CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Expanded Home Health Value-Based Purchasing (HHVBP) Model

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Abt

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OASISanswers

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Contents

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, acronyms, and definitions used in the expanded Model in Appendix A and Appendix B. In addition to the Guide, CMS provides HHAs resources, 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 staff involved with the expanded Model should register for the Expanded HHVBP Model listserv to receive emails alerting HHAs of 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. 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. Resources to assist HHAs with implementation of the HHVBP Model are available on the Expanded HHVBP Model webpage: https://www.cms.gov/priorities/innovation/innovation-models/ expanded-home-health-value-based-purchasing-model There are help desks to support HHAs with implementation of the expanded Model, as 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) (**Exhibit 2**).

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

Exhibit 1. HHVBP Model and iQIES Help Desks Contact Information

HHVBP Model Help Desk	iQIES Help Desk
Questions related to the Model implementation, calculations, reports, and available HHVBP resources. Email: HHVBPquestions@cms.hhs.gov	Technical questions related to Internet Quality Improvement 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 HH CAHPS Help Desks Contact Information

Home Health Quality Reporting Program Help Desks	
Home Health Quality Help Desk	**Home Health CAHPS**
Questions related to OASIS 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 Home Health CAHPS Survey or the Patient Survey Star Ratings. Email: hhcahps@rti.org Phone: 1 (866) 354-0985

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 year of data collection 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 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 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. The evaluation of the original Model also found reductions in unplanned acute care hospitalizations and skilled nursing facility (SNF) stays, resulting in reductions in inpatient and SNF spending[1] 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. 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, as reported in the Evaluation of the HHVBP Model – Sixth Annual Report.

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 HHVBP Model

On January 8, 2021, CMS announced the certification of HHVBP for nationwide expansion.[2] The goals of the 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 Medicare HH PPS. Performance

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1 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 November 21, 2024.

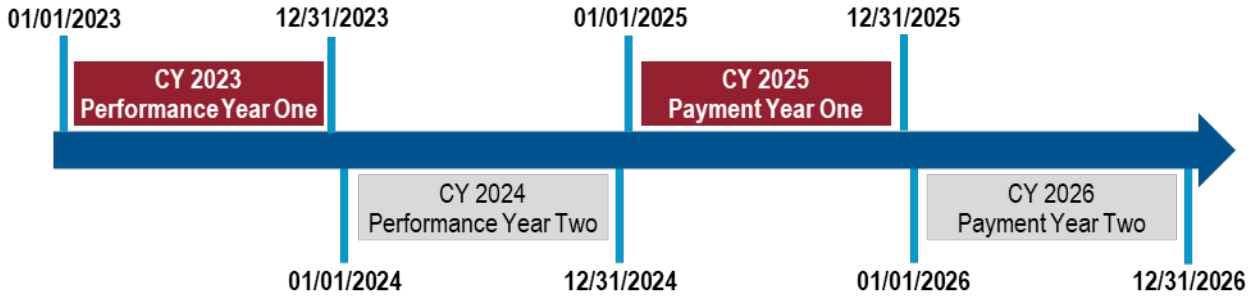
2 Centers for Medicare & Medicaid Services. CMS Takes Action to Improve Home Health Care for Seniors, Announces Intent to Expand Home Health Value-Based Purchasing Model. January 2021; https://www.cms.gov/newsroom/press-releases/cms-takes-action-improve-home-health-care-seniors-announces-intent-expand-home-health-value-based. Accessed November 21, 2024.

is assessed by both achievement and improvement across a set of quality measures. For details about the expanded Model measure set, please refer to Section 4.

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 will apply a reduction or increase of up to 5% to an HHA's Medicare fee-for-service (FFS) payments, 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, CY 2023, began January 1, 2023. During each performance year of the expanded Model, CMS will assess the HHA performance on the quality measures to determine payment adjustment amounts that will be applied during the respective payment year. **Exhibit 3** is an example of payment and model years' timeline for the CY 2024 and CY 2025 performance years and the CY 2025 payment year.

Exhibit 3. Example CY 2023 Performance Year and CY 2025 Payment Year, and CY 2024 Performance Year and CY 2026 Payment Year Timeline for the Expanded HHVBP Model



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 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 2025, 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.
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 *For more information, please see Section 9.	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 Total Performance Score (TPS) and payment adjustment. • Updates effective CY 2025 • Updated the applicable measure set and measure weights. 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.

Agency Change of Ownership (CHOW)

If a change in 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, then the HHA baseline and the performance year scores transfer to the new owners.

Billing Process

There are no changes to an HHA's billing processes for the expanded HHVBP Model. Under the expanded Model, payment adjustments (Adjusted Payment Percentage, or APP) are the amount by which a competing HHA's final Medicare FFS claim payment amount under the HH PPS is changed in accordance with the methodology described in §484.370. Under the expanded Model, CY 2023 is the first performance year and CY 2025 will be the first payment year. CMS will apply a payment adjustment of a maximum of 5% upward or downward in CY 2025 based on an HHA's performance in CY 2023. CY 2024 is the second performance year and CY 2026 will be the second payment year. CMS will apply a payment adjustment of a maximum of 5% upward or downward in CY 2026 based on an HHA's performance in CY 2024.

Once CMS calculates the APP for HHAs eligible for a payment adjustment, the process is as follows for HH PPS claims for Medicare FFS beneficiaries:

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

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

Staying Up to Date

To stay informed about the expanded Model, HHAs can consider taking the following actions:

- Review the HH PPS final rules (See Exhibit 4 for links to final rules). See the final rules' table of contents to locate information on the expanded HHVBP Model.
- Visit and bookmark the Expanded HHVBP Model webpage.
- Subscribe to the Expanded HHVBP Model listserv by entering your email address on the contact form, then select "Home Health Value-Based Purchasing (HHVBP) Expanded Model" from the *Center for Medicare and Medicaid Innovations (CMMI)* section. To ensure you receive expanded Model communications via email, please add "cmslists@subscriptions.cms.hhs.gov" to your email safe sender list.
- Confirm agency access to Internet Quality Improvement and Evaluation System (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 Home Health Agency (HHA) Providers.
- Access and review the quarterly Interim Performance Reports (IPRs) and the Annual Performance Reports (APRs) available in iQIES in the "HHA Provider Preview Reports" folder.
- Review the quality measures in the expanded Model. See Appendix C.
- Contact the HHVBP Help Desk with questions: HHVBPquestions@cms.hhs.gov.

Implementation

The expanded Model is a mandatory model. All Medicare-certified HHAs will be subject to future 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 four (4) components: collection and submission of quality measure data (already reported by HHAs through the HH QRP), total performance scoring, performance feedback reports, and payment adjustments. **Exhibit 5** highlights these components and the key aspects of each. For more information on the components *in context of CY 2023 and CY 2024 performance years*, refer to the following sections:

- Quality Measures Data: Section 4
- Total Performance Scoring: Section 5
- Payment Adjustment: Section 6
- Interim Performance Reports: Section 7.3
- Annual Reports: Section 7.4

For information about the expanded Model changes finalized in the CY 2024 HH PPS, please see Section 9.

Exhibit 5. Expanded HHVBP Model Components – CY 2023 and CY 2024 Performance Years

Quality Measure Data

Data Collection

Follow current data collection systems that are in place for the OASIS-based, claims-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.

Total Performance Scoring

An HHA that meets the minimum threshold of at least five (5) quality measures will receive a TPS.

Measure Category	Number of Measures	Threshold
OASIS-based	5	20 home health quality episodes
Claims-based	2	20 home health stays
HHCAHPS Survey-based	5	40 completed surveys

Interim Performance Reports (IPR)

Preliminary IPR

Provide preliminary performance scores, achievement and improvement points, and TPS. 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.

Final IPR

Provide preliminary performance scores, achievement and improvement points, and TPS, as well as any changes resulting from approved recalculations.

Annual Performance Reports (APR)

Preview APR

APRs include information on quality measure performance and the HHA's Adjusted Payment Percentage (APP). Available in iQIES annually in August.

Recalculation Requests

HHAs may request recalculation of performance scores if a HHA believes there is evidence of an error. HHAs must submit requests within 15 days following Preview APR availability in iQIES.

Preliminary APR

Available in iQIES in September or October after recalculation requests are considered

Reconsideration Requests & Administrator Review

HHAs that submit a recalculation request may submit a reconsideration request within 15 days if it disagrees with the results of a recalculation request. An HHA may request CMS Administrator review of reconsideration decisions within 7 days.

Final APR

HHAs will be notified when their Final APR is available in iQIES (at least 30 days prior to the first payment adjustment).

Adjusted Payment Percentage (APP)

The APP is the percentage by which a competing HHA's final Medicare fee-for service final claim payment is changed. CMS will apply a payment adjustment of a maximum of 5% upward or downward to competing HHAs' final claim payment.

The Final APR includes the APP and is available no later than 30 calendar days before the payment adjustment takes effect.

1. Eligibility Criteria

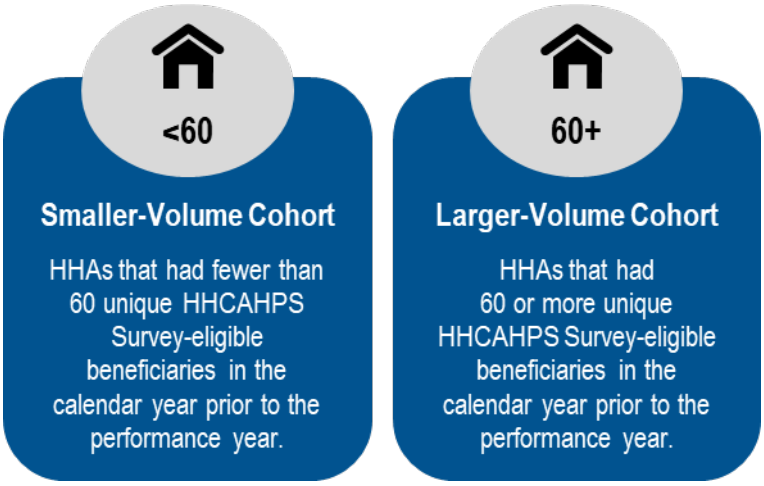
Participation in the expanded Model is mandatory for all Medicare-certified HHAs with a CCN in the 50 States, District of Columbia, and U.S. territories. A "competing HHA" is an HHA that has current Medicare certification and receives Medicare HH PPS payments from CMS. Services include those provided to individuals who are dually eligible, e.g., individuals enrolled in both Medicare and Medicaid.

All HHAs that are Medicare-certified before January 1, 2022, will have their CY 2023 performance assessed and are eligible for a CY 2025 payment adjustment. All HHAs that are Medicare-certified before January 1, 2023, will have their CY 2024 performance assessed and are eligible for a CY 2026 payment adjustment. 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 to the corresponding payment year.

2. Cohorts

For the expanded Model, CMS establishes cohorts prospectively, determined by the number of unique HHCAHPS Survey-eligible beneficiaries for each HHA in the calendar year prior to the performance year. HHAs compete in either a nationwide larger-volume cohort or nationwide smaller-volume cohort. This approach allows for grouping of HHAs that are of similar size and more likely to receive scores on the same set of measures, for purposes of setting benchmarks and achievement thresholds and determining payment adjustments. **Exhibit 6** shows the definition of each cohort – smaller-volume and larger-volume. It is possible that the assigned cohort for an HHA will change depending on the beneficiary count during the applicable CY. For example, an HHA with a beneficiary count 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. Cohort assignments are updated once a year in July based on the calendar year prior to the performance year.

Exhibit 6. Smaller-Volume and Larger-Volume Cohort Definitions



CMS believes that separating smaller- and larger-volume HHAs into cohorts under the expanded HHVBP Model facilitates like comparisons by allowing the majority of HHAs to compete for payment adjustments against other HHAs of similar size and on similar measures. 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 adjusted payment percentages (APP). Using nationwide, rather than state/territory-based cohorts in data 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 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) 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). Competing HHAs that perform similarly to others in the same volume-based cohort may receive a small, or no, payment adjustment.

3. Model Years

There are several types of years for the Model: performance year, payment year, Model baseline year and HHA baseline years. Each category aligns with the calendar year (January 1 – December 31).

3.1 Performance Year

Performance year refers to the CY during which CMS uses performance on applicable measures to calculate an HHA's Total Performance Score (TPS). The first performance year began on January 1, 2023.

3.2 Payment Year

The payment year is the CY in which the adjusted payment percentage (APP) for a designated performance year applies. The payment year is two (2) CYs after the performance year. For example, HHAs certified by Medicare before January 1, 2022 that have sufficient data will have their performance assessed during CY 2023 (the first performance year), receive their first APR in CY 2024, and be eligible for the APP in CY 2025 (the first payment year).

3.3 Baseline Years

CMS uses a baseline year for calculations at the Model level for each of the two (2) cohorts, referred to as the Model baseline year, and a baseline year for calculations at the individual HHA level, referred to as the HHA baseline year. CMS provides baseline year data via IPRs and APRs as soon as administratively feasible, dependent on the availability of quality measure data.

Model baseline year. The CY used to determine the cohort-specific achievement threshold and benchmark for each measure is the Model baseline year. For the CY 2023 and CY 2024 performance years, the Model baseline year is CY 2022. For information about the Model baseline year changes effective at the start of CY 2025 performance year, see Section 9.

HHA baseline year. The CY 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 for each quality measure using the HHA's Medicare-certification date and determining whether the HHA has sufficient data to establish a baseline year for a particular quality measure:

- HHAs with a date of Medicare Certification prior to January 1, 2022: The HHA's baseline year is CY 2022.

Model Year Definitions

- ✓ **CY 2023** – First Performance Year
- ✓ **CY 2025** – First Payment Year (based on performance in CY 2023)

Achievement threshold is 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, used to calculate achievement points for each measure.

Benchmark is the mean of the top decile (90th percentile) of all HHAs' performance scores on a specified quality measure during the 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.*

Improvement threshold is an individual competing HHA's performance on an applicable measure during the HHA baseline year, used to calculate improvement points for each measure.

- HHAs with a date of Medicare Certification on or after January 1, 2022: The HHA's baseline year is the first full calendar year of services beginning after the date of Medicare certification.

Note that the HHA baseline years listed above refer to the first possible baseline year for an HHA for each quality measure. If an HHA does not have sufficient data to create a measure score for a measure in the first possible baseline year, the following year(s) may qualify to become the HHA baseline year if the HHA has sufficient data for that measure in that 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 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 7 illustrates the Model baseline year, HHA baseline year, performance year, and payment year based on the date of Medicare certification for HHAs certified through December 31, 2023. For HHAs certified after December 31, 2023, see Section 9.

Exhibit 7. Model Baseline, HHA Baseline, Performance, and Payment Years

Medicare-certification Date	Model Baseline Year*	HHA Baseline Year**	Performance Year (CY)	Payment Year (CY)
1	2	3	4	5
Prior to January 1, 2022	2022	2022	2023	2025
January 1, 2022 – December 31, 2022	2022	2023	2024	2026
January 1, 2023 – December 31, 2023	2022	2024	2025	2027

* CY 2022 is the Model baseline year used to determine the benchmarks and achievement thresholds for the CY 2023 and CY 2024 Performance Years. CY 2023 is the Model baseline year used to determine the benchmarks and achievement thresholds for CY 2025 and subsequent Performance Years.

** For HHAs certified on or after January 1, 2022, the HHA baseline year will be the first full CY of services beginning after the date of Medicare certification if sufficient data are available in that year. HHA baseline years refer to the first possible baseline year for each quality measure dependent upon an HHA having 1) a full calendar year of data and 2) meeting the minimum data threshold, for 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. For more information, please see Section 3.3.

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. Furthermore, health equity is a CMS priority. CMS will continue to analyze whether adding health equity measures to the expanded Model could reduce disparities in home health care.

Medicare-certified HHAs are evaluated using measures designed to encompass multiple National Quality Strategy (NQS)domains 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.

Additionally, the finalized expanded Model quality measure set aligns with data already submitted by HHAs under the HH QRP and through the process for submitting Medicare FFS claims to minimize provider documentation burden. There are three (3) data sources for the expanded Model quality measures: OASIS-based data, Medicare FFS claims, and HHCAHPS Survey-based data. **Exhibit 8** provides details of each measure category and source. For the full list of applicable quality measures used in the expanded Model, please refer to Appendix C.

Exhibit 8. Expanded HHVBP Model Applicable Measure Category Descriptions

Category Description
OASIS-based Measures
OASIS-based measures are calculated using data collected in the Outcome and Assessment Information Set (OASIS) 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.
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. Lower values indicate fewer adverse or negative events for patients at that HHA. For more information on claims-based measures, refer to the CMS Home Health Quality Reporting Program website.
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 thirty-four 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 Total Performance Score (TPS) calculations for the smaller-volume cohort.*

*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. 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. HHAs do not submit OASIS data for patients receiving maternity-related services and patients under the age of 18.

4.1 Payers Included in the Expanded HHVBP Model

Payment adjustments in the expanded Model apply only to HH Medicare FFS claims. Quality measures used in the expanded Model are calculated using data from all Medicare and Medicaid payers (health care insurances), as shown in **Exhibit 9.**

Note that 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.

Exhibit 9. Payers Included in the Expanded HHVBP Model

Measure Category	Payer(s)
OASIS-based Measures and HHCAHPS Survey-based Measures	Medicare FFS, Medicare Advantage, Medicaid FFS, and Medicaid Managed Care
Claims-based Measures	Medicare FFS

4.2 Quality Measure Data Submission

Quality measures in the expanded Model are calculated using data HHAs submit on Medicare FFS claims, and to meet HHQRP and HHCAHPS requirements.

4.3 OASIS-based Measures for the CY 2023 and CY 2024 Performance Years

The OASIS-based measures included in the quality measure set for the expanded HHVBP Model include:

- Discharged to Community
- Improvement in Dyspnea (Dyspnea)
- Improvement in Management of Oral Medications (Oral Medications)
- Total Normalized Composite Change in Mobility (TNC Mobility)
- Total Normalized Composite Change in Self-Care (TNC Self-Care)

In the calculation of OASIS-based measures, a quality episode begins with either a Start of Care (SOC) or Resumption of Care (ROC) and ends with a transfer, death at home, or discharge for a patient, regardless of the length of time between the start and ending events. For descriptions of the OASIS-based measures such as Improvement in Dyspnea, Discharged to Community, and Improvement in Management of Oral Medications), please refer to the Home Health Outcome Measures Table.

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.

For the complete list of OASIS-based measures contained in the expanded Model quality measure set please refer to Appendix C. For additional information on OASIS-based measures,

including measure exclusions, please refer to the CMS Home Health Quality Reporting Program website.

OASIS-based Measures: Total Normalized Composite Measures

Two (2) measures unique to the expanded Model for the CY 2023 and CY 2024 performance years are the TNC Mobility and TNC Self-Care measures. These two measures will be replaced with the OASIS-based Discharge Function Score (DC Function) measure effective for the CY 2025 performance year.

The TNC composite measures calculate the magnitude of change based on a normalized amount of possible change for nine (9) OASIS-based Activities of Daily Living (ADL) items.

The TNC measures are calculated using quality episodes that begin with a SOC/ROC and end with a discharge. Not included in the calculation are quality episodes that begin with a SOC/ROC and end with a transfer or death at home, since these time points do not include the M-items used in the measures.

The three (3) OASIS items used for TNC Mobility are:

- Toilet Transferring (M1840)
- Bed Transferring (M1850)
- Ambulation/Locomotion (M1860)

The six (6) OASIS items used for TNC Self-Care measure are:

- Grooming (M1800)
- Upper Body Dressing (M1810)
- Lower Body Dressing (M1820)
- Bathing (M1830)
- Toileting Hygiene (M1845)
- Eating (M1870)

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

The data included in the OASIS-based measures are OASIS quality episodes that ended during the 12-month performance year data period, determined from the date of the OASIS end of care assessment.

For additional information about risk adjustment under the expanded Model, please refer to the resources on the Expanded HHVBP Model webpage, under "Quality Measures."

4.4 Claims-based Measures

Claims-based measures are derived from Medicare FFS claims data submitted to CMS for payment purposes by HHAs and other providers. For the CY 2023 performance year/CY 2025 payment year, the claims-based measures include the following two (2) measures in the expanded Model measure set:

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

These measures will be retired from the expanded HHVBP Model measure set and replaced with the claims-based measures Potentially Preventable Hospitalization (PPH) and Discharge to Community (DTC) effective for the CY 2025 performance year.

Claims-based measures provide data related to the use of health care services (for example, hospitals, emergency departments, etc.) resulting from a change in patient health status. CMS calculates claims- based measures using claims data submitted to CMS for payment purposes. Therefore, HHAs do not need to submit additional information for purposes of calculating claims-based measures. The source data for these claims-based measures are 12 months of claims data during the applicable performance period for the expanded Model. The data included in the claims-based measures are home health stays with a start date during the 12-month performance year data period. Home health stays are constructed through analysis of Medicare FFS claims.

Details for the claims-based measures contained in the expanded Model quality measure set are available in Appendix C. 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 the resources on the Expanded HHVBP Model webpage, under "Quality Measures."

4.5 HHCAHPS Survey-based Measures

HHCAHPS Survey-based measures are not included in the TPS calculations for the smaller-volume cohort. These measures are not calculated in expanded Model performance reports for the smaller-volume cohort and no achievement thresholds or benchmarks are calculated.

The Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Survey is the first national standardized and publicly reported survey of home health care patients' perspectives of their skilled home care. The HHCAHPS Survey specifically presents home health patients with a set of standardized questions about their home health care providers and about the quality of their home health care. The HHCAHPS Survey-based measures in the expanded Model measure set are the following five (5) components of the survey:

- Care of Patients (Professional Care)
- Communications between Providers and Patients (Communication)
- Specific Care Issues (Team Discussion)
- Overall Rating of Home Health Care (Overall Rating)
- Willingness to Recommend the Agency (Willingness to Recommend)

The HHCAHPS Survey-based measures are also part of the HH QRP's data submission requirements, under 42 CFR 484.245(b). HHAs are required to contract with an approved, independent HHCAHPS Survey vendor to administer the HHCAHPS on its behalf, in accordance with § 484.245(b)(1)(iii)(B). Therefore, HHAs do not need to submit any additional HHCAHPS Survey-based measure data beyond data already submitted on their behalf as a requirement under HH QRP.

HHCAHPS Survey respondents are sampled or selected from sample months during the 12-month performance year data period. HHCAHPS Survey participants are selected or sampled

from all survey-eligible patients receiving services from an HHA during a sample month and during a 60-day lookback period. HHCAHPS Survey participants can include patients discharged during the sample month, as well as those continuing to receive services. To reduce reporting burden, patients are not asked to participate in the HHCAHPS Survey more than once every six (6) months.

For details on the HHCAHPS Survey-based measures, please refer to Appendix C. For more information, visit the Home Health Care CAHPS Survey website and the Expanded HHVBP Model webpage, under "HHVBP Resources – Quality Measures."

5. Total Performance Scoring Methodology

The goal of the total performance scoring methodology is to produce a Total Performance Score (TPS) for each qualifying HHA based on its care points derived from each weighted quality measure performance score included in the expanded Model. A qualifying HHA 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 then uses the TPS for all HHAs in a cohort to determine an annual distribution of value-based payment adjustments among HHAs in each cohort. The total performance scoring methodology under the expanded Model aligns with those adopted for other Medicare value- based purchasing programs. Additional resources to assist HHAs with understanding the TPS are available on the Expanded HHVBP Model webpage, under "Total Performance Score & Payment Adjustment."

5.1 Overview

Under the expanded Model, the performance scoring methodology results in a TPS for each qualifying HHA based on risk-adjusted performance scores for each applicable quality measure.

CMS then compares each HHA's TPS to the TPS of other HHAs within its respective cohort. For more information on cohorts, please refer to Section 2. **Exhibit 10** summarizes the steps for determining the TPS. Please note that CMS does not require HHAs to conduct the calculations necessary to assess performance.

Exhibit 10. 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.
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 ten (10), which quantify HHA performance on a given quality measure compared to HHAs in the same cohort.
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.
4	CMS identifies the higher of each HHA's achievement or improvement score for each applicable measure, which become care points.
5	The TPS is calculated by weighting and summing care points for each applicable measure.

5.2 Minimum Number of Applicable Measures and Minimum Thresholds

The calculation of a TPS requires an HHA to have sufficient measure data. The following is the minimum data threshold 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.

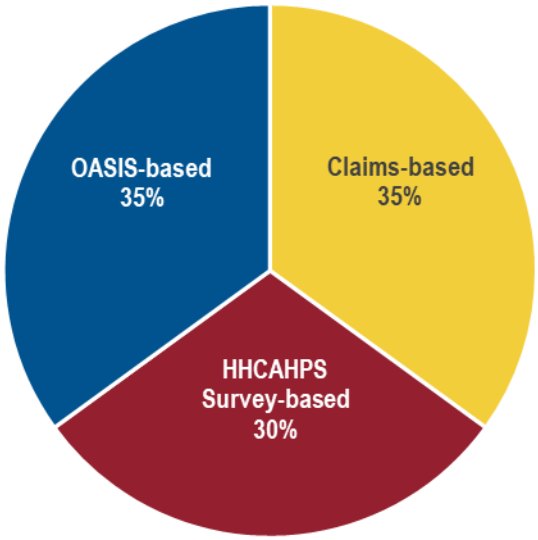
HHCAHPS Survey-based measures are not reported or included in TPS calculations for the smaller-volume cohort so that HHAs in this cohort are more likely to receive scores on the same set of measures.

In addition, an HHA must have sufficient data to allow calculation of at least five (5) of the total measures in the baseline year and performance year periods to receive a TPS and be eligible for a payment adjustment.

5.3 Weighting through CY 2024

There are 12 quality measures in the expanded Model quality 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, as shown in **Exhibit 11**.

Exhibit 11. Expanded HHVBP Model Measure Categories by Weight



If both claims-based measures have sufficient data, the ACH measure has three (3) times the weight of the ED Use measure. The ACH measure is weighted more heavily because it reflects a more severe health event, and inpatient hospitalizations generally result in more Medicare spending than the average emergency department visit that does not lead to an acute hospital admission.

For the OASIS-based measures, TNC Self-Care and TNC Mobility are weighted more heavily than the Dyspnea, Discharged to Community, and Oral Medications measures. Because TNC Self-Care and TNC Mobility measures are composed of multiple OASIS items, they are weighted 1.5 times the weight of the remaining three (3) OASIS-based measures.

For more information on within-category measure weights for the CY 2023 and CY 2024 Performance Years, refer to Appendix D.

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 smaller-volume cohort HHA has sufficient data for OASIS-based and claims-based measures but not HHCAHPS Survey-based measures, then the OASIS-based and claims-based measures each count for 50%. If two (2) measure categories are missing, the remaining category is weighted at 100%.

For more information on measure weights and redistribution of weights, refer to Appendix E.

5.4 Weighting Beginning CY 2025

Beginning in CY 2025 there will be 10 quality measures in the expanded Model quality measure set, which includes three () 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 as shown in Exhibit 11.

5.5 Calculation of Achievement Thresholds, Benchmarks, and Improvement Thresholds

Benchmarks and achievement thresholds for each volume-based cohort are based on HHA performance in the designated Model baseline year. The expanded Model benchmarks and achievement thresholds for the CY 2023 performance year/CY 2025 payment year were based on performance data from the designated Model baseline year of CY 2022 (January 1, 2022, through December 31, 2022). Achievement thresholds, benchmarks, and improvement thresholds will be updated with the CY 2025 measure set. The achievement threshold and benchmark for each applicable measure, for each cohort, and the improvement threshold for each HHA are available in each HHA's Interim Performance Report (IPR) and Annual Performance Reports (APR).

Calculation of the 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 (CY 2022). 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 (CY 2022). CMS uses the benchmark for calculating both the achievement score and the improvement score.

Calculation of the 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, relative to other HHAs in its cohort in the designated baseline year (CY 2022). CMS calculates an achievement score separately for each applicable measure using the formula in **Exhibit 12**.

Exhibit 12. Achievement Score Formula

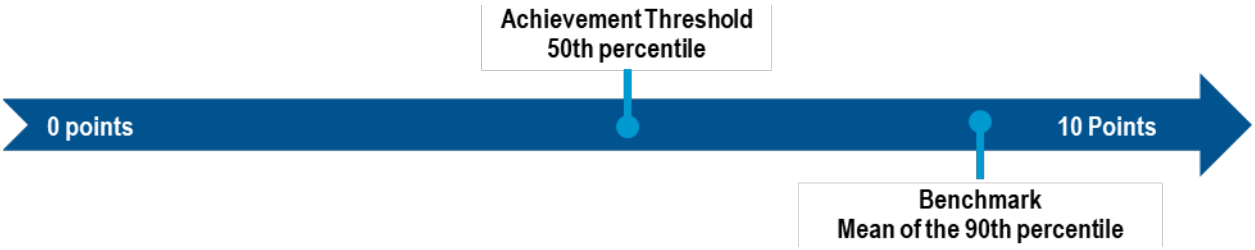
$$Achievement\ Score = 10x\ (\frac{HHA\ Performance\ Score - Achievement\ Threshold}{Benchmark - Achievement\ Threshold})$$

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**).

- 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 a 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 a HHA performance score that is less than or equal to the achievement threshold receives zero (0) points for achievement.

Exhibit 13. Achievement Score Rules



Calculation of the Improvement Thresholds

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.

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

Calculation of the Improvement Score

To determine each HHA's level of performance on each applicable measure in the performance year relative to its own performance in the baseline year, 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 (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**.

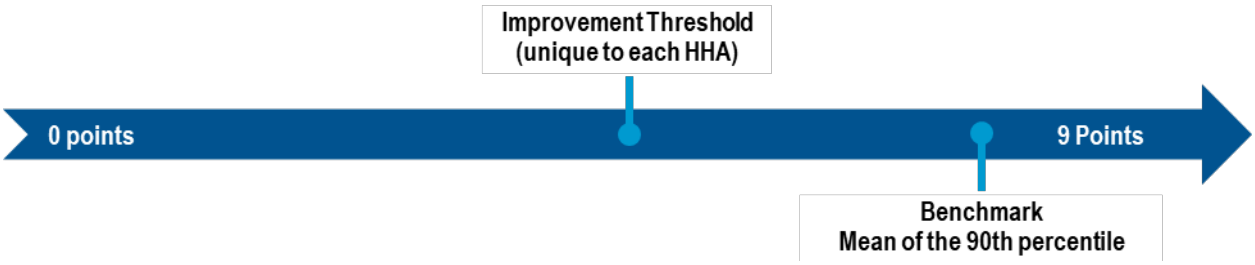
Exhibit 14. Improvement Score Formula

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

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 (visually depicted in **Exhibit 15**).

- 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.

Exhibit 15. Improvement Score Rules



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

Exhibit 16 summarizes the calculation of the achievement thresholds and benchmarks, in addition to the improvement threshold, which is an individual agency's performance on each applicable measure during the HHA's designated HHA baseline year.

Calculation of Care Points

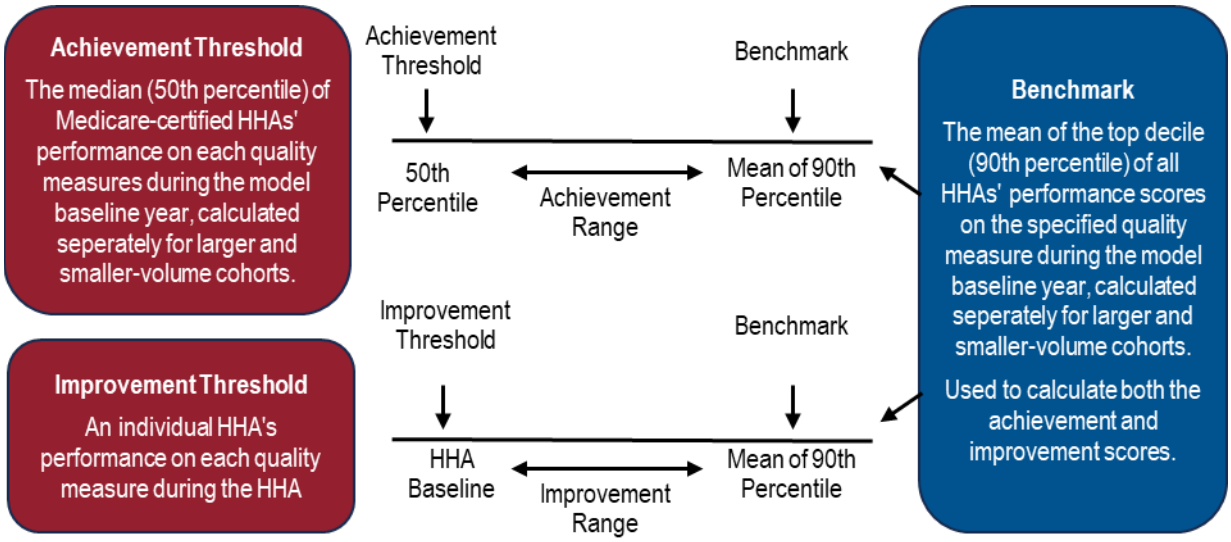
Care points are the higher of achievement points or improvement points for each measure reported in the IPR or APR.

Calculation of the TPS

The calculation of TPS is based on care points, HHA cohort assignment, and expanded HHVBP Model quality measure weights. The TPS, in addition to the factors used in calculation, are reported to HHAs in quarterly IPRs and APRs. TPS calculations use care points for up to the total number of quality measures. If an HHA does not have sufficient data to generate care points

for at least five (5) of the total 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 below.

Exhibit 16. Achievement Thresholds, Improvement Thresholds, and Benchmarks



Step 1. Apply Measure Weights to Produce 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 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). **Exhibit 17** provides a measure weight table used under various measure reporting scenarios.

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

Exhibit 17. Weighted Measure Points Formula

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

Step 2. Sum Weighted Measure Points to Produce TPS

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:

$$Sum\ of\ Weighted\ Measure\ Points = \boldsymbol{TPS}$$

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

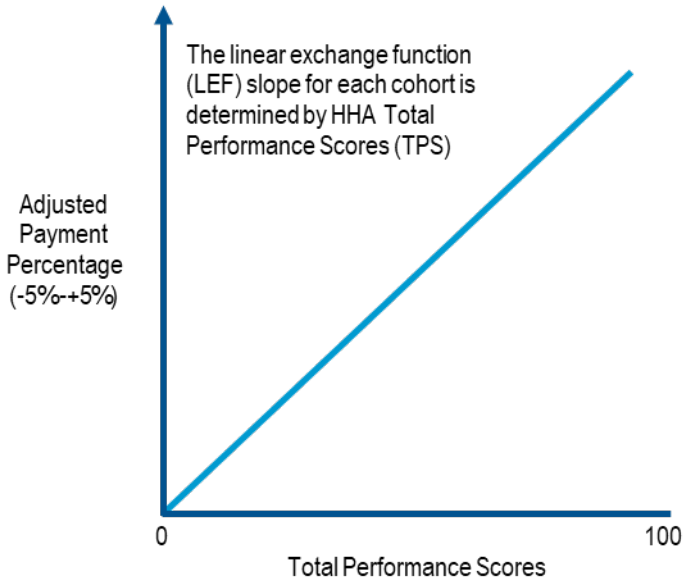
Payment adjustments are the amount by which a competing HHA's final claim payment amount under the HH PPS is changed in accordance with the methodology described in § 484.370. Under the expanded HHVBP Model, CY 2023 is the first performance year and CY 2025 will be the first payment year in which an HHA is eligible to receive a payment adjustment.

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

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 on 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**.

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 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 5%, CMS takes the excess from the agencies with > 5% and applies this excess to the cohort-level TPS-Adjusted Payment Amount. This TPS-Adjusted Payment amount (including the excess > 5%) is then used to calculate the agency and cohort LEF Ratio (Column 5). The LEF (adjusted to account for the excess >5%) is then used to calculate the agency and cohort values for (Columns 6, 7, 8) as described in the rows below.
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 5% payment reduction.
7	**Determine the HHA Final TPS-Adjusted Payment Percentage (APP)** • Subtract 5% from the HHA TPS-Adjusted Payment Percentage (Column C7). • The Final TPS-Adjusted Payment Percentage (Column C8) is capped at +/- 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 12-month data periods that are updated each quarter. CMS issues two (2) versions of the IPR—a Preliminary version and a Final 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. 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 on 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. IPRs and APRs are not available to the public. 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 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 on iQIES, such as the Star Ratings. These reports contain details on agency performance on a variety of quality measures, including those included in the expanded Model, except for the Total Normalized Composite (TNC) measures. Because the TNC measures are unique to the HHVBP Model, they are not currently publicly reported on Care Compare or other CMS reports. However, HHAs might consider reviewing their agency's performance on the Confidential Feedback Reports and Care Compare for the individual measures that are derived from the same OASIS items included in the TNC Mobility and TNC Self Care measures to see if performance offers any insights regarding quality improvement efforts. These reports 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.

Home health agencies (HHAs) are encouraged to review their IPRs to gain insights into their performance across a range of quality measures compared to their peers, consider the drivers of performance, and identify opportunities for improvement. HHAs have an opportunity to 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 issued the first APR in August 2024. A summary of the timeline for IPRs and the APR for the CY 2023 performance year/CY 2025 payment year, and for the CY 2024 performance year/CY2026 payment year, by report and data type is available in **Exhibit 20**. The measure performance periods for each report cover 12 months of performance data for each expanded Model quality measure category. It is important to note that data collection periods differ among the types of measures which results in differences in data availability by measure category.

Exhibit 20. Timeline for CY 2023 Performance Year/ CY 2025 Payment Year and CY 2024 Performance Year/CY 2026 Payment Year by Report Type and Time Periods for Performance Data

Report Title	OASIS-based Measures	Claims-based and HHCAHPS Survey-based Measures
July 2023 Interim Performance Report (IPR)	4/01/2022 – 3/31/2023	1/01/2022 – 12/31/2022
October 2023 IPR	7/01/2022 – 6/30/2023	4/01/2022 – 3/31/2023
January 2024 IPR	10/01/2022 – 9/30/2023	7/01/2022 – 6/30/2023
April 2024 IPR	1/01/2023 – 12/31/2023	10/01/2022 – 9/30/2023
July 2024 IPR	4/01/2023 – 3/31/2024	1/01/2023 – 12/31/2023
CY 2024 Annual Performance Report (APR)	1/01/2023 – 12/31/2023	1/01/2023 – 12/31/2023
October 2024 IPR	7/01/2023 – 06/30/2024	4/01/2023 – 3/31/2024
January 2025 IPR	10/01/2023 – 90/30/2024	7/01/2023 – 6/30/2024
April 2025 IPR	1/01/2024 – 12/31/2024	10/01/2023 – 9/30/2024
July 2025 IPR*	4/01/2024 – 3/31/2025	1/01/2024 – 12/31/2024
CY 2025 APR	1/01/2024 – 12/31/2024	1/01/2024 – 12/31/2024

*For the OASIS-based measures not included in the CY 2025 measure set, namely 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 2023 IPR included OASIS-based measure performance data for 12 months ending 6/30/2023. The claims-based and HHCAHPS Survey-based measures included performance data for 12 months ending 3/31/2023

The APR includes OASIS-based, claims-based and HHCAHPS Survey- based measure performance data for the prior calendar year. The CY 2024 APR included 12 months ending 12/31/2023 (for all measures), and included the HHA Final TPS-Adjusted Payment Percentage that will apply to the HHA's 2025 Medicare FFS claims.

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 by 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 HHAs with sufficient data for reporting at least one quality measure for the performance year data period.

The quality measure values reported on 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 in the measures were pulled. The quality improvement reports on iQIES provide quality data earlier than the HHVBP Model IPRs and APRs, since the quality improvement reports are not limited by a quarterly reporting timeline, and they can be produced more quickly because they do not include the ranking of HHAs within respective nationwide cohorts.

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. In addition, for the applicable measure set effective through CY 2024 HHVBP Model-specific performance reports provide competing HHAs with TNC Change Reference data and a Scorecard. The TNC Change Reference data helps HHAs gauge their performance on the individual OASIS items included in the two (2) composite measures. It informs HHAs of the percentage of episodes in which there was no change, positive change, or negative change for each OASIS item. The Measure Scorecard helps HHAs better understand how each individual measure contributes to the TPS.

Values for OASIS-based measures reported in the expanded Model performance reports (Improvement in Dyspnea and Improvement in Management of Oral Medications) and those reported in the iQIES Review and Correct Reports may differ. Differences may be due to risk adjustment, as the iQIES Review and Correct Reports use observed measure values and expanded Model performance reports use risk adjusted values.

There are 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:

- Time frame covered by the data,
- Risk adjustment and risk-adjustment model used,
- Time frame when the data are extracted,
- Completeness of the data, which can vary based on when the data were extracted,
- 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. The HHVBP Model reports are based on OASIS assessment data submitted to CMS by HHAs, Medicare claims data, and HHCAHPS data collected by HHCAHPS Survey vendors and submitted to CMS.

7.3 Interim Performance Report (IPR)

Beginning July 2023, the 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 (1) quality measure in the quarterly reporting period for the performance year.

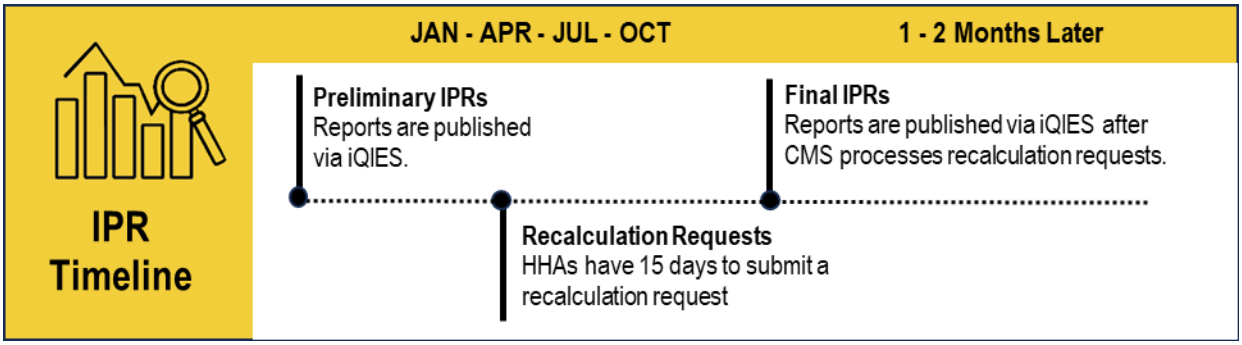
The quarterly IPR contains information on interim quality measure performance based on the 12 most recent months of data available. The IPR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. In addition, the IPR provides 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.

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

IPR Versions and Recalculation Request 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 recalculation request process.

Exhibit 21. IPR Availability and Recalculation Request 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 just a post office box); and
- A copy of any supporting documentation, not containing Protected Health Information (PHI), the HHA wishes to submit in electronic form.

The result of the recalculation will appear in the Final IPR. If an HHA does not request a recalculation, the HHA will still receive a Final IPR.

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, which is not the TPS used for the APP.

For a description of the contents of each tab in the IPR, 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 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 receive an APR for the CY 2024 performance year if the HHA: Was Medicare-certified prior to January 1, 2023, and
  - Has 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 new measure set.

APR Versions

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. 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.

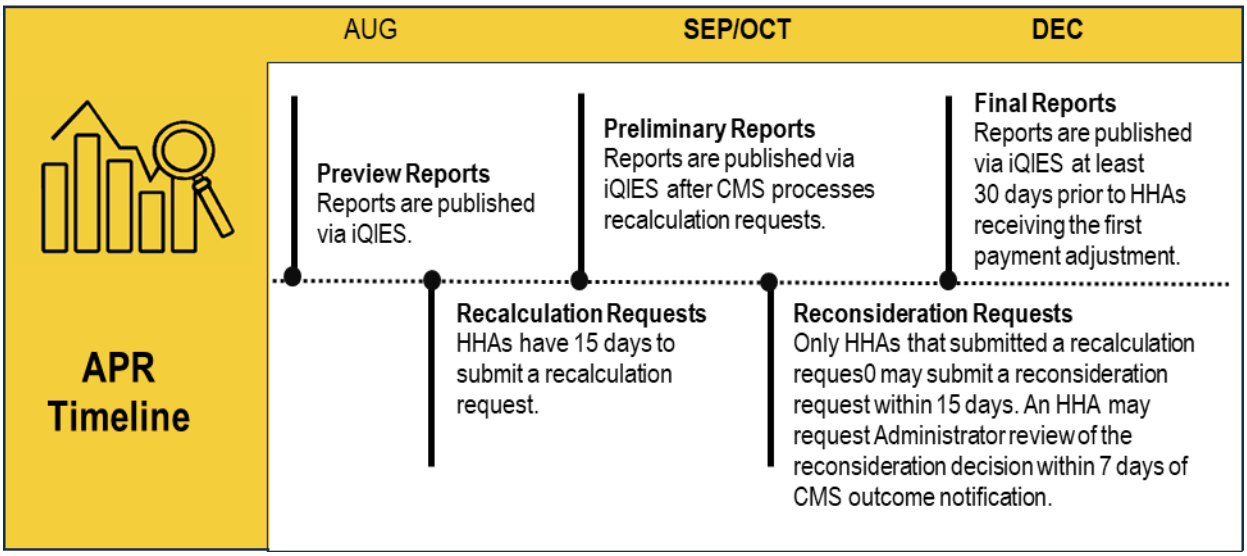
If an HHA disagrees with the results of CMS's recalculation request decision that is reflected in the Preliminary APR, the HHA may submit a ***reconsideration request*** within 15 calendar days after CMS issues the Preliminary APR. Only HHAs that submit a recalculation request may submit a reconsideration 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.

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.

Exhibit 22 illustrates the timeline of when CMS publishes the APR versions and the recalculation request, reconsideration request, and Administrator review processes.

Exhibit 22. APR Availability, Recalculation, and Reconsideration Request Timeline



8. Public Reporting

Public reporting of performance data for the expanded Model will begin with the CY 2023 performance year/CY 2025 payment year and will be available to the public on the Provider Data Catalog (PDC) website. CMS plans to first publicly report HHVBP data in January 2025 on the PDC. 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 will follow the same approximate timeline for publicly reporting the payment adjustment for the upcoming calendar year, as well as the related performance data. In addition, CMS will provide definitions for the Total Performance Score (TPS) and the TPS Percentile Ranking methodology, as well as descriptions of the scoring and payment adjustment methodology to ensure the public understands the relevance of these data points and the process for calculating.

CMS will publicly report 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);
  - TPS percentile ranking; and
  - Payment adjustment percentage for a given year.

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

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

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

9.1 Expanded HHVBP Model Changes Effective CY 2024

Measure Removal Factors

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

- Measure performance among HHAs is so high and unvarying that meaningful distinctions in improvements in performance can no longer be made (that is, topped out).
- Performance or improvement on a measure does not result in better patient outcomes.
- A measure does not align with current clinical guidelines or practice.
- A more broadly applicable measure (across settings, populations, or conditions) for the particular topic is available.
- A measure that is more proximal in time to desired patient outcomes for the particular topic is available.
- A measure that is more strongly associated with desired patient outcomes for the particular topic is available.
- Collection or public reporting of a measure leads to negative unintended consequences other than patient harm.
- The costs associated with a measure outweigh the benefit of its continued use in the program.

Appeals Process

As finalized in the CY 2024 HH PPS, beginning with the CY 2024 calendar year an HHA may request ***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***. A summary of the timeline for IPRs and the APR for the CY 2024 performance year/CY 2026 payment year by report and data type is available in **Exhibit 23**. The measure performance periods for each report cover 12 months of performance data for each expanded Model quality measure category.

Exhibit 23. Timeline for CY 2024 Performance Year and CY 2026 Payment Year by Report Type and Time Periods for Performance Data

Report Title	OASIS-based Measures	Claims-based and HHCAHPS Survey-based Measures
July 2024 Interim Performance Report (IPR)	4/01/2023 – 3/31/2024	1/01/2023 – 12/31/2023
CY 2024 Annual Performance Report (APR) 2024	1/01/2023 – 12/31/2023	1/01/2023 – 12/31/2023
October 2024 IPR	7/01/2023 – 6/30/2024	4/01/2023 – 3/31/2024

Report Title	OASIS-based Measures	Claims-based and HHCAHPS Survey-based Measures
January 2025 IPR	10/01/2023 – 9/30/2024	7/01/2023 – 6/30/2024
April 2025 IPR	1/01/2024 – 12/31/2024	10/01/2023 – 9/30/2024
July 2025 IPR*	4/01/2024 – 3/31/2025	1/01/2024 – 12/31/2024
CY 2025 APR	1/01/2024 – 12/31/2024	1/01/2024 – 12/31/2024

*For the OASIS-based measures not included in the CY 2025 measure set, namely 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.

9.2 Expanded HHVBP Model Changes Effective CY 2025

Quality Measures

OASIS-based Measures

Beginning with the CY 2025 performance year, the OASIS-based measures below will be removed from the expanded Model quality measure set:

- Discharged to Community (DTC)
- Total Normalized Composite Change in Mobility (TNC Mobility)
- Total Normalized Composite Change in Self-Care (TNC Self-Care)

The OASIS-based measures for the expanded Model beginning with the CY 2025 performance year are:

- Improvement in Dyspnea (Dyspnea)
- Improvement in Management of Oral Medications (Oral Medications)
- Discharge Function Score (DC Function)

Claims-based Measures

Beginning with the CY 2025 performance year, the two claims-based measures below will be removed from the expanded Model quality measure set:

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

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

- Home Health Within-Stay Potentially Preventable Hospitalization (PPH)
- Discharge to Community-Post Acute Care (DTC-PAC)

For additional information on these measures, please email the HH QRP Help Desk at homehealthqualityquestions@cms.hhs.gov.

Exhibit 24 summarizes the differences in quality measure sets for the CY 2023 and CY 2024 performance years compared to measures that will begin with the CY 2025 performance year.

Exhibit 24. Applicable Measure Sets – by Performance Year

Quality Measure	CY 2023, CY 2024	Beginning CY 2025
OASIS-based Measures		
Discharged to Community	X	
Improvement in Dyspnea	X	X
Improvement in Management of Oral Medications	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
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
Discharge to Community-Post Acute Care (DTC-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
Willingness to Recommend the Agency	X	X

Model Baseline Year

Beginning with the CY 2025 performance year, the Model baseline year, used the calculate the achievement threshold and benchmark for each applicable measure, will be CY 2023 for applicable measures in the measure set, except the claims-based Discharge to Community-Post Acute Care (DTC-PAC) measure, which uses two years of data, as shown in **Exhibit 25**.

Exhibit 25. Model Baseline, Performance, and Payment Years starting with the CY 2025 Performance Year and Based on Medicare Certification Date

Medicare-certification Date	Model Baseline Year*	Performance Year (CY)	Payment Year (CY)
Prior to January 1, 2024	2023	2025	2027
January 1, 2024 – December 31, 2024**	2023	2026	2028
January 1, 2025 – December 31, 2025	2023	2027	2029

* The Model baseline year for the claims-based DTC-PAC measure will be CY 2022 and CY 2023 for the 2-year performance year spanning CY 2024 and CY 2025.

Total Performance Score: Measure Weighting

Please note that the measure category weights were not changed by the CY 2024 HH PPS final rule. The measure category weights are the same for CY 2023 and CY 2024, as well as beginning CY 2025. The measure category weight is distributed to the measures within that category. **Exhibit 26** shows the individual measure weights for quality measures in the CY 2023 and CY 2024 performance years, and for performance years beginning CY 2025.

For information on within-category measure weights, refer to Appendix H.

Exhibit 26. Measure Weights – by Performance Year

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

Appendix A. Expanded HHVBP Model Glossary of Terms and Definitions

The table below contains the list of common terms definitions used specifically in the expanded Model and referenced throughout this document.

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 will be available on the Interim Performance Report (IPR) and the Annual Performance Report (APR).
Achievement Range	A scale between the achievement threshold and the designated benchmark, along which an HHA will receive achievement points for a given measure.
Achievement Threshold	The median (50th percentile) of Medicare-certified HHAs' performance scores on each quality measure during the designated Model baseline year, calculated separately for the larger and smaller-volume cohorts. CMS uses the achievement threshold for calculating the achievement score.
Annual Performance Report (APR)	A performance feedback report available to HHAs in iQIES only. The APR focuses primarily on the HHA's payment adjustment percentage for the following payment year and includes an explanation of when CMS will apply the adjustment and how CMS determined this adjustment relative to the HHA's performance scores.
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	Beginning with the CY 2024 an HHA may request 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:*** The year 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: • Sufficient data to establish a baseline year for a particular quality measure, and • The HHA's Medicare-certification date: – **HHAs with a Date of Medicare Certification prior to January 1, 2022:** The HHA's baseline year is CY 2022 (January 1, 2022 – December 31, 2022). – **HHAs with a Date of Medicare Certification on or after January 1, 2022:** The HHA's baseline year is the first full calendar year of services beginning after the date of Medicare certification. If an HHA does not have sufficient data to create a measure score in the first possible baseline year, the following year(s) may qualify to become the HHA baseline year if the HHA has sufficient data. ***Model Baseline Year:*** The year against which CMS calculates the achievement thresholds and benchmarks values for each quality measure by cohort.
Benchmark	The mean of the top decile (90th percentile) of all Medicare-certified HHAs' performance scores on the specified quality measure during the Model baseline year, calculated separately for the larger and smaller-volume cohorts. CMS uses the benchmark for calculating both the achievement score and the improvement score.
Care Points	The higher of achievement points or improvement points for each measure with sufficient data reported in the Interim Performance Report and Annual Performance Report.
CCN	An HHA's six (6)-digit (all numeric) CMS Certification Number.
Claims-based Measures	For the expanded HHVBP Model, the utilization measures calculated using Medicare FFS claims data. Claims-based utilization measures provide information related to the use of health care services (e.g., hospitals, emergency departments, etc.) resulting from a change in patient health status. 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 HHCAHPS Survey- eligible beneficiaries for each HHA in the year prior to the performance year. • Smaller-volume cohort: the group of competing HHAs that had fewer than 60 unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year. • Larger-volume cohort: the group of competing HHAs that had 60 or more unique HHCAHPS Survey-eligible beneficiaries in the calendar year prior to the performance year.
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.

Terminology	Definition
HHA Performance Score	The risk adjusted value for each applicable measure based on the HHA's performance in a given performance year data period.
Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)	A publicly reported survey that measures the experiences of people receiving home health care from Medicare-certified home health agencies. For the HHCAHPS Survey-based measure category, there are five (5) individual components that each serves as single measure under the expanded Model. Details on the HHCAHPS Survey scoring methodology are available on the HHCAHPS website. See Appendix 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 will receive improvement points for a given measure.
Improvement Score (Also referred to as improvement points)	During the performance year for each applicable measure, an HHA will receive an improvement score, quantifying the 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) will include an HHA's improvement points for each measure with sufficient data.
Improvement Threshold (Also referred to as the baseline year score)	An individual competing HHA's performance on an applicable measure during the HHA baseline year.
Internet Quality Improvement Evaluation System (iQIES)	iQIES serves as the only access site for all HHVBP performance feedback reports for the expanded HHVBP Model. Only iQIES users authorized to view an HHA's OASIS Quality report can access HHVBP reports. If an HHA needs to register a user or experiences trouble locating or downloading reports, please contact the QIES/iQIES Service Center at (800) 339-9313 or by email at iqies@cms.hhs.gov.
Interim Performance Report (IPR)	A performance feedback report 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.

Terminology	Definition
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, managed care, etc.
Payment Year	The calendar year in which the adjusted payment percentage for a designated performance year applies.
Percentile Ranking	A percentile ranking compares competing HHA's performance to those of other HHAs within the same cohort.
Performance Year	The calendar year during which OASIS-based, claims-based, and HHCAHPS Survey-based measure data are used for the purpose of calculating an HHA's Total Performance Score (TPS).
Pre-Implementation Year	CY 2022 was the pre-implementation year to allow HHAs time to prepare for implementation of the expanded HHVBP Model. During this time, CMS provided education and support to competing HHAs. HHAs used this time to assess their performance on the set of quality measures used in the expanded Model.
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 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 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.

Terminology	Definition
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 – April 2023*" and the "*Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures*" documents, available on the Expanded HHVBP Model webpage.
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 – April 2023*" 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
ADL	Activity of Daily Living
APP	Adjusted Payment Percentage
APR	Annual Performance Report
AT	Achievement Threshold
BM	Benchmark
CAHPS	Consumer Assessment of Healthcare Providers and Systems
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
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 Evaluation System
LEF	Linear Exchange Function
NPRM	Notice of Proposed Rulemaking
NQS	National Quality Strategy
OASIS	Outcome and Assessment Information Set
P4P	Pay for Performance
PDC	Provider Data Catalog
PHI	Protected Health Information
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

Acronym	Term
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 Measure Sets for the Expanded HHVBP Model

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

NQS Domains	Measure Title/ Short Form Name	Measure Type	Identifier	Data Source	Numerator*	Denominator*
OASIS-based Measures						
Communication & Care Coordination	Discharged to Community	Outcome	NQF 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	NQF0176	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.
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.

NQS Domains	Measure Title/ Short Form Name	Measure Type	Identifier	Data Source	Numerator*	Denominator*
Claims- based Measures						
Efficiency & Cost Reduction	Acute Care Hospitalization During the First 60 Days of Home Health/ ACH	Outcome	NQF0171	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	NQF0173	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	NQF 0517	CAHPS	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one (1) NQF-endorsed measure.	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one (1) NQF-endorsed measure.

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

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

NQS 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	NQF0176	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, GG1030B, GG0130C, GG0170A, GG0170C, GG0170D, GG0170E, GG0170F, GG0170I, GG0170J, GG0170R	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	NQF0173	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.

NQS Domains	Measure Title/ Short Form Name	Measure Type	Identifier	Data Source	Numerator*	Denominator*
HHCAHPS Survey- based Measures						
Patient & Caregiver Centered Experience	Home Health Consumer Assessment Healthcare Providers and Systems (HHCAHPS) Survey	Outcome	NQF 0517	CAHPS	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one (1) NQF- endorsed measure.	Survey-based. HHCAHPS has five (5) component questions that together are used to represent one (1) NQF- endorsed measure.

Appendix D. Within-Category Measure Weights – CY 2023 and CY 2024 Performance Years

Exhibit D-1. Within-category Weights – Performance Years CY 2023 – CY 2024

Quality Measures	Within-category Weight
OASIS-based Measures	
Discharged to Community	16.67%
Improvement in Dyspnea	16.67%
Improvement in Management of Oral Medications	16.67%
TNC Change in Mobility	25.00%
TNC Change in Self-Care	25.00%
Claims-based Measures	
ACH	75.00%
ED Use	25.00%
HHCAHPS Survey- based Measures	
Care of Patients	20.00%
Communication Between Providers and Patients	20.00%
Specific Care Issues	20.00%
Overall Rating of Home Health Care	20.00%
Willingness to Recommend the Agency	20.00%

Appendix E. Measure Weighting and Re-Weighting – CY 2023 and CY 2024 Performance Years

The weights of the measure categories, when one (1) category is removed, are based on the relative weight of each category when all measures are used. For example, for the smaller-volume cohort, the TPS does not include HHCAHPS Survey-based measures, so weighting only applies to the OASIS-based and claims- based measures at 50 percent each.

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

Quality Measures	Measure Weights			
	All Measures	No HHCAHPS	No Claims	No Claims or HHCAHPS
OASIS-based Measures				
Discharged to Community	5.83%	8.33%	8.98%	16.67%
Improvement in Dyspnea	5.83%	8.33%	8.98%	16.67%
Improvement in Management of Oral Medications	5.83%	8.33%	8.98%	16.67%
TNC Change in Mobility	8.75%	12.5%	13.46%	25.00%
TNC Change in Self-Care	8.75%	12.5%	13.46%	25.00%
Total for OASIS-based Measures	***35.00%***	***50.00%***	***53.85%***	***100.00%***
Claims- based Measures				
ACH	26.25%	37.50%	0.00%	0.00%
ED Use	8.75%	12.50%	0.00%	0.00%
Total for claims-based Measures	***35.00%***	***50.00%***	***0.00%***	***0.00%***
HHCAHPS Survey- based Measures				
Care of Patients	6.00%	0.00%	9.23%	0.00%
Communication Between Providers and Patients	6.00%	0.00%	9.23%	0.00%
Specific Care Issues	6.00%	0.00%	9.23%	0.00%
Overall Rating of Home Health Care	6.00%	0.00%	9.23%	0.00%
Willingness to Recommend the Agency	6.00%	0.00%	9.23%	0.00%
Total for HHCAHPS Survey-based Measures	***30.00%***	***0.00%***	***46.15%***	***0.00%***

Appendix F. Examples of Achievement and Improvement Scores and Care Points Calculations – CY 2023 and CY 2024 Performance Years

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 2023 (for the first performance year).

Fictional 123 HHA Example of Earning Maximum Achievement Points

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

Measure	Achievement Threshold*	Benchmark**	123 HHA CY 2023 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 2023 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 F-2. HHA Example of Earning Partial Improvement Points

Measure	Achievement Threshold*	Benchmark**	ABC HHA Improvement Threshold***	ABC HHA CY 2023 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 2023 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 F-3. HHA Example of Not Earning Achievement or Improvement Points

Measure	Achievement Threshold*	Benchmark**	XYZ HHA Improvement Threshold ***	XYZ HHA CY 2023 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 2023 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 G. Interim Performance Report (IPR) Tabs and Descriptions – CY 2023 and CY 2024 Performance Years

For more information about the IPR contents, please refer to the July 27, 2023 learning event, *"Overview of the Interim Performance Report (IPR): The July 2023 IPR"* on the Expanded HHVBP Model webpage. The images of each tab within the IPR will reflect July 2024 IPR.

Table of Contents Tab

The Table of Contents tab contains the title of the report, e.g., "July 2024 Interim Performance Report," along with the following HHA-specific information:

- CCN
- Name & Address
- Cohort assignment
- Name, description, and hyperlink for each tab included in the IPR

Overview Tab

The Overview tab contains:

- 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.
- 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 2022. In this case cohort-specific information in the report is based on the larger-volume cohort, which most HHAs fall into.
- 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. HHAs must have sufficient data to receive a TPS.
- Instructions for submitting a recalculation request.

Exhibit G-1. IPR Table of Contents Tab

Home Health Value-Based Purchasing (HHVBP) Model

July 2024 Interim Performance Report

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

Table of Contents (TOC)

Worksheet/Tab	Description
Overview	This 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, and following performance years, respectively.
Model Resources	The "Model Resources" worksheet resources is designed to assist with understanding the expanded HHVBP Model and the Model reports.

Exhibit G-2. IPR 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:

OASIS-based Measures	April 1, 2023 to March 31,
Claims-based Measures	January 1, 2023 to December 31, 2023
HHCAHPS Survey-based Measures	January 1, 2023 to December 31, 2023

This IPR provides the preliminary Achievement Thresholds and Benchmarks for the CY 2025 applicable measure set (see "CY 2025 AT and BM" tab). 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.
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.

Your HHA's Interim Total Performance Score (TPS):	0.000

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).
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@abtassoc.com.

Recalculation requests must contain the following information, as cited in the CY 2022 HH PPS final rule (p. 62331) and CFR § 484.375:
- The provider's name, address associated with the services delivered, and CMS Certification Number (CCN).
- The basis for requesting recalculation to include the specific data that the HHA believes is inaccurate or the calculation the HHA believes is incorrect.
- Contact information for a person at the HHA with whom CMS or its agent can communicate about this request, including name, email address, telephone number, and mailing address (must include physical address, not
- 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 contains information that HHAs can use to assess how well they performed throughout the performance year when compared to performance of their peers in their cohort during the Model baseline year. The Achievement tab contains:

- The list of applicable measures by category (available on each tab containing performance measure data, except for the TNC Change Reference tab).
- 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."
- 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.
- 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.

Improvement Tab

The Improvement tab contains information that HHAs can use to assess how well they performed throughout the performance year when compared to performance during their HHA baseline year. The Improvement tab contains:

- The list of applicable measures by category (available on each tab containing performance measure data, except for the TNC Change Reference Tab).
- 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 carry over from the respective columns in the Achievement Tab.
- Time periods listed in the Baseline Year Data Period column are the HHA's baseline year for each measure.
- 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.
- 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 G-3. IPR Achievement Tab

Achievement Points

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						10.000
Improvement in Dyspnea						10.000
Improvement in Management of Oral Medications						10.000
Total Normalized Composite (TNC) Change in Mobility [f]						10.000
Total Normalized Composite (TNC) Change in Self-Care [g]						10.000
Claims-based Measures						
Acute Care Hospitalizations						10.000
Emergency Department Use Without Hospitalization						10.000
HHCAHPS Survey-based Measures						
Care of Patients						10.000
Communications Between Providers and Patients						10.000
Specific Care Issues						10.000
Overall Rating of Home Health Care						10.000
Willingness to Recommend the Agency						10.000

Exhibit G-4. IPR Improvement Tab

Improvement Points

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							9.000
Improvement in Dyspnea							9.000
Improvement in Management of Oral Medications							9.000
Total Normalized Composite (TNC) Change in Mobility [g]							9.000
Total Normalized Composite (TNC) Change in Self-Care [h]							9.000
Claims-based Measures							
Acute Care Hospitalizations							9.000
Emergency Department Use Without Hospitalization							9.000
HHCAHPS Survey-based Measures							
Care of Patients							9.000
Communications Between Providers and Patients							9.000
Specific Care Issues							9.000
Overall Rating of Home Health Care							9.000
Willingness to Recommend the Agency							9.000

Care Points Tab

The Care Points tab contains the higher of achievement points or improvement points for each measure reported. The Improvement tab contains:

- Whether the HHA had Sufficient Data for Measure Inclusion indicated by "yes" or "no."
- Includes both the agency's Achievement and Improvement Points from the respective tabs.
- 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."

Measure Scorecard Tab

The Measure Scorecard tab contains information that supports HHAs with understanding how each individual measure contributes to their TPS. The Measure Scorecard tab contains:

- Values in the Your HHA's Care Points column, which carry over from the Care Points Tab.
- The next column indicates the Maximum Possible Points, which is 10 for each measure.
- 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").
- 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.
- Percentile Ranking within Your HHA's Cohort compares the HHA's ranking to all agencies in the cohort, as cited in footnote "c".
- The TPS Statistics for Your HHA's Cohort table, which provides a breakdown of percentile rankings within the cohort.

Exhibit G-5. IPR Care Points Tab

Care Points

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					
Improvement in Dyspnea					
Improvement in Management of Oral Medications					
Total Normalized Composite (TNC) Change in Mobility					
Total Normalized Composite (TNC) Change in Self-Care					
Claims-based Measures					
Acute Care Hospitalizations					
Emergency Department Use Without Hospitalization					
HHCAHPS Survey-based Measures					
Care of Patients					
Communications Between Providers and Patients					
Specific Care Issues					
Overall Rating of Home Health Care					
Willingness to Recommend the Agency					

Number of Measures Included			Summed Care Points:		

Exhibit G-6. IPR Measure Scorecard Tab

Measure Scorecard

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		10.000		
Improvement in Dyspnea		10.000		
Improvement in Management of Oral Medications		10.000		
Total Normalized Composite (TNC) Change in Mobility		10.000		
Total Normalized Composite (TNC) Change in Self-Care		10.000		
Sum of OASIS-based Measures		**50.000**		
Claims-based Measures				
Acute Care Hospitalizations		10.000		
Emergency Department Use Without Hospitalization		10.000		
Sum of Claims-based Measures		**20.000**		
HHCAHPS Survey-based Measures				
Care of Patients		10.000		
Communications Between Providers and Patients		10.000		
Specific Care Issues		10.000		
Overall Rating of Home Health Care		10.000		
Willingness to Recommend the Agency		10.000		
Sum of HHCAHPS Survey-based Measures		**50.000**		
Sum of All Measures		**120.000**		

Total Performance Score (TPS)	
Number of Measures Included	
Your HHA's Summed Care Points	
Your HHA's Interim TPS	
Percentile Ranking within Your HHA's Cohort [c]	

TNC Change Reference Tab

The TNC Change Reference tab contains information to assist HHAs in understanding their performance on the individual OASIS items included in the two 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. The TNC Change Reference tab contains:

- OASIS-based performance data specific to the two (2) Total Normalized Composite (TNC) Change measures, 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 number of eligible quality episodes used to generate the TNC Change measures.
- 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").
- 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.

Achievement Thresholds & Benchmarks Tab

The Achievement Thresholds & Benchmarks tab contains the timeframes and data used to calculate the final achievement thresholds and benchmarks. The Achievement Thresholds & Benchmarks tab contains:

- 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.
- 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).
- 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 G-7. IPR TNC Change Reference Tab

Performance Summary for TNC Change Measures [b]

Your HHA's count of eligible quality episodes [c]						
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)						
M1850 Transferring (0-5)						
M1860 Ambulation/Locomotion (0-6)						
Total Normalized Composite (TNC) Change in Self-Care						
M1800 Grooming (0-3)						
M1810 Ability to Dress Upper Body (0-3)						
M1820 Ability to Dress Lower Body (0-3)						
M1830 Bathing (0-6)						
M1845 Toileting Hygiene (0-3)						
M1870 Feeding or Eating (0-5)						

Exhibit G-8. Achievement Thresholds & Benchmarks Tab

Final Achievement Thresholds and Benchmarks

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					
Improvement in Dyspnea					
Improvement in Management of Oral Medications					
Total Normalized Composite (TNC) Change in Mobility					
Total Normalized Composite (TNC) Change in Self-Care					
Claims-based Measures					
Acute Care Hospitalizations					
Emergency Department Use Without Hospitalization					
HHCAHPS Survey-based Measures					
Care of Patients					
Communications Between Providers and Patients					
Specific Care Issues					
Overall Rating of Home Health Care					
Willingness to Recommend the Agency					

Appendix H. Within-Category Measure Weights – CY 2025 Performance Year

Exhibit H-1. Measure Weighting – Performance Years CY 2025

Quality Measures	Within-category Weight
OASIS-based Measures	
Discharge Function Score	57.14%
Improvement in Dyspnea	17.14%
Improvement in Management of Oral Medications	25.71%
Claims-based Measures	
Potentially Preventable Hospitalization	74.29%
Discharge to Community—Post Acute Care	25.71%
HHCAHPS Survey- based Measures	
Care of Patients	20.00%
Communication Between Providers and Patients	20.00%
Specific Care Issues	20.00%
Overall Rating of Home Health Care	20.00%
Willingness to Recommend the Agency	20.00%

Appendix I. Accessible Graphics

Exhibit I-1. Accessible Graphic Text

Exhibit	Text
Exhibit 3	Timeline for Rollout of the Expanded HHVBP Model. This is a timeline for the Expanded HHVBP Model rollout beginning with 1/1/22 through 12/31/25. The original HHVBP Model ended on 12/31/2021, and the expanded HHVBP Model began on 1/1/2022. CY 2022 serves as the Pre- Implementation Year. CY 2023 serves as Performance Year One. CY 2024 serves as Performance Year Two. CY 2025 serves as Performance Year Three and Payment Year One.
Exhibit 5	A graphic showing: 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: Sufficient Measure Data Requirements are (20 home health quality episodes for the OASIS-based Measure Category, 20 home health stays for the Claims- based Measure Category, and 40 completed surveys for the HHCAHPS Survey-based Measure Category) + the calculation of at least five (5) of the twelve (12) measures. 3. Interim Performance Reports (IPRs): a. Provide preliminary score for the achievement and improvement points for each measure for that quarter. Available in iQIES quarterly in January, April, July, and October. b. 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. Final IPRs: c. Provide preliminary 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: Provide an HHA's APP. Available in iQIES annually in August. Annual Reports include information on quality measure performance and the Adjusted Payment Percentage (APP). b. Recalculation Requests: HHAs may request a recalculation of performance scores if a HHA believes there is evidence of an error. HHAs must submit requests within 15 days following Preview APR availability in iQIES. c. Preliminary APR: Available in iQIES in September or October after recalculation requests are considered. d. Reconsideration Requests and Administrator Review: HHAs that submit a recalculation request may submit a reconsideration request within 15 days if it disagrees with the results of a recalculation request. An HHA may request CMS Administrator review of reconsideration decisions within 7 days. e. Final APR: HHAs will be notified when their Final APR is available in iQIES (at least 30 days prior to the first payment adjustment). 5. Payment Adjustments: The APP is the percentage by which a competing HHA's final Medicare fee-for service final claim payment is changed. CMS will apply a payment adjustment of a maximum of 5% upward or downward to competing HHAs' final claim payment. The Final APR includes the APP and is available no later than 30 calendar days before the payment adjustment takes effect. before the payment adjustment takes effect

Exhibit	Text
Exhibit 17	This graphic defines Achievement Threshold as the median (50th percentile) of Medicare-certified HHAs' performance on each quality measure during the designated baseline year, calculated separately for the larger and smaller-volume cohort, Improvement Threshold as an individual HHAs' performance on each quality measure during the HHA's designated baseline year, and Benchmark as the mean of the top decile (90th percentile) of all HHAs' performance scores on the specified quality measure during the baseline year, calculated separately for the larger and smaller-volume cohorts; used to calculate both the achievement score and the improvement score. The graphic explains the interconnection between these variables. An achievement score can be between 0 and 10 points for each quality measure and is calculated using a formula that includes an achievement threshold and benchmark. The achievement threshold is the median (50th percentile) of Medicare-certified HHAs' performance scores on each quality measure during the designated baseline year calculated separately for the larger and smaller-volume cohorts. The benchmark is the mean of the top decile (90th percentile) of Medicare-certified HHA performance on each quality measure during the designated baseline year, calculated separately for the larger and smaller- volume cohorts. It is used for calculating both the achievement score and the improvement score. In between these values – the achievement threshold and the benchmark – lies the achievement range. If and where an agency's performance on a quality measure falls within this range when compared to agencies within the respective cohort determines the HHA's achievement score for a specific quality measure. An improvement score can be between 0 and 9 improvement points for each measure using a formula that incorporates an improvement threshold and the same benchmark as the achievement score uses. The improvement threshold is an individual agency's performance on an applicable measure during the HHA's designated baseline year. The benchmark is defined in the same manner as for the achievement score—the mean of the top decile (90th percentile) of Medicare-certified HHA performance on each quality measure during the designated baseline year, calculated separately for the larger- and smaller-volume cohorts. In between these two values – the improvement threshold and the benchmark – is the improvement range. If and where an agency's performance on a quality measure falls within this numeric improvement range, when compared to agencies within the respective cohort, determines the HHA's improvement score for a specific quality measure.
Exhibit 22	IPR Availability, Recalculation, and Reconsideration Request Timeline. This is an illustration of the timeline of when CMS publishes the Preliminary and Final IPRs and the recalculation request process. Preliminary IPRs are published via iQIES quarterly, in January, April, July, and October. HHAs have 15 days to submit a recalculation request after the preliminary IPR is published. Final IPRs are published to iQIES after CMS processes recalculation requests 1-2 months after the Preliminary IPRs are published.
Exhibit 23	Illustration of the timeline of when CMS publishes the Annual Report versions and the recalculation and reconsideration request processes. Preview Reports are published via iQIES in August. HHAs have 15 days to submit a recalculation request after the preview report is published. Preliminary Reports are published to iQIES after CMS processes recalculation requests in September and October. Only HHAs that submitted a recalculation request may submit a reconsideration request within 15 days. 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. Final Reports are published via iQIES in December, at least 30 days prior to HHAs receiving the first payment adjustment.