for the data included in the analyses. As a result, CMS does not expect measure results to be identical and the ability to compare is limited.

Q3007. Are the claims-based measures included in the expanded HHVBP Model measure set for the CY 2023 and CY 2024 performance years risk-adjusted? Where can HHAs find more information on the risk-adjustment methodology for these measures?

The measure set for the expanded HHVBP Model calendar year (CY) 2023 and CY 2024 performance years includes the two (2) claims-based measures, Acute Care Hospitalization During the First 60 Days of Home Health (ACH) measure and Emergency Department Use without Hospitalization During the First 60 Days of Home Health (ED Use) measure. To account for beneficiary characteristics that may affect the risk of ACH or ED Use, the risk adjustment model uses potential risk factors that fall into five (5) categories:

1. Prior care setting
2. Health status
3. Demographics
4. Enrollment status
5. Interactions terms

For further information on the risk adjustment methodology for the two (2) claims-based measures, please download this **set of materials** from the *Downloads* section of the **CMS Home Health Quality Measures webpage**. For questions related to the claims-based measures, please email: **homehealthqualityquestions@cms.hhs.gov**.

Q3008. How are the two (2) OASIS-based TNC measures, Total Normalized Composite Change in Mobility (TNC Mobility), and Total Normalized Composite Change in Self-Care (TNC Self-Care) defined, and where can HHAs locate additional information for these two (2) measures?

For the calendar year (CY) 2023 and CY 2024 performance years, the Total Normalized Composite Change in Mobility (TNC Mobility) measures the magnitude of change (positive change, no change, or negative change) based on normalized total possible change across three (3) OASIS-based ADL items: M1840 Toilet Transferring, M1850 Bed Transferring, and M1860 Ambulation/Locomotion.

Total Normalized Composite Change in Self-Care (TNC Self-Care) measures the magnitude of change (positive change, no change, or negative change) based on normalized total possible change across six (6) OASIS-based Activities of Daily Living (ADL) items: M1800 Grooming, M1810 Upper Body Dressing, M1820 Lower Body Dressing, M1830 Bathing, M1845 Toileting Hygiene, and M1870 Eating.

TNC Mobility and TNC Self-Care are calculated using episodes of care that begin with a Start of Care/Resumption of Care (SOC/ROC) ending with a discharge from the agency during the reporting period, except for those meeting the exclusion criteria.

Resources specific to the expanded HHVBP Model TNC Change composite measures are available on the Expanded HHVBP Model webpage, under "Quality Measures."

Q3009.2 When will the claims-based measures, Acute Care Hospitalization During the First 60 Days of Home Health (ACH) and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (ED Use), be replaced with the measure Home Health Within Stay Potentially Preventable Hospitalization (PPH)?

The measure set for the expanded HHVBP Model calendar year (CY) 2023 and CY 2024 performance years includes Acute Care Hospitalization During the First 60 Days of Home Health Use (ACH) and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (ED Use) as the two (2) claims-based measures.

For the expanded HHVBP Model measure set, the Home Health Within Stay Potentially Preventable Hospitalization (PPH) measure will replace the ACH and ED Use measures beginning with the CY 2025 performance year. Please email the Home Health Quality Help Desk at homehealthqualityquestions@cms.hhs.gov for questions about the claims-based measures.

The list of Expanded HHVBP Model applicable measure sets for CY 2023, CY 2024, and CY 2025, are available in Appendix D: Applicable Measure Sets: CY 2023 and 2024 Performance Years vs CY 2025 Performance Year for the Expanded HHVBP Model.

Q3010.1 What factors are included in the calculations of the quality measures included in the expanded HHVBP Model for the CY 2023 and CY 2024 performance years?

Information on each quality measure included in the expanded HHVBP Model for the CY 2023 and CY 2024 performance years is available in **Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years**.

For additional information related to the:

- Total Normalized Composite (TNC) Change measures, please refer to these resources available on the Expanded HHVBP Model webpage, under "Quality Measures."
- OASIS-based measures and claims-based measures, please refer to the Home Health Quality Measures Outcomes Table, 2024**.** For questions related to the OASIS-based measures and the claims-based measures, please email homehealthqualityquestions@cms.hhs.gov.
- HHCAHPS Survey-based measures, please refer to the HHCAHPS measure specifications on the HHCAHPS website. For questions related to the HHCAHPS Survey-based measures, please email: hhcahps@rti.org or call 1-866-354-0985.

Q3011.2 Do the measures used in the expanded HHVBP Model address maintenance patients where the goal is to stabilize, but not necessarily show improvement? What about patients who are likely to decline?

Every home health agency (HHA) serves a different patient population, commonly referred to as a patient case-mix or patient mix. Some HHAs have patients with more chronic and complex needs, while others primarily serve patients who recover from more acute conditions. These patients may have different expected health outcomes and different expected costs. To promote fairer comparison across HHAs that serve different types of patients, CMS applies risk adjustment to each of the expanded HHVBP Model quality measures.

Risk adjustment is necessary to account for differences in patient case-mix among different HHAs that affect performance on outcome measures. That is, age and pre-existing conditions may impact how patients perform on outcome measures. Risk adjustment accounts for the differing types of patients served by HHAs, enables comparison across HHAs, and aims to prevent providers from avoiding the sickest patients and preferencing the healthiest. The risk adjustment methodology, using a predictive model developed specifically for each measure, compensates for differences in the patient population served by different home health agencies. For more information on risk adjustment and the description of risk factors, please see the **CMS Home Health Quality Measures webpage**.

For the calendar year (CY) 2023 and CY 2024 performance years, the Total Normalized Composite (TNC) Change measures account for maintenance patients. For additional information related to the TNC Change composite measures, please refer to the resources available on the **Expanded HHVBP Model webpage**, under "Quality Measures."

For questions related to risk adjustment for the

- OASIS-based measures (excluding the TNC Change measures) and the claims-based measures, please email: **homehealthqualityquestions@cms.hhs.gov**.
- TNC Change measures, please email: HHVBPquestions@cms.hhs.gov.
- HHCAHPS Survey-based measures, please email: **hhcahps@rti.org** or call 1-866-354-0985.

Q3012. Is the claims-based acute care hospitalization measure hospitalizations at 60-days or 30-days after home health admission? What is the definition of a stay for the Acute Care Hospitalization During the First 60 Days of Home Health and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health claims-based measures?

For the calendar year (CY) 2023 and CY 2024 performance years, the two (2) claims-based measures included in the expanded HHVBP Model are "Acute Care Hospitalization During the First 60 Days of Home Health (ACH)" and "Emergency Department Use without Hospitalization During the First 60 days of Home Health." For these two measures, a home health stay is calculated as a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days. Information on each quality measure in the expanded Model, including links to technical specifications, is available in **Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years**.

For more information on the claims-based measures, please refer to the Home Health Quality Measures Outcomes Table, 2024. For questions related to claims-based measures in the expanded Model, email: **homehealthqualityquestions@cms.hhs.gov**.

Q3013.1 What is the time period for selection of HHCAHPS Surveys for expanded Model reports?

Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) respondents are sampled or selected from sample months during the 12-month performance year data period. HHCAHPS

Survey participants are selected or sampled from all eligible patients receiving services from a home health agency (HHA) during a sample month and the month immediately preceding the sample month. HHCAHPS Survey participants can include patients discharged during the sample month, as well as those continuing to receive services. To reduce respondent burden, after a patient has been included in a sample, they are not eligible to be included in the sample for the next five (5) months.

For more information on the HHCAHPS Survey-based measures, please refer to **HHCAHPS measure specifications** on the HHCAHPS website. For questions related to the HHCAHPS Survey-based measures, email: **hhcahps@rti.org** or call 1-866-354-0985.

For additional information about the expanded Model reports and performance year data periods, see **Section VI. Reports**.

Q3014.1 Are there risk adjustment models for the quality measures included in the expanded HHVBP Model? Is risk adjustment calculated at the HHA parent level or at the branch level?

Yes, there are risk adjustment models for the quality measures applied in the expanded HHVBP Model, and these are calculated at the agency or CCN level. For example, age and pre-existing conditions may impact how patients perform on outcome measures. Risk adjustment accounts for the differing types of patients served by home health agencies (HHAs), enables comparison across HHAs, and aims to prevent providers from avoiding the sickest patients and preferencing the healthiest. The risk adjustment

methodology, using a predictive model developed specifically for each measure, compensates for differences in the patient population served by different home health agencies.

Risk adjustment is necessary to account for differences in patient case mix among different HHAs that affect performance on outcome measures. Every HHA serves a different patient population, commonly referred to as a patient case-mix or patient mix. Some HHAs have patients with more chronic and complex needs, while others primarily serve patients who recover from more acute concerns. These patients have different expected health outcomes and different expected costs. CMS does not expect all patients to improve. To promote fairer comparison across agencies that serve different types of patients, CMS has applied risk adjustment to each of the expanded HHVBP Model quality measures.

The established risk adjustment methods vary by OASIS-based, claims-based, and HHCAHPS Survey-based measures. In general, CMS conducts the risk adjustment process in three stages for each quality outcome for the OASIS-based and claims-based measures:

1. Building the prediction model – Creation of a statistical model to predict the outcome of a home health patient for a given quality outcome.
2. Aggregating the results to the agency level – Aggregation of the observed and predicted rates for each home health outcome for each agency (e.g., CCN level).
3. Applying the risk adjustment algorithm – Adjustment of the HHA's observed rate by the difference between the national predicted and the HHA's predicted rates.

For more information on risk adjustment and the description of risk factors, please see the Risk Adjustment Technical Steps and Risk Factor Specifications, 2024 document on the CMS Home Health Quality Measures webpage.

The risk adjustment process for HHCAHPS Survey-based measures is different from the process described above. Please refer to the document titled Patient-Mix Adjustment Factors for Home Health

Care CAHPS Survey (HHCAHPS) Results Publicly Reported on Care Compare in January 2024 on the HHCAHPS website that outlines the risk adjustment process for HHCAHPS measures in detail.

Information on each quality measure included in the expanded HHVBP Model is available in Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years.

For questions related to risk adjustment for the:

- OASIS-based measures (excluding the TNC Change measures) and the claims-based measures, please email: **homehealthqualityquestions@cms.hhs.gov**.
- TNC Change measures, please email **HHVBPquestions@cms.hhs.gov**.
- HHCAHPS Survey-based measures, please email:hhcahps@rti.org or call 1-866-354-0985.

Q3015. How is the HHA-level predicted score calculated for the two (2) Total Normalized Composite (TNC) Change measures that are part of the applicable measure set for the CY 2023 and CY 2024 performance years?

Predicted values are obtained from a regression model using a set of risk factors, as cited in the "Technical Specifications for the Total Normalized Composite Change Measures - April 2023" and

"Technical Specifications for the Total Normalized Composite Change Measures – October 2021" documents, available on the Expanded HHVBP Model webpage.

A home health agency's (HHA's) predicted value is the average of the episode-level predicted values, based on individual patient risk profiles, across all eligible quality episodes for that agency, and the national predicted value is based on the patient risk profiles across all eligible quality episodes for all agencies in the U.S.

Additional resources specific to the expanded HHVBP Model TNC Change composite measures are available on the Expanded HHVBP Model webpage under "Quality Measures."

Q3016. What OASIS-based, claims-based, and HHCAHPS Survey-based data will be included in the quality measures reported in the calendar year (CY) 2024 Annual Performance Report (APR)?

The CY 2024 APR will include the following data from the CY 2023 performance year:

- OASIS-based measures – quality episodes ending in CY 2023.
- Claims-based measures – home health stays that begin during CY 2023. The time period for the claims-based measures is 60 days following the start of the home health stay.
- HHCAHPS Survey-based measures – HHCAHPS surveys completed for eligible patients seen by home health agencies during CY 2023.

Q3017. How do the Total Normalized Composite (TNC) Change Measures for the CY 2023 and CY 2024 performance years consider individuals who may not have goals for improvement?

The risk adjustment methodology for the Total Normalized Composite (TNC) Change measures is designed to take into account instances where the goal of home health care is to maintain the patient's current condition or to prevent or slow further deterioration of the patient's condition by including risk factors for a wide variety of beneficiary-level characteristics, including age, risk for hospitalization, living arrangements and caregivers available, pain, cognitive function, baseline functional status, and others. For instance, a beneficiary with impaired cognition may not be expected to improve in self-care as much as a beneficiary without cognitive impairment. In effect, the self-care change score could shift up slightly for a beneficiary with impaired cognition relative to a beneficiary without cognitive impairment to account for the difference in expectations (as cited in **CY 2022 HH PPS**).

Resources specific to the expanded HHVBP Model TNC Change composite measures are available on the Expanded HHVBP Model webpage under "Quality Measures."

Q3018. If a home health patient is hospitalized twice in the first 60 days of home health, are both hospitalizations counted in the claims-based measure, Acute Care Hospitalization During the First 60 days of Home Health (ACH)? Would it make a difference if the patient is transferred or discharged in terms of calculating the HHA performance score for this quality measure?

For the calendar year (CY) 2023 and CY 2024 performance years, the Acute Care Hospitalization During the First 60 days of Home Health (ACH) measure reports the 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. The numerator for this quality measure includes the number of home health stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital in the 60 days following the start of the home health stay. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days. *See* **Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years** for further details on this claims-based measure.

For questions related to the measure calculations for the claims-based measures included in the expanded HHVBP Model quality measure set, please email the CMS Home Health Quality Help Desk at **homehealthqualityquestions@cms.hhs.gov**.

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Q3019. Are HHCAHPS Survey-based measures included in TPS calculations for the smaller-volume cohort?

Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Survey-based measures are not included in the Total Performance Score (TPS) calculations for the smaller-volume cohort. These measures are not calculated in expanded HHVBP Model performance reports for the smaller-volume cohort and no achievement thresholds or benchmarks are calculated.

The expanded Model national cohorts were constructed to group home health agencies (HHAs) of similar size that are likely to receive scores on the same set of measures for the purposes of setting benchmarks and achievement thresholds and determining payment adjustments. While some HHAs in the smaller-volume cohort have sufficient data to calculate HHCAHPS Survey-based measures, these HHAs constitute a small subset of the cohort. HHCAHPS Survey-based measures are not reported or included in TPS calculations for the smaller-volume cohort so that HHAs in this cohort are more likely to receive scores on the same set of measures.

Q3020.1 What changes starting in CY 2023 relate to the applicable measures in the expanded HHVBP Model?

Transition from OASIS-D1 to OASIS-E: *Effective 1/1/2023,* OASIS-E replaced OASIS-D1. The OASIS-E Instrument and Manual are available on the **CMS OASIS Data Sets** webpage. While this transition did not result in the addition of any new measures to the expanded HHVBP Model applicable measures set, the retirement of items from OASIS-D1 did contribute to the need to update the risk models used in measure calculation.

Risk Model Updates: Risk adjustment calculations for the OASIS-based quality measures used in the expanded Model will incorporate changes associated with the 1/1/2023 risk models update. Updates to the risk models include:

- Depression Screening (PHQ-2 Score) was replaced with Patient Mood Screening (PHQ-2 to 9).
- Home Care Diagnoses were replaced with CMS-Hierarchical Condition Categories (CMS-HCCs).

Measure Exclusions for Patients Transferred or Discharged to Hospice: Patients discharged (RFA 9) to a non-institutional hospice (M2420 = 3) where M0906 (Discharge/Transfer/Death Date) is 1/1/2023 or later are excluded from all OASIS-based applicable measures:

- Improvement in Dyspnea
- Improvement in Management of Oral Medications
- Total Normalized Composite (TNC) Change in Mobility
- Total Normalized Composite (TNC) Change in Self-Care
- Discharged to Community
  - Note that for the Discharged to Community measure, quality episodes in which patients were transferred to an institutional hospice (M2410 = 4) and with a M0906 Discharge/Transfer/Death Date of 1/1/2023 or later are also excluded from the measure.

The *Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 2.0***,** available on the **Home Health Quality Measures webpage,** contains additional information about the Home Health Quality Reporting Program measure calculations.

Expanded HHVBP Model TNC Measures: Note that the Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 2.0 does not have specifications for the TNC Change measures, as these measures are unique to the expanded Model.

Resources specific to the TNC Change Measures are available on the **Expanded HHVBP Model webpage** under "Quality Measures."

Q3021.1 How is risk adjustment for the TNC Change measures calculated for a patient admitted to an HHA using OASIS-D1 and discharged using OASIS-E?

For the calendar year (CY) 2023 and CY 2024 performance years, the risk models used to calculate the Total Normalized Composite (TNC) Change measures will depend on the timing of the quality episode's Start of Care (SOC) or Resumption of Care (ROC) assessment. Quality episodes with a SOC/ROC assessment completed in 2022 will use the 2022 OASIS-D1 risk models. Quality episodes with a SOC/ROC assessment completed in 2023 (M0090 – Date Assessment Completed is 1/1/2023 or later) will use the 2023 risk models.

Information and resources about the risk adjustment methodology specific to the expanded HHVBP Model are available on the Expanded HHVBP Model webpage including "*Risk Adjustment in the Expanded HHVBP Model*."

Q3022.2 Does discharge to a non-institutional hospice negatively impact the OASIS-based Discharged to Community measure that is included in the CY 2023 and CY 2024 applicable measure set?

The applicable measure set for the calendar year (CY) 2023 and CY 2024 performance years includes the OASIS-based Discharged to Community quality measure. This quality measure reports the percentage of home health quality episodes after which patients remained in the community.

Quality episodes in which patients are transferred or discharged to hospice, patients who die, and patients whose discharge disposition is unknown, are excluded from the Discharged to Community measure.

Discharged to Community measure exclusions apply to quality measures that end in a:

- Transfer to an inpatient hospice (M0100 Reason for assessment - RFA 6 or 7 Transferred, and M2410 Inpatient Facility response is 4 hospice) and with a M0906 Discharge/Transfer/Death Date of 1/1/2023 or later, or
- Discharge to a non-institutional/home hospice (M0100 Reason for assessment - RFA 9 Discharge from Agency, and M2420 Discharge Disposition response is 3 non-institutional hospice), and with a M0906 Discharge/Transfer/Death Date of 1/1/2023 or later, or
- Death at home (M0100 Reason for assessment - RFA 8 Death at Home), or
- Discharge from agency (M0100 Reason for assessment - RFA 9 Discharge from Agency) for which the patient's discharge disposition is unknown (M2420 Discharge Disposition response is unknown "UK").

Q3023. What changes cited in the calendar year (CY) 2024 Home Health Prospective Payment System (HH PPS) final rule relate to the expanded HHVBP Model applicable measure set for the CY 2024 performance year?

Changes cited in the CY 2024 HH PPS final rule apply to the applicable measure set for the CY 2025 performance year and do not apply to the applicable measure set for the CY 2023 or CY 2024 performance years. For the list of applicable measures, please see **Appendix A: Measure Set for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years**. For

more information about impacts to the expanded HHVBP Model finalized in the CY 2024 HH PPS final rule, please see **Q7001** and **Q7002**.

IV. Total Performance Scoring Methodology

The goal of the total performance scoring methodology is to produce a Total Performance Score (TPS) for each qualifying HHA based on its performance scores for each applicable measure included in the expanded HHVBP Model. CMS uses the HHA's TPS to determine an annual distribution of value-based payment adjustments (adjusted payment percentage) within each cohort.

Q4001.1 What is the TPS?

The Total Performance Score (TPS) is the numeric score awarded to each qualifying home health agency (HHA) based on the performance scores for each applicable measure. CMS determines the TPS by multiplying the care points by the applicable measure weight and summing the weighted measure points. CMS determines the TPS by weighting and summing the higher of that HHA's achievement or improvement score for each applicable measure. A qualifying HHA will receive a numeric score ranging from zero (0) to 100.

For the calendar year (CY) 2023 and CY 2024 performance years, of the 12 measures, an HHA must have sufficient data to allow calculation of at least five (5) measures to calculate scores in the baseline year and performance year.

The following is the minimum threshold of data an HHA must have for each applicable measure to receive a measure score:

- For OASIS-based measures, 20 home health quality episodes.
- For claims-based measures, 20 home health stays.
- For the HHCAHPS Survey-based measures, 40 completed surveys (see **Q3019** for more information relevant to HHAs assigned to the smaller-volume cohort).

If an HHA is missing all measures from a single measure category, CMS will redistribute the weights for the remaining two (2) measure categories such that the proportional contribution remains consistent with the original weights. For example, HHCAHPS Survey-based measures are not included in the TPS calculations for the smaller-volume cohort. This requires redistributing weights to the claims-based (otherwise weighted 35%) and OASIS-based (otherwise weighted 35%) measure categories, such that the claims-based and OASIS-based measure categories are each weighted at 50% of the total TPS.

Q4002.3 In the expanded HHVBP Model, what are the Model baseline year and the HHA baseline year, and how are these used in calculating the Total Performance Score (TPS)?

CMS uses two (2) types of baseline years in the expanded HHVBP Model: The Model baseline year and the home health agency (HHA) baseline year. CMS uses a baseline year for calculations at the Model-level for each of the two (2) cohorts, referred to as the Model baseline year, and a baseline year for calculations at the individual HHA level, referred to as the HHA baseline year.

Model Baseline Year:

The *Model baseline year* is used to measure an HHA's performance within their applicable size cohort, smaller-volume HHAs or larger-volume HHAs, using benchmarks and achievement thresholds based on

the most recent data available. For the purposes of calculating the benchmarks and achievement thresholds in the expanded HHVBP Model:

- CY 2023 and CY 2024 Performance Years, the Model baseline year is CY 2022, as cited in the CY 2023 Home Health Prospective Payment System (HH PPS) final rule
- Beginning with the CY 2025 Performance Year, the Model baseline year is CY 2023 regardless of the Medicare certification date, as cited in the CY 2024 HH PPS final rule. (See **Q7002** and **Appendix F** for specific information regarding changes to the Model beginning CY 2025 Performance Year and the 2-year Model Baseline Years for the Discharge to Community-Post-Acute Care measure)

HHA Baseline Year:

- The *HHA baseline year,* unique to each individual competing HHA and quality measure, is the first full calendar year beginning after the Medicare certification date and is used to determine the improvement threshold for each quality measure. An HHA's baseline year is determined by the HHA's Medicare certification date and whether the HHA had sufficient data to establish a baseline year for a particular quality measure. As cited in the **CY 2023 Home Health Prospective Payment System (HH PPS) final rule** for the CY 2023 and CY 2024 performance years:
  - HHAs with a date of Medicare Certification prior to January 1, 2022: The HHA's baseline year is CY 2022.
  - HHAs with a date of Medicare Certification on or after January 1, 2022: The HHA's baseline year is the first full calendar year of services beginning after the date of Medicare certification.

Exhibit 3 summarizes the Model and HHA baseline years by Medicare certification date for the CY 2023 and CY 2024 performance years. CMS may consider changes for the expanded Model through future rulemaking.

Exhibit 3. Model and HHA Baseline, Performance and Payment Years based on Medicare certification date

Medicare-certification Date	Model Baseline Year* (for Achievement Threshold)	HHA Baseline Year** (for Improvement Threshold)	Performance Year (CY)	Payment Year (CY)
Prior to January 1, 2022	2022	2022	2023	2025
Prior to January 1, 2022	2022	2022	2024	2026
On January 1, 2022–December 31, 2022	2022	2023	2024	2026

* CY 2022 is the Model baseline year used to determine the benchmark and achievement thresholds for CY 2023 and CY 2024 Performance Year. CY 2023 is the Model baseline year used to determine the benchmark and achievement thresholds for HHAs with sufficient measure data, beginning CY 2025 Performance Year.

** For HHAs certified on or after January 1, 2022, the HHA baseline year will be the first full CY of services beginning after the date of Medicare certification. CMS uses the HHA's Medicare certification date and the year in which the HHA has sufficient data for a specific quality measure to establish the HHA baseline year for a particular quality measure and to calculate the HHA's unique improvement threshold for each quality measure.

Q4004.3 What benchmarks apply to the expanded HHVBP Model and when will the final benchmarks used to calculate the Total Performance Score (TPS) be available?

Note that the HHA baseline years listed in **Exhibit 3** refer to the first ***possible*** baseline year for an HHA. An HHA must have sufficient data to establish a baseline year for each quality measure. If an HHA does

not have sufficient data to create a measure score in the first possible baseline year, the following year(s) may qualify to become the HHA baseline year if the HHA has sufficient data. For more information on sufficient data for the TPS calculation, refer to **Q4001.1**.

CMS sets all benchmarks and achievement thresholds for each quality measure by cohort, based on all home health agencies' (HHAs') performance data in the designated baseline year cited in the most current Home Health Prospective Payment System (HH PPS) final rule. The CY 2023 HH PPS final rule cites that calendar year (CY) 2022 is the Model baseline year used to calculate benchmarks and achievement thresholds for CY 2023 and CY 2024 Performance Years. These benchmarks and achievement thresholds for the CY 2023 and CY 2024 Performance Years have been available since the July 2023 Interim Performance Report (IPR).

The CY 2024 HH PPS final rule cites that CY 2023 is the Model baseline year used to calculate benchmarks and achievement thresholds beginning with the CY 2025 Performance Year. CMS anticipates providing achievement thresholds and benchmarks beginning with the CY 2025 Performance Year in July 2024.

Q4005. What is the minimum amount of measure data needed for an HHA to receive a TPS and be subject to a payment adjustment?

To receive a Total Performance Score (TPS) and be subject to a payment adjustment, a home health agency (HHA) must meet a minimum threshold of data. In addition, an HHA must have sufficient data to allow calculation of at least five (5) of the 12 quality measures in the baseline and performance years for calendar year (CY) 2023 and CY 2024.

The minimum threshold of data an HHA must have per measure, per reporting period for each measure category is the following for each:

- OASIS-based measures, 20 home health quality episodes.
- Claims-based measures, 20 home health stays.
- HHCAHPS Survey-based measures, 40 completed surveys.

Q4006. What if an HHA does not meet the minimum of five (5) applicable measures to receive a TPS and a corresponding payment adjustment?

A home health agency (HHA) that does not meet the minimum threshold of episodes or completed HHCAHPS Surveys on five (5) or more applicable measures for a given performance year will not receive a Total Performance Score (TPS) or be subject to a payment adjustment for the respective payment year. Instead, the HHA will be paid for services in an amount equivalent to what would have been paid under section **§ 1895 of the Social Security Act (42 U.S.C. 1395fff)**.

HHAs that do not meet the minimum threshold to receive a TPS will still receive quarterly Interim Performance Reports (IPRs) if there is sufficient data to calculate at least one of the applicable measures. HHAs will continue to have the opportunity to receive a TPS in the next performance year and be eligible for a payment adjustment in the next payment year.

To receive a TPS and be subject to a payment adjustment, an HHA must meet the minimum data threshold of five (5) or more of the applicable measures for a given performance year.

Q4008. How does a change in ownership (CHOW) affect the baseline year for an HHA?

The HHA baseline year is the calendar year used to determine the improvement threshold for each measure for each individual competing HHA. CMS determines an HHA's baseline year by the HHA's Medicare-certification date.

If a change in ownership (CHOW) results in the use of a new CCN, neither the baseline nor the performance year score would transfer to the new CCN. If the agency continues to use the same CCN, then the baseline and the performance year scores transfer to the new owners.

Q4009. Why are the measures Acute Care Hospitalization During the First 60 Days of Home Health (ACH) and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (ED Use) weighted higher than other measures? Do the ACH and ED Use measures take into account planned admissions or elective procedures?

For the calendar year (CY) 2023 and CY 2024 performance years, CMS places a higher weight on the ACH measure because it reflects a more severe health event and because inpatient hospitalizations generally result in more Medicare spending than the average emergency department visit that does not lead to an acute hospital admission.

For more information on the claims-based measures, please refer to the Home Health Quality Measures Outcomes Table, 2024. For questions related to claims-based measures in the expanded HHVBP Model, email: homehealthqualityquestions@cms.hhs.gov.

Q4010. Why can an HHA earn up to 10 achievement points but only up to nine (9) improvement points toward its Total Performance Score (TPS)?

Within the context of the expanded HHVBP Model, improvement refers to a home health agency's (HHA's) performance compared to its own historic performance and achievement refers to an HHA's performance compared to all HHAs within the applicable volume-based cohort. To incentivize all HHAs to provide high-quality care, CMS awards more points for achievement than for improvement. CMS uses the higher of either the achievement or improvement points to calculate the Total Performance Score (TPS). Using the higher of achievement or improvement points allows for the recognition of HHAs that have made improvements, though their HHA performance score for an applicable measure may still be relatively worse in comparison to other HHAs in their cohort. By limiting the improvement points to a scale across zero (0) to nine (9), achievement is prioritized relative to improvement in performance scoring.

Q4011.1 How are an HHA's weighted measure points calculated?

A home health agency's (HHA's) weighted measure points are calculated by dividing the HHA's care points for the measure by the maximum possible points [10 points] and multiplying by the designated measure weight. This information is in each HHA's Interim Performance Report (IPR) and Annual Performance Report (APR) on the Measure Scorecard Tab, if the HHA has sufficient data. CMS does not require HHAs to conduct the calculations necessary to assess performance.

For more information on weighting for the calendar year (CY) 2023, CY 2024, and beginning CY 2025 performance years, please refer to:

Appendix B: Measure Weighting and Re-Weighting for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years

Appendix C: Within-Category Measure Weights for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years.

For additional information on the expanded HHVBP Model care points, Total Performance Score (TPS), and Payment Adjustment methodologies, see the resources available on the **Expanded HHVBP Model webpage,** under "Total Performance Score & Payment Methodology."

Q4012. Can the Total Performance Score potentially change if a previously submitted OASIS assessment is corrected and resubmitted in iQIES?

The expanded HHVBP Model Interim Performance Reports (IPRs) and Annual Performance Reports (APRs) are based on OASIS assessment data submitted by home health agencies (HHAs) to CMS, Medicare claims data, and HHCAHPS Survey data collected by HHA vendors who then submit to CMS.

A quality episode is the unit of analysis for OASIS-based measures. Quality episodes are constructed by sorting HHA assessments by individual served and effective date, then pairing up assessments that mark the beginning and end of a quality episode. Assessments that had been submitted, but were subsequently inactivated and replaced, are not used in the construction of quality episodes or the calculation of any expanded HHVBP Model OASIS-based measure (including the TNC Change measures).

Based on the timing of OASIS submissions and data corrections, as well as calculations included in the expanded HHVBP Model reports, the data originally submitted could impact the quality measure scores for the OASIS-based measures and the Total Performance Score (TPS) reported in the expanded HHVBP Model IPRs and APRs. This would depend on whether the corrected data was received before processing had begun for OASIS data used for a specific IPR or APR. If a correction is received before this processing begins occurs, it will be reflected in the quality measure scores for the OASIS-based measures.

Q4016. If our HHA does not receive any completed HHCAHPS surveys for one or more quarters during the performance year, how will the HHCAHPS Survey-based measures be calculated for the performance year?

The expanded HHVBP Model Annual Performance Report (APR) calculations are based on the number of completed HHCAHPS surveys received during the 12-month reporting period and are not based on the number of completed HHCAHPS surveys an HHA receives each quarter. For the APR anticipated to be published in August 2024, HHCAHPS Survey-based measure performance is based on HHCAHPS

surveys completed in CY 2023. To receive Care Points on the APR, the HHA must have a minimum of 40 completed surveys in the performance year data period.

In the expanded HHVBP Model performance reports, there are 12 quality measures in the expanded Model quality measure set for the calendar year (CY) 2023 and CY 2024. The measures include five (5) OASIS-based measures, two (2) Medicare Fee-for-Service (FFS) claims-based measures, and five (5) HHCAHPS Survey-based measures. The OASIS-based, claims-based, and HHCAHPS Survey-based measure categories are weighted 35%, 35%, and 30%, respectively. If an HHA is missing all measures from one (1) measure category, the weights for the remaining two (2) measure categories are redistributed so that the proportional contribution remains consistent with the original weights. These redistributed measure categories sum to 100% of the HHA's TPS. For example, if a smaller-volume cohort HHA has sufficient data for OASIS-based and claims-based measures, then the OASIS-based and claims-based measures each count for 50%. If two (2) measure categories are missing, the remaining category is weighted at 100%.

Q4017. Why did our HHA receive zero (0) Achievement Points and zero (0) Improvement Points for some of the quality measures listed on our HHA's Model Performance Report?

OASIS-based and HHCAHPS Survey-based measures in the expanded HHVBP Model Performance Feedback Reports (i.e., Interim Performance Report [IPR], Annual Performance Report [APR]):

- An HHA will receive zero (0) **achievement points** when "Your HHA's Performance Year Measure Value" is worse than (i.e., lower than) or equal to "Your Cohort's Achievement Threshold."
- An HHA will receive zero (0) **improvement points** when "Your HHA's Performance Year Measure Value" is worse than (i.e., lower than) or equal to "Your HHA's Improvement Threshold".
- An "HHA's Performance Year Measure Value" that is lower than or equal to "Your Cohort's Achievement Threshold" (for achievement points) or "Your HHA's Improvement Threshold" (for improvement points) would be unfavorable.

Claims-based measures in the expanded HHVBP Model Performance Feedback Reports (i.e., Interim Performance Report [IPR], Annual Performance Report [APR]):

- An HHA will receive zero (0) **achievement points** when "Your HHA's Performance Year Measure Value" is worse than (i.e., higher than) or equal to "Your Cohort's Achievement Threshold."
- An HHA will receive zero (0) **improvement points** when "Your HHA's Performance Year Measure Value" is worse than (i.e., higher than) or equal to "Your HHA's Improvement Threshold".
- An "HHA's Performance Year Measure Value" that is higher than or equal to "Your Cohort's Achievement Threshold" (for achievement points) or "Your HHA's Improvement Threshold" (for improvement points) would be unfavorable.

See the Glossary for the terms Achievement Score (also referred to as achievement points) and Improvement Score (also referred to as improvement points).

V. Payment Adjustments

Payment adjustments are the amount by which a competing HHA's final claim payment amount under the HH PPS is changed in accordance with the methodology described in § 484.370.

Q5001.2 What level of payment adjustment can an HHA expect?

The amount of each HHA's payment adjustment, a maximum of 5% upward or downward, depends on the home health agency's (HHA's) Total Performance Score (TPS) and the performance of other HHAs in the assigned cohort. For example, calendar year (CY) 2023 is the first performance year and CY 2025 will be the first payment year. CMS will apply a payment adjustment of a maximum of 5% upward or downward in CY 2025 based on an HHA's performance in CY 2023.

An HHA's performance relative to the performance of its cohort is a key factor in determining the linear exchange function (LEF) that works as another driver in the calculation of each HHA's payment adjustment. See the **CY 2022 HH PPS final rule** for additional information on the LEF for the expanded Model.

An HHA with a TPS higher than the cohort average would receive a positive payment adjustment. An HHA with a TPS lower than the cohort average would receive a negative payment adjustment.

Q5002. What claims are payment adjustments applied to? Are HHVBP payment adjustments applied to all aggregate Medicare home health payments, or only Medicare payments from the first home health episode in a string of contiguous episodes?

The expanded HHVBP Model payment adjustments are applied to Home Health Prospective Payment Systems (HH PPS) claims for Medicare fee-for-service (FFS) beneficiaries. Medicare HH PPS payment adjustments are not made to aggregate revenue but occur for each final Medicare FFS claim an agency submits with a payment episode "through date" in the expanded Model payment year. CMS will notify home health agencies (HHAs) of their payment adjustment percentage prior to finalizing each Annual Performance Report.

Through the expanded Model, CMS will adjust the HH PPS final claim payment amount to an HHA with a "through date" in the HHVBP payment year by an amount up to or down to the maximum applicable percent. Medicare PPS payment adjustments are not made to aggregate revenue but occur for each final Medicare PPS claim an agency submits for claims with a payment episode "through date" in the HHVBP payment year.

For example, if a final claim amount is $3,500.00 and the payment adjustment percentage is 1.018%, the payment adjustment would be: $3500 multiplied by 0.01018, which equals an additional $35.63 included in the payment.

$3500*0.01018 = $35.63

Q5003.1 What is the linear exchange function (LEF)?

The linear exchange function (LEF) is used to translate a home health agency's (HHA's) Total Performance Score (TPS) into a percentage of the value-based payment adjustment earned by each HHA. Performance measurement is based on a LEF which only includes competing HHAs.

Under the expanded HHVBP Model, payment adjustments will be made to the Home Health Prospective Payment System (HH PPS) final claim payment amount as calculated in accordance with HH PPS regulations at **§ 484.370** using a LEF, similar to the methodology utilized by the Hospital Value-Based

Purchasing (HVBP) Program (76 FR 26533). For more information on the LEF for the expanded Model, including step-by-step calculations, please refer to the **CY 2022 HH PPS final rule**.

Q5004.1 Will the percentile rankings reported in the expanded HHVBP Model Interim Performance Reports (IPRs) and Annual Performance Reports (APRs) correlate with the adjusted payment percentage?

The percentile rankings and the adjusted payment percentage serve different purposes. A home health agency's (HHA's) percentile ranking compares an HHA's measure performance value to those of the HHAs within the same cohort. Percentile rankings reported on the expanded HHVBP Model Interim Performance Reports (IPRs) and Annual Performance Reports (APRs) enable HHAs to know how their performance compares to other HHAs within the same cohort. Percentile rankings are provided for care points awarded for each reported quality measure on the Care Points tab and for the Total Performance Score (TPS) on the Measure Scorecard tab. An HHA's adjusted payment percentage is available only in the APR.

Additional information is provided in **Q5001** and **Q5003**, and the resource *"How the Total Performance Score (TPS) Becomes the Final Payment Adjustment,"* located on the Expanded HHVBP Model webpage.

Q5005. How is an HHA's measure performance used in the determination of the adjusted payment percentage?

In the expanded HHVBP Model, the determination of home health agency (HHA) performance involves the assessment of both achievement and improvement across a set of quality measures. To incentivize all HHAs to provide high-quality care, CMS awards more points for achievement than for improvement within the context of the expanded Model.

Competing HHAs that demonstrate delivery of higher quality of care in a given performance year relative to other HHAs in their same volume-based cohort will have their HH PPS claims final payment amount adjusted higher than the amount that otherwise would be paid. Conversely, competing HHAs that do not perform as well as other competing HHAs in the same volume-based cohort will have their HH PPS claims final payment amount reduced. Competing HHAs with performance at or near the average for the volume-based cohort will receive a small or no payment adjustment.

The following series of resources is available on the Expanded HHVBP Model webpage to assist HHAs in understanding how performance on quality measures may impact the TPS and future Medicare payments:

- *"How Measure Performance Becomes Care Points"*
- *"How Care Points Become the Total Performance Score (TPS)"*
- *"How the Total Performance Score (TPS) Becomes the Final Payment Adjustment"*

Q5006.1 Does an HHA's percentile ranking affect the TPS?

A home health agency's (HHA's) percentile ranking compares an HHA's measure performance value to the HHAs in an HHA's cohort. HHA percentile ranking is not used in the calculation of an HHA's final Total Performance Score (TPS).

Q5007.2 What is the billing process for the expanded HHVBP Model?

There are no changes to a home health agency's (HHA's) billing process for the expanded HHVBP Model.

Under the expanded Model, payment adjustments (Adjusted Payment Percentage, or APP) are the amount by which a competing HHA's final claim payment amount under the HH PPS is changed in accordance with the methodology described in **§484.370**. The payment adjustments in the expanded HHVBP Model apply only to HH PPS claims for Medicare fee-for-service beneficiaries. The expanded Model does not affect claims submission. For services provided during the designated payment year, CMS will apply a payment adjustment to competing HHA's final claim payment amount of a maximum of 5% upward or downward. For example, CY 2023 is the first performance year and CY 2025 will be the first payment year. CMS will apply a payment adjustment of a maximum of 5% upward or downward in CY 2025 based on an HHA's performance in CY 2023.

Once CMS calculates the APP for HHAs eligible for a payment adjustment, the process is as follows for Home Health Prospective Payment System (HH PPS) claims for Medicare FFS beneficiaries:

1. The HHA submits a final claim as usual. There is no change in this process.
2. The Medicare claims processing system reviews the claim, calculates payment, and applies the APP to the claim.
3. The Medicare Administrative Contractor (MAC) pays the claims and returns the remittance advice with the claim. Please note, the adjustment amount is not separately identified on the remittance advice.

For additional questions about billing, please visit the **Home Health PPS webpage**.

VI. Reports

CMS publishes two (2) types of regular reports that provide HHAs information on their performance and payment adjustments. CMS publishes all expanded HHVBP Model reports to **iQIES**. The first report is the Interim Performance Report (IPR), issued quarterly. The IPR provides HHAs with information on their measure performance in the expanded Model, based on the 12 most recent months of data available. The IPR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. Using the IPRs, HHAs can assess and track their performance relative to peers in their respective cohort throughout the expanded Model performance year. CMS issues two (2) versions of the IPR—a preliminary version and a final version.

Home health agencies (HHAs) are encouraged to review their IPRs to gain insights into their performance across a range of quality measures compared to their peers, consider the drivers of performance, and identify opportunities for improvement. HHAs have an opportunity to compare data in the quarterly IPRs to assess performance throughout each performance year.

There are quality improvement resources designed to support HHAs with improving performance in the expanded HHVBP Model. These resources are available on the Expanded HHVBP Model webpage under the "Quality Improvement" category.

The second report is the Annual Performance Report (APR). The APR provides HHAs with information on their measure performance in the expanded Model, based on data from the prior calendar year. Like the IPR, the APR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. Additionally, the APR includes the HHA's payment adjustment percentage for the upcoming CY, an explanation of when the adjustment will apply,

and how CMS determined the adjustment relative to HHA performance scores. The APR includes an average TPS for the cohort on the Annual Payment Adjustment tab. CMS issues three (3) versions of the APR – preview, preliminary, and final.

For all reports, the home health episodes or patients included vary according to measure category as shown in **Exhibit 8**.

Exhibit 8: Data Included in Expanded Model Quality Measure Categories

Measure Category	Data Included
OASIS-based measures	OASIS quality episodes that ended during the 12-month performance year data period, determined from the date of the OASIS end of care assessment
Claims-based measures	Home health stays with a start date during the 12-month performance year data period. Home health stays are constructed through analysis of Medicare fee-for-service claims.
HHCAHPS Survey-based measures	HHCAHPS Survey respondents sampled or selected from sample months during the 12-month performance year data period. HHCAHPS Survey participants are selected or sampled from all eligible patients receiving services from an HHA during a sample month and during a 60-day lookback period. HHCAHPS Survey participants can include patients discharged during the sample month, as well as those continuing to receive services. To reduce reporting burden, patients are not asked to participate in the HHCAHPS Survey more than once every six (6) months.

The IPRs and APRs are available through the Internet Quality Improvement and Evaluation System (iQIES). iQIES users authorized to view an HHA's OASIS quality report will be notified via email (GovDelivery) of the distribution of HHVBP reports. For security reasons, CMS does not email these reports to HHAs, nor does CMS notify users of report availability when they log into iQIES.

Q6001.4 Will CMS notify HHAs when the Interim Performance Reports (IPRs) and Annual Performance Reports (APR) are available? How will HHAs access the reports?

CMS will send an email through the **Expanded HHVBP Model listserv, and the iQIES listserv (for registered iQIES users),** announcing the availability of the reports in iQIES.

Expanded HHVBP Model reports are available to home health agencies (HHAs) only via **iQIES**, in the "HHA Provider Preview Reports" folder, by the CCN assigned to the HHA. If a provider has more than one (1) CCN, a report will be available for each CCN. Only iQIES users authorized to view an HHA's reports can access the expanded HHVBP Model reports. **Access Instructions** are available on the **Expanded HHVBP Model webpage under "Model Reports**." The final version of expanded HHVBP Model performance feedback reports are available in iQIES for 730 days after publication. When the report retention changes are implemented, final versions of the IPRs and APRs that are older than 730 days will be permanently deleted by the iQIES system. The number of days the report will be available in iQIES is directly related to the date when the report was generated or made available in your CCN's My Report folder in iQIES.

Only authorized iQIES users for an HHA will have access to expanded Model reports. Should you need to register as an iQIES user, experience difficulty locating the expanded HHVBP Model reports, or experience difficulty downloading a report, please contact the iQIES Service Center at 1-800-339-9313, Monday through Friday, 8:00 AM-8:00 PM ET, or by email **(iqies@cms.hhs.gov**). To create a ticket online or track an existing ticket, please go to **CCSQ Support Central.**

Q6002.3 How often will HHAs receive an Interim Performance Report (IPR)? When will the first IPR be available for the first performance year?

The Interim Performance Report (IPR) is published quarterly. The July 2023 IPR was the first quarterly report that contained calendar year (CY) 2023 performance year data. Performance during CY 2023 informs adjustments for the CY 2025 payment year. For the CY 2023 performance year, only active HHAs that were Medicare-certified prior to January 1, 2022, and meet the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year will receive an IPR.

For the CY 2024 performance year, only active HHAs that were Medicare-certified prior to January 1, 2023, and meet the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year will receive an IPR.

Q6003. What does the Interim Performance Report (IPR) include?

The quarterly Interim Performance Report (IPR) contains information on quality measure performance based on the 12 most recent months of data available. The IPR provides feedback to home health agencies (HHAs) about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. The IPR provides HHAs the opportunity to assess and track their performance relative to peers in their respective cohort. Each IPR includes the following information:

- Quarterly update on the HHA's Total Performance Score (TPS)
- Percentile rankings reflecting the agency's performance relative to the performance of other HHAs in their cohort
- Total Normalized Composite (TNC) Change Reference to assist HHAs in understanding their performance on the individual OASIS items included in the two (2) composite measures, in addition to the percentage of episodes in which there was no change, positive change, or negative change for each OASIS item
- Scorecard information that will support HHAs with understanding how each individual measure contributes to their TPS

Please note that IPRs are based on the 12 most recent months of performance data, while the Annual Performance Reports are based on data during a given performance year, so there may be differences in the HHA's TPS given the different time periods the reports are based on.

Q6004. Expanded HHVBP Model performance data do not match any of the data I have seen on other reports. Does this mean that the Interim Performance Report (IPR) data are wrong?

No. The data on the Interim Performance Report (IPR) are calculated using a subset of the risk adjusted values sourced through Care Compare for OASIS-based and claims-based measures, as well as other sources such as HHCAHPS. Differences in individual quality measure scores between what is presented on Care Compare and found in the IPR are most likely due to differences in the time periods for the data included in the analyses presented on Care Compare and the IPRs.

Q6005. I use vendor reports for my quality data and the report values on their reports are different from those on the Interim Performance Report (IPR). Why? Should I use the vendor reports?

There could be several reasons why vendor-generated reports differ from CMS reports, including, but not limited to, timeframe when the data are extracted by the vendor, the completeness of the data used by the vendor, data sources used, completeness of data, and/or the formulas and rounding rules used by the vendor when calculating values.

CMS cannot provide guidance on data, analysis, or reports from software or data benchmarking vendors. The Interim Performance Reports (IPRs) are based on OASIS assessment data submitted by home health agencies (HHAs) to CMS, Medicare claims data, and HHCAHPS data collected by HHA vendors and submitted to CMS.

Q6006.1 What can an HHA do if we think there may be an inaccuracy in the Interim Performance report (IPR)?

Publication of quarterly Interim Performance Reports (IPRs) occurs in two (2) stages: 1) a Preliminary IPR, and 2) a Final IPR. As cited in the CY 2022 HH PPS final rule (p. 62331) and Code of Federal Regulations (CFR) §484.375, the Preliminary IPR provides home health agency (HHA) with an opportunity submit a recalculation request for applicable measures and interim performance scores if the agency believes there is evidence of a discrepancy in the calculation (e.g., the HHA did not receive achievement points for the OASIS-based Dyspnea applicable measure even though the HHA's achievement points exceeded the cohort's achievement threshold for this applicable measure).

Please note, the recalculation request does not apply to errors in data submission since submission requirements for the expanded Model align with the current CFRs. HHAs must electronically report all OASIS data collected in accordance with the Medicare Conditions of Participation (CoPs) (**§484.45**), and as a condition for payment (**§484.205(c)**). HHAs are required to submit HHCAHPS Survey-based measure data for the Home Health Quality Reporting Program (HH QRP) under **§484.355(a)(1)(ii)**.

To dispute the calculation of the performance scores in the Preliminary IPR, an HHA must submit a recalculation request ***within 15 calendar days after publication*** of the Preliminary IPR. HHAs may submit requests for recalculation by emailing **hhvbp_recalculation_requests@abtassoc.com**.

Recalculation requests must contain the following information, as cited in the **CY 2022 HH PPS final rule** (p. 62331) and CFR **§484.375**:

- The provider's name, address associated with the services delivered, and CMS Certification Number (CCN).
- The basis for requesting recalculation to include the specific data that the HHA believes is inaccurate or the calculation the HHA believes is incorrect.
- Contact information for a person at the HHA with whom CMS or its agent can communicate about this request, including name, email address, telephone number, and mailing address (must include physical address, not just a post office box).
- A copy of any supporting documentation, not containing PHI, the HHA wishes to submit in electronic form.

The Final IPR will reflect any changes resulting from an approved recalculation. All HHAs that received a Preliminary IPR will receive a Final IPR, even if the HHA did not submit a recalculation request.

Q6007. When will the first Annual Performance Report (APR) be available?

CMS anticipates the first preview version of the Annual Performance Report (APR) available in August 2024. This first APR will provide information on the calendar year (CY) 2023 performance year, and the CY 2025 payment year. Each competing HHA will receive a confidential APR via **iQIES.**

The first quarterly IPR of the expanded HHVBP Model was published in July 2023. The July 2023 IPR included 12 months of data ending March 31, 2023, for OASIS-based quality measure performance scores and 12 months of data ending December 31, 2022, baseline data, for claims-based and HHCAHPS Survey-based quality measure performance scores.

CMS anticipates the first APR for the expanded HHVBP Model will be available in August 2024. This first APR will provide information on performance year 1, CY 2023, and the CY 2025 payment year.

Q6008. What does the Annual Performance Report (APR) include?

The Annual Performance Report (APR) provides home health agencies (HHAs) with information on their measure performance in the expanded Model, based on data from the prior calendar year (CY). Like the IPR, the APR will provide feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. Additionally, the APR will include the HHA's payment adjustment percentage for the upcoming CY, an explanation of when the adjustment will apply, and how CMS determined the adjustment relative to the HHA's final Total Performance Score (TPS).

Each competing HHA will receive three (3) confidential versions: a Preview APR, a Preliminary APR (if applicable), and a Final APR. The first APR will be based on the CY 2023 performance year (January 1, 2023 to December 31, 2023) with the first payment adjustment applied to each HH PPS final claim payment amount as calculated in accordance with HH PPS policies as codified at **§ 484.370** for Medicare fee-for-service claims with through dates between January 1, 2025 and December 31, 2025.

Q6009.1 Can an HHA appeal the data included in the APR?

During review of the Preview Annual Performance Report (APR)**,** a home health agency (HHA) may submit a *recalculation request* within 15 calendar days after CMS issues the report if they believe there is a calculation error. If an HHA disagrees with the results of the recalculation request reflected in

the Preliminary APR, the HHA may submit a *reconsideration request* within 15 calendar days after CMS issues the Preliminary APR. Only HHAs that submit a recalculation request may submit a reconsideration request.

Beginning with the CY 2024 APR, which will contain data for the calendar year (CY) 2023 performance year, an HHA may request a*n Administrator review* of a reconsideration decision within seven (7) calendar days from CMS' notification of the outcome of the reconsideration request.

For detailed instructions on how to submit a recalculation request, during the designated time period, refer to the "*Expanded HHVBP Model IPR Recalculation Instructions*" available under "Model Reports" on the Expanded HHVBP Model webpage.

Q6011. Who can access the expanded HHVBP Model performance feedback reports?

Only iQIES users authorized to view a home health agency's (HHA's) report can access expanded HHVBP Model reports. For support with registration for iQIES, please contact the QIES/iQIES Service Center by phone at (800) 339-9313 or email **iqies@cms.hhs.gov**.

There is an iQIES Onboarding Guide posted to the QIES Technical Support Office (QTSO): **https://qtso.cms.gov/software/iqies/reference-manuals**. The iQIES Onboarding Guide provides instructions regarding how to request a user role.

Q6012.1 Are the data and information in the expanded HHVBP Model IPR and APR calculated and reported at the branch level, the parent level, or by CCN?

Participation in the expanded HHVBP Model is based on the home health agency's (HHA's) CMS Certification Number (CCN). The Total Performance Score (TPS) and Adjusted Payment Percentage (APP) calculations use data reported by the HHA's CCN.

Expanded Model reports will be available in iQIES by the CCN assigned to the HHA. If an organization has more than one (1) CCN, a report will be available for each CCN.

Q6013. On the TNC Change Reference tab, does the list of OASIS items refer only to the OASIS items or also to measures?

On the TNC Change Reference tab, the first column lists the nine (9) OASIS items used to calculate the two (2) TNC Change measures (see screenshot below). Specifically, there are three (3) OASIS items – Toilet Transferring, Transferring, and Ambulation/Locomotion — used to calculate the TNC Change in Mobility measure. There are six (6) OASIS items – Grooming, Upper Body Dressing, Lower Body Dressing, Bathing, Toileting Hygiene, and Feeding or Eating – used to calculate the TNC Change in Self-Care measure. Data shown in the TNC Change Reference tab are not risk adjusted.

Exhibit 9: TNC Change Reference Tab

Report	Interim Performance Report (IPR) for July 2024
CCN	999999
HHA Name	We Love Home Health
HHA Address	999 Home Health Ln, Home Health, MD 99999
Your HHA's Cohort	Larger-volume

Performance Summary for TNC Change Measures [a]

Your HHA's count of eligible quality episodes [b]	1,342					
OASIS Item [c]	**Changes in OASIS Item Responses between SOC/ROC and EOC as a Percent of Eligible Quality Episodes [d]**					
	YOUR HHA			**AVERAGE FOR YOUR HHA'S COHORT [e]**		
	No Change	**Positive Change**	**Negative Change**	**No Change**	**Positive Change**	**Negative Change**
Total Normalized Composite (TNC) Change in Mobility						
M1840 Toilet Transferring (0-4)	10%	89%	1%	28%	71%	1%
M1850 Transferring (0-5)	4%	95%	1%	19%	80%	1%
M1860 Ambulation/Locomotion (0-6)	6%	94%	1%	20%	79%	1%
Total Normalized Composite (TNC) Change in Self-Care						
M1800 Grooming (0-3)	13%	86%	1%	23%	76%	1%
M1810 Ability to Dress Upper Body (0-3)	9%	90%	1%	21%	78%	1%
M1820 Ability to Dress Lower Body (0-3)	10%	89%	1%	20%	79%	1%
M1830 Bathing (0-6)	6%	93%	1%	16%	82%	1%
M1845 Toileting Hygiene (0-3)	7%	92%	0%	22%	77%	1%
M1870 Feeding or Eating (0-5)	43%	54%	3%	49%	49%	3%

The table presents the *changes* in OASIS item responses between Start of Care or Resumption of Care, and End-of-Care, as a percentage of eligible quality episodes. The HHA can also compare their agency with the average for their cohort presented in the right half of the table.

Q6014. What is the relationship between HHA performance under the expanded HHVBP Model and performance for Star Ratings? How can the Star Ratings help HHAs understand current opportunities for improvement?

Home health agencies (HHAs) already have a variety of reports from the Home Health Quality Reporting Program (HH QRP) available in the Internet Quality Improvement and Evaluation System (**iQIES**).

These reports contain details on agency performance on a variety of quality measures, including those included in the expanded HHVBP Model (except for Total Normalized Composite (TNC) Measures). Because the TNC measures are unique to the expanded Model, they are not currently publicly reported on Care Compare or on other CMS reports. However, HHAs might consider looking at their agency's performance on the Confidential Feedback Reports and Care Compare for the individual measures that are derived from the same OASIS items included in the TNC Mobility and TNC Self-Care measures, to see if performance offers any insights regarding quality improvement efforts. These reports in iQIES can inform current quality assurance and performance improvement (QAPI) programs as required under the Conditions of Participation (CoPs) §484.65.

The methodologies for the Total Performance Score (TPS) for the expanded Model and the Star Ratings for the HH QRP are similar in that they combine results from multiple risk adjusted quality measures to produce a summary score or rating of HHA performance. Below are some differences between the TPS and Star Ratings:

- The **TPS combines results from OASIS-based, claims-based, and HHCAHPS Survey-based measures.** The TPS weighs points earned specific to the measure and measure category. Star Ratings are computed separately for the Quality of Patient Care and Patient Survey domains.
- An HHA's TPS is compared to other agencies within the respective cohort—smaller-volume or larger-volume nationwide. For the Star Ratings, an HHA's ratings are compared at the national level only.

- The TPS offers an opportunity for HHAs to earn points for both improvement and achievement. Star Ratings recognize quality measure HHA performance in a specified time period, without reference to past performance.
- The time periods for the HH QRP data used for TPS and Star Ratings may not align.

For more information, please refer to the resource "How to use Existing Quality Assurance and Performance Improvement (QAPI) Processes to Support Improvement in the Expanded HHVBP Model" on the **Expanded HHVBP Model webpage**.

For additional information on the expanded Model TPS and Payment Adjustment methodology, see the resources available on the **Expanded HHVBP Model webpage,** under "Total Performance Score & Payment Adjustment."

Q6015. Is any of the data on the Total Normalized Composite (TNC) Change Reference tab in the Interim Performance Report (IPR) and Annual Performance Report (APR) risk-adjusted?

The TNC Change Reference tab in the Interim Performance Report (IPR) and Annual Performance Report (APR) presents observed changes, as a percent of eligible quality episodes, in OASIS M-item responses for the home health agency (HHA) and for the cohort. These data are not risk adjusted.

The measure values for all quality measures shown in the IPR and APR Achievement and Improvement tabs, including the TNC Change in Mobility and TNC Change in Self-Care measures, are risk adjusted. Resources specific to the expanded HHVBP Model TNC measures are available on the Expanded HHVBP Model webpage, under "Quality Measures."

Q6017.1 Does the information on the iQIES Review and Correct Report impact expanded HHVBP Model reports?

Per the **Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual (Version 2.0)**, located in the Downloads section of the **CMS Home Health Quality Measures webpage**, the iQIES Review and Correct Reports contain agency-level measure information. The User's Manual contains additional details about these reports. The iQIES Review and Correct Reports include information related to several assessment-based measures currently used in the expanded HHVBP Model. Assessment-based measures are referred to as OASIS-based measures in the expanded Model.

The iQIES Review and Correct Reports include information on two (2) of the five (5) expanded Model OASIS-based measures included in the calendar year (CY) 2023 and CY 2024 performance years:

- Improvement in Dyspnea/Dyspnea
- Improvement in Management of Oral Medications/Oral Medications

The expanded Model includes two (2) OASIS-based measures, unique to the expanded Model for the CY 2023 and CY 2024 performance years, which are available only on the expanded Model Reports (not on the iQIES Review and Correct Reports):

- Total Normalized Composite Change in Mobility/TNC Mobility
- Total Normalized Composite Change in Self-Care/TNC Self-Care

In addition, for the CY 2023 and CY 2024 Performance Years the expanded Model includes the OASIS-based Discharged to Community quality measure, which is also not on the iQIES Review and Correct Report.

Note that values for OASIS-based measures reported in the expanded Model performance reports (Improvement in Dyspnea and Improvement in Management of Oral Medications) and those reported in the iQIES Review and Correct Reports may differ. Differences may be due to risk adjustment, as the iQIES Review and Correct Reports use observed measure values and expanded Model performance reports use risk adjusted values. Other differences may be due to reporting periods and data availability. Corrections made to OASIS assessments by an HHA based on information presented in the iQIES Review and Correct Reports or other reasons will be reflected in the data used in the expanded Model.

For more information on the iQIES Review and Correct Reports, please see the **CMS Home Health Quality Measures webpage.**

Q6018. In the HHVBP performance feedback reports, are the "Your HHA's Performance Year Measure Value" and the "Your HHA's Cohort Statistics" risk adjusted?

The values shown in the "Your HHA's Performance Year Measure Value" column and "Your HHA's Cohort Statistics" values are risk adjusted. Risk adjustment accounts for differences in patient case mix among different home health agencies (HHAs) that affect performance on outcome measures. For more information on risk adjustment in the expanded HHVBP Model, please refer to **Q3014.1.**

Q6019. How can an HHA compare their performance to other HHAs in their cohort?

Home health agencies (HHAs) will be able to compare their performance to other agencies in their cohort using the Interim Performance Reports (IPRs), issued quarterly, and the Annual Performance Reports (APRs).

Both the IPR and APR will include "TPS Statistics for Your HHA's Cohort," which provides the Total Performance Score (TPS) for the 25th, 50th, 75th, and 99th percentiles for the HHA's cohort. This information provides the HHA with the opportunity to see how their TPS compares to other HHAs in the cohort.

The APR will also include the "Final TPS-Adjusted Payment Percentage (APP) Statistics for Your HHA's Cohort," which provides the APP for the Mean, 25th, 50th, 75th, and 99th percentiles for the HHA's cohort. Using these statistics, HHAs will be able to compare their APP with other HHAs in the cohort.

The first IPR was made available in July 2023. The first APR will be available in August 2024.

Q6021.1 When will HHAs receive expanded Model reports for the CY 2023 and CY 2024 performance years? What data will each report include?

Exhibit 10 shows the timelines for CY 2023 and CY 2024 performance years, noting the publication date and the 12-month data period for each measure category.

- For the CY 2023 performance year, only active HHAs that were Medicare-certified prior to January 1, 2022, and **meet the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year** will receive IPRs.
- For the CY 2024 performance year, only active HHAs that were Medicare-certified prior to January 1, 2023, **and meet the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year** will receive IPRs.

Exhibit 10. Timeline for CY 2023 and CY 2024 Performance Years by Report Type, Measure Category, and Data Period

Performance Year	Report Type	OASIS-based Measures	Claims-based and HHCAHPS Survey-based Measures
CY 2023	**July 2023 Interim Performance Report (IPR)**	4/1/2022 – 3/31/2023	1/1/2022 – 12/31/2022
	October 2023 IPR*	7/1/2022 – 6/30/2023	4/1/2022 – 3/31/2023
	January 2024 IPR	10/1/2022 – 9/30/2023	7/1/2022 – 6/30/2023
	April 2024 IPR	1/1/2023 – 12/31/2023	10/1/2022 – 9/30/2023
	July 2024 IPR	4/1/2023 – 3/31/2024	1/1/2023 – 12/31/2023
	Annual Performance Report (APR) (CY 2024 APR – in August 2024)	1/1/2023 – 12/31/2023	1/1/2023 – 12/31/2023
CY 2024	**July 2024 IPR**	4/1/2023 – 3/31/2024	1/1/2023 – 12/31/2023
	October 2024 IPR	7/1/2023 – 6/30/2024	4/1/2023 – 3/31/2024
	January 2025 IPR	10/1/2023 – 9/30/2024	7/1/2023 – 6/30/2024
	April 2025 IPR	1/1/2024 – 12/31/2024	10/1/2023 – 9/30/2024
	July 2025 IPR	4/1/2024 – 3/31/2025	1/1/2024 – 12/31/2024
	Annual Performance Report (APR) (CY 2025 APR – in August 2025)	1/1/2024 – 12/31/2024	1/1/2024 – 12/31/2024

*The same TNC performance measure values are reported in both the October 2023 and July 2023 IPRs due to a major update in iQIES. For more information, please see **Q6028**.

Q6022. For HHAs that participated in the original HHVBP Model, how do the expanded Model reports compare to those received in the original Model?

Performance feedback reports under the expanded HHVBP Model are specific to the regulations and policies for the expanded Model. Although the format of the original and expanded Model performance reports is similar, expanded HHVBP Model performance reports are not intended for comparison with original Model performance reports.

Q6023. Why is there a dash (-) for some measures in performance reports?

A dash (-) indicates no or insufficient data are available. Measures with no or insufficient data available are excluded from the TPS calculation.

There are minimum data requirements that home health agencies (HHAs) must meet for the calculation of risk-adjusted quality measures. These requirements include:

A minimum threshold of data required per reporting period for each of the measures, as follows:

- OASIS-based – 20 home health quality episodes
- Claims-based – 20 home health stays
- HHCAHPS Survey-based – 40 completed surveys*

An HHA must have sufficient data to allow calculation of at least five (5) of the 12 measures to calculate a TPS.

*As noted in **Q3019**, HHCAHPS Survey-based measures are not included in the TPS calculations for the smaller-volume cohort regardless of the number of completed surveys for the performance year data period.

Q6024. Why does my HHA's IPR show "0.000" care points for some measures in the Measures Scorecard Tab?

On the **Measure Scorecard Tab**, the values in the *Your HHA's Care Points* column carry over from the **Care Points Tab**. See **Q4017**.

Q6025. Is the Total Performance Score (TPS) available in the Interim Performance Report (IPR)?

The Interim Performance Report (IPR) includes an interim Total Performance Score (TPS) allowing home health agencies (HHAs) to track performance based on available data. HHAs can also see where their TPS currently ranks in comparison to other HHAs in their cohort.

It is important to note that HHAs must have sufficient data for at least five (5) of the 12 quality measures to receive a TPS.

For the calendar year (CY) 2023 performance year, a final TPS will not be available until August 2024, in the Annual Performance Report (APR). The APR will include performance data for all 12 months of CY 2023.

Q6026. How can an HHA compare its Total Performance Score (TPS) with other agencies in the cohort?

On the **Measures Scorecard Tab**, the value in the *Percentile Ranking within Your HHA's Cohort* compares the home health agency's (HHA's) ranking to all agencies in the cohort, expressed in quartiles, as cited in footnote "c" in the Interim Performance Report (IPR). The *TPS Statistics for Your HHA's Cohort* table provides a breakdown of percentile rankings within the cohort.

The TPS statistics shown in the **Measure Scorecard Tab** of the IPRs are provided for information purposes only and are not used in payment adjustment calculations.

Q6027. Can I access patient-level data in the expanded HHVBP Model performance feedback reports?

CMS is unable to provide any patient-level data in the expanded HHVBP Model performance feedback reports. HHAs should refer to their iQIES reports or internal databases to track how each patient performed at End of Care (EOC) relative to Start of Care/Resumption of Care (SOC/ROC).

Q6028. In the Final October 2023 IPR, I noticed changes in performance data for the following OASIS-based measures: Discharged to Community, Improvement in Dyspnea, and Improvement in Oral Medications. However, I do not see updated data for the two (2) OASIS-based Total Normalized Composite (TNC) measures. Why was updated data available for the three (3) other OASIS-based measures and not the TNC measures?

A major update to iQIES in mid-April impacted production of the Total Normalized Composite (TNC) measures for the October 2023 Interim Performance Report (IPR). As a result, HHAs will see the same TNC performance measure values in the October 2023 IPRs that were reported on the July 2023 IPRs, using the time period April 1, 2022 to March 31, 2023. There are differences in the processes for producing the TNC measures as compared to the other OASIS-based measures for the expanded Model. Therefore, the other OASIS-based measures values are current and cover the time period of July 1, 2022 to June, 30, 2023.

While the delay in updating the TNC measures for the October IPR does impact the interim Total Performance Score (TPS) shown, this issue will be resolved for future IPRs and will not impact the final TPS for the calendar year (CY) 2023 performance year, which will appear in the CY 2024 Annual Performance Report (APR).

\II. CY 2024 HH PPS Expanded HHVBP Model Policy and Program Implementation Changes

On November 1, 2023, CMS published the CY 2024 HH PPS final rule, which included a series of changes to the expanded Model.

Q7001. What changes to the expanded Model that were finalized in the calendar year (CY) 2024 Home Health Prospective Payment System (HH PPS) final rule begin in CY 2024?

On November 1, 2023, CMS published the CY 2024 HH PPS final rule, which included a series of changes to the expanded Model. The changes that ***begin CY 2024*** are:

Measure removal factors. In the CY 2024 HH PPS final rule, CMS codified the factors for removal of a measure from HHVBP. CMS may remove a quality measure from the expanded HHVBP Model based on one or more of the following factors:

- Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made (that is, topped out).
- Performance or improvement on a measure does not result in better patient outcomes.
- A measure does not align with current clinical guidelines or practice.
- A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- A measure that is more strongly associated with desired patient outcomes for the particular topic is available.

- Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
- The costs associated with a measure outweigh the benefit of its continued use in the program.

Appeals process. Beginning with the CY 2024 Annual Performance Report (APR), for the CY 2023 performance year/CY 2025 payment year, HHAs may request *Administrator review* of a reconsideration decision within seven (7) days from CMS' notification to the HHA contact of the outcome of the *reconsideration request*[22]. CMS will publish the first APR in August 2024.

Q7002. What changes to the expanded Model that were finalized in the calendar year (CY) 2024 Home Health Prospective Payment System (HH PPS) rule beginning in CY 2025?

On November 1, 2023, CMS published the CY 2024 HH PPS final rule, which included a series of changes to the expanded Model. The changes that ***begin CY 2025*** affect the quality measure set and the Model baseline year. CMS may propose changes for subsequent years of the expanded HHVBP Model through future rulemaking.

Quality Measure Set Changes

a. ***OASIS-based Measures***. Beginning with the CY 2025 performance year, the OASIS-based measures below will be removed from the expanded Model quality measure set:
   i. Discharged to Community (DTC)
   ii. Total Normalized Composite Change in Mobility (TNC Mobility)
   iii. Total Normalized Composite Change in Self-Care (TNC Self-Care)

b. The OASIS-based measures for the expanded Model beginning with the CY 2025 performance year are:
   i. Improvement in Dyspnea (Dyspnea)
   ii. Improvement in Management of Oral Medications (Oral Medications)
   iii. Discharge Function Score (DC Function)

c. ***Claims-based Measures*.** Beginning with the CY 2025 performance year, the two claims-based measures below will be removed from the expanded Model quality measure set:
   i. Acute Care Hospitalizations During the First 60 Days of Home Health (ACH)
   ii. Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (ED Use)

The claims-based measure replacements for the expanded Model beginning with the CY 2025 performance year are:

- Home Health Within-Stay Potentially Preventable Hospitalization (PPH)

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[2] An HHA may request a reconsideration of the *Preliminary APR* if it disagrees with the results of a recalculation request presented in the *Preliminary APR*. HHAs can submit a reconsideration request and supporting documentation via instructions provided by CMS within 15 calendar days after CMS issues the *Preliminary APR*. Only HHAs that submit a recalculation request may submit a reconsideration request.

- Discharge to Community-Post Acute Care (DTC-PAC)

For additional information on these measures, please refer to the following appendices:

- **Appendix D: Applicable Measure Sets: CY 2023 and 2024 Performance Years vs CY 2025 Performance Year for the Expanded HHVBP Model**
- **Appendix E: Measure Weights - CY 2023 and CY 2024 vs CY 2025 Performance Years for the Expanded HHVBP Model**
- **Appendix F: Data Periods Used for CY 2025 Performance Year/CY 2027 Payment Year for the Expanded HHVBP Model**

For questions about these measures, please email the Home Health Quality Help Desk at homehealthqualityquestions@cms.hhs.gov.

Model Baseline Year

Beginning with the CY 2025 performance year, the Model baseline year[3] will be CY 2023 for applicable measures in the measure set, except for the claims-based Discharge to Community-Post Acute Care (DTC-PAC) measure. The DTC-PAC measure uses two years of data. For the DTC-PAC measure, the Model baseline years are CY 2022 and CY 2023 combined. **Exhibit 11** lists the data period for the Model baseline year by applicable measure for the CY 2025 performance year/CY 2027 payment year.

Exhibit 11. Model Baseline Year and Performance Year Data Periods Used for the CY 2025 Performance Year, by Applicable Measure

Measure		Data Period for the Model Baseline Year (CY)	Data Period for the Performance Year (CY)
OASIS-based Measures	Discharge Function Score (DC Function)	2023	2025
	Improvement in Dyspnea	2023	2025
	Improvement in Management of Oral Medications	2023	2025
Claims-based Measures	Potentially Preventable Hospitalizations (PPH)	2023	2025
	Discharge to Community-Post-Acute Care (DTC- PAC)	2022 & 2023	2024 & 2025
HHCAHPS Survey-based Measures	Care of Patients	2023	2025
	Communications Between Providers and Patients	2023	2025
	Specific Care Issues	2023	2025
	Overall Rating of Home Health Care	2023	2025
	Willingness to Recommend the Agency	2023	2025

Q7003. When can competing HHAs expect to start receiving performance data – such as benchmarks, achievement thresholds, and improvement thresholds – for the calendar year (CY) 2025 performance year quality measure set?

To help provide feedback to HHAs on the quality measure set for the calendar year (CY) 2025 performance year, CMS plans to make the most current HHA-specific performance data for the applicable measures, including the achievement thresholds and benchmarks, available to each HHA in iQIES. CMS

[3] The year against which CMS calculates the achievement thresholds and benchmarks values for each quality measure by cohort.

anticipates providing achievement thresholds and benchmarks applicable to the CY 2025 Performance Year in July 2024.

Q7004. What performance year data time periods apply to the Discharge to Community-Post Acute Care (DTC-PAC) claims-based measure that is part of the expanded HHVBP Model applicable measure set starting January 1, 2025?

The calculation of the Discharge to Community-Post Acute Care (DTC-PAC) claims-based measure uses two years of data. **Exhibit 12** shows the Model baseline years and performance year data periods for the DTC-PAC claims-based measure for the calendar year (CY) 2025 and CY 2026 performance years.

Exhibit 12. Performance Year Data Periods for the DTC-PAC Claims-based Measure

Performance Year (CY)	Model Baseline Year (CY)	Performance Year Data Period (CY)	Payment Year (CY)
2025	2022 & 2023	2024 & 2025	2027
2026	2022 & 2023	2025 & 2026	2028

For questions about this measure, please email the Home Health Quality Help Desk at homehealthqualityquestions@cms.hhs.gov.

Appendix A. Measure Set for the Expanded HHVBP Model – CY 2023, CY2024, and Beginning CY 2025 Performance Years

Measure Category	Measure Type and NQS Domains	Measure Title/ Short Form Name CMIT Measure ID CBE Status	CY 2023 & CY 2024	Beginning CY 2025	Data Source	Numerator*	Denominator*	Measure Specifications
OASIS-based	Utilization Outcome and Communication & Care Coordination	Discharged to Community [CMIT Measure ID #00210-01-C-HHVBP (CBE 9999 - not endorsed)]	Yes	No	OASIS (M2410) (M2420)	Number of home health quality episodes where the assessment completed at the discharge indicates the patient remained in the community after discharge (M2420 Response 1 or 2).	Number of home health quality episodes ending with a discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.	Home Health Quality Measures Outcomes Table, 2024
OASIS-based	Outcome – Health and Clinical Quality of Care	Improvement in Dyspnea/Dyspnea [CMIT Measure ID #0369 (CBE 9999 - not endorsed)]	Yes	Yes	OASIS (M1400) (M2420) (M0100)	Number of home health quality episodes where the discharge assessment indicates less dyspnea at discharge than at start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.	Home Health Quality Measures Outcomes Table, 2024 Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 2.0.
OASIS-based	Outcome – Functional and Patient Safety	Improvement in Management of Oral Medications/ Oral Medication [CMIT Measure ID #0371 (CBE 0176 -endorsed)]	Yes	Yes	OASIS (M2020) (M1710) (M1720) (M2420)	Number of home health episodes of care where the value recorded on the discharge assessment indicates less impairment in taking oral medications correctly at discharge than at start (or resumption) of care.	Number of home health episodes of care ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.	Home Health Quality Measures Outcomes Table, 2024 Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 2.0.

APPENDIX A.MEASURE SET FOR THE EXPANDED HHVBP MODEL – CY 2023, CY2024, AND BEGINNING CY 2025 PERFORMANCE YEARS

Measure Category	Measure Type and NQS Domains	Measure Title/ Short Form Name CMIT Measure ID CBE Status	CY 2023 & CY 2024	Beginning CY 2025	Data Source	Numerator*	Denominator*	Measure Specifications
OASIS-based	Outcome - Functional and Patient and Family Engagement	Total Normalized Composite Change in Mobility/TNC Mobility* [CMIT Measure ID #1398 (CBE 9999 - not endorsed)]	Yes	No	OASIS (M1840) (M1850) (M1860)	The total normalized change in mobility functioning across three (3) OASIS items (toilet transferring, bed transferring, and ambulation/locomotion).	A prediction model is computed at the episode level. The HHA mean predicted value and the national mean predicted values are used to calculate the risk adjusted rate for the HHA, which is calculated using this formula: HHA Risk Adjusted = HHA Observed + National Predicted – HHA Predicted.	HHVBP Model Composite Outcome Measures, 10/20/2021 Expanded HHVBP Model: Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures May 2023 Expanded Home Health Value- Based Purchasing (HHVBP) Model Technical Specifications for the Total Normalized Composite (TNC) Change Measures: April 28, 2023
OASIS-based	Outcome - Functional and Patient and Family Engagement	Total Normalized Composite Change in Self-Care/TNC Self-Care* [CMIT Measure ID #1676 (CBE 9999 - not endorsed)]	Yes	No	OASIS (M1800) (M1810) (M1820) (M1830) (M1845) (M1870)	The total normalized change in self-care functioning across six (6) OASIS items (grooming, bathing, upper & lower body dressing, toilet hygiene, and eating).	A prediction model is computed at the episode level. The HHA mean predicted value and the national mean predicted values are used to calculate the risk adjusted rate for the HHA, which is calculated using this formula: HHA Risk Adjusted = HHA Observed + National Predicted – HHA Predicted.	HHVBP Model Composite Outcome Measures, 10/20/2021 Expanded HHVBP Model: Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures May 2023 Expanded Home Health Value- Based Purchasing (HHVBP) Model Technical Specifications for the Total Normalized Composite (TNC) Change Measures: April 28, 2023

Measure Category	Measure Type and NQS Domains	Measure Title/ Short Form Name CMIT Measure ID CBE Status	CY 2023 & CY 2024	Beginning CY 2025	Data Source	Numerator*	Denominator*	Measure Specifications
OASIS-based	Outcome – Health And Patient and Caregiver Centered Experience	Discharge Function Score [CMIT Measure ID #1698 (CBE 9999 - not endorsed)]	No	Yes	OASIS (GG0130A) (GG0130B) (GG0130C) (GG0170A) (GG0170C) (GG0170D) (GG0170E) (GG0170F) (GG0170I) (GG0170J) (GG0170R) (M1021) (M1023) (M1700) (M2420)	Number of home health quality episodes where the observed discharge function score for Section GG function items is equal to or greater than the calculated expected discharge function score.	Number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.	Home Health Quality Measures Outcomes Table, 2024 Discharge Function Score for Home Health (HH) Technical Report, Updated March 2024
Claims-based	Utilization Outcome and Efficiency & Cost Reduction	Acute Care Hospitalization During the First 60 Days of Home Health /ACH [CMIT Measure ID #0012 (CBE 0171 - endorsed)]	Yes	No	CCW (Claims)	Number of home health stays for patients who have a Medicare FFS claim for an unplanned admission to an acute care hospital in the 60 days following the start of the home health stay.	Number of home health stays that begin during the 12-month observation period.	Home Health Quality Measures Outcomes Table, 2024 Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 2.0.
Claims-based	Utilization Outcome and Efficiency & Cost Reduction	Emergency Department Use Without Hospitalization During the First 60 Days of Home Health/ED Use [CMIT Measure ID #0233 (CBE 0173 - endorsed)]	Yes	No	CCW (Claims)	Number of home health stays for patients who have a Medicare FFS 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.	Number of home health stays that begin during the 12-month observation period.	Home Health Quality Measures Outcomes Table, 2024 Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 2.0.

Measure Category	Measure Type and NQS Domains	Measure Title/ Short Form Name CMIT Measure ID CBE Status	CY 2023 & CY 2024	Beginning CY 2025	Data Source	Numerator*	Denominator*	Measure Specifications
Claims-based	Utilization Outcome and Care Coordination	Discharge to Community – Post-Acute Care (DTC-PAC) [CMIT Measure ID #0210 (CBE 3477 - endorsed)]	No	Yes	CCW (Claims)	The risk-adjusted prediction of the number of HH stays resulting in a discharge to the community (Patient Discharge Status codes equal to 01 or 81), without an unplanned admission to an ACH/LTCH or death in the 31-day post-discharge observation window. For DTC-PAC, an HH stay is a sequence of HH payment episodes separated by two or fewer days. A separation between HH payment episodes greater than two days results in separate HH stays.	The risk-adjusted expected number of discharges to community. This estimate includes risk adjustment for patient characteristics with the HHA effect removed. The "expected" number of discharges to community is the predicted number of risk-adjusted discharges to community if the same patients were treated at the average HHA appropriate to the measure. Numerator over denominator times the national observed DTC-PAC rate equals the reported risk-standardized rate.	Home Health Quality Measures Outcomes Table, 2024 Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 2.0.

APPENDIX A.MEASURE SET FOR THE EXPANDED HHVBP MODEL – CY 2023, CY2024, AND BEGINNING CY 2025 PERFORMANCE YEARS

Measure Category	Measure Type and NQS Domains	Measure Title/ Short Form Name CMIT Measure ID CBE Status	CY 2023 & CY 2024	Beginning CY 2025	Data Source	Numerator*	Denominator*	Measure Specifications
Claims-based	Utilization Outcome and Care Coordination	Home Health Within-Stay Potentially Preventable Hospitalization (PPH) [CMIT Measure ID #1222 (CBE 9999 - not endorsed)]	No	Yes	CCW (Claims)	The risk-adjusted prediction of the number of HH stays with at least one potentially preventable hospitalization (i.e., in an ACH/LTCH) or observation stay. For PPH, an HH stay is a sequence of HH payment episodes separated by two or fewer days. A separation between HH payment episodes greater than two days results in separate HH stays.	The risk-adjusted expected number of hospitalizations or observation stays. This estimate includes risk adjustment for patient characteristics with the HHA effect removed. The "expected" number of hospitalizations or observation stays is the projected number of risk-adjusted hospitalizations or observation stays if the same patients were treated at the average HHA appropriate to the measure. Numerator over denominator times the national observed PPH rate equals the reported risk-standardized rate.	Home Health Quality Measures Outcomes Table, 2024 Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 2.0.
HHCAHPS Survey-based Measure	Patient-Reported Outcome-Based Performance and Patient & Caregiver Centered Experience	Home Health Consumer Assessment Healthcare Providers and Systems (HHCAHPS) Survey [CMIT Measure ID #0153 (CBE 0517 - endorsed)]	Yes	Yes	CAHPS	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one CBE-endorsed measure.	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one CBE-endorsed measure.	Home Health Care CAHPS Survey: The official website for news and information about the HHCAHPS Survey Steps for Calculating Global Ratings and Composite Scores for the Home Health Care CAHPS Survey Revised October 2013

*Because the Total Normalized Composite (TNC) Change in Mobility and TNC Change in Self-Care measures are composite measures rather than simply outcome measures, the terms "Numerator" and "Denominator" do not apply. For information on the TNC Change in Mobility and TNC Change in Self-Care measures, see the expanded HHVBP Model resources, "*Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures," "Calculating Episode-Level Predicted Values for the Total Normalized Composite (TNC) Change Measure," "Technical Specifications for the Total Normalized Composite Change Measures - April 2023," and Technical Specifications for the Total Normalized Composite Change Measures – October 2021,"* located on the Expanded HHVBP Model webpage.

Sources include CY 2024 HH PPS final rule, TABLE D1: CURRENT MEASURE SET FOR THE EXPANDED HHVBP MODEL , TABLE D2: PROPOSED MEASURE SET FOR THE EXPANDED HHVBP MODEL

Appendix B. Measure Weighting* and Re-Weighting for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years

Measure Category	Quality Measures	*CY 2023 & CY 2024 Measure Weights*				*Beginning CY 2025 Measure Weights*			
		All Measures	No HHCAHPS	No Claims	No Claims or HHCAHPS	All Measures	No HHCAHPS	No Claims	No Claims or HHCAHPS
OASIS-based Measures	Discharged to Community	5.83%	8.33%	8.98%	16.67%	_	_	_	_
	Improvement in Dyspnea	5.83%	8.33%	8.98%	16.67%	6.00%	8.57%	9.23%	17.14%
	Improvement in Management of Oral Medications	5.83%	8.33%	8.98%	16.67%	9.00%	12.86%	13.84%	25.71%
	TNC Change in Mobility	8.75%	12.5%	13.46%	25.00%	_	_	_	_
	TNC Change in Self-Care	8.75%	12.5%	13.46%	25.00%	_	_	_	_
	Discharge Function Score	_	_	_	_	20.00%	28.57%	30.77%	57.14%
	Total for OASIS-based measures	**35.00%**	**50.00%**	**53.85%**	**100.00%**	**35.00%**	**50.00%**	**53.85%**	**100.00%**
Claims-based Measures	ACH	26.25%	37.5%	0.00%	0.00%	_	_	_	_
	ED Use	8.75%	12.5%	0.00%	0.00%	_	_	_	_
	Discharge to Community – Post-Acute Care (DTC-PAC)	_	_	_	_	9.00%	12.86%	0.00%	0.00%
	Home Health Within-Stay Potentially Preventable Hospitalization (PPH)	_	_	_	_	26.00%	37.14%	0.00%	0.00%
	Total for claims-based measures	**35.00%**	**50.00%**	**0.00%**	**0.00%**	**35.00%**	**50.00%**	**0.00%**	**0.00%**
HHCAHPS Survey-based Measures	Care of Patients	6.00%	0.00%	9.23%	0.00%	6.00%	0.00%	9.23%	0.00%
	Communication Between Providers and Patients	6.00%	0.00%	9.23%	0.00%	6.00%	0.00%	9.23%	0.00%
	Specific Care Issues	6.00%	0.00%	9.23%	0.00%	6.00%	0.00%	9.23%	0.00%
	Overall Rating of Home Health Care	6.00%	0.00%	9.23%	0.00%	6.00%	0.00%	9.23%	0.00%
	Willingness to Recommend the Agency	6.00%	0.00%	9.23%	0.00%	6.00%	0.00%	9.23%	0.00%
	Total for HHCAHPS Survey-based measures	**30.00 %**	**0.00%**	**46.15%**	**0.00%**	**30.00%**	**0.00%**	**46.15%**	**0.00%**

*The weights of the measure categories, when one (1) category is removed, are based on the relative weight of each category when all measures are used. For example, if an HHA is missing the HHCAHPS category, the remaining two (2) measure categories (OASIS-based and claims-based) represent 50% each.

Sources include CY 2024 HH PPS final rule, TABLE D3. CURRENT AND PROPOSED MEASURE CATEGORY WEIGHTS BY QUALITY MEASURE IN THE EXPANDED HHVBP MODEL, TABLE D4. PROPOSED MEASURE WEIGHT REDISTRIBUTIONS FOR HHAS IN THE LARGER-VOLUME AND SMALLER-VOLUME COM

Appendix C. Within-Category Measure Weights for the Expanded HHVBP Model – CY 2023, CY 2024, and Beginning CY 2025 Performance Years

Measure Category	Quality Measures	CY 2023 and CY 2024 Within-category Weight	Beginning CY 2025 Within-category Weight
OASIS-based Measures	Discharged to Community	16.67%	_
	Improvement in Dyspnea	16.67%	17.14%
	Improvement in Management of Oral Medications	16.67%	25.71%
	TNC Change in Mobility	25.00%	_
	TNC Change in Self-Care	25.00%	_
	Discharge Function Score	_	57.14%
Claims-based Measures	ACH	75.00%	_
	ED Use	25.00%	_
	Discharge to Community – Post-Acute Care (DTC-PAC)	_	25.71%
	Home Health Within-Stay Potentially Preventable Hospitalization	_	74.29%
HHCAHPS Survey-based Measures	Care of Patients	20.00%	20.00%
	Communication Between Providers and Patients	20.00%	20.00%
	Specific Care Issues	20.00%	20.00%
	Overall Rating of Home Health Care	20.00%	20.00%
	Willingness to Recommend the Agency	20.00%	20.00%

Sources include **CY 2024 HH PPS final rule**, TABLE D3. CURRENT AND PROPOSED MEASURE CATEGORY WEIGHTS BY QUALITY MEASURE IN THE EXPANDED HHVBP MODEL, TABLE D4. PROPOSED MEASURE WEIGHT REDISTRIBUTIONS FOR HHAS IN THE LARGER-VOLUME AND SMALLER-VOLUME COHORT.

Appendix D. Applicable Measure Sets: CY 2023 and CY 2024 Performance Years vs CY 2025 Performance Year for the Expanded HHVBP Model

Category	Quality Measure	Performance Years	
		CY 2023 & CY 2024	CY 2025
OASIS-based Measures	Discharged to Community	✓	-
	Improvement in Dyspnea	✓	✓
	Improvement in Management of Oral Medications	✓	✓
	Total Normalized Composite (TNC) Change in Mobility	✓	-
	Total Normalized Composite (TNC) Change in Self-Care	✓	-
	Discharge Function Score (DC Function)	-	✓
Claims-based Measures	Acute Care Hospitalization (ACH)	✓	-
	Emergency Department Use without Hospitalization (ED Use)	✓	-
	Home Health Within-Stay Potentially Preventable Hospitalization (PPH)	-	✓
	Discharge to Community- Post Acute Care (DTC-PAC)	-	✓
HHCAHPS Survey-based Measures	Care of Patients	✓	✓
	Communication Between Providers and Patients	✓	✓
	Specific Care Issues	✓	✓
	Overall Rating of Home Health Care	✓	✓
	Willingness to Recommend the Agency	✓	✓

Sources include CY 2024 HH PPS final rule, TABLE D1: CURRENT MEASURE SET FOR THE EXPANDED HHVBP MODEL , TABLE D2: PROPOSED MEASURE SET FOR THE EXPANDED HHVBP MODEL.

Appendix E. Measure Weights – CY 2023 and CY 2024 vs CY 2025 Performance Years for the Expanded HHVBP Model

Measure Category	Quality Measures	*Finalized Redistributions*			
		Current Measure Weights* (CY 2023, CY 2024)		Measure Weights Beginning CY 2025	
		Larger-Volume Cohort	Smaller-Volume Cohort	Larger-Volume Cohort	Smaller-Volume Cohort
OASIS-based Measures	Discharged to Community	5.83%	8.33%	-	-
	Improvement in Dyspnea	5.83%	8.33%	6.00%	8.57%
	Improvement in Management of Oral Medications	5.83%	8.33%	9.00%	12.86%
	TNC Change in Mobility	8.75%	12.5%	-	-
	TNC Change in Self-Care	8.75%	12.5%	-	-
	Discharge Function Score	-	-	20.00%	28.57%
	Sum of OASIS-based measures	**35.00%**	**50.00%**	**35.00%**	**50.00%**
Claims-based Measures	Acute Care Hospitalization	26.25%	37.50%	-	-
	Emergency Department Use	8.75%	12.50%	-	-
	Potentially Preventable Hospitalization	-	-	26.00%	37.14%
	Discharge to Community- Post Acute Care	-	-	9.00%	12.86%
	Sum of Claims-based measures	**35.00%**	**50.00%**	**35.00%**	**50.00%**
HHCAHPS Survey-based Measures	Care of Patients	6.00%	0.00%	6.00%	0.00%
	Communication Between Providers and Patients	6.00%	0.00%	6.00%	0.00%
	Specific Care Issues	6.00%	0.00%	6.00%	0.00%
	Overall Rating of Home Health Care	6.00%	0.00%	6.00%	0.00%
	Willingness to Recommend the Agency	6.00%	0.00%	6.00%	0.00%
	Sum of HHCAHPS Survey-based measures	**30.00 %**	**0.00%**	**30.00%**	**0.00%**
Sum	**Sum of All Measures**	**100.00 %**	**100.00 %**	**100.00 %**	**100.00 %**

*The weights of the measure categories, when one (1) category is removed, are based on the relative weight of each category when all measures are used. For example, if an HHA is missing the HHCAHPS category, the remaining two (2) measure categories (OASIS-based and claims-based) each have a weight of 50%. Source includes CY 2024 HH PPS final rule, TABLE D4. PROPOSED MEASURE WEIGHT REDISTRIBUTIONS FOR HHAS IN THE LARGER-VOLUME AND SMALLER-VOLUME COHORT.

Appendix F. Data Periods Used for CY 2025 Performance Year/CY 2027 Payment Year for the Expanded HHVBP Model

Measure Category	Quality Measures	Data Period	Data Period Used for Model Baseline Year*	Data Period Used for Performance Year	Payment Year
OASIS-based Measures	Discharge Function Score	1-year	CY 2023	CY 2025	CY 2027
	Improvement in Dyspnea	1-year	CY 2023	CY 2025	CY 2027
	Improvement in Management of Oral Medications	1-year	CY 2023	CY 2025	CY 2027
Claims-based Measures	Potentially Preventable Hospitalization	1-year	CY 2023	CY 2025	CY 2027
	Discharge to Community—Post Acute Care	2-year	CY 2022/2023	CY 2024/2025	CY 2027
HHCAHPS Survey-based Measures	Care of Patients	1-year	CY 2023	CY 2025	CY 2027
	Communication Between Providers and Patients	1-year	CY 2023	CY 2025	CY 2027
	Specific Care Issues	1-year	CY 2023	CY 2025	CY 2027
	Overall Rating of Home Health Care	1-year	CY 2023	CY 2025	CY 2027
	Willingness to Recommend the Agency	1-year	CY 2023	CY 2025	CY 2027

* Source includes **CY 2024 HH PPS final rule**.