CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Expanded Home Health Value-Based Purchasing (HHVBP) Model

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Abt

University of Colorado Anschutz Medical Campus

OASISanswers

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List of Exhibits

Introduction

Welcome to the Expanded Home Health Value-Based Purchasing (HHVBP) Model

Per the Calendar Year (CY) 2022 Home Health Prospective Payment System (HH PPS) final rule, the original HHVBP Model ended for home health agencies (HHAs) in the nine (9) participating states as of December 31, 2021. Beginning January 1, 2022, the expanded Model began for all Medicare-certified HHAs in the 50 states, District of Columbia, and U.S. territories.

The Expanded HHVBP Model Guide serves as a resource for competing HHAs in the expanded Model. Before reading this guide, please review the glossary of terms and definitions in Appendix A and acronyms in Appendix B used in the expanded Model. In addition to this Expanded HHVBP Model Guide, CMS provides HHAs with additional resources that are available on the Expanded HHVBP Model webpage. For a list of available resources, please refer to the Expanded HHVBP Model Resource Index.

Communication and Announcements

All agency staff involved with the expanded Model should register for the Expanded HHVBP Model listserv to receive emails about milestones, learning event announcements, and important guidance from CMS. Staff can subscribe to the expanded Model listserv at any time. The steps to subscribe to the listserv are:

1. Navigate to the listserv: https://public.govdelivery.com/accounts/USCMS/subscriber/new.
2. Enter your email address.
3. Select "Home Health Value-Based Purchasing (HHVBP) Expanded Model" from the *Center for Medicare and Medicaid Innovation (CMMI)* section.
4. Click "Submit" at the bottom of the page.

To ensure receipt of email communications about the expanded Model, please add "cmslists@subscriptions.cms.hhs.gov" to your email safe sender list. Listserv subscribers can update subscriptions, modify a password or email address, or stop subscriptions at any time on the listserv page. For assistance with the subscription service, please contact Subscriber Help.

Help Desks

CMS provides information and resources to all HHAs competing in the expanded Model. There are help desks to support HHAs with the navigation of the expanded Model, which are shown in **Exhibit 1.** In addition, there are help desks available to support HHAs with questions about the Home Health Quality Reporting Program (HH QRP) and the Home Health CAHPS Survey (HHCAHPS) (see **Exhibit 2**).

Note: When sending an email to a help desk, please do not send any identifiable patient information through email. Identifiable patient information 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, please include in your email the CMS Certification Number (CCN) and postal address

for your agency to assist with the processing of the inquiry. See **Exhibit 1** and **Exhibit 2** for details on the information to include in your email to a help desk.

Exhibit 1. HHVBP Model and iQIES Help Desks Contact Information

HHVBP Model Help Desk	iQIES Help Desk
Questions related to the Model's implementation, calculations, reports, and available HHVBP resources. Email: HHVBPquestions@cms.hhs.gov	Technical questions related to Internet Quality Improvement and Evaluation System (iQIES) platform registration, navigation, or assistance with accessing reports. Email: iQIES@cms.hhs.gov Phone: 1 (800) 339-9313
When sending an email to either help desk, please include the following information: • Your first and last name • Email address • CCN(s) or Facility ID (do not include Taxpayer Identification Number (TIN)) • Facility/agency name and address • If CCN or Facility ID is unknown, please include facility/agency name and zip code	

Exhibit 2. HH QRP and HHCAHPS Help Desks Contact Information

Home Health Quality Reporting Program Help Desks	
Home Health Quality Help Desk	**Home Health CAHPS (HHCAHPS)**
Questions related to OASIS (Outcome and Assessment Information Set) coding & OASIS documentation, quality reporting requirements & 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), and quality assessment only (QAO)/pay for reporting (P4R). Email: homehealthqualityquestions@cms.hhs.gov	Questions related to the HHCAHPS or the Patient Survey Star Ratings. Email: hhcahps@rti.org Phone: 1 (866) 354-0985

Staying Up to Date

To stay informed about the expanded Model, HHAs may take the following actions:

- Review the HH PPS final rules. See **Exhibit 4** and the final rules' tables of content to locate information on the expanded HHVBP Model.
- Visit and bookmark the Expanded HHVBP Model webpage. Subscribe to the Expanded HHVBP Model listserv as outlined in the "Communication and Announcements" section.
- Confirm agency access to iQIES and confirm all identifying information (e.g., name, address, CCN) in the expanded HHVBP Model reports are accurate. For more information, please review the QIES Technical Support Office webpage for HHAs.
- Access and review the quarterly Interim Performance Reports (IPRs) and the Annual Performance Reports (APRs) available to eligible HHAs in iQIES in the "HHA Provider Preview Reports" folder.
- Review the Model's applicable measure sets by performance year (e.g., Appendix C).
- Contact the HHVBP Help Desk if you have any questions: HHVBPquestions@cms.hhs.gov.

Overview of the HHVBP Model

The Original HHVBP Model

As authorized by section 1115A of the Social Security Act and finalized in the Calendar Year (CY) 2016 Home Health Prospective Payment System (HH PPS) final rule, the CMS Center for Medicare and Medicaid Innovation (CMMI) implemented the HHVBP Model ("original HHVBP Model") in nine (9) states on January 1, 2016. The final performance year for the original HHVBP Model ended on December 31, 2020. The design of the original HHVBP Model leveraged the successes and lessons learned from other CMS value-based purchasing programs and demonstrations to shift from volume-based payments to a model designed to promote the delivery of higher quality care to Medicare and Medicaid beneficiaries. The specific goals of the original HHVBP Model were to:

1. Provide incentives for better quality care with greater efficiency;
2. Study new potential quality and efficiency measures for appropriateness in the home health setting; and
3. Enhance the current public reporting process.

The original HHVBP Model resulted in an average 4.6% improvement in HHAs' Total Performance Scores (TPS) and an average annual savings of $141 million to Medicare without evidence of adverse risks.[1] The evaluation of the original HHVBP Model also found reductions in unplanned acute care hospitalizations (ACH) and skilled nursing facility (SNF) stays, resulting in reductions in inpatient and SNF spending.[2] Based on these findings, the U.S. Secretary of Health and Human Services determined that expansion of the original HHVBP Model would further reduce Medicare spending and improve the quality of care of home health patients. In October 2020, the CMS Chief Actuary certified that expansion of the HHVBP Model, with HHA payment adjustments made in a budget-neutral manner, would produce Medicare savings if expanded to all states. The original HHVBP Model findings were sustained through the end of the original Model, as reported in the Evaluation of the HHVBP Model – Sixth Annual Report published in May 2023.

[1] Arbor Research, L&M Policy Research. Evaluation of the Home Health Value-Based Purchasing (HHVBP) Model: Third Annual Report. September 2020; https://www.cms.gov/priorities/innovation/data-and-reports/2020/hhvbp-thirdann-rpt. Accessed October 9, 2025.

[2] Office of the Actuary. Certification of Home Health Value-Based Purchasing (HHVBP) Model. October 2020; https://www.cms.gov/files/document/ certification-home-health-value-based-purchasing-hhvbp-model.pdf. Accessed October 9, 2025.

The Expanded HHVBP Model

In January 2021, CMS announced the certification of HHVBP for nationwide expansion.[3] The goals of the expanded HHVBP Model (or "expanded Model") continue to focus on improved quality of care without increased spending. The expanded Model incentivizes Medicare-certified HHAs to provide higher quality and more efficient care to beneficiaries within the Home Health Prospective Payment System (HH PPS). Performance is assessed by both achievement and improvement across a set of quality measures. For details about the applicable expanded Model measures by performance year, please refer to Section 4.

The expanded HHVBP Model began on January 1, 2022 and includes Medicare-certified HHAs in the 50 states, District of Columbia, and U.S. territories.

The expanded Model began on January 1, 2022, and includes Medicare-certified HHAs in the 50 states, District of Columbia, and U.S. territories. CMS applies a payment adjustment ranging from negative five percent to positive five percent (–5% to +5%) to an HHA's Medicare fee-for-service (FFS) payments (per claim), based on their performance against a set of quality measures relative to peer performance in the same cohort (Section 2). Performance on these quality measures in a designated year (performance year) impacts payment adjustments in a later year (payment year). See Appendix C for applicable measures.

The first performance year of the expanded HHVBP Model was CY 2023. During each performance year of the expanded Model, CMS assesses each HHA's performance on the quality measures to determine payment adjustment amounts that will be applied to the HHA during the payment year corresponding to the respective performance year. **Exhibit 3** shows the timeline of the expanded Model by performance year and corresponding payment year through CY 2028.

Exhibit 3. Timeline for the Expanded HHVBP Model by Performance Year/Payment Year through CY 2028

Home Health Prospective Payment System (HH PPS) Final Rules

CMS implements the federal regulations governing the expanded Model through rulemaking. Proposed and final HH PPS rules are published annually. The HH PPS final rules have detailed information on the applicable measures, calculations, scoring, and payment adjustments used in the expanded Model for specified performance and payment years. The HH PPS notice of proposed rulemaking (NPRM), with a 60-day public comment period, is published in June or July each year. The HH PPS final rule is published in October or November each year. This

[3] Centers for Medicare & Medicaid Services. CMS Takes Action to Improve Home Health Care for Seniors, Announces Intent to Expand Home Health Value-Based Purchasing Model. January 2021; https://www.cms.gov/newsroom/press-releases/cms-takes-action-improve-home-health-care-seniors-announces-intent-expand-home-health-value-based. Accessed June 4, 2025.

process allows the public to preview and comment on proposed regulations and for CMS to consider updates to the proposed regulations. **Exhibit 4** lists the HH PPS final rules CMS published for CY 2022 through CY 2026, including brief summaries of the changes impacting the expanded Model by final rule year.

Exhibit 4. HH PPS Final Rules Impacting the expanded HHVBP Model

Final Rule	Date Published	Summary of HHVBP Model Changes
CY 2022 HH PPS final rule	November 9, 2021	• CMS finalized the expanded Model. • CMS finalized annual public reporting of quality performance data under the expanded HHVBP Model.
CY 2023 HH PPS final rule	November 4, 2022	• Changed the Model baseline year from CY 2019 to CY 2022 starting in CY 2023. • Changed the HHA baseline year from CY 2019 to CY 2022 for existing HHAs with a Medicare certification date prior to January 1, 2019, and from 2021 to 2022 for HHAs with a Medicare certification date prior to January 1, 2022 starting in the CY 2023 performance year. • Quality measures and measure weights apply to performance years 2023 and 2024, payment years 2025 and 2026.
CY 2024 HH PPS final rule	November 1, 2023	**Updates effective CY 2024** • Codified measure removal factors finalized in the CY 2022 HH PPS final rule. • Added the opportunity to request a CMS Administrator review of reconsideration decisions of the annual TPS and payment adjustment. **Updates effective CY 2025** • Updated the applicable measure set and measure weights, including adding Discharge (DC) Function, Potentially Preventable Hospitalizations (PPH), and Discharge to Community – Post Acute Care (DTC-PAC). • Updated the Model baseline year from CY 2022 to CY 2023.
CY 2025 HH PPS final rule	November 1, 2024	**This rule included no changes to the Expanded HHVBP Model** • Summarized the comments received on a request for information (RFI) related to potential future measure concepts for the expanded HHVBP Model. • Provided an update on potential approaches for integrating health equity into the expanded HHVBP Model.
CY 2026 HH PPS final rule	December 2, 2025	**Updates effective CY 2026** • Removed three (3) HHCAHPS-based quality measures from HHVBP applicable measure set. • Updated applicable measure set and measure weights, including adding OASIS-based Improvement in Bathing, Improvement in Upper Body Dressing, and Improvement in Lower Body Dressing; and claims-based Medicare Spending Per Beneficiary-Post Acute Care (MSPB-PAC). • Summarized the comments received on information (RFI) related to the respecified Falls With Major Injury (FMI) quality measure and potential future changes to the HHCAHPS measure set.

Agency Change of Ownership (CHOW)

If a change in an agency's ownership (CHOW) results in the use of a new CCN, neither the HHA baseline (see Section 3) nor the performance year score will transfer to the new CCN. If the agency continues to use the same CCN used prior to the CHOW, then the HHA baseline and the performance year scores transfer to the new owners.

Billing Process

There are no changes to HHA billing processes due to the expanded HHVBP Model. Under the expanded Model, payment adjustments (or APP) are the amount by which a competing HHA's final Medicare FFS claim payment amount under the HH PPS is changed in accordance with the methodology described in §484.370. The same APP value is applied to each of an agency's Medicare FFS claims with a "through date" in the payment year. Under the expanded Model, CY 2023 was the first performance year and CY 2025 was the corresponding first payment year. CMS applies a payment adjustment of a maximum of five percent (5%) upward or downward in CY 2025 based on HHA performance in CY 2023. CY 2024 was the second performance year and CY 2026 will be the corresponding second payment year. CMS will apply a payment adjustment of a maximum of five percent (5%) upward or downward in CY 2026 based on HHA performance in CY 2024. Similarly,

- CY 2025 is the third performance year and CY 2027 will be the corresponding third payment year. CMS will apply a payment adjustment of a maximum of five percent (5%) upward or downward in CY 2027 based on HHA performance in CY 2025.
- CY 2026 will be the fourth performance year and CY 2028 will be the corresponding fourth payment year. CMS will apply a payment adjustment of a maximum of five percent (5%) upward or downward in CY 2028 based on HHA performance in CY 2026.

CMS applies the payment adjustment percentage to Home Health Prospective Payment System (HH PPS) Medicare claims, which are only available for Medicare (FFS) beneficiaries. Please note that this does not preclude other non-Medicare FFS payers from utilizing an agency's HHVBP annual payment adjustment.

Once CMS calculates the HHA's APP for HHAs eligible for a payment adjustment, the process is as follows for individual HH PPS claims from HHAs 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 claim and returns the remittance advice with the claim. Please note, while the HHVBP adjustment amount is not separately identified on the remittance advice, a QV code may be visible in the MAC's online claim history. The QV code, or Value-based purchasing adjustment amount, is the dollar amount of the difference between the HHA's value-based purchasing adjusted payment and the payment amount that would have otherwise been made. May be a positive or a negative amount.

Note: When there is a Medicare Secondary claim, the HHVBP adjustment is applied to the calculation of what would be Medicare's primary payment. This adjusted amount is then used to calculate the secondary payment. The HHVBP adjustment is not applied directly to the secondary claim.

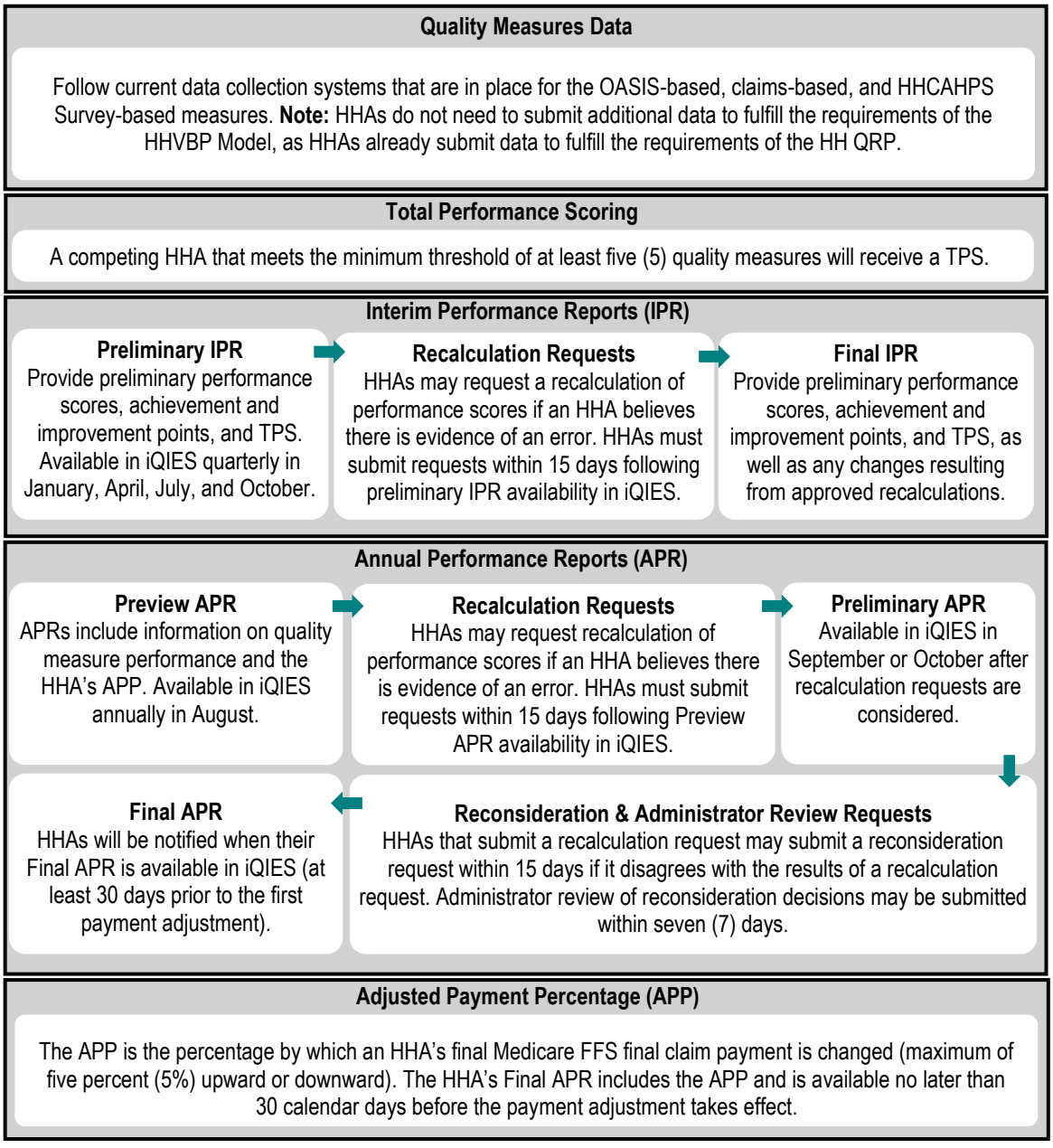
Additionally, applying the sequestration adjustment is the final step in processing a claim. For questions about billing, please visit the Home Health PPS webpage.

Implementation

All Medicare-certified HHAs are subject to Medicare FFS payment adjustments according to expanded Model regulations. Medicare-certified HHAs are not required to enroll/register or submit data (beyond other home health program requirements). The expanded Model encompasses the following four (4) components, which are also outlined in **Exhibit 5**:

1. Quality Measures Data: Section 4
2. Total Performance Scoring: Section 5
3. Payment Adjustment: Section 6
4. Performance Feedback Reports: Interim Performance Reports (IPRs): Section 7.3; Annual Performance Reports (APRs): Section 7.4

Exhibit 5. Expanded HHVBP Model Components



1. Eligibility Criteria

Participation in the expanded Model is mandatory for all Medicare-certified HHAs with a CCN in the 50 states, District of Columbia, and U.S. territories. A "competing HHA" is an HHA that has an active Medicare certification and receives Medicare HH PPS payments from CMS.

All HHAs that are Medicare-certified before January 1, 2022, had their CY 2023 performance assessed and were eligible for a CY 2025 payment adjustment. Please see **Exhibit 6** for additional details on the first possible performance and payment years for Medicare certification dates through CY 2026.

Exhibit 6. First Possible Performance Year/Payment Year by Medicare certification date

Medicare Certification Date	First Possible Performance Year*	First Possible Payment Year
Prior to January 1, 2022	CY 2023	CY 2025
January 1 – December 31, 2022	CY 2024	CY 2026
January 1 – December 31, 2023	CY 2025	CY 2027
January 1 – December 31, 2024	CY 2026	CY 2028
January 1 – December 31, 2025	CY 2027	CY 2029
January 1 – December 31, 2026	CY 2028	CY 2030

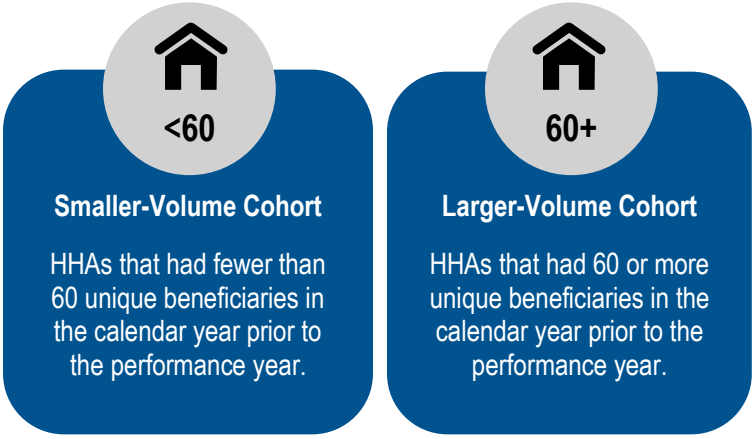
* To be eligible to compete in the first possible performance year based on the Medicare certification date, HHAs must have sufficient data in both the HHA baseline and performance year on at least five (5) measures to create a TPS and APP. More details on Model years such as HHA baseline years, please refer to Section 3. Information on minimum data thresholds by measure category is outlined in Section 5.1.

HHVBP payment adjustments only impact Medicare FFS claims, if a competing HHA does not submit any Medicare FFS claims in a given payment calendar year, no HHVBP payment adjustment will apply for that payment year.

2. Cohorts

For the expanded Model, CMS assigns all HHAs to one of two (1 of 2) nationwide volume-based cohorts: larger-volume cohort or smaller-volume cohort. The assignment of an agency to a cohort is determined by the number of unique beneficiaries served by an HHA with a completed quality episode in the calendar year prior to the performance year. HHAs then compete in either the larger-volume cohort or smaller-volume cohort. This approach groups HHAs that are of similar size and are therefore more likely to receive scores on the same set of measures. Setting benchmarks and achievement thresholds and determining payment adjustments occurs for each cohort. **Exhibit 7** shows the definition of the smaller-volume cohort and larger-volume cohort.

Exhibit 7. Smaller-Volume and Larger-Volume Cohort Definitions



The definition of the beneficiary-based cutoff used to define the two (2) cohorts is derived from the HHCAHPS requirement allowing HHAs that serve fewer than 60 unique HHCAHPS Survey-eligible beneficiaries to request an exemption from participating in the HHCAHPS survey for a given Annual Payment Update (APU) period based on agency size.

Cohort assignments are updated once a year in July based on the calendar year prior to the performance year. Therefore, the assigned cohort for an HHA may change each performance year depending on the beneficiary count during the applicable CY. For example, an HHA with a unique beneficiary count of less than 60 during CY 2024, will be assigned to the smaller-volume cohort for the CY 2025 performance year. If this same HHA experiences an increase to more than 60 beneficiaries in CY 2025, the HHA will be assigned to the larger-volume cohort for the CY 2026 performance year.

CMS believes the use of nationwide smaller- and larger-volume cohorts allows for appropriate groupings of HHAs under the expanded Model by including enough HHAs in each cohort for purposes of setting stable and reliable benchmarks and achievement thresholds and allowing for a wide distribution of (APPs). Using nationwide, rather than state/territory-based cohorts for performance comparisons is consistent with the SNF and Hospital VBP Programs, in addition to the Home Health Care 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 not heavily skewed by outliers. The LEF, which is discussed in Section 6, is designed so that the majority of

the payment adjustment values fall closer to the median and a smaller percentage of HHAs receive adjustments at the higher and lower ends of the distribution. However, when only a small number of HHAs fall within a cohort, one (1) 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 HHVBP 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. Typically, the majority of HHAs fall within the larger-volume cohort. 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 Medicare FFS claims final payment amount adjusted higher (upward maximum of five percent (5%)) 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 Medicare FFS claims final payment amount reduced (downward maximum of five percent (5%). Competing HHAs that perform similarly to others in the same volume-based cohort may receive a small, or no, payment adjustment. Note that the CY 2022 HH PPS final rule outlines the rationale for selecting nationwide cohorts.

3. Model Years

There are several types of years for the Model:

1. Performance year,[4]
2. Payment year,
3. Baseline year (i.e., Model baseline and HHA baseline years).[4]

Each type of model year is described in the following paragraphs.

3.1 Performance Year

Performance year(s) refer to the CY(s) for which CMS uses performance on applicable measures to calculate an HHA's overall performance in the expanded HHVBP Model, referred to as the agency's TPS.

3.2 Payment Year

The payment year is the CY in which the APP for a designated performance year is applied to all Medicare FFS claims. The payment year is two (2) CYs following the performance year (see **Exhibit 3**).

3.3 Baseline Year

CMS uses baseline year(s) for calculations *at the Model level* for each of the two 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**. CMS provides baseline year data to HHAs confidentially via the expanded HHVBP Model's IPRs and APRs as soon as administratively feasible, dependent on the availability of quality measure data.

Model baseline year. The CY(s) used to determine the cohort-specific achievement threshold and benchmark (see Section 5) for each applicable measure is the Model baseline year (see **Exhibit 7**).

HHA baseline year. The CY(s) that CMS uses to compare an HHA's performance score by measure during a performance year and calculate each HHA's unique improvement threshold. CMS determines an HHA's baseline year(s) for each quality measure using the HHA's Medicare-certification date and determining whether the HHA has sufficient data to establish a baseline year(s) for a particular quality measure. For HHAs certified on or after January 1, 2022, the HHA baseline year(s) will be the first full CY(s) of services beginning after the date of Medicare certification if sufficient data are available in that year (see **Exhibit 8**). HHA baseline years refer to the first possible baseline year(s) for each quality measure dependent upon an HHA having 1) full calendar year(s) of data and 2) meeting the minimum data threshold, for

[4] Performance year, Model baseline year, and HHA baseline year cover either one or two calendar years (January 1 – December 31), depending on whether a measure is a one-year or two-year measure (see Section 4 for details on quality measures used in the expanded HHVBP Model. A payment year always refers to one (1) calendar year.

each measure. If an HHA does not have sufficient data for any measure in the first possible baseline year, the following year(s) may qualify to become the HHA baseline year.

An agency's HHA baseline year may differ by measure for multiple reasons. For example:

- The OASIS-based and claims-based measure categories have different minimum data thresholds than the HHCAHPS Survey-based measure category required for computing a measure score. An HHA may have sufficient data for some measure categories and not for others.
- The OASIS-based and claims-based measure categories include different payer populations. Quality episodes that are included in the calculations for OASIS-based measures (e.g., those for Medicare FFS and Medicare Advantage, and Medicaid and managed Medicaid patients) are not included in the calculations for claims-based measures (Medicare FFS only). An HHA may have sufficient data for OASIS-based measures, but not for claims-based measures.
- Measures within the OASIS-based measure category have different measure-specific exclusions. For example, episodes for which the patient, at start/resumption of care, was not short of breath at any time would be excluded from the Improvement in Dyspnea measure but would not (on that basis) be excluded from the Management of Oral Medications measure. An HHA may have sufficient data for some, but not all, measures within a category.

Exhibit 8. Model baseline year and HHA baseline year by performance year/payment year and Medicare certification date

Medicare Certification Date	Performance Year 2023/ Payment Year 2025		Performance Year 2024/ Payment Year 2026		Performance Year 2025/ Payment Year 2027*		Performance Year 2026/ Payment Year 2028*	
	Model Baseline Year	HHA Baseline Year	Model Baseline Year	HHA Baseline Year	Model Baseline Year	HHA Baseline Year	Model Baseline Year	HHA Baseline Year
Prior to January 1, 2022	2022	2022	2022	2022	2023	2023	2023	2023
January 1, 2022 – December 31, 2022	-	-	2022	2023	2023	2023	2023	2023
January 1, 2023 – December 31, 2023	-	-	-	-	2023	2024	2023	2024
January 1, 2024 – December 31, 2024	-	-	-	-	-	-	2023	2025

* Please note that the Performance Years, Model Baseline Years and HHA Baseline Years for Discharge to Community – Post Acute Care (DTC-PAC) and Medicare Spending per Beneficiary - Post Acute Care (MSPB-PAC) are two years, including the year prior to the year listed in this exhibit.

4. Quality Measures

CMS applies principles from the CMS Meaningful Measures Initiative in selecting the applicable measures for inclusion in the expanded Model. A central driver of the Model's quality measure set is to have a broad, high impact on care delivery and support priorities to improve health outcomes, quality, safety, efficiency, and experience of care for patients.

Medicare-certified HHAs are evaluated using measures designed to encompass multiple domains captured in the CMS National Quality Strategy (NQS) and provide future flexibility to incorporate and study newly developed measures over time. Additionally, the expanded Model quality measures strive to encompass a holistic view of the patient beyond a particular disease, functional status, state, or care setting. Moreover, CMS prioritizes outcome measures that have the potential to follow patients across multiple settings, reflect a multi-faceted approach, and foster the intersection of health care delivery and population health.

To minimize provider documentation burden, quality measures used in the expanded Model align with data already submitted by HHAs under the HH QRP and through the process for submitting Medicare FFS claims.

There are no additional data submission requirements for the expanded HHVBP Model.

Three (3) data sources and respective payer sources are used for the expanded Model quality measures: (Outcome and Assessment Information Set) OASIS data, Medicare FFS claims, and HHCAHPS Survey data. **Exhibit 9** describes each measure category, including payer sources used, and **Exhibit 10** provides an overview of applicable measures by performance year.

Exhibit 9. Expanded HHVBP Model Applicable Measure Category Descriptions and Payer Sources

Category Description	Payer Source
OASIS-based Measures	
OASIS-based measures are calculated using data collected via the OASIS instrument submitted by HHAs for Medicare and Medicaid patients (including Medicare Advantage and Medicaid managed care).* OASIS data are used for multiple purposes including quality measure calculation, risk adjustment of quality measures, and payment systems. For more information on OASIS-based quality measures, refer to the CMS Home Health Quality Reporting Program website. Note: Although HHAs are required to collect and submit OASIS data on all patients, regardless of payer effective 7/1/2025 (with a voluntary phase-in period of 1/1/2025 – 6/30/2025), the OASIS-based quality measures in the expanded HHVBP Model will continue to report only data for Medicare FFS, Medicare Advantage (Medicare managed care), Medicaid, and Medicaid managed care. CMS will monitor the all-payer OASIS data and will notify providers when decisions are made for future uses for quality or payment purposes, including if, when or how non-Medicare/non-Medicaid OASIS data will be used for the expanded HHVBP Model.	Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid Managed Care
Claims-based Measures	
Claims-based measures represent a subset of outcome measures used in the HH QRP calculated using Medicare FFS claims data submitted by HHAs and other providers. The claims-based measures evaluate the rate of utilization of specific services that may indicate quality of care concerns within the HHA. For more information on claims-based measures, refer to the CMS Home Health Quality Reporting Program website.	Medicare FFS
HHCAHPS Survey-based Measures	
The HHCAHPS Survey-based measures use data from the Home Health Consumer Assessment of Healthcare Providers and System® (HHCAHPS) Survey and includes the payers of Medicare and Medicaid (including Medicare Advantage and Medicaid managed care). The HHCAHPS Survey, a nationally standardized and publicly reported survey, measures the experiences of patients receiving home health care from Medicare-certified HHAs. The survey has 34 questions administered to a sample of patients who have received at least one (1) skilled visit by the HHA in the sample month and at least two (2) skilled visits in the lookback period. For more information about the HHCAHPS measure, visit the Home Health CAHPS Survey website. *The HHCAHPS Survey-based measures are not included in the TPS calculations for the smaller-volume cohort.*	Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid Managed Care

* HHAs are not required to collect and submit OASIS data for patients under the age of 18, patients receiving maternity services, and patients receiving only personal care, chore, or housekeeping services.

Exhibit 10. Applicable Measure Set by Performance Year

Quality Measure	CY 2023/ CY 2024	CY 2025	CY 2026
OASIS-based Measures			
Discharged to Community	X		
Improvement in Dyspnea	X	X	X
Improvement in Management of Oral Medications	X	X	X
Total Normalized Composite (TNC) Change in Mobility	X		
Total Normalized Composite (TNC) Change in Self-Care	X		
Discharge Function Score (DC Function)		X	X
Improvement in Bathing			X
Improvement in Upper Body Dressing			X
Improvement in Lower Body Dressing			X
Claims-based Measures			
Acute Care Hospitalization (ACH)	X		
Emergency Department Use without Hospitalization (ED Use)	X		
Home Health Within-Stay Potentially Preventable Hospitalization (PPH)		X	X
Discharge to Community-Post Acute Care (DTC-PAC)		X	X
Medicare Spending Per Beneficiary-Post Acute Care (MSPB-PAC)			X
HHCAHPS Survey-based Measures			
Care of Patients	X	X	
Communication Between Providers and Patients	X	X	
Specific Care Issues	X	X	
Overall Rating of Home Health Care	X	X	X
Willingness to Recommend the Agency	X	X	X

The following three (3) sections outline the measures included in each measure category by performance year corresponding to the CY 2023/CY 2024, CY 2025, and CY 2026 applicable measure sets, respectively.

Note: Payment adjustments in the expanded Model apply only to HH Medicare FFS claims. While the data from the OASIS-based and HHCAHPS Survey-based measures come from patients with all Medicare and Medicaid payers, an agency's payment adjustment will be applied only to Medicare HH FFS claims. More on the payment adjustment methodology can be found in Section 6.

4.1 CY 2023/CY 2024 Applicable Measure Set

For **performance year CY 2023/payment year CY 2025** and **performance year CY 2024/payment year CY 2026**, the applicable measure set (CY 2023/CY 2024 applicable measure set) includes five (5) OASIS-based, two (2) claims-based, and five (5) HHCAHPS-based measures, as outlined in the following paragraphs.

OASIS-based Measures

The five (5) OASIS-based measures included in the CY 2023/CY 2024 applicable measure set are:

1. Discharged to Community – One-year (1) measure
2. Improvement in Dyspnea (Dyspnea) – One-year (1) measure
3. Improvement in Management of Oral Medications (Oral Medications) – One-year (1) measure
4. Total Normalized Composite Change in Mobility (TNC Mobility) – One-year (1) measure
5. Total Normalized Composite Change in Self-Care (TNC Self-Care) – One-year (1) measure

Effective in CY 2025, the TNC Mobility and TNC Self-Care measures were replaced by the OASIS-based Discharge Function Score (DC Function) measure. In addition, the OASIS-based Discharged to Community measure was replaced with the claims-based Discharge to Community-Post Acute Care (DTC-PAC) measure.

Claims-based Measures

Claims-based measures are derived from Medicare FFS claims data submitted to CMS for payment purposes by HHAs and other providers. The two (2) claims-based measures included in the CY 2023/CY 2024 applicable measure set are:

1. Acute Care Hospitalizations During the First 60 days of Home Health (ACH) – One-year (1) measure
2. Emergency Department Use without Hospitalization During the First 60 Days of Home Health (ED Use) – One-year (1) measure

Effective in CY 2025, these two (2) measures were retired from the expanded HHVBP Model and replaced with the claims-based measures Home Health Within-Stay Potentially Preventable Hospitalization (PPH) and Discharge to Community-Post Acute Care (DTC-PAC).

HHCAHPS Survey-based Measures

The five (5) HHCAHPS Survey-based measures included in the CY 2023/CY 2024 applicable measure set are:

1. Care of Patients (Professional Care) – One-year (1) measure
2. Communications between Providers and Patients (Communication) – One-year (1) measure

3. Specific Care Issues (Team Discussion) – One-year (1) measure
4. Overall Rating of Home Health Care (Overall Rating) – One-year (1) measure
5. Willingness to Recommend the Agency (Willingness to Recommend) – One-year (1) measure

4.2 CY 2025 Applicable Measure Set

For **performance year CY 2025/payment year CY 2027**, the applicable measure set (CY 2025 applicable measure set) includes three (3) OASIS-based, two (2) claims-based, and five (5) HHCAHPS Survey-based measures, as outlined in the following paragraphs.

OASIS-based Measures

The three (3) OASIS-based measures included in the CY 2025 applicable measure set are:

1. Improvement in Dyspnea (Dyspnea) – One-year (1) measure
2. Improvement in Management of Oral Medications (Oral Medications) – One-year (1) measure
3. Discharge Function Score (DC Function) – One-year (1) measure

Effective in CY 2026, three (3) additional OASIS-based measures will be added to the OASIS-based measure category, namely Improvement in Bathing, Improvement in Upper Body Dressing, and Improvement in Lower Body Dressing.

Claims-based Measures

The two (2) claims-based measures included in the CY 2025 applicable measure set are:

1. Discharge to Community-Post Acute Care (DTC-PAC) – Two-year (2) measure
2. Home Health Within-Stay Potentially Preventable Hospitalizations (PPH) – One-year (1) measure

Effective in CY 2026, one (1) additional claims-based measure will be added to the claims-based measure category, namely the Medicare Spending Per Beneficiary-Post Acute Care (MSPB-PAC) measure.

HHCAHPS Survey-based Measures

The five (5) HHCAHPS Survey-based measures included in the CY 2025 applicable measure set are:

1. Care of Patients (Professional Care) – One-year (1) measure
2. Communications between Providers and Patients (Communication) – One-year (1) measure
3. Specific Care Issues (Team Discussion) – One-year (1) measure
4. Overall Rating of Home Health Care (Overall Rating) – One-year (1) measure
5. Willingness to Recommend the Agency (Willingness to Recommend) – One-year (1) measure

Beginning April 2026, the Center for Medicare (CM) has proposed changes to the HHCAHPS survey. These changes affect the survey questions used to calculate the Care of Patients, Communications between Providers and Patients, and Specific Care Issues measures. A full year of data for the revised HHCAHPS Survey-based measures will not be available until CY 2027. Given these changes, the affected measures will not be included in the applicable measure set for CY 2026.

4.3 CY 2026 Applicable Measure Set

For **performance year CY 2026/payment year CY 2028**, the applicable measure set (CY 2026 applicable measure set) includes six (6) OASIS-based, three (3) claims-based, and two (2) HHCAHPS Survey-based measures, as outlined in the following paragraphs.

OASIS-based Measures

The six (6) OASIS-based measures included in the CY 2026 applicable measure set are:

1. Improvement in Dyspnea (Dyspnea) – One-year (1) measure
2. Improvement in Management of Oral Medications (Oral Medications) – One-year (1) measure
3. Improvement in Bathing (Bathing) – One-year (1) measure
4. Improvement in Upper Body Dressing (Upper Body Dressing) – One-year (1) measure
5. Improvement in Lower Body Dressing (Lower Body Dressing) – One-year (1) measure
6. Discharge Function Score (DC Function) – One-year (1) measure

Claims-based Measures

The claims-based measures include the following three (3) measures in the CY 2026 applicable measure set:

1. Discharge to Community-Post Acute Care (DTC-PAC) – Two-year (2) measure
2. Home Health Within-Stay Potentially Preventable Hospitalizations (PPH) – One-year (1) measure
3. Medicare Spending Per Beneficiary-Post Acute Care (MSPB-PAC) – Two-year (2) measure

HHCAHPS Survey-based Measures

The two (2) HHCAHPS Survey-based measures included in the CY 2026 applicable measure set are:

1. Overall Rating of Home Health Care (Overall Rating) – One-year (1) measure
2. Willingness to Recommend the Agency (Willingness to Recommend) – One-year (1) measure

4.4 Additional Notes by Measure Category

The following resource lists provide links to resources with additional information by measure category. For the complete list of applicable measures included in the CY 2023/CY 2024, CY 2025, and CY 2026 applicable measure sets, respectively, please refer to Appendix C.

OASIS-based Measures

- Please refer to the "Home Health Outcome Measures Table" for detailed descriptions of the OASIS-based measures (see "Downloads" section on the Home Health Quality Measures webpage);
- For additional information on OASIS-based measures, including measure exclusions, please refer to the CMS Home Health Quality Reporting Program website; and
- For additional information about risk adjustment under the expanded Model, please refer to the resources on the Expanded HHVBP Model webpage, under "Quality Measures."
- As further outlined in Section 5, the minimum threshold of data an HHA must have for each applicable OASIS-based measure to receive a measure score is 20 home health quality episodes.

Claims-based Measures

- For more information on claims-based measures, refer to the Home Health Outcome Measures Table available on the CMS Home Health Quality Reporting Program website; and
- For additional information about risk adjustment under the expanded Model, please refer to the resources on the Expanded HHVBP Model webpage, under "Quality Measures."
- As further outlined in Section 5, the minimum threshold of data an HHA must have for each applicable claims-based measure to receive a measure score is 20 home health stays.

HHCAHPS Survey-based Measures

- For more information, visit the Home Health Care CAHPS Survey website and the Expanded HHVBP Model webpage, under "HHVBP Resources – Quality Measures."
- As further outlined in Section 5, the minimum threshold of data an HHA must have for each applicable HHCAHPS Survey-based measure to receive a measure score is 40 completed surveys. Note: HHCAHPS Survey-based measures are not included in the TPS calculations for the smaller-volume cohort.

5. Total Performance Scoring Methodology

The goal of the total performance scoring methodology is to produce a Total Performance Score (TPS). The TPS is a numeric score awarded to each qualifying HHA that ranges between zero (0) and one hundred (100). It is derived from the HHA's performance on the expanded Model's applicable measure set. An HHA qualifying for a TPS has sufficient data in the baseline year and the performance year and meets the minimum threshold of data for each measure category (see Section 5.2). CMS uses the TPS for all HHAs in a cohort to determine an annual distribution of value-based payment adjustments among HHAs in each cohort. For more information on cohorts, please refer to Section 2. The total performance scoring methodology under the expanded Model aligns with those adopted for other Medicare value-based purchasing programs. **Exhibit 11** summarizes the steps for determining the TPS.

Exhibit 11. Expanded HHVBP Model TPS Calculation Steps

Step	Description
1	For each HHA, a risk-adjusted performance score for each applicable measure is calculated using performance year data. Refer to Section 5.1 for details on minimum data thresholds by measure category.
2	For each applicable measure, an achievement score, or achievement points, is calculated using the cohort achievement threshold and benchmark. Achievement points are a numeric value between zero (0) and 10, which quantify HHA performance on a given quality measure compared to HHAs in the same cohort. Refer to Section 5.2 for additional details on this step.
3	For each applicable measure, an improvement score, or improvement points, is calculated using the HHA improvement threshold. Improvement points are a numeric value between zero (0) and nine (9), which quantifies HHA quality measure performance during the performance year compared to quality measure performance during the HHA baseline year. Refer to Section 5.3 for additional details on this step.
4	CMS identifies the higher of each HHA's achievement or improvement score for each applicable measure, which become care points. Refer to Section 5.4 for additional details on this step.
5	The TPS is calculated by summing weighted care points from the total number of quality measures available with sufficient data, if the minimum threshold of five (5) quality measures is met. Refer to Section 5.5 and Section 5.6 for measure category weights by applicable measure set. See Section 5.7 for additional details on calculating an HHA's TPS.

5.1 Minimum Data Thresholds

The calculation of a TPS requires an HHA to have sufficient measure data. The following is the minimum data threshold in which an HHA must have for each applicable measure per reporting period to receive a measure score in the baseline year and performance year period:

- OASIS-based measures: 20 home health quality episodes.
- Claims-based measures: 20 home health stays.
- HHCAHPS Survey-based measures (for the larger-volume cohort only): 40 completed surveys.

Note: 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 applicable measures.

5.2 Calculation of Achievement Points

During the performance year data period for each applicable measure, an HHA will receive an achievement score, quantifying the HHAs' 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.

The following paragraphs outline the key components of calculating a quality measure's achievement points (also called achievement score).

Achievement Thresholds and Benchmarks

Achievement thresholds are the median (50th percentile) of all HHAs' performance scores on each quality measure within each cohort during the Model baseline year(s) (e.g., CY 2022 for performance year CY 2024). A simplified way of thinking about the achievement threshold is that 50% of HHAs have scores below this value and 50% of HHAs have scores above this value.

Benchmarks are the mean of the top decile (90th percentile) of all HHAs' performance scores on each quality measure within each cohort during the Model baseline year(s) (e.g., CY 2022 for performance year CY 2024). CMS uses the benchmark for calculating both the achievement score and the improvement score.

Please refer to Section 3.3 for the calendar years used to calculate achievement thresholds and benchmarks by applicable measure set.

Achievement Score

The achievement thresholds and benchmarks for each cohort are used to calculate the achievement scores (also referred to as achievement points) for each measure. An HHA can earn between zero (0) and 10 achievement points for each applicable measure based on its performance during the performance year(s), relative to other HHAs in its cohort in the designated baseline year (e.g., CY 2022 for performance year CY 2024). CMS calculates an achievement score separately for each applicable measure using the formula in **Exhibit 12**.

Exhibit 12. Achievement Score Formula

$$Achievement\ Score = 10x\ \left(\frac{HHA\ Performance\ Score - Achievement\ Threshold}{Benchmark - Achievement\ Threshold}\right)$$

CMS rounds each measure's achievement points to the third decimal point. Rounding ensures precision in scoring and ranking HHAs within each cohort. To ensure the achievement score falls within the range of zero (0) and 10 points, CMS applies the following rules to the achievement score calculation (visually depicted in **Exhibit 13**).

For measures where a higher measure value indicates better performance, including all OASIS-based, the claims-based DTC-PAC measure, and all HHCAHPS Survey-based measures:

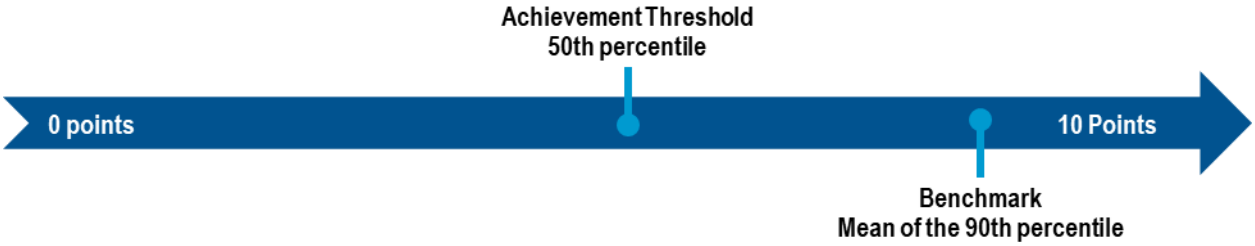
- An HHA with an HHA performance score greater than or equal to the benchmark receives the maximum of 10 points for achievement.
- An HHA with an HHA performance score greater than the achievement threshold (but below the benchmark) receives greater than zero (0) but less than 10 points for achievement (prior to rounding), 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 measures where a higher measure value indicates worse performance, including, the claims-based ACH, PPH, and MSPB-PAC measures:

- An HHA with an HHA performance score less than or equal to the benchmark receives the maximum of 10 points for achievement.
- An HHA with an HHA performance score less than the achievement threshold (but above the benchmark) receives greater than zero (0) but less than 10 points for achievement (prior to rounding), by applying the achievement score formula.
- An HHA with an HHA performance score that is higher than or equal to the achievement threshold receives zero (0) points for achievement.

Exhibit 13. Achievement Score Rules



5.3 Calculation of Improvement Points

During the performance year for each applicable measure, an HHA will receive an improvement score, quantifying the HHAs' 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. The following paragraphs outline the key components of calculating a quality measure's improvement points (also called improvement score).

Improvement Thresholds

Improvement threshold is an individual competing HHA's performance score on an applicable measure during the HHA baseline year.

The HHA's baseline year performance score on each applicable measure is also known as the "improvement threshold." Once the HHA baseline year is established for a given measure, the HHA baseline year and resultant improvement threshold value remains the same for all associated performance years. For the improvement threshold to be calculated on each applicable measure an HHA must have for each measure 1) a full calendar year of data two (2) years of data for DTC-PAC and MSPB-PAC) and 2) meet the minimum data threshold.

Please refer to Section 3.3 for the calendar years used to calculate improvement thresholds by applicable measure set.

Improvement Score

To determine each HHA's level of performance on each applicable measure in the performance year(s) relative to its own performance in the baseline year(s), CMS calculates the improvement score (also referred to as improvement points) for each measure. HHAs receive points along an

improvement range, which is a scale between each HHA's performance during the HHA baseline year(s) (i.e., their improvement threshold) and the benchmark. This benchmark is the same benchmark used in the achievement score calculation. To incentivize all HHAs to provide high-quality care, CMS allows fewer maximum points for improvement than achievement within the context of the expanded Model; HHAs can earn between zero (0) and nine (9) improvement points for each applicable measure. These points are based on the degree of improvement in an HHA's performance score relative to its own improvement threshold and the difference between the benchmark and the HHA's improvement threshold.

CMS calculates the improvement score separately for each applicable measure using the formula in **Exhibit 14**.

Exhibit 14. Improvement Score Formula

$$Improvement\ Score = 9x\left(\frac{HHA\ Performance\ Score - Improvement\ Threshold}{Benchmark - Improvement\ Threshold}\right)$$

Like achievement points, CMS rounds improvement points for each measure to the third decimal point. To ensure the improvement score falls within the range of zero (0) to nine (9) points, CMS applies the following rules to the improvement score calculation (see **Exhibit 15**).

For measures where a higher measure value indicates better performance, including all OASIS-based, the claims-based DTC-PAC measure, and all HHCAHPS Survey-based measures:

- If the HHA performance score is greater than or equal to the benchmark and the improvement threshold is below the benchmark, the HHA receives an improvement score of nine (9) points.
- If the HHA performance score and improvement threshold are greater than the benchmark, the HHA receives an improvement score of zero (0) points.
- If the HHA performance score is greater than its improvement threshold but below the benchmark (within the improvement range), the HHA receives an improvement score that is greater than zero (0) and less than nine (9) (before rounding), based on the improvement score formula.
- If the HHA performance score is less than or equal to its improvement threshold for the measure, the HHA receives zero (0) points for improvement.

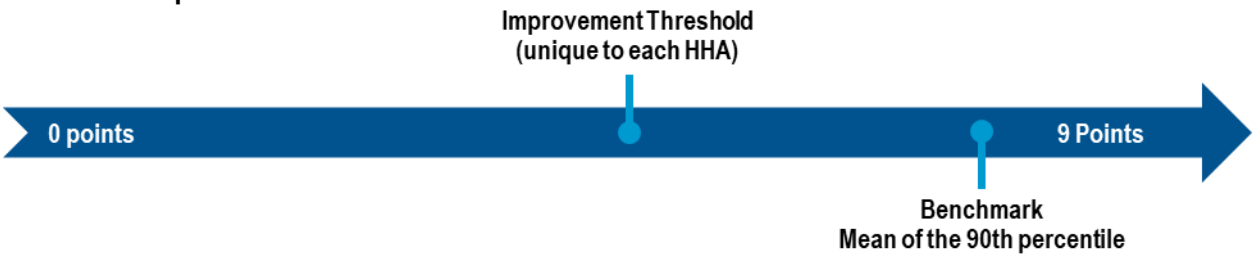
For measures where a higher measure value indicates worse performance, including, the claims-based ACH, PPH, and MSPB-PAC measures:

- If the HHA performance score is less than or equal to the benchmark and the improvement threshold is above the benchmark, the HHA receives an improvement score of nine (9) points.
- If the HHA performance score and improvement threshold are less than the benchmark, the HHA receives an improvement score of zero (0) points.
- If the HHA performance score is less than its improvement threshold but above the benchmark (within the improvement range), the HHA receives an improvement score that

is greater than zero (0) and less than nine (9) (before rounding), based on the improvement score formula.

- If the HHA performance score is greater than or equal to its improvement threshold for the measure, the HHA receives zero (0) points for improvement.

Exhibit 15. Improvement Score Rules



Please refer to Appendix E for examples of calculating achievement and improvement scores.

5.4 Calculation of Care Points

HHA achievement points and improvement points for each measure are compared. The higher of achievement points or improvement points for each measure become care points.

Note that care points for each measure are weighted before they are summed up to create an HHA's TPS. The following two sections outline the details on measure category weighting by applicable measure sets and measure re-weighting if one (1) or more measure categories are missing.

5.5 Measure Category Weighting

Each measure category (i.e., OASIS-based, claims-based, or HHCAHPS Survey-based) has a designated weight. Measures within a measure category may have different weights relative to one another. Within-measure category weights by measure set are further outlined in Appendix D. The following paragraphs in this section focus on describing measure category weights for the CY 2023/ CY2024, CY 2025, and CY 2026 measure sets, respectively.

- In CY 2023/ CY 2024, there are 12 quality measures in the expanded Model's applicable measure set, which includes five (5) OASIS-based measures, two (2) 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, accounting for 100% of the TPS.
- Beginning in CY 2025, there are 10 quality measures in the expanded Model's applicable measure set, which includes three (3) OASIS-based measures, two (2) claims-based measures, and five HHCAHPS Survey-based measures. The OASIS-based, claims-based, and HHCAHPS Survey-based measure categories are weighted 35%, 35%, and 30% respectively, accounting for 100% of the TPS.
- Beginning in CY 2026, there will be 11 quality measures in the expanded Model's applicable measure set, which will include six OASIS-based measures, three claims-based measures, and two HHCAHPS Survey-based measures. The OASIS-based, claims-

based, and HHCAHPS Survey-based measure categories will be 40%, 40%, and 20% respectively, accounting for 100% of the TPS.

5.6 Measure Re-Weighting

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 larger-volume cohort HHA has sufficient data for OASIS-based and claims-based measures but not HHCAHPS Survey-based measures in the CY 2024 performance year, the OASIS-based and claims-based measure categories each count for 50%. If two (2) measure categories are missing, the remaining category is weighted at 100%. For more information on measure weights and redistribution of weights when one or two measure categories are missing, refer to Appendix E.

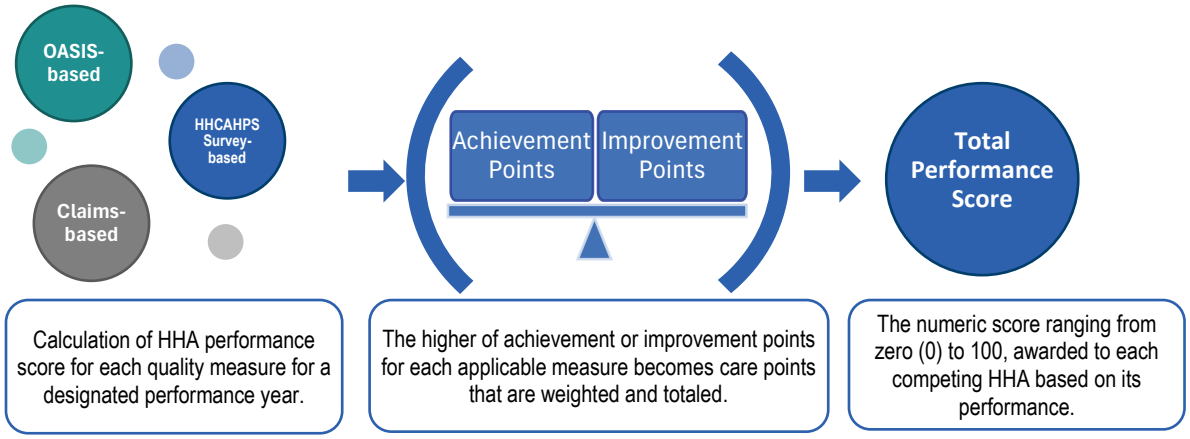
- For within-category measure weights and redistribution of weights when one (1) or two (2) measure categories are missing related to the CY 2023/CY 2024 applicable measure set, refer to Appendix D, **Exhibit D-1**.
- For within-category measure weights and redistribution of weights when one (1) or two (2) measure categories are missing related to the CY 2025 applicable measure set, refer to Appendix D, **Exhibit D-2**.
- For within-category measure weights and redistribution of weights when one (1) or two (2) measure categories are missing related to the CY 2026 applicable measure set, refer to Appendix D, **Exhibit D-3**.

5.7 Total Performance Score Calculation

An HHA's TPS is defined as the sum of weighted care points from the total number of quality measures available with sufficient data, if the minimum threshold of five (5) quality measures is met. The TPS, in addition to the factors used in its calculation, are reported to HHAs in quarterly IPRs and APRs. If an HHA does not have sufficient data to generate care points for at least five (5) of the applicable measures, a TPS will not be calculated. These HHAs will still receive IPRs and are eligible to compete for payment adjustments in the future. The steps used for TPS calculation are shown in **Exhibit 16**.

An HHA must have sufficient data to allow calculation of at least five of the total measures in the baseline year and performance years to receive a TPS and be eligible for a payment adjustment.

Exhibit 16. TPS Components and Calculations



Calculation of Weighted Measure Points

Measure weights are specific to each quality measure category and to individual measures within a category. Measure weights are redistributed proportionally when one (1) or more categories of measures or measures within a category are not applicable (e.g., due to having insufficient data to report a measure or measure category). See Section 5.5 for details on measure category weighting and Section 5.6 for measure re-weighting if one (1) or more measure categories are missing.

For each competing HHA, and for each applicable measure, measure weights are applied using the following formula in **Exhibit 17**:

Exhibit 17. Weighted Measure Points Formula

$$\left(\frac{Care\ Points}{Maximum\ Possible\ Care\ Points}\right)\ x\ Measure\ Weight = Weighted\ Measure\ Points$$

Sum of Weighted Measure Points

Per the final step in calculating the TPS outlined in **Exhibit 10**, each HHA with at least five (5) and up to the total number of applicable measures is assigned a TPS, which is the sum of the HHA's weighted measure points (or weighted care points). For additional information about the expanded Model TPS methodology, please see the resources available on the Expanded HHVBP Model webpage, under "HHVBP Resources – Total Performance Score & Payment Adjustment."

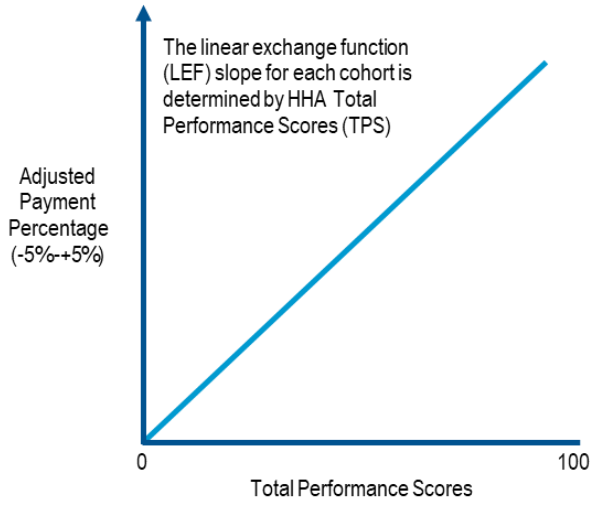
6. Payment Adjustment Methodology

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. Under the expanded HHVBP Model, CY 2023 was the first performance year and CY 2025 is the first payment year in which an HHA is eligible to receive a payment adjustment.

CMS applies the APP for all eligible HHAs to their Medicare FFS payments. If the payment percentage is positive, the payment amount increases according to the APP. If the payment percentage is negative, the agency's payment amount decreases according to the APP. For eligible HHAs, the APP ranges from minus five percent (-5%) to plus five percent (+5%) and is applied to final Medicare FFS payments in the payment year. Medicare PPS payment adjustments are not made to aggregate revenue but occur for each final Medicare FFS claim an agency submits for claims with a payment episode "through date" in the expanded Model payment year. CMS will notify HHAs of their payment adjustment percentage via the Preview and Preliminary APR prior to issuing the Final APR in iQIES.

An equation known as the linear exchange function (LEF) is used to translate each HHA's TPS into an HHA's payment adjustment percentage, as shown in **Exhibit 18**.

Exhibit 18. Payment Adjustment Methodology



The amount of each HHA's payment adjustment depends on two (2) factors:

1. The HHA's TPS, and
2. The performance of other HHAs in the assigned cohort: An HHA's performance relative to the performance of its cohort is a key factor in determining the LEF that works as another driver in the calculation of each HHA's payment adjustment. The LEF is designed so the majority of the payment adjustment percentages fall closer to the median and a smaller percentage of HHAs will have the highest or lowest level of payment adjustments. HHAs that have a TPS that is average in relationship to other HHAs in their cohort would not receive any payment adjustment.

6.1 Adjusted Payment Percentage Calculation

The payment year LEF ratio is calculated separately for each expanded HHVBP Model cohort, based on the following steps, as shown in **Exhibit 19**. Note that references to columns (e.g., Column C2) in this exhibit refer to the columns in the table found on the "Annual Payment Adjustment" tab in the APR.

Exhibit 19. Linear Exchange Function (LEF) Calculation

Step	Description
1	**Determine the HHA's Prior Year Payment** • For each HHA, the Prior Year Payment (Column C2) is the total Medicare FFS home health claims payment for the year prior to the performance year.
2	**Determine the HHA Unadjusted Payment Amount** • For each HHA, the HHA Unadjusted Payment Amount (Column C3) is calculated by multiplying the five percent (5%) maximum payment percentage by the Prior Year Payment in Step 1 (Column C2). • The total Unadjusted Payment Amount for all HHAs in the cohort is in the row below (Sum C3).
3	**Determine the HHA TPS-Adjusted Payment Amount** • For each HHA, the HHA TPS Adjusted Payment Amount (Column C4) is calculated by dividing the TPS (Column C1) by 100 and multiplying it by the Unadjusted Payment Amount (Column C3). • The total TPS-Adjusted Payment Amount for all HHAs in the cohort is in the row below (Sum C4). • As the maximum payment adjustment in the expanded HHVBP Model is five percent (5%), CMS takes the excess from the agencies with more than five percent (5%) and applies this excess to the cohort-level TPS-Adjusted Payment Amount. This redistributes performance payments across all remaining HHAs within each cohort to finalize the LEF. This TPS-Adjusted Payment amount (including the excess greater than five percent (5%)) is then used to calculate the agency and cohort LEF Ratio (Column 5). The LEF (adjusted to account for the excess greater than five percent(5%)) is then used to calculate the agency and cohort values for (Columns 6, 7, 8) as described in the rows below. This is done to ensure budget neutrality.
4	**Calculate the Linear Exchange Function (LEF) Ratio (Column C5)** • Divide the cohort-level Unadjusted Payment Amount (Column C3) by the cohort-level TPS- Adjusted Payment Amount (Column C4). This is the Linear Exchange Function (LEF) Ratio. The LEF ratio is the same for each HHA in the respective cohort.
5	**Determine the HHA Final TPS-Adjusted Payment Amount** • The HHA Final TPS-Adjusted Payment Amount (Column C6) is calculated by multiplying the HHA TPS-Adjusted Payment Amount (Column C4) by the LEF Ratio (Column C5).
6	**Determine the HHA TPS-Adjusted Payment Percentage** • The HHA TPS-Adjusted Payment Percentage (Column C7) is calculated by dividing the HHA TPS- Adjusted Payment Amount (Column C6) by the Prior Year Payment (Column C2). This represents the gross payment percentage applicable to your HHA without accounting for the five percent (5%) payment reduction.
7	**Determine the HHA Final TPS-Adjusted Payment Percentage (APP)** • Subtract five percent (5%) from the HHA TPS-Adjusted Payment Percentage (Column C7). • The Final TPS-Adjusted Payment Percentage (Column C8) is capped at positive or negative five percent (+/- 5%).

Each competing HHA will receive their HHA-specific TPS and APP calculations, in addition to the respective aggregate cohort statistics, in the APR.

For additional information about the expanded Model payment adjustment methodology, please see the resources available on the Expanded HHVBP Model webpage, under "HHVBP Resources – Total Performance Score & Payment Adjustment."

7. Performance Feedback Reports

CMS publishes two (2) types of regular reports that provide HHAs information on their performance and APP.

- The first report type is the Interim Performance Report (IPR), issued quarterly (see Section 7.3). The information in the IPR reflects calculation of the TPS based on rolling data periods that are updated each quarter. CMS issues two (2) versions of the IPR – a Preliminary version and a Final version. Note that the Final version replaces the Preliminary version.
- The second report is the Annual Performance Report (APR) (see Section 7.4). The APR provides HHAs with information on their measure performance in the expanded Model, based on data from the prior calendar year(s). 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. Resources specific to expanded Model reports are available on the Expanded HHVBP Model webpage under "HHVBP Resources – Model Reports."

> The OASIS Quality Improvement reports (e.g., Outcome Report, Outcome Tally Report, Review & Correct Report) currently available in iQIES provide quality data earlier than the expanded HHVBP Model-specific performance reports because the iQIES generated reports are not limited by a quarterly run-out of data and a calculation of competing peer-rankings.

Expanded Model IPRs and APRs are only available to HHAs through iQIES. CMS does not make IPRs and APRs publicly available. iQIES users authorized to view an HHA's OASIS Quality Report will be notified via email (GovDelivery) of the distribution of HHVBP performance feedback 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.

CMS will send an email through the iQIES listserv and through the Expanded HHVBP Model listserv announcing the availability of the reports in iQIES. Instructions on how to access the HHVBP Model reports are available in the document titled *"Expanded HHVBP Model Reports – Access Instructions,"* located on the Expanded HHVBP Model webpage under "HHVBP Resources – Model Reports." Final reports are available in iQIES for 730 days after publication, then archived. After this period, HHAs must email iqies@cms.hhs.gov to request their report. The IPRs and APRs are designed to drive quality improvement and to complement other quality data resources provided through iQIES and other quality tracking systems (e.g., vendor-supported systems, benchmarking systems, and private payer systems).

In addition to the HHVBP performance feedback reports, HHAs also have a variety of reports from the HH QRP available in iQIES, such as the Quality of Patient Care Star Ratings report. These reports contain details on agency performance on a variety of quality measures, including those used in the expanded Model.

These reports can inform an HHA's current Quality Assurance and Performance Improvement (QAPI) programs. QAPI programs are required for HHAs under the HH Conditions of Participation (CoPs) §484.65. 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 review data in the quarterly IPRs to assess performance throughout each performance year. Quality improvement resources designed to support HHAs with improving performance in the expanded Model are available on the Expanded HHVBP Model webpage under "HHVBP Resources – Quality Improvement."

7.1 Report Timing

CMS issued the first IPR in July 2023 and the first APR in August 2024. A summary of the timeline for IPRs and the APR through October 2027, by report and measure category is available in **Exhibit 20**. The measure performance period for each report covers 12 months of performance data for each one (1) year quality measure and 24 months of performance data for each two (2) -year quality measure. Note that data collection periods differ among the types of measures, resulting in differences in data availability by measure category.

Exhibit 20. End of Performance Period by Measure Category and Report

Report Title	OASIS-based Measures*	Claims-based and HHCAHPS Survey-based Measures*
January 2025 IPR	9/30/2024	6/30/2024
April 2025 IPR	12/31/2024	9/30/2024
July 2025 IPR**	3/31/2025	12/31/2024
CY 2025 APR	**12/31/2024**	**12/31/2024**
October 2025 IPR***	6/30/2025	3/31/2025
January 2026 IPR	9/30/2025	6/30/2025
April 2026 IPR	12/31/2025	9/30/2025
July 2026 IPR	3/31/2026	12/31/2025
CY 2026 APR	**12/31/2025**	**12/31/2025**
October 2026 IPR****	6/30/2026	3/31/2026
January 2027 IPR	9/30/2025	6/30/2026
April 2027 IPR	12/31/2026	9/30/2026
July 2027 IPR	3/31/2026	12/31/2026
CY 2027 APR	**12/31/2026**	**12/31/2026**
October 2027 IPR	6/30/2027	3/31/2027

*The reporting period for all measures is 12 months except for DTC-PAC and MSPB-PAC claims-based measures which are 24 months.
**For the OASIS-based measures included in the CY 2024 measure set but not included in the CY 2025 measure set (i.e., Discharged to Community, TNC Change in Mobility, and TNC Change in Self-Care), the reporting period will cover 12 months of data ending December 31, 2024.
***The October 2025 IPR will be the first performance report that calculates an agency's TPS based on the CY 2025 measure set.
****The October 2026 IPR will be the first performance report that calculates an agency's TPS based on the CY 2026 measure set.

7.2 Important Notes about the Expanded HHVBP Model Reports

As defined in the CY 2022 HH PPS final rule, participation in the expanded Model is based on the HHA's CCN. The calculations of the TPS and APP use data reported under the HHA's CCN. Reports are available by the HHA's CCN. If your HHA has more than one (1) CCN, then a report will be available for each CCN.

CMS will provide IPRs to all eligible HHAs with sufficient data in both the baseline and performance year(s) for at least one quality measure in the reporting period. The quality measure values reported in the IPRs and APRs may differ from those displayed on Care Compare or on other quality improvement reports in iQIES. The differences may result from different data collection dates between the IPRs and the iQIES quality improvement reports or small discrepancies that may result from differences in the dates that the source data used when the measures were extracted.

The primary difference between the OASIS quality improvement reports currently available on iQIES and the HHVBP Model-specific performance reports is that the HHVBP Model IPRs and APRs consolidate the performance measures used in the expanded Model, provide a peer-ranking to other competing HHAs within the same volume-based cohort, and provide the TPS.

Values for OASIS-based measures reported in the expanded Model performance reports 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.

There are several reasons why an HHA's data on vendor reports may be different from what is reported in HHVBP Model reports. These include, but are not limited to, the following:

- Timing of data submissions and data corrections, and when data are extracted
- Time frame covered by the data,
- Risk adjustment model used,
- Application of measure exclusions, or
- Formulas and rounding rules used when calculating values.

Be advised that CMS cannot provide guidance on data, analysis, or reports from software or data benchmarking vendors.

7.3 Interim Performance Report (IPR)

The quarterly IPR contains information on interim quality measure performance based on the 12 most recent months of data available (24 months for DTC-PAC and MSPB-PAC). The IPR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. In addition, the IPR provides HHAs an ongoing opportunity to assess and track their performance relative to peers in their respective cohort. Updated cohort assignments will be recalculated annually and made available in the July IPR.

As of July 2023, quarterly IPRs have been available to each HHA in iQIES if the HHA:

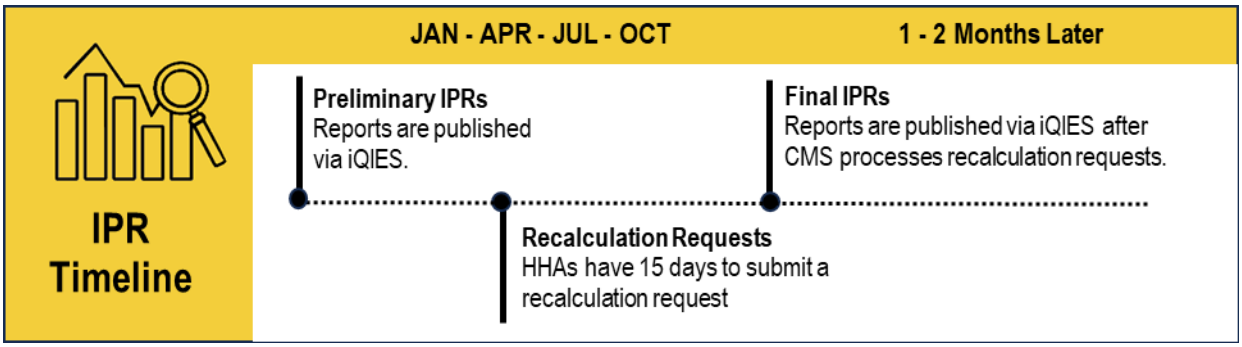
- Was Medicare–certified by the end of the calendar year that is two years prior to the performance year; and
- Meets the minimum threshold of data for at least one quality measure in the quarterly reporting period for the baseline and performance year(s).

Please note that IPRs are based on the 12 most recent months of performance data available (24 months for DTC-PAC and MSPB-PAC), while the APRs are based on performance data in the given performance year(s), so there may be differences in the HHA's TPS given the different time periods the reports cover.

IPR Versions and Appeals Process

Publication of the IPR each quarter includes reports in two (2) stages – a Preliminary IPR and a Final IPR. The publication of the Preliminary IPR provides HHAs with an opportunity to review their data. If an HHA believes there is an error in the Preliminary IPR, the HHA may submit a recalculation request within 15 calendar days from when CMS issues the Preliminary IPR. **Exhibit 21** illustrates the timeline for availability of the Preliminary and Final IPRs and the appeals process.

Exhibit 21. IPR Versions and Appeals Process Timeline



HHAs may submit requests for recalculation by emailing hhvbp_recalculation_requests@abtglobal.com. Recalculation requests must contain the following information:

- The provider's name, address associated with the services delivered, and 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 only a post office box); and
- A copy of any supporting documentation, not containing Protected Health Information (PHI) or Personally Identifiable Information (PII), the HHA wishes to submit in electronic form.

Note: When submitting recalculation and reconsideration requests:

- CMS asks HHAs to only include one (1) CCN per request.
- If you are submitting a recalculation request due to a suspected discrepancy between measure values reported in your IPR and measure values calculated internally or by your HHA's vendor, please consider providing a copy of the internal/vendor report used to generate the internal data to assist CMS with investigating your HHA's request.
- If possible, confirm whether 1) your internal data are risk-adjusted and 2) the data source used to generate your internal measure values (e.g., OASIS data, claims data).
- **Please do not include any PHI/PII.**

An HHA's Final IPR is available about two (2) months after the Preliminary IPR. The Final IPR reflects any changes made because of recalculation requests. The Final IPR provides the *final TPS score and points for each measure* based on performance data covered in that IPR. Note: If an HHA does not request a recalculation, the HHA will still receive a Final IPR.

For a visual guide to a recent IPR based on a fictional HHA that includes screenshots of key tabs (also referred to as worksheets) and accompanying explanations of their content, please refer to Appendix G.

7.4 Annual Performance Report (APR)

Like the IPR, the APR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. The purpose of the APR is to provide:

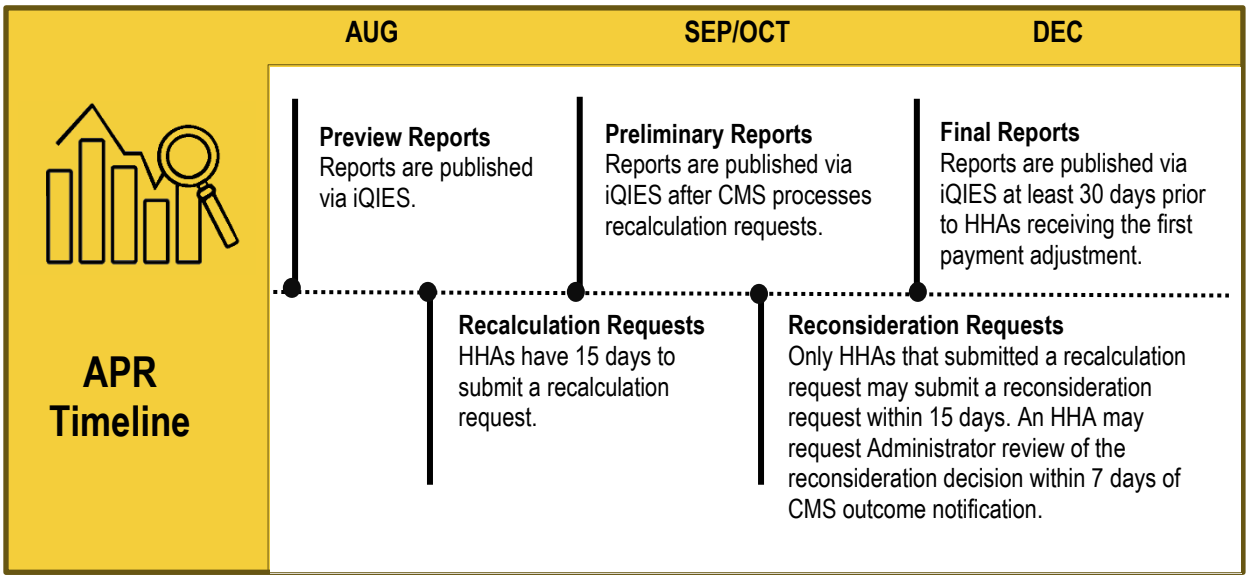
- The HHA's TPS based on complete performance year(s) data;
- The APP applied in the corresponding payment year, if applicable; and
- An explanation of how CMS determined the APP based on the HHA's performance scores relative to the performance of other HHAs in its cohort.
- HHAs will have received an APR for the CY 2024 performance year if the HHA:
  - Was Medicare-certified prior to January 1, 2023, and
  - Had sufficient data for at least five (5) measures to generate a TPS and more than zero (0) dollars in claims in the calendar year prior to the performance year.

Note that the CY 2025 APRs will be the last APR to use the measure set based on CY 2024 performance. The CY 2026 APRs, based on CY 2025 performance, will be the first to use the CY 2025 measure set. The CY 2027 APRs, based on CY 2026 performance, will be the first to use the CY 2026 measure set.

APR Versions and Appeals Process

Publication of the APR includes three (3) stages – a Preview APR, Preliminary APR, and a Final APR. The publication of the Preview APR provides competing HHAs with an opportunity to review their data. **Exhibit 22** illustrates the timeline of when CMS publishes the APR versions and the appeals process, including recalculation request, reconsideration request, and Administrator review processes.

Exhibit 22. APR Versions and Appeals Process Timeline



During review of the Preview APR, an HHA may submit a ***recalculation request*** within 15 calendar days after CMS issues the Preview APR if they believe there is an error. The Preliminary APR reflects the results of any changes due to recalculation requests. Please refer to the Expanded HHVBP Purchasing Model IPR and APR Recalculation Instructions for instructions on how to submit a recalculation request.

If an HHA disagrees with the results of CMS' recalculation request decision that is 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.

Per the CY 2024 HH PPS final rule, an HHA 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.

HHAs may submit requests for recalculation by emailing hhvbp_recalculation_requests@abtglobal.com. Recalculation requests must contain the following information:

- The provider's name, address associated with the services delivered, and 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 only a post office box); and
- A copy of any supporting documentation, not containing PHI/PII, the HHA wishes to submit in electronic form.

Note: When submitting recalculation and reconsideration requests:

- CMS asks HHAs to only include one CCN per request.
- If you are submitting a recalculation request due to a suspected discrepancy between measure values reported in your APR and measure values calculated internally or by your HHA's vendor, please consider providing a copy of the internal/vendor report used to generate the internal data to assist CMS with investigating your HHA's request.
- If possible, confirm whether 1) your internal data are risk-adjusted and 2) the data source used to generate your internal measure values (e.g., OASIS data, claims data).
- **Please do not include any PHI/PII.**

CMS makes the Final APR available after all recalculation requests, reconsideration requests and Administrator reviews are processed, and no later than 30 calendar days before the payment adjustment takes effect in the subsequent calendar year, for all competing HHAs.

8. Public Reporting

Public reporting of performance data for the expanded Model began with the CY 2023 performance year/CY 2025 payment year and was made available to the public on the Provider Data Catalog (PDC) website in January of 2025. The 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 HHAs.

CMS follows the same approximate timeline for publicly reporting the payment adjustment for the upcoming calendar year, as well as the related performance data.

CMS publicly reports the following information for the expanded HHVBP Model:

- Applicable measure benchmarks and achievement thresholds for each smaller- 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;
  - Total Performance Score (TPS); and
  - Payment adjustment percentage for a given year.

The expanded Model's performance data is supplemental to the Home Health Quality of Patient Care and Patient Survey Star Ratings and does not form a part of these or other star ratings. Publicly reporting performance data under the expanded Model enhances the current home health public reporting processes, as it better informs 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).

Appendix A. Expanded HHVBP Model Glossary of Terms 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 HHAs' 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. An HHA's performance year measure value must exceed the designated achievement threshold for a measure to receive achievement points for that 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: $\text{Achievement Score} = 10 \times \left(\frac{\textit{HHA Performance Score} - \textit{Achievement Threshold}}{\textit{Benchmark} - \textit{Achievement Threshold}} \right)$ Source data used to calculate an achievement score are derived from iQIES. The achievement score for each measure with sufficient data are available in 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 receives 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.
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 FFS claim submitted with a payment episode "through date" in the corresponding expanded Model payment year.
Administrator Review (also referred to as CMS Administrator Review)	Beginning with the CY 2024 APR, an HHA may request CMS Administrator review of a reconsideration decision for the APR within seven (7) days from CMS' notification to the HHA contact of the outcome of the reconsideration request.

Terminology	Definition
Baseline Years	***HHA Baseline Year(s):*** The year(s) against which CMS will compare an HHA's performance score for each applicable performance measure. 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 1) sufficient data to establish a baseline year for a particular quality measure, and 2) the HHA's Medicare-certification date. If an HHA does not have sufficient data to create a measure score in the first possible baseline year(s), the following year(s) may qualify to become the HHA baseline year(s) for that measure if the HHA has sufficient data. Please refer to Section 3 for more details. ***Model Baseline Year(s):*** The year(s) against which CMS calculates the achievement thresholds and benchmarks values for each quality measure by cohort. Please note that the HHA Baseline Years and Model Baseline Years for Discharge to Community – Post Acute Care (DTC-PAC) and Medicare Spending per Beneficiary (MSPB) are comprised of two (2) years of data. Please refer to Section 3 for more details.
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 IPR and APR..
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 FFS claims data. Claims-based utilization measures provide information related to the use of health care services (e.g., hospitals, emergency departments) resulting from a change in patient health status. These measures use health care 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 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 beneficiaries in the calendar year prior to the performance year. This grouping is based on the definition of HHAs that are exempt from participation in the HHCAHPS survey in accordance with §484.245. Please refer to Section 2 for more details. • Larger-volume cohort: the group of competing HHAs that had 60 or more unique beneficiaries in the calendar year prior to the performance year. This grouping is based on the definition of HHAs participating in the HHCAHPS survey in accordance with §484.245. Please refer to Section 2 for more details.
Competing Home Health Agency (HHA or HHAs)	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 each applicable measure based on the HHA's performance in a given performance year data period.

Terminology	Definition
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 E and the CY 2022 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 receives 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 HHAs' 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 HHAs 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 Interim Performance Report (IPR) and the Annual Performance Report (APR) 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 and 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 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 D.
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 C for the OASIS-based measures used in the expanded HHVBP Model.
Payer	Health care coverage such as Medicare, Medicaid, or managed care

Terminology	Definition
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(s)	The calendar year(s) 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.
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. The specific quality measures for each performance year are detailed in Appendix C.
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. Per the CY 2024 HH PPS final rule, an HHA may request CMS Administrator review of a reconsideration decision within seven (7) days from CMS' notification to the HHA contact of the outcome of the reconsideration request. Only HHAs that submit a recalculation request may submit a reconsideration request.
Total Normalized Composite (TNC) Change in Mobility (Effective through CY 2024)	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 (M1840, M1850, and M1860). CMS calculates the risk-adjusted Total Normalized Composite (TNC) Change in Mobility 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*" and "*Technical Specifications for the Total Normalized Composite Change Measures – January 2025*" and the "*Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures*" documents, available on the Expanded HHVBP Model webpage.

Terminology	Definition
Total Normalized Composite (TNC) Change in Self-Care (Effective through CY 2024)	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 (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 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 – January 2025*" and the "*Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures*" documents, 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.

Appendix B. Common Expanded HHVBP Model Acronyms

Acronym	Term
ACH	Acute Care Hospitalization
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
CMMI	CMS Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CoPs	Conditions of Participation
CY	Calendar Year
DTC	Discharge to Community
DTC-PAC	Discharge to Community-Post Acute Care
ED Use	Emergency Department Use
EOC	End of Care
FAQ	Frequently Asked Question
FFS	Fee-for-Service
HH	Home Heath
HH PPS	Home Heath 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
iQIES	Internet Quality Improvement and Evaluation System
LEF	Linear Exchange Function
MSPB-PAC	Medicare Spending Per Beneficiary – Post Acute Care
NPRM	Notice of Proposed Rulemaking
NQS	National Quality Strategy
OASIS	Outcome and Assessment Information Set
P4P	Pay for Performance
PAC	Post Acute Care
PDC	Provider Data Catalog
PHI	Protected Health Information

Acronym	Term
PII	Personal Identifiable Information
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

Appendix C. Applicable Measures for the Expanded HHVBP Model

Exhibit C-1. Expanded HHVBP Model Applicable Measures – Performance Years CY 2023 and CY 2024

Domains	Measure Title/ Short Form Name	Measure Type	Measure ID	Data Source	Numerator*	Denominator*
OASIS-based Measures						
Communication & Care Coordination	Discharged to Community	Outcome	3477	OASIS - M2420	Number of home health episodes where the assessment completed at the discharge indicates the patient remained in the community after discharge.	Number of home health episodes of care ending with discharge or transfer to inpatient facility during the reporting period, other than those covered by generic or measure-specific exclusions.
Clinical Quality of Care	Improvement in Dyspnea/ Dyspnea	Outcome	N/A	OASIS - M1400	Number of home health episodes of care 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.
Patient Safety	Improvement in Management of Oral Medications/ Oral Medication	Outcome	0176	OASIS - M2020	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.
Patient and Family Engagement	Total Normalized Composite Change in Mobility/ TNC Mobility*	Composite Outcome	N/A	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.

Domains	Measure Title/ Short Form Name	Measure Type	Measure ID	Data Source	Numerator*	Denominator*
OASIS-based Measures						
Patient and Family Engagement	Total Normalized Composite Change in Self-Care/TNC Self-Care*	Composite Outcome	N/A	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.
Claims-based Measures						
Efficiency & Cost Reduction	Acute Care Hospitalization During the First 60 Days of Home Health/ ACH	Outcome	0171	CCW (Claims)	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.	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
Efficiency & Cost Reduction	Emergency Department Use without Hospitalization During the First 60 days of Home Health/ED Use	Outcome	0173	CCW (Claims)	Number of home health stays for patients who have a Medicare claim for outpatient emergency department use and no claims for acute care hospitalization in the 60 days following the start of the home health stay.	Number of home health stays that begin during the 12-month observation period. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.
HHCAHPS Survey-based Measures						
Patient & Caregiver Centered Experience	Home Health Consumer Assessment Healthcare Providers and Systems (HHCAHPS) Survey	Outcome	0513	CAHPS	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one (1) CBE - endorsed measure.	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one (1) CBE- endorsed measure.

Exhibit C-2. Expanded HHVBP Model Applicable Measures – Performance Year CY 2025

Domains	Measure Title/ Short Form Name	Measure Type	Measure ID	Data Source	Numerator*	Denominator*
OASIS-based Measures						
Clinical Quality of Care	Improvement in Dyspnea/ Dyspnea	Outcome	N/A	OASIS - M1400	Number of home health episodes of care 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.
Patient Safety	Improvement in Management of Oral Medications/ Oral Medication	Outcome	0176	OASIS - M2020	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.
Patient and Family Engagement	Discharge Function Score/ DC Function	Outcome	N/A	OASIS - GG0130A-C, GG0170A, C, D, E, F, I, J, and R.	Number of home health quality episodes where the observed discharge function score for Section GG function items is equal 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.
Claims-based Measures						
Efficiency & Cost Reduction	Discharge to Community-Post Acute Care (DTC-PAC)	Outcome	N/A	CCW (Claims)	The risk-adjusted prediction of the number of HH stays resulting in a discharge to the community (Patient discharge code 01 or 81) without an unplanned admission to an ACG/LTCH or death in the 31 days post-discharge observation window.	The risk-adjusted expected number of discharges to the community. The estimate includes risk adjustment for patient characteristics with the HHA effect removed.
Efficiency & Cost Reduction	Home Health Within-Stay Potentially Preventable Hospitalization (PPH)	Outcome	0173	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.	The risk-adjusted expected number of hospitalizations or observation stays. The estimate includes risk adjustment for patient characteristics with the HHA effect removed.

Domains	Measure Title/ Short Form Name	Measure Type	Measure ID	Data Source	Numerator*	Denominator*
HHCAHPS Survey-based Measures						
Patient & Caregiver Centered Experience	Home Health Consumer Assessment Healthcare Providers and Systems (HHCAHPS) Survey	Outcome	0513	CAHPS	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one (1) CBE-endorsed measure.	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one (1) CBE-endorsed measure.

Exhibit C-3. Expanded HHVBP Model Applicable Measures – Performance Year CY 2026

Domains	Measure Title/ Short Form Name	Measure Type	Identifier	Data Source	Numerator*	Denominator*
OASIS-based Measures						
Clinical Quality of Care	Improvement in Dyspnea/ Dyspnea	Outcome	N/A	OASIS - M1400	Number of home health episodes of care 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.
Patient Safety	Improvement in Management of Oral Medications/ Oral Medication	Outcome	0176	OASIS - M2020	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.
Clinical Quality of Care	Improvement in Bathing	Outcome	0174	OASIS - M1830	Number of home health quality episodes where the value recorded on the discharge assessment indicates less impairment in bathing at discharge than at start (or resumption) of care.	Number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Clinical Quality of Care	Improvement in Upper Body Dressing	Outcome	N/A	OASIS - M1810	Number of home health quality episodes where the value recorded on the discharge assessment indicates less impairment in dressing their upper body at discharge than at start (or resumption) of care.	Number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Clinical Quality of Care	Improvement in Lower Body Dressing	Outcome	N/A	OASIS - M1820	Number of home health quality episodes where the value recorded on the discharge assessment indicates less impairment in dressing their lower body at discharge than at start (or resumption) of care.	Number of home health quality episodes ending with a discharge during the reporting period, other than those covered by generic or measure-specific exclusions.
Patient and Family Engagement	Discharge Function Score/ DC Function	Outcome	N/A	OASIS - GG0130A-C, GG0170A, C, D, E, F, I, J, and R.	Number of home health quality episodes where the observed discharge function score for Section GG function items is equal 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.

Domains	Measure Title/ Short Form Name	Measure Type	Identifier	Data Source	Numerator*	Denominator*
Claims-based Measures						
Efficiency & Cost Reduction	Discharge to Community (DTC-PAC)	Outcome	3477	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 DTCPAC, 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 projected 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.
Efficiency & Cost Reduction	Medicare Spending Per Beneficiary - Post-Acute Care (MSPB-PAC)		N/A		The numerator (MSPB-PAC Amount) is the average observed over expected (as predicted through risk adjustment) Medicare spending for a home health agency's MSPB-PAC HH's episodes, multiplied by the national average MSPB-PAC HH spending. MSPB-PAC HH episodes include the Medicare spending for Parts A and B services during the episode window, subject to certain exclusions for clinically unrelated services. The episode window consists of a treatment period (days 1-60 of the home health Medicare FFS claim, or day 1 to discharge for a claim subject to a PEP adjustment) and an associated services period (day 1 of the home health claim through to 30 days after the end of the treatment period).	The denominator is the episode-weighted national median MSPB- PAC Amount across all home health agencies for the two-year observation period. Episodes triggered by a claim outside the 50 states, D.C., Puerto Rico, and U.S. territories. Ep

Domains	Measure Title/ Short Form Name	Measure Type	Identifier	Data Source	Numerator*	Denominator*
Claims-based Measures						
Efficiency & Cost Reduction	Home Health Within-Stay Potentially Preventable Hospitalization (PPH)	Outcome	0173	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.	The risk-adjusted expected number of hospitalizations or observation stays. The estimate includes risk adjustment for patient characteristics with the HHA effect removed. 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.
HHCAHPS Survey-based Measures						
Patient & Caregiver Centered Experience	Home Health Consumer Assessment Healthcare Providers and Systems (HHCAHPS) Survey	Outcome	0513	CAHPS	Survey-based. Two (2) HHCAHPS component questions 1) Overall Rating of Home Health Care (Overall Rating) and 2) Willingness to Recommend the Agency (Willingness to Recommend).	Survey-based. Two (2) HHCAHPS component questions 1) Overall Rating of Home Health Care (Overall Rating) and 2) Willingness to Recommend the Agency (Willingness to Recommend).

Appendix D. Measure Weights by Performance Year

Exhibit D-1. Measure Weighting – Performance Years CY 2023 and CY 2024

Quality Measures	Within-category weight	*Category Measure Weights*				
		All Measures	No HHCAHPS	No Claims	No Claims or HHCAHPS	No OASIS or Claims
OASIS-based Measures						
Discharged to Community	16.67%	5.83%	8.33%	8.98%	16.67%	0.00%
Improvement in Dyspnea	16.67%	5.83%	8.33%	8.98%	16.67%	0.00%
Improvement in Management of Oral Medications	16.67%	5.83%	8.33%	8.98%	16.67%	0.00%
TNC Change in Mobility	25.00%	8.75%	12.50%	13.46%	25.00%	0.00%
TNC Change in Self-Care	25.00%	8.75%	12.50%	13.46%	25.00%	0.00%
Total for OASIS-based Measures	**100.00%**	**35.00%**	**50.00%**	**53.85%**	**100.00%**	**0.00%**
Claims-based Measures						
ACH	75.00%	26.25%	37.50%	0.00%	0.00%	0.00%
ED Use	25.00%	8.75%	12.50%	0.00%	0.00%	0.00%
Total for Claims-based Measures	**100.00%**	**35.00%**	**50.00%**	**0.00%**	**0.00%**	**0.00%**
HHCAHPS Survey-based Measures						
Care of Patients	20.00%	6.00%	0.00%	9.23%	0.00%	20.00%
Communication Between Providers and Patients	20.00%	6.00%	0.00%	9.23%	0.00%	20.00%
Specific Care Issues	20.00%	6.00%	0.00%	9.23%	0.00%	20.00%
Overall Rating of Home Health Care	20.00%	6.00%	0.00%	9.23%	0.00%	20.00%
Willingness to Recommend the Agency	20.00%	6.00%	0.00%	9.23%	0.00%	20.00%
Total for HHCAHPS Survey-based Measures	**100.00%**	**30.00%**	**0.00%**	**46.15%**	**0.00%**	**100.00%**

Exhibit D-2. Measure Weighting – Performance Year CY 2025

Quality Measures	Within-category weight	*Category Measure Weights*			
		All Measures	No HHCAHPS	No Claims	No OASIS or Claims
OASIS-based Measures					
Discharge Function Score (DC Function)	57.14%	20.00%	28.57%	30.77%	0.00%
Improvement in Dyspnea	17.14%	6.00%	8.57%	9.23%	0.00%
Improvement in Management of Oral Medications	25.71%	9.00%	12.86%	13.85%	0.00%
Total for OASIS-based Measures	**100.00%**	**35.00%**	**50.00%**	**53.85%**	**0.00%**
Claims-based Measures					
Discharge to Community—Post Acute Care (DTC-PAC)	25.71%	9.00%	12.86%	0.00%	0.00%
Potentially Preventable Hospitalization (PPH)	74.29%	26.00%	37.14%	0.00%	0.00%
Total for claims-based Measures	**100.00%**	**35.00%**	**50.00%**	**0.00%**	**0.00%**
HHCAHPS Survey-based Measures					
Care of Patients	20.00%	6.00%	0.00%	9.23%	20.00%
Communication Between Providers and Patients	20.00%	6.00%	0.00%	9.23%	20.00%
Specific Care Issues	20.00%	6.00%	0.00%	9.23%	20.00%
Overall Rating of Home Health Care	20.00%	6.00%	0.00%	9.23%	20.00%
Willingness to Recommend the Agency	20.00%	6.00%	0.00%	9.23%	20.00%
Total for HHCAHPS Survey-based Measures	**100.00%**	**30.00%**	**0.00%**	**46.15%**	**100.00%**

Exhibit D-3. Measure Weighting – Performance Year CY 2026

Quality Measures	Within-category weight	*Category Measure Weights*			
		All Measures	No HHCAHPS	No Claims	No Claims or HHCAHPS
OASIS-based Measures					
Discharge Function Score (DC Function)	37.50%	15.00%	18.75%	25.00%	37.50%
Improvement in Dyspnea	17.50%	7.00%	8.75%	11.67%	17.50%
Improvement in Management of Oral Medications	27.50%	11.00%	13.75%	18.33%	27.50%
Improvement in Bathing	8.75%	3.50%	4.38%	5.83%	8.75%
Improvement in Upper Body Dressing	4.38%	1.75%	2.19%	2.92%	4.38%
Improvement in Lower Body Dressing	4.38%	1.75%	2.19%	2.92%	4.38%
Total for OASIS-based Measures	**100.00%**	**40.00%**	**50.00%**	**66.67%**	**100.00%**
Claims-based Measures					
Discharge to Community (DTC-PAC)	37.50%	15.00%	18.75%	0.00%	0.00%
Medicare Spending Per Beneficiary - Post-Acute Care (MSPB-PAC)	25.00%	10.00%	12.50%	0.00%	0.00%
Home Health Within-Stay Potentially Preventable Hospitalization (PPH)	37.50%	15.00%	18.75%	0.00%	0.00%
Total for Claims-based Measures	**100.00%**	**40.00%**	**50.00%**	**0.00%**	**0.00%**
HHCAHPS Survey-based Measures					
Overall Rating of Home Health Care	50.00%	10.00%	0.00%	16.67%	0.00%
Willingness to Recommend the Agency	50.00%	10.00%	0.00%	16.67%	0.00%
Total for HHCAHPS Survey-based Measures	**100.00%**	**20.00%**	**0.00%**	**33.33%**	**0.00%**

Appendix E. Examples of Achievement and Improvement Scores and Care Points Calculations – CY 2024 Performance Year

The fictional examples below demonstrate how the performance scoring methodology is applied to the claims-based, OASIS-based, and HHCAHPS Survey-based measure categories. These examples, from fictitious agencies 123 HHA, ABC HHA, and XYZ HHA, are based on illustrative data from CY 2022 (for the designated HHVBP Model baseline year) and hypothetical data for CY 2024.

Fictional 123 HHA Example of Earning Maximum Achievement Points

Exhibit E-1. HHA Example of Earning Maximum Achievement Points

Measure	Achievement Threshold*	Benchmark**	123 HHA CY 2024 Performance Year Score	123 HHA Achievement Points
Improvement in Dyspnea	75.358	97.676	98.348	10

*The achievement threshold is calculated as the median or the 50th percentile of HHA performance from the CY 2022 Model baseline year for the same volume-based cohort.
**The benchmark is calculated as the mean of the top decile of HHA performance from the CY 2022 Model baseline year for the volume-based cohort.

The example above shows 123 HHA's CY 2024 performance year score for the Improvement in Dyspnea measure was 98.348, exceeding both the CY 2022 achievement threshold and benchmark established for the volume-based cohort. This means that 123 HHA earned the maximum 10 achievement points based on its performance score. As a reminder, CMS uses the higher of either the achievement or improvement scores to calculate care points. Therefore, 123 HHA's improvement score is irrelevant in the calculation because 123 HHA's performance score for the Dyspnea measure is 10 achievement points (circled in green), and the maximum number of improvement points possible is nine (9).

Fictional ABC HHA Example of Earning Partial Improvement Points

Exhibit E-2. HHA Example of Earning Partial Improvement Points

Measure	Achievement Threshold*	Benchmark**	ABC HHA Improvement Threshold***	ABC HHA CY 2024 Performance Year Score	ABC HHA Achievement Points	ABC HHA Improvement Points
Improvement in Dyspnea	75.358	97.676	52.168	76.765	0.630	4.864

*The achievement threshold is calculated as the median or the 50th percentile of HHA performance from the CY 2022 Model baseline year for the same volume-based cohort.
**The benchmark is calculated as the mean of the top decile of HHA performance from the CY 2022 Model baseline year for the volume-based cohort.
***The improvement threshold is calculated as the HHA's baseline year score, in this case CY 2022, but depends on when the HHA was Medicare-certified and whether the minimum data threshold was met.
For more information, please refer to the Calculation of the Improvement Threshold section.

In the example above, ABC HHA performance on the Dyspnea measure was 52.168 for the CY 2022 baseline year (the improvement threshold) and increased to 76.765 (which is above the achievement threshold of 75.358) for the CY 2024 performance year.

- ABC HHA would earn 0.630 achievement points, calculated by the following equation:

$$10 * (76.765-75.358)/(97.676-75.358) = 0.630$$

- ABC HHA would earn 4.864 improvement points, calculated by the following equation based on ABC HHA period-to-period improvement:

$$9 * (76.765-52.168)/(97.676-52.168) = 4.864$$

Because the higher of the achievement and improvement scores is used, ABC HHA receives 4.864 care points (circled in green in the table above) for the Dyspnea measure.

Fictional XYZ HHA Example of Not Earning Achievement or Improvement Points

Exhibit E-3. HHA Example of Not Earning Achievement or Improvement Points

Measure	Achievement Threshold*	Benchmark**	XYZ HHA Improvement Threshold ***	XYZ HHA CY 2024 Performance Year Score	XYZ HHA Achievement Points	XYZ HHA Improvement Points
TNC Self-Care	75.358	97.676	70.266	58.487	0	0

*The achievement threshold is calculated as the median or the 50th percentile of HHA performance from the CY 2022 Model baseline year for the same volume-based cohort.
**The benchmark is calculated as the mean of the top decile of HHA performance from the CY 2022 Model baseline year for the volume-based cohort.
***The improvement threshold is calculated as the HHA's baseline year score, in this case CY 2022, but depends on when the HHA was Medicare-certified and whether the minimum data threshold was met.
For more information, please refer to the Calculation of the Improvement Threshold section.

In the example above, XYZ HHA performance declined on the TNC Self-Care measure, falling from 70.266 in the HHA's baseline year to 58.487 during the CY 2024 performance year. XYZ HHA performance during the performance year was lower than the achievement threshold of 75.358 and, as a result, XYZ HHA receives zero (0) points based on achievement (circled in green above). XYZ HHA also receives zero (0) points for improvement (circled in green above) because its performance during the performance year was lower than its improvement threshold. XYZ HHA receives zero (0) care points for the TNC Self-Care measure.

Appendix F. Interim Performance Report (IPR) Tabs and Descriptions – April 2025 IPR

Appendix F provides a visual guide to a recent IPR (i.e., April 2025 IPR) for a fictional HHA and includes screenshots of key tabs and accompanying explanations of their content. This appendix is intended to offer a clear reference for understanding the report structure and contents to ensure that HHAs can interpret and apply performance data effectively as part of their quality improvement efforts. For each tab, we provide numbered lists of key features which correspond to the numbered labels in the respective exhibit.

Note: Supplementary tabs that provide information on future measure sets at the time of report publication are not included in this appendix. Specifically, these supplementary tabs are the two tabs pertaining to the CY 2025 measure set labeled "CY 2025 AT and BM" and "CY 2025 Baseline" (see these tabs listed in **Exhibit F-1**).

Table of Contents Tab

The Table of Contents tab (see **Exhibit F-1**) contains the title of the report, e.g., "April 2025 Interim Performance Report," along with the following HHA-specific information:

1. CCN
2. Name & Address
3. Cohort assignment
4. Name, description, and a hyperlink for each tab included in the IPR

Exhibit F-1. IPR Table of Contents

Home Health Value-Based Purchasing (HHVBP) Model

April 2025 Interim Performance Report

Your HHA

1	**CCN**	999999
2	**HHA Name**	We Love Home Health
	HHA Address	999 Home Health Ln, Home Health, MD 99999
3	**Your HHA's Cohort**	Larger-volume

Table of Contents (TOC)

Worksheet/Tab	Description
Overview	The "Overview" worksheet provides details about this Model report, an overview of the expanded HHVBP Model, and how your home health agency (HHA) can submit a recalculation request.
Achievement	The "Achievement" worksheet shows your HHA's Achievement Points.
Improvement	The "Improvement" worksheet shows your HHA's Improvement Points.
Care Points	The "Care Points" worksheet shows your HHA's total points (i.e., "Care Points") based on the higher of your HHA's Achievement or Improvement Points.
Measure Scorecard	The "Measure Scorecard" worksheet outlines the calculation of your HHA's Total Performance Score (TPS) and how it compares to HHAs in your HHA's cohort.
TNC Change Reference	The "TNC Change Reference" worksheet displays your HHA's performance on individual OASIS items composing the Total Normalized Composite (TNC) change measures.
AT and BM	The "AT and BM" worksheet reports final Achievement Thresholds (AT) and Benchmarks (BM) by volume-based cohort for the quality measure set applicable to the first two performance years, CY 2023 and CY 2024, respectively.
CY 2025 AT and BM	The "CY 2025 AT and BM" worksheet reports preliminary Achievement Thresholds (AT) and Benchmarks (BM) by volume-based cohort for the quality measure set applicable to the third performance year, CY 2025.
CY 2025 Baseline	The "CY 2025 Baseline" worksheet reports on your HHA's preliminary Improvement Thresholds for the CY 2025 applicable measure set.
Model Resources	The "Model Resources" worksheet resources is designed to assist with understanding the expanded HHVBP Model and the Model reports.

4

Overview Tab

The Overview tab (see **Exhibit F-2**) contains:

1. Performance year data time periods for each quality measure category. Note that the data periods vary by measure category due to different data lags for the OASIS-based, claims-based, and HHCAHPS Survey-based measures.
2. Explanation of the cohort assignment. If there is an "N/A" in Your HHA's Cohort, an HHA could not be assigned to a cohort based on data available for CY 2023. In this case cohort-specific information in the report is based on the larger-volume cohort, which most HHAs fall into.
3. Interim Total Performance Score (TPS). The TPS is a numeric score, ranging from zero (0) to 100, awarded to each qualifying HHA based on the performance scores and weighting for each applicable measure. Note that HHAs must have sufficient data to receive a TPS.
4. Instructions for submitting a recalculation request.

Exhibit F-2. Overview Tab

This Interim Performance Report

This Interim Performance Report (IPR) provides your HHA's measure performance compared to home health agencies (HHAs) in your HHA's cohort using performance year data covering the following time periods:

1

OASIS-based Measures	January 1, 2024 to December 31, 2024
Claims-based Measures	October 1, 2023 to September 30, 2024
HHCAHPS Survey-based Measures	October 1, 2023 to September 30, 2024

This IPR provides the preliminary Achievement Thresholds and Benchmarks and Improvement Thresholds for the CY 2025 applicable measure set (see "CY 2025 AT and BM" tab and "CY 2025 Baseline" tab, respectively). HHA performance for the CY 2025 applicable measure set will determine payment adjustments applied to CY 2027 Medicare fee-for-service (FFS) claims. The Model baseline year for the CY 2025 performance year is CY 2023 for all measures except Discharge to Community – Post Acute Care (DTC-PAC). For the DTC-PAC measure, the Model baseline year is CY 2022 and CY 2023. The "Model Resources" worksheet resources is designed to assist with understanding the expanded HHVBP Model and the Model reports.

2

For this IPR, your HHA's cohort is determined by your HHA's unique beneficiary count in CY 2023.

Cohorts are determined based on each HHA's unique beneficiary count in the prior calendar year and updated once a year in July. If your HHA's cohort shows "N/A" (Not Applicable), your HHA could not be assigned to a cohort for this report and cohort information presented in this report is based on the larger-volume cohort, which most HHAs fall into. Updates to your cohort assignment will appear in future reports as applicable. Please refer to the Expanded HHVBP Model Guide at https://innovation.cms.gov/innovation-models/expanded-home-health-value-based-purchasing-model for additional information.

3

Your HHA's Interim Total Performance Score (TPS):	36.898

The Expanded HHVBP Model

The HHVBP Model is designed to support greater quality and efficiency of care among Medicare-certified HHAs nationally. Under this model, Medicare payments made to HHAs are dependent on the HHAs' performance on specified quality measures relative to their peers (i.e., value-based payments). The HHVBP Model was first tested among HHAs in nine states from January 1, 2016 to December 31, 2021. National expansion began on January 1, 2022. Calendar Year (CY) 2022 was the pre-implementation year. The first full performance year for the expanded HHVBP Model is CY 2023. For more information related to the expanded HHVBP Model, please refer to the CY 2022 and CY 2023 Home Health Prospective Payment System (HH PPS) Final Rules.

Submitting a Recalculation Request

Publication of quarterly 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 CFR §484.375, the Preliminary IPR provides an 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 score/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 current Code of Federal Regulations (CFRs). HHAs must electronically report all OASIS data collected in accordance with the Medicare Conditions of Participation (CoPs) (§484.55), 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 §484.245(b)(1).

4

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. The Final IPR will reflect any changes resulting from an approved recalculation.

HHAs may submit requests for recalculation by emailing hhvbp_recalculation_requests@abtglobal.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.

Instructions on how to submit a recalculation request are available on the Expanded HHVBP Model webpage, under "Reports".

Achievement Tab

The Achievement tab (see **Exhibit F-3**) contains information that HHAs can use to assess how well they performed during the performance year compared to other HHAs in their cohort. The Achievement tab contains:

1. The list of applicable measures by category (note that this is available on each tab containing performance measure data, except for the TNC Change Reference tab).
2. Performance Year Data Period for each applicable measure (Note that this is also reported in the Overview tab. The Performance Year Data Period varies by measure category due to different data lags, as cited in footnote "a."
3. Your HHA's Performance Year Measure Value for each measure.
4. Your Cohort's Achievement Threshold (AT) and Your Cohort's Benchmark (BM). The Model baseline year is used to determine the AT and BM for each measure.
5. Your HHA's Achievement points and maximum possible achievement points. Footnote "e" illustrates the formula used to calculate Your HHA's achievement points. The value in the Your Performance Year Measure Value column must exceed the value in the Your Cohort's Achievement Threshold column for an HHA to receive achievement points for a measure.

Exhibit F-3. IPR Achievement Tab

1	2	3	4		5	
Measure	**Performance Year Data Period [a] (12-Month End Date)**	**Your HHA's Performance Year Measure Value [b]**	**Your Cohort's Achievement Threshold [c]**	**Your Cohort's Benchmark [d]**	**Your HHA's Achievement Points [e]**	**Maximum Possible Achievement Points**
OASIS-based Measures						
Discharged to Community	12-31-2024	67.792	72.652	84.249	0.000	10.000
Improvement in Dyspnea	12-31-2024	84.899	86.305	98.512	0.000	10.000
Improvement in Management of Oral Medications	12-31-2024	90.212	80.990	97.899	5.454	10.000
Total Normalized Composite (TNC) Change in Mobility [f]	12-31-2024	0.948	0.744	1.011	7.640	10.000
Total Normalized Composite (TNC) Change in Self-Care [g]	12-31-2024	2.508	2.123	2.733	6.311	10.000
Claims-based Measures						
Acute Care Hospitalizations	09-30-2024	11.726	13.907	7.773	3.556	10.000
Emergency Department Use Without Hospitalization	09-30-2024	13.475	11.782	4.689	0.000	10.000
HHCAHPS Survey-based Measures						
Care of Patients	09-30-2024	92.047	89.254	94.448	5.377	10.000
Communications Between Providers and Patients	09-30-2024	88.496	86.626	93.036	2.917	10.000
Specific Care Issues	09-30-2024	88.214	82.048	91.198	6.739	10.000
Overall Rating of Home Health Care	09-30-2024	85.122	85.941	94.337	0.000	10.000
Willingness to Recommend the Agency	09-30-2024	80.834	79.986	91.202	0.756	10.000

Notes:

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

N/A = Not Applicable.

[a] Performance Year Data Periods vary by measure category due to different data lags for OASIS-based, claims-based measures, and HHCAHPS Survey-based measures.

[b] The Performance Year Measure Value is also referred to as "HHA Performance Score".

[c] The Achievement Threshold is the median measure value for HHAs in your HHA's cohort in CY 2022.

[d] The Benchmark is the mean of the top decile measure values for HHAs in your HHA's cohort in CY 2022.

[e] The formula for calculating the Achievement Points is:

$$10 \times \left(\frac{\textit{HHA Performance Score} - \textit{Achievement Threshold}}{\textit{Benchmark} - \textit{Achievement Threshold}} \right)$$

Achievement Points are only calculated if the HHA had sufficient data to calculate both HHA Improvement Threshold and HHA Performance Score for a given measure.

For more information on how Achievement Points are calculated under the HHVBP Model, please refer to the Expanded HHVBP Model Guide.

[f] Measures the magnitude of change based on normalized total possible change across three OASIS-based Activities of Daily Living (ADL) items (M1840 Toilet Transferring, M1850 Bed Transferring, and M1860 Ambulation/Locomotion). For more information, please refer to the Expanded HHVBP Model Guide.

[g] Measures the magnitude of change based on normalized total possible change across six 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 Feeding or Eating). For more information, please refer to the Expanded HHVBP Model Guide.

Improvement Tab

The Improvement tab (see **Exhibit F-4**) contains information that HHAs can use to assess how well they performed during the performance year compared to their baseline year. The Improvement tab contains:

1. The list of applicable measures by category (available on each tab containing performance measure data, except for the TNC Change Reference Tab).
2. Performance Year Data Period for each applicable measure that carries over from the Overview Tab. The Performance Year Data Period can vary by measure category due to different data lags, as cited in footnote "a." The data in the Performance Year Data Period and Your HHA's Performance Year Measure Value columns match the corresponding section of the Achievement tab.
3. Time periods for the Baseline Year Data Period. Note that these are based on the HHA's baseline year for each measure.
4. Your HHA's Performance Year Measure Value for each measure.
5. Your HHA's Improvement Threshold is the HHA's performance on an applicable measure during the HHA baseline year for that measure. Your Cohort's Benchmark values found on the Improvement Tab are the same as those in the Achievement Tab.
6. Your HHA's improvement points and maximum possible improvement points. Footnote "f" illustrates the formula used to calculate Your HHA's improvement points. The value in the Your HHA's Performance Year Measure Value column must exceed the value in the Your HHA's Improvement Threshold column for an HHA to receive improvement points for a measure.

Exhibit F-4. IPR Improvement Tab

1	2	3	4	5		6	
Measure	**Performance Year Data Period [a] (12-Month End Date)**	**Baseline Year Data Period [b] (12-Month End Date)**	**Your HHA's Performance Year Measure Value [c]**	**Your HHA's Improvement Threshold [d]**	**Your Cohort's Benchmark [e]**	**Your HHA's Improvement Points [f]**	**Maximum Possible Improvement Points**
OASIS-based Measures							
Discharged to Community	12-31-2024	12-31-2022	67.792	62.747	84.249	2.112	9.000
Improvement in Dyspnea	12-31-2024	12-31-2022	84.899	83.058	98.512	1.072	9.000
Improvement in Management of Oral Medications	12-31-2024	12-31-2022	90.212	83.770	97.899	4.103	9.000
Total Normalized Composite (TNC) Change in Mobility [g]	12-31-2024	12-31-2022	0.948	0.822	1.011	6.000	9.000
Total Normalized Composite (TNC) Change in Self-Care [h]	12-31-2024	12-31-2022	2.508	2.282	2.733	4.510	9.000
Claims-based Measures							
Acute Care Hospitalizations	09-30-2024	12-31-2022	11.726	12.338	7.773	1.207	9.000
Emergency Department Use Without Hospitalization	09-30-2024	12-31-2022	13.475	14.530	4.689	0.965	9.000
HHCAHPS Survey-based Measures							
Care of Patients	09-30-2024	12-31-2022	92.047	90.785	94.448	3.101	9.000
Communications Between Providers and Patients	09-30-2024	12-31-2022	88.496	88.742	93.036	0.000	9.000
Specific Care Issues	09-30-2024	12-31-2022	88.214	89.189	91.198	0.000	9.000
Overall Rating of Home Health Care	09-30-2024	12-31-2022	85.122	87.341	94.337	0.000	9.000
Willingness to Recommend the Agency	09-30-2024	12-31-2022	80.834	79.927	91.202	0.724	9.000

Notes:

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

N/A = Not Applicable.

[a] Performance Year Data Periods vary by measure category due to different data lags for OASIS-based, claims-based measures, and HHCAHPS survey-based measure components.

[b] The Baseline Year varies depending on the measure and data availability for your HHA.

[c] The Performance Year Measure Value is also referred to as "HHA Performance Score".

[d] The Improvement Threshold is also referred to as "HHA Baseline Year Score".

[e] The Benchmark is the mean of the top decile of measure values for HHAs in your HHA's cohort in CY 2022.

[f] The formula for calculating the Improvement Points is:

$$9 \times \left(\frac{\textit{HHA Performance Score} - \textit{HHA Improvement Threshold}}{\textit{Benchmark} - \textit{HHA Improvement Threshold}} \right)$$

Improvement Points are only calculated if the HHA had sufficient data to calculate both HHA Improvement Threshold and HHA Performance Score for a given measure. For more information on how Improvement Points are calculated under the HHVBP Model, please refer to the Expanded HHVBP Model Guide.

[g] Measures the magnitude of change based on normalized total possible change across three OASIS-based Activities of Daily Living (ADL) items (M1840 Toilet Transferring, M1850 Bed Transferring, and M1860 Ambulation/Locomotion). For more information, please refer to the Expanded HHVBP Model Guide.

[h] Measures the magnitude of change based on normalized total possible change across six 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 Feeding or Eating). For more information, please refer to the Expanded HHVBP Model Guide.

Care Points Tab

The Care Points tab (see **Exhibit F-5**) reports the higher of achievement points or improvement points for each measure reported. The Care Points tab contains:

1. Whether the HHA had Sufficient Data for Measure Inclusion indicated by "Yes" or "No."
2. The HHA's achievement and improvement points which are carried over from the respective tabs.
3. Your HHA's Percentile Ranking is determined by comparing an HHA's care points to those of all HHAs in the same cohort. Your HHA's Percentile Ranking provides HHA's with information about where the agency's care points fall within the assigned cohort for each applicable measure, by quartile, as cited in footnote "b."

Exhibit F-5. IPR Care Points Tab

	1	2		3	
Measure	**Sufficient Data for Measure Inclusion?**	**Your HHA's Achievement Points**	**Your HHA's Improvement Points**	**Your HHA's Care Points [a]**	**Your HHA's Percentile Ranking Within Your HHA's Cohort [b]**
OASIS-based Measures					
Discharged to Community	Yes	0.000	2.112	2.112	25-49
Improvement in Dyspnea	Yes	0.000	1.072	1.072	<25
Improvement in Management of Oral Medications	Yes	5.454	4.103	5.454	50-74
Total Normalized Composite (TNC) Change in Mobility	Yes	7.640	6.000	7.640	≥75
Total Normalized Composite (TNC) Change in Self-Care	Yes	6.311	4.510	6.311	50-74
Claims-based Measures					
Acute Care Hospitalizations	Yes	3.556	1.207	3.556	50-74
Emergency Department Use Without Hospitalization	Yes	0.000	0.965	0.965	25-49
HHCAHPS Survey-based Measures					
Care of Patients	Yes	5.377	3.101	5.377	≥75
Communications Between Providers and Patients	Yes	2.917	0.000	2.917	50-74
Specific Care Issues	Yes	6.739	0.000	6.739	≥75
Overall Rating of Home Health Care	Yes	0.000	0.000	0.000	<25
Willingness to Recommend the Agency	Yes	0.756	0.724	0.756	25-49
Number of Measures Included	12		Summed Care Points:	42.899	50-74

Notes:

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

N/A = Not Applicable.

[a] Your HHA's Care Points are the higher of your HHA's Achievement or Improvement Points.

[b] Your HHA's Percentile Ranking is computed by comparing your HHA's Care Points to those of the HHAs in your HHA's cohort:

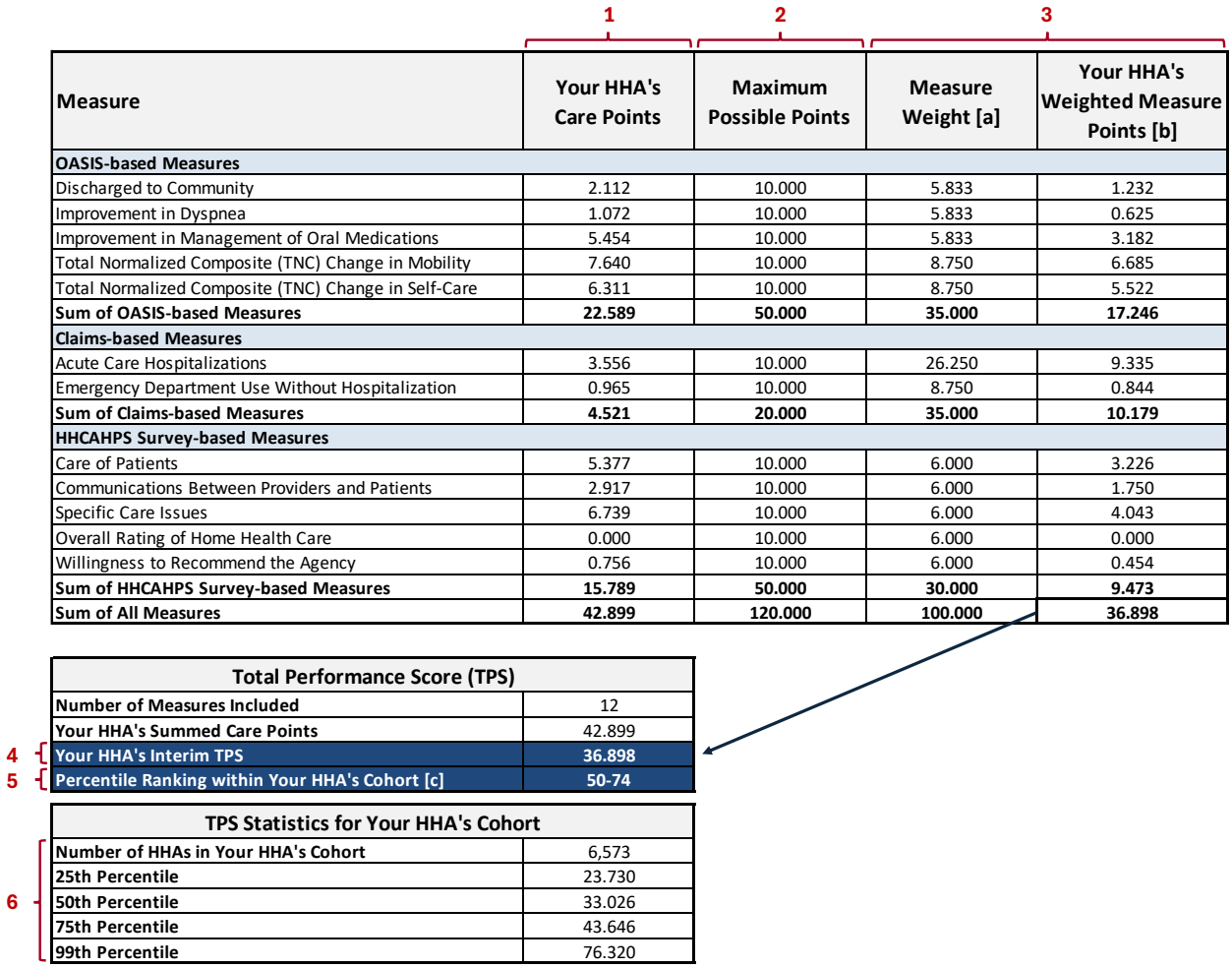
- <25 indicates that, on this measure, your HHA is performing in the lowest (worst performing) quartile in your HHA's cohort.
- 25-49 indicates that, on this measure, your HHA is performing in the second lowest quartile in your HHA's cohort.
- 50-74 indicates that, on this measure, your HHA is performing in the second highest quartile in your HHA's cohort.
- ≥75 indicates that, on this measure, your HHA is performing in the highest (best performing) quartile in your HHA's cohort.

Measure Scorecard Tab

The Measure Scorecard tab (see **Exhibit F-6**) contains information that supports HHAs with understanding how each individual measure contributes to their TPS. The Measure Scorecard tab contains:

1. Values in the Your HHA's Care Points column, which carry over from the Care Points Tab.
2. The Maximum Possible Points, which is 10 for each measure.
3. Your HHA's Weighted Measure Points for each applicable measure, which are calculated by dividing Your HHA's Care Points by the Maximum Possible Points, then multiplying by the Measure Weight (footnote "b").
4. The interim TPS, which is a numeric score, ranging from zero (0) to 100, awarded to each qualifying HHA based on the performance scores for each applicable measure.
5. Percentile Ranking within Your HHA's Cohort compares the HHA's ranking to all agencies in the cohort, as cited in footnote "c".
6. The TPS Statistics for Your HHA's Cohort table, which provides a breakdown of percentile rankings within the cohort.

Exhibit F-6. IPR Measure Scorecard Tab



Measure	Your HHA's Care Points	Maximum Possible Points	Measure Weight [a]	Your HHA's Weighted Measure Points [b]
OASIS-based Measures				
Discharged to Community	2.112	10.000	5.833	1.232
Improvement in Dyspnea	1.072	10.000	5.833	0.625
Improvement in Management of Oral Medications	5.454	10.000	5.833	3.182
Total Normalized Composite (TNC) Change in Mobility	7.640	10.000	8.750	6.685
Total Normalized Composite (TNC) Change in Self-Care	6.311	10.000	8.750	5.522
Sum of OASIS-based Measures	**22.589**	**50.000**	**35.000**	**17.246**
Claims-based Measures				
Acute Care Hospitalizations	3.556	10.000	26.250	9.335
Emergency Department Use Without Hospitalization	0.965	10.000	8.750	0.844
Sum of Claims-based Measures	**4.521**	**20.000**	**35.000**	**10.179**
HHCAHPS Survey-based Measures				
Care of Patients	5.377	10.000	6.000	3.226
Communications Between Providers and Patients	2.917	10.000	6.000	1.750
Specific Care Issues	6.739	10.000	6.000	4.043
Overall Rating of Home Health Care	0.000	10.000	6.000	0.000
Willingness to Recommend the Agency	0.756	10.000	6.000	0.454
Sum of HHCAHPS Survey-based Measures	**15.789**	**50.000**	**30.000**	**9.473**
Sum of All Measures	**42.899**	**120.000**	**100.000**	**36.898**

Total Performance Score (TPS)	
Number of Measures Included	12
Your HHA's Summed Care Points	42.899
Your HHA's Interim TPS	**36.898**
Percentile Ranking within Your HHA's Cohort [c]	**50-74**

TPS Statistics for Your HHA's Cohort	
Number of HHAs in Your HHA's Cohort	6,573
25th Percentile	23.730
50th Percentile	33.026
75th Percentile	43.646
99th Percentile	76.320

Notes:

Dash (-) indicates no or insufficient data available. Measures with no or insufficient data available are excluded from the TPS calculation.
N/A = Not Applicable.
[a] The weights for each measure may vary depending on the availability of measures within each measure category. For more information, please refer to the Expanded HHVBP Model Guide.

[b] Your HHA's Weighted Measure Points are calculated by dividing your HHA's Care Points by the Maximum Possible Points and multiplying by the Measure Weight. The totals for each measure category are computed by summing across the individual measures within the measure category.

[c] Your HHA's Percentile Ranking is computed by comparing your HHA's TPS to those of the HHAs in your HHA's cohort:

- <25 indicates that your HHA is performing in the lowest (worst performing) quartile in your HHA's cohort.
- 25-49 indicates that your HHA is performing in the second lowest quartile in your HHA's cohort.
- 50-74 indicates that your HHA is performing in the second highest quartile in your HHA's cohort.
- ≥75 indicates that your HHA is performing in the highest (best performing) quartile in your HHA's cohort.

TNC Change Reference Tab

The TNC Change Reference tab (see **Exhibit F-7**) contains information to assist HHAs in understanding their performance on the individual OASIS items included in the two (2) TNC composite measures, in addition to the percentage of episodes in which there was no change, positive change, or negative change for each OASIS item. These OASIS-based performance data are specific to the two (2) Total Normalized Composite (TNC Change measures and are not risk-adjusted. 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). The TNC Change Reference tab contains:

1. The number of eligible quality episodes used to generate the TNC Change measures.
2. The percentage of observed change in OASIS item responses between SOC/ROC and EOC, as a percentage of the eligible quality episodes in columns under "YOUR HHA" (as cited in footnote "e").
3. HHAs can compare their agency's performance on the TNC measures with the average for their cohort by reviewing the columns under "Average for Your HHA's Cohort," which present the average percentages by the level of change between SOC and EOC (No Change, Positive Change, Negative Change) for all HHAs in the cohort with at least 20 eligible episodes in the performance year data period.

Exhibit F-7. IPR TNC Change Reference Tab

	1	2		3		
Your HHA's count of eligible quality episodes [c]	**341**					
OASIS Item [d]	**Changes in OASIS Item Responses between SOC/ROC and EOC as a Percent of Eligible Quality Episodes [e]**					
	YOUR HHA			**AVERAGE FOR YOUR HHA'S COHORT [f]**		
	% No Change	**% Positive Change**	**% Negative Change**	**% No Change**	**% Positive Change**	**% Negative Change**
Total Normalized Composite (TNC) Change in Mobility						
M1840 Toilet Transferring (0-4)	16%	81%	3%	27%	72%	1%
M1850 Transferring (0-5)	14%	83%	3%	20%	79%	1%
M1860 Ambulation/Locomotion (0-6)	13%	85%	2%	19%	80%	1%
Total Normalized Composite (TNC) Change in Self-Care						
M1800 Grooming (0-3)	14%	84%	2%	18%	81%	1%
M1810 Ability to Dress Upper Body (0-3)	15%	82%	3%	17%	82%	1%
M1820 Ability to Dress Lower Body (0-3)	13%	84%	2%	18%	81%	1%
M1830 Bathing (0-6)	16%	82%	2%	15%	84%	1%
M1845 Toileting Hygiene (0-3)	15%	83%	1%	18%	81%	1%
M1870 Feeding or Eating (0-5)	32%	62%	6%	41%	58%	2%

Notes:

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

SOC = Start of Care; ROC = Resumption of Care; EOC = End of Care. N/A = Not Applicable.

[a] Your HHA's cohort is determined by your HHA's unique beneficiary count in CY 2023.

If your HHA's cohort shows "N/A" (Not Applicable), your HHA could not be assigned to a cohort in this report and cohort information presented in this report is based on the larger-volume cohort, which most HHAs fall into. Updates to your cohort assignment will appear in future reports as applicable. For more information, please refer to the Expanded HHVBP Model Guide.

[b] This table is a reference tool for HHAs to view their performance on the components of the two TNC change measures. It is not intended to provide HHAs with all the information needed to construct the TNC change measures. HHAs should refer to their iQIES reports or internal databases to track how each patient performed at EOC relative to SOC/ROC. Please refer to the Expanded HHVBP Model Guide for more information on the TNC change measures.

[c] The count of quality episodes used in constructing each TNC Normalized Composite measure. For more information on measure specifications, including exclusions, please refer to the Expanded HHVBP Model Guide.

[d] Response value range in parentheses. OASIS item response zero (0) indicates independence in performing the activity and higher values indicate less independence in performing the activity.

[e] For each HHA, eligible quality episodes used in constructing the TNC change measures are categorized as follows:

- The episode is categorized as "No Change" if the End of Care (EOC) item value is the same as the Start of Care (SOC)/Resumption of Care (ROC) item value.
- The episode is categorized as "Positive Change" if the EOC item value indicates greater independence (lower response value) compared with the SOC/ROC item value.
- The episode is categorized as "Negative Change" if the EOC item value indicates less independence (higher response value) compared with the SOC/ROC item value.

The counts for each category are divided by the total number of eligible quality episodes to obtain the percentages shown in the table. Due to rounding, percentages may not add up to 100%.

[f] "Average for Your HHA's Cohort" represents the average percentages by category (No Change, Positive Change, Negative Change) for all HHAs in your HHA's cohort. Due to rounding, percentages may not add up to 100%.

Achievement Thresholds & Benchmarks Tab

The Achievement Thresholds & Benchmarks tab (see Exhibit F-8) contains the timeframes and data used to calculate the final achievement thresholds and benchmarks. The Achievement Thresholds & Benchmarks tab contains:

1. The Data Period column, which indicates the data used to calculate the final achievement thresholds and benchmarks. Note that achievement thresholds and benchmarks are not calculated for HHCAHPS measures for HHAs in the smaller-volume cohort. The achievement thresholds & benchmarks are calculated specific to each cohort for each applicable measure based on the Model baseline year, which is calendar year (CY) 2022 for the CY 2023 performance year.
2. Achievement Threshold: the 50th percentile or median measure values for all HHAs in the specific cohort; used for calculating the achievement score (see Achievement Tab).
3. Benchmark: the mean of the top decile of measure values for all HHAs in the specific cohort. Used for calculating both the achievement score and the improvement score (see Achievement and Improvement Tabs).

Exhibit F-8. Achievement Thresholds & Benchmarks Tab

	1	2		3	
Measure	Data Period [b] (12-Month End Date)	Achievement Threshold [c]		Benchmark [c]	
		Smaller-volume Cohort	Larger-volume Cohort	Smaller-volume Cohort	Larger-volume Cohort
OASIS-based Measures					
Discharged to Community	12-31-2022	66.012	72.652	88.914	84.249
Improvement in Dyspnea	12-31-2022	74.818	86.305	99.991	98.512
Improvement in Management of Oral Medications	12-31-2022	68.978	80.990	99.409	97.899
Total Normalized Composite (TNC) Change in Mobility	12-31-2022	0.605	0.744	0.987	1.011
Total Normalized Composite (TNC) Change in Self-Care	12-31-2022	1.726	2.123	2.773	2.733
Claims-based Measures					
Acute Care Hospitalizations	12-31-2022	12.011	13.907	4.869	7.773
Emergency Department Use Without Hospitalization	12-31-2022	8.327	11.782	1.245	4.689
HHCAHPS Survey-based Measures					
Care of Patients	12-31-2022	-	89.254	-	94.448
Communications Between Providers and Patients	12-31-2022	-	86.626	-	93.036
Specific Care Issues	12-31-2022	-	82.048	-	91.198
Overall Rating of Home Health Care	12-31-2022	-	85.941	-	94.337
Willingness to Recommend the Agency	12-31-2022	-	79.986	-	91.202

Notes:

N/A = Not Applicable.

[a] Your HHA's cohort is determined by your HHA's unique beneficiary count in CY 2023.

If your HHA's cohort shows "N/A" (Not Applicable), your HHA could not be assigned to a cohort in this report and cohort information presented in this report is based on the larger-volume cohort, which most HHAs fall into. Updates to your cohort assignment will appear in future reports as applicable. For more information, please refer to the Expanded HHVBP Model Guide.

[b] Data period for calculating the final Achievement Thresholds and Benchmarks.

[c] The 50th percentile (median) measure value for HHAs in your HHA's cohort is the final Achievement Threshold for each measure. The mean of the top decile measure values for HHAs in your HHA's cohort is the final Benchmark. The final Achievement Threshold and Benchmark for each measure is based on CY 2022 baseline year data. Achievement Thresholds and Benchmarks are not calculated for HHCAHPS Survey-based measures for HHAs in the smaller-volume cohort. For additional guidance on how to interpret your HHA's cohort statistics, please refer to the Expanded HHVBP Model Guide.

Appendix G. Accessible Graphics Text

Exhibit	Text
Exhibit 3	This exhibit shows a graphic displaying the timeline for the expanded HHVBP Model by performance year and corresponding payment year through calendar year (CY) 2028: • First performance year (CY 2023) impacts payments in the first payment year (CY 2025). • Second performance year (CY 2024) impacts payments in the second payment year (CY 2026). • Third performance year (CY 2025) impacts payments in the third payment year (CY 2027). • Fourth performance year (CY 2026) impacts payments in the fourth payment year (CY 2028).
Exhibit 5	This exhibit shows a graphic with the following information: 1. Quality Measures Data: Follow current data collection systems that are in place for the OASIS-based, and HHCAHPS Survey-based measures. Note: HHAs do not need to submit additional data to fulfill the requirements of the HHVBP Model, as HHAs already submit data to fulfill the requirements of the HH QRP. 2. Total Performance Scoring: A competing HHA that meets the minimum threshold of at least five (5) quality measures will receive a TPS. 3. Interim Performance Reports (IPRs): a. Preliminary IPR: Provide preliminary performance scores, achievement and improvement points for each measure for that quarter. Available in iQIES quarterly in January, April, July, and October. • Recalculation Requests: HHAs may request a recalculation of performance scores if an HHA believes there is evidence of an error. HHAs must submit requests within 15 days following Preliminary IPR availability in iQIES. b. Final IPR: Provide performance scores, achievement and improvement points, and TPS, as well as any changes resulting from approved recalculations. 4. Annual Performance Reports (APRs): a. Preview APR: APRs include information on quality measure performance and the APP. Available in iQIES annually in August. • Recalculation Requests: HHAs may request a recalculation of performance scores if an HHA believes there is evidence of an error. HHAs must submit requests within 15 days following Preview APR availability in iQIES. b. Preliminary APR: Available in iQIES in September or October after recalculation requests are considered. • Reconsideration and Administrator Review Requests: HHAs that submit a recalculation request may submit a reconsideration request within 15 days if it disagrees with the results of a recalculation request decision. An HHA may request Administrator review of reconsideration decisions within seven (7) days. c. Final APR: HHAs will be notified when their Final APR is available in iQIES (at least 30 days prior to the applicable payment year). 5. Payment Adjustments: The APP is the percentage by which a competing HHA's final Medicare FFS final claim payment is changed (maximum of five percent (5%) upward or downward). The Final APR includes the APP and is available no later than 30 calendar days before the payment adjustment takes effect.
Exhibit 7	This exhibit defines volume-based cohorts. CMS assigns all HHAs to one of two nationwide volume-based cohorts: larger-volume cohort or smaller-volume cohort. The assignment of an HHA to a cohort is determined by the number of unique beneficiaries served by an HHA with a completed quality episode in the calendar year prior to the performance year. HHAs then compete in either the larger-volume cohort or smaller-volume cohort. • The smaller-volume cohort includes HHAs that had fewer than 60 unique beneficiaries in the calendar year prior to the performance year. • The larger-volume cohort includes HHAs that 60 or more unique beneficiaries in the calendar year prior to the performance year.

Exhibit	Text
Exhibit 13	This describes the relationship between the achievement score (also referred to as achievement points), the achievement threshold, and the benchmark. The achievement score determines each HHA's level of performance on each applicable measure in the performance year(s) relative to other HHAs within the respective volume-based cohort in the Model baseline year. The achievement score falls within the range of zero (0) to 10 points.
Exhibit 15	This exhibit describes the relationship between the improvement score (also referred to as improvement points), the HHA's improvement threshold, and the benchmark. The improvement score determines each HHA's level of performance on each applicable measure in the performance year(s) relative to its own performance in the baseline year(s). The improvement score falls within the range of zero (0) to nine (9) points.
Exhibit 16	This exhibit visually presents the Total Performance Score (TPS) Components, the relationship between the components, and how the components are used to calculate the TPS. 1. HHA performance scores are calculated for each quality measure for a designated performance year. 2. HHA performance scores are used to calculate achievement and improvement points for each applicable measure. 3. The higher of achievement or improvement points for each applicable measure become Care Points. 4. Care points for each measure are weighted and then totaled. 5. The result is the TPS, a numeric score ranging from zero (0) to one hundred (100) that is awarded to each competing HHA based on its performance.
Exhibit 18	This exhibit illustrates the relationship between the TPS and APP. As the TPS, which ranges from zero (0) to one hundred (100), increases, so does the resulting APP, which ranges from negative five percent to positive five percent (–5% to +5%). The Payment Adjustment Methodology for the expanded HHVBP Model relies on an equation known as the Linear Exchange Function (LEF) which is used to translate each HHA's TPS into the payment adjustment percentage applied in the corresponding payment year. For example, calendar year (CY) 2023 was the first performance year and CY 2025 was the corresponding first payment year. 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. CMS applies the APP for all eligible HHAs to their Medicare FFS payments. • If the payment percentage is positive, the payment amount increases according to the APP. • If the payment percentage is negative, the agency's payment amount decreases according to the APP. CMS will notify HHAs of their payment adjustment percentage via the Preview and Preliminary APR prior to issuing the Final APR in iQIES.
Exhibit 21	The exhibit visually displays the IPR availability and the appeals process timeline: 1. Preliminary IPRs: CMS publishes Preliminary IPRs via iQIES in January, April, July, and October. • Recalculation Requests: HHAs have 15 days to submit a recalculation request after the Preliminary IPR is published. 2. Final IPRs: Final IPRs are published to iQIES after CMS processes recalculation requests one to two (1-2) months after the Preliminary IPRs are published.
Exhibit 22	1. This exhibit visually displays the APR availability and the appeals process timeline: Preview APRs: CMS publishes Preview Reports via iQIES in August. • Recalculation Requests: HHAs have 15 days to submit a recalculation request after the preview report is published. 2. Preliminary APRs: Preliminary Reports are published to iQIES after CMS processes recalculation requests. • Reconsideration Request: Only HHAs that submitted a recalculation request may submit a reconsideration request within 15 days after Preliminary Reports are published. • An HHA 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. 3. Final APRs: Final Reports are published via iQIES in December, at least 30 days prior to HHAs receiving the first payment adjustment.