



2025 Technical Expert Panel Meeting

**Home Health Quality
Reporting Program (HH QRP)
and Expanded Home Health
Value-Based Purchasing
(HHVBP) Model
Summary Report**

Submitted by:

Abt Global
6130 Executive Boulevard
Rockville, MD 20852

Submitted to:

Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

June 2026

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About This Report

The Centers for Medicare & Medicaid Services (CMS) contracted with Abt Global (Abt) to support the implementation of the expanded Home Health Value-Based Purchasing (HHVBP) Model and the Home Health Quality Reporting Program (HH QRP). The contract name is Quality Reporting Program (QRP) and Value-Based Purchasing (VBP): Quality Measures and Assessment Instruments Development and Maintenance. The contract number is 75FCMC18D0014, Task Order number 75FCMC24F0011.

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Authors

Abt Global LLC



Abt Global LLC | 6130 Executive Boulevard | Rockville, MD 20852

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Background

Introduction

Abt convened the Technical Expert Panel (TEP) for a virtual meeting held on December 9, 2025. The virtual meeting covered potential future modifications to the expanded Home Health Value-Based Purchasing (HHVBP) Model and Home Health Quality Reporting Program (HH QRP) performance measures and public reporting of data to create greater alignment between the two programs. This report provides an overview of the topics discussed during this meeting and a summary of feedback from the TEP members.

TEP Responsibilities

The TEP was convened to provide expert input on potential refinements to the expanded HHVBP Model and HH QRP. Specifically, the TEP was charged with the following:

- Review relevant materials (e.g., a summary of findings from analyses of measures, a summary of public comments in response to a Notice of Proposed Rulemaking).
- Provide input and advice on potential changes to the measures and scoring methodology used in the expanded HHVBP Model and HH QRP.
- Provide input on future measure concepts.
- Provide input on potential changes to increase alignment between HH QRP and the expanded HHVBP Model.
- Collaboratively consider previously gathered relevant information and public comments to assess the validity and feasibility of proposed refinements to the expanded HHVBP Model and HH QRP.
- Ensure that refinements to the measures and scoring methodology used in the expanded HHVBP Model and HH QRP are meaningful for the home health populations and transparent to providers in these settings.

TEP Composition

In August 2023, a call for nominations for potential TEP members in support of the expanded HHVBP Model was disseminated through several CMS webpages and various stakeholder listservs. The goal was to solicit nominations from a diverse group of experts, including home health clinicians and staff, patient advocates, caregivers, methodologists, and researchers. Among those nominees, Abt selected 14 individuals from diverse backgrounds, reflecting a range of perspectives and expertise.

In fall 2025, this group of experts was asked to participate as the TEP for the HHVBP–HH QRP alignment efforts. Twelve of the originally selected nominees continue to serve on the TEP. Abt identified additional potential candidates to ensure that the TEP in December 2025 represented the full range of perspectives needed to inform HHVBP–HH QRP alignment. This effort resulted in one additional member joining the TEP.

The 2025 TEP included 13 members from 10 states and the District of Columbia. Members bring experience in clinical work, patient advocacy, quality improvement, and research. Six

TEP members have experience as family caregivers to patients receiving home health. Additionally, at least one TEP member has personally received home health. Two TEP members were unable to attend the 2025 TEP. **Exhibit 1** presents the name and a brief profile of each TEP member. For a detailed background of each TEP member, please see **Appendix A**.

Exhibit 1. List of TEP Members

Name	State	Relevant Experience and Areas of Expertise	Experience as Family Caregiver? (Yes/No)
Alicia Arbaje,* MD, MPH, PhD, FACP	MD	Geriatrician, professor, and health services researcher; collaborated with academic- and community-based HHAs for 20+ years (as a researcher and as a practicing clinician); currently serves as Medical Director for an HHA.	Yes
Dawnita Brown, MA, MS, CCC, CCE, CCF	MD	Family caregiver with lived experience; founder of caregiver-centered initiatives supporting family caregivers nationwide; expertise in caregiver well-being, health equity, and community-based care.	Yes
April Coxon, RN, CLHP	TX	RN with 23 years of chronic disease management and performance improvement experience; Executive Vice President of Quality at HHA (Healing Hands Healthcare); PQM selected PRMR (Pre-Rulemaking Measure Review) Committee member for Post Acute Care; PQM MSR Recommendation Group; CMS CMMI GUIDE Model Participant.	No
Shekinah Fashaw-Walters, PhD, MSN	PA	Health services researcher, professor, and consultant; expertise with health equity and structural racism in home health, post-acute, and long-term care.	Yes
Cindy Krafft, PT, MS, HCS-O	GA	PT with 25+ years of home health experience; educator on OASIS data collection; expertise on stabilization of function.	No
Terri Lindsey, RN, BSN, COS-C, CPHQ	VA	RN with 40 years' experience; Quality Outcomes Specialist at HHA (Bon Secours Mercy Health Home Health and Hospice, Richmond, VA).	Yes
Trudy Mallinson, PhD, OTR/L, FACRM, FAOTA, NZROT	D.C.	Occupational Therapist, professor, and health services researcher; expertise in quality measures development in post-acute care.	Yes
Molly McDonald, PT, DPT, MBA, CHC, COS-C	WA	Chief Quality and Compliance Officer (Frontpoint Health); expertise in agency financial, quality, and clinical operations, experience designing and implementing new programs including Value Based Purchasing, Star Ratings, and new payment models.	No

Name	State	Relevant Experience and Areas of Expertise	Experience as Family Caregiver? (Yes/No)
Tracy Mroz, PhD, OTR/L, FAOTA	WA	Occupational Therapist, professor, and health services researcher; expertise in access to and quality of home health care for Medicare beneficiaries, including in rural settings.	No
Dana Mukamel, PhD, MS	CA	Distinguished Professor and health services researcher; expertise in QMs for long-term care providers and investigating the impact in terms of behavior, quality, and cost.	No
Zainab Toteh Osakwe,* PhD, RN, NP, FAAN	NY	PhD-trained nurse, health services researcher, and professor; experienced as a home health nurse, administrator, and leader, with expertise in OASIS.	No
Steven Pamer, PT, MPA, CGS	OH	HHA Administrator & Director of Rehabilitation Services (Cleveland Clinic Home Health Care).	Yes
Madeline Sterling, MD, MPH, MS	NY	Primary care doctor and health services researcher at Weill Cornell Medicine, New York, NY; expertise in improving patient outcomes in HH; Director, Initiative on Home Care Work, Cornell University, Ithaca, NY.	No

* Not in attendance.

The remainder of this report presents an overview of the expanded HHVBP Model and HH QRP and a summary of the TEP meeting discussions. Alignment discussions included proposed approaches to measure set alignment, provider reporting alignment, and scoring rule changes. The report summarizes the feedback provided by TEP members on each topic, followed by conclusions and next steps.

Program Overview

This section summarizes the goals, incentive structures, and reporting frameworks of the [expanded HHVBP Model](#) and [HH QRP](#) – the two programs for which the Centers for Medicare & Medicaid Services (CMS) is considering opportunities to further improve alignment. It is intended to provide context for the alignment proposals and TEP feedback presented in subsequent sections.

Overall, both programs use many of the same quality measures, but they operate under different reporting timelines, and provider deliverables. HH QRP has a greater emphasis on public reporting of performance data. HH QRP publicly reports quality measures and Quality of Patient Care (QoPC) and Patient Survey Star Ratings through the Medicare.gov care compare tool and the CMS Provider Data Catalog (PDC). While HHVBP makes Annual Performance Report (APR) data available through the PDC, its emphasis is on reports that provide information on measure performance and payment adjustment amounts. HH QRP has a pay-for-reporting component through the link between an Annual Payment Update (APU) and compliance with data submission requirements.¹

Home Health Value-Based Purchasing (HHVBP) Model

The expanded HHVBP Model is designed to improve the quality and efficiency of home health care by adjusting Medicare fee-for-service payments based on a home health agency (HHA)'s performance on a defined set of quality measures. HHAs receive a positive or negative payment adjustment based on a Total Performance Score (TPS), which reflects both achievement relative to cohort-based peers and improvement over time.

HHVBP Model performance information is communicated to HHAs by means of quarterly Interim Performance Reports (IPRs) and Annual Performance Reports (APRs). IPRs provide periodic feedback during the performance year, while APRs report on performance results that are translated into the payment adjustments applied in the payment year.

Home Health Quality Reporting Program (HH QRP)

The HH QRP is intended to promote standardized data collection and public transparency. Under HH QRP, HHAs must submit required Outcome and Assessment Information Set (OASIS) and, when applicable, Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAPHS) Survey data to avoid a reduction to their APU. HH QRP does not adjust payments based on performance levels.

HH QRP generates several distinct provider-facing reports. Quality Assessment Only (QAO) quarterly reports and APU annual reports are used to assess compliance with OASIS and HHCAPHS data reporting requirements for payment purposes, while Provider Preview Reports (PPRs) allow HHAs to review quality measure performance, and QoPC and Patient

¹ The HH QRP APU requirements are governed by the following: Failure to submit data required under section 1895(b)(3)(B)(v) of the Act with respect to a program year will result in the reduction of the annual payment update (comprised of the market basket index minus a productivity adjustment) otherwise applicable to an HHA for the corresponding calendar year by 2 percentage points.

Survey Star Ratings prior to public reporting on the Medicare.gov Care Compare tool and the PDC.

Context for HH QRP-HHVBP Alignment Proposals

CMS has identified substantial opportunities to better align the HH QRP and the expanded HHVBP Model. While the HH QRP and expanded HHVBP Model share similar goals and measures, differences in measure sets, reporting periods, and performance assessment processes may create unnecessary complexity and administrative burden for HHAs and potentially confusing signals for providers and the public.

To address these issues, CMS asked the TEP to provide feedback on potential changes to reporting periods, performance and public reporting timelines, and scoring and display policies aimed at improving alignment between the two programs. **Exhibit 2** summarizes key HHVBP and HH QRP provider-facing reports, including their primary purpose, reporting periods, and role in payment or public reporting, to illustrate where misalignments currently occur.

Exhibit 2. Overview of HHVBP and HH QRP Provider-Facing Reports

Report	Primary Purpose	Reporting/Performance Period	Used For	
			Payment	Public Reporting
HHVBP				
Interim Performance Report (IPR)	Provides interim feedback on performance and progress toward a Total Performance Score (TPS)	Rolling 12- or 24-month performance period, updated quarterly	No	No
Annual Performance Report (APR)	Reports final performance results and establishes the payment adjustment for the payment year	Calendar year performance period	Yes	Yes
HH QRP				
Quality Assessment Only (QAO) Reports	Assess compliance with quarterly OASIS data submission requirements	Rolling 12-month reporting periods	No	No
Annual Payment Update (APU) Determination	Determines whether the HHA receives the full APU based on reporting compliance	July 1 – June 30 reporting period (OASIS); April 1 – March 31 reporting period (HHCAHPS)	Yes	Yes
Provider Preview Reports (PPRs)	Allow HHAs to review quality measure results and Star Ratings prior to public reporting	Based on finalized measure data for a given public reporting refresh	No	Yes

Measure Set Alignment

HHVBP and HH QRP both measure HHA quality of care, but the programs use different measure sets to evaluate performance. As of December 2025, the CY 2025 and CY 2026 HHVBP applicable measure sets include ten and eleven quality measures, respectively. HH QRP currently includes 18 quality measures, with seven of these quality measures being used in the QoPC Star Ratings. **Exhibit 3** demonstrates which quality measures are included in the two programs as of the time the TEP convened.

Exhibit 3. Quality Measures Used in HHVBP and HH QRP in CY 2026

Measure	Included in		
	HHVBP	HH QRP Star Ratings (QoPC/Patient Survey)	HH QRP (but not in Star Ratings)
OASIS-based Measures			
Discharge Function Score [^]	Yes	No	Yes
Improvement in Bathing*	Yes	Yes	No
Improvement in Upper Body Dressing*	Yes	No	Yes
Improvement in Lower Body Dressing*	Yes	No	Yes
Improvement in Bed Transferring	No	Yes	No
Improvement in Ambulation/Locomotion	No	Yes	No
Improvement in Dyspnea	Yes	Yes	No
Improvement in Management of Oral Medications	Yes	Yes	No
Timely Initiation of Care	No	Yes	No
Changes in Skin Integrity – Post Acute Care	No	No	Yes
Falls with Major Injury	No	No	Yes
Transfer of Health Information to Provider	No	No	Yes
Transfer of Health Information to Patient	No	No	Yes
Influenza Immunization Received	No	No	Yes
Drug Regimen Review	No	No	Yes
Claims-based Measures			
Potentially Preventable Hospitalizations	Yes	Yes	No
Discharge to Community – Post Acute Care [^]	Yes	No	Yes
Medicare Spending per Beneficiary – Post Acute Care*	Yes	No	Yes
Potentially Preventable Readmissions	No	No	Yes
HCAHPS Survey-based Measures			
Care of Patients**	Yes	Yes	No
Communication Between Providers and Patients**	Yes	Yes	No
Specific Care Issues**	Yes	Yes	No
Overall Rating of Care Provided by HHA	Yes	Yes	No
Willingness to Recommend HHA	Yes	No	Yes

[^] Measure expected to be added to QoPC Star Ratings in the near future.

* Measure added to the HHVBP Model starting with the CY 2026 applicable measure set.

** Measure removed from the HHVBP Model starting with the CY 2026 applicable measure set.

While CMS intends to maintain some differences between the programs, planned additions of Discharge to Community (DTC-PAC) and the Discharge (DC) Function Score measure to the QoPC Star Ratings by CY 2027 will increase alignment between the two programs. Note that CMS does not plan to use MSPB-PAC in QoPC Star Ratings as this measure is an efficiency measure that is appropriate for HHVBP but not QoPC Star Ratings. Furthermore, CMS does not plan to use Timely Initiation of Care in HHVBP as the measure is topped out.

In addition to the planned additions to the measure set used in calculating QoPC Star Ratings, the Abt team asked the TEP whether additional changes to the HHVBP and/or HH QRP QoPC Star Ratings measure sets should be considered. The following two potential measure set modifications to the measure sets used in HHVBP and QoPC Star Ratings to increase alignment were presented to the TEP:

1. Adding Improvement in Bathing, Lower Body Dressing, and Upper Body Dressing measures to the HH QRP QoPC Star Ratings.
2. Removing Improvement in Bed Transferring and Improvement in Ambulation/ Locomotion measures from the QoPC Star Ratings once the DC Function Score measure is included in HH QRP QoPC Star Ratings to reduce mobility-specific overlap. overlap in mobility-specific domains that are used in the calculation of the DC Function Score measure.

Summary of TEP Feedback

The TEP strongly supported alignment between HHVBP and HH QRP measure sets. TEP members discussed the separation of the expanded HHVBP Model and HH QRP, and whether it would be feasible or desirable to eventually create a single unified program. Some members noted that there are philosophical differences between HH QRP and HHVBP; HHVBP focuses primarily on patient outcomes, whereas the HH QRP QoPC Star Ratings include agency process measures. As such, TEP members see value in preserving both programs for the foreseeable future but suggested that CMS consider the possibility of eventually consolidating the two programs.

Several members of the TEP supported adding the Improvement in Bathing, Lower Body Dressing, and Upper Body Dressing measures to QoPC Star Ratings to create a more complete set of self-care measures. TEP members also favored removing Improvement in Bed Transferring and Improvement in Ambulation/Locomotion measures from the QoPC Star Ratings after the DC Function Score measure is added to the QoPC Star Rating measure set, to avoid duplication. TEP members emphasized that, once the DC Function Score measure is incorporated into the QoPC Star Ratings, retaining Improvement in Bed Transferring and Improvement in Ambulation/Locomotion measures would result in duplicative measurement and confusion, particularly during the transition from OASIS-based M1800 measures to GG-based measures. Several TEP members voiced concerns about the two programs' joint reliance on OASIS-based M1800 measures and stressed the importance of developing GG item-based measures to replace them in both programs.

Public Reporting Alignment

HHVBP and HH QRP currently differ in their reporting periods, data submission requirements, and the timing and format of performance reports. In particular, the programs apply different thresholds and timelines for data submission and review, even when they rely on overlapping measures. These differences may create confusion for HHAs, complicate performance tracking, and increase administrative burden for both HHAs and CMS. For example, under HHVBP, HHAs must meet minimum data thresholds to receive a Total Performance Score and a payment adjustment. Specifically, HHAs must have sufficient data to be scored on at least five HHVBP applicable measures during the reporting period. In contrast, HH QRP focuses on data submission compliance rather than performance scoring: HHAs must submit a sufficient volume of “matching” OASIS assessments and, if applicable, HHCAHPS Surveys to meet Annual Payment Update (APU) and quarterly Quality Assessment and Assurance (QAO) requirements, or face payment reductions.²

To explore opportunities for improving alignment, the TEP was asked to provide feedback on potential changes related to reporting periods and performance reports.

Reporting Periods and Performance Reports

HHVBP uses a calendar year for performance measurement and payment adjustment as reported in Annual Performance Reports (APRs), while HH QRP OASIS APU operates on a July 1 through June 30 reporting period and HH QRP HHCAHPS APU operates on an April 1 to March 31 reporting period for the APU determination.

The TEP was asked to provide feedback on aligning the reporting periods used across HHVBP and HH QRP. In particular, the HH QRP APU reporting period would be revised to a CY cycle to align with the data used in the HHVBP APRs. This change would allow alignment of the HH QRP OASIS and HHCAHPS APU components with the HHVBP payment’s reference timeline.

Aside from differences in reporting periods, HH QRP and HHVBP release performance reports on different schedules, which can result in HHAs receiving performance results for the same measures for different performance periods at different points in time. This misalignment reflects differences in data cut-off dates, review and correction periods, and report release timelines across the two programs. HHAs may struggle with tracking their quality performance on two separate timelines, or reconciling differences in scores that stem from timing rather than performance. These discrepancies force providers to monitor two different reporting timelines, manage two different correction periods, and interpret two performance summaries which may appear contradictory. Due to report misalignments, CMS

² For HHVBP, “sufficient data” refers to meeting the minimum data thresholds required to calculate a Total Performance Score; that is, at least 20 cases for claims-based and OASIS-based measures and at least 40 completed HHCAHPS surveys, in both the baseline and performance years, for at least five measures. For HH QRP, APU and QAO requirements are based on submission completeness, including submission of at least 90 percent of “matching” OASIS assessments and participation in HHCAHPS data collection when applicable, rather than on performance scoring. For more information, please visit [Home Health Quality Reporting Requirements | CMS](#).

must maintain multiple performance calculation cycles, separate review infrastructures, and additional quality control processes.

One source of this misalignment is the longer HH QRP Provider Preview Report (PPR) review and correction period compared with HHVBP timelines. Shortening the HH QRP review and correction period and aligning report release schedules would allow HH QRP PPRs and HHVBP Interim Performance Reports (IPRs) to be released at the same time. Under this approach, the quality measure data publicly reporting on the Compare Tool would be more current by approximately three months than under current HH QRP release timelines, reducing lag and improving consistency across programs. For an example scenario of how updates to the PPR reporting could foster alignment between IPR and PPR reports, see **Exhibit 4**.

Exhibit 4. Aligned HHVBP Preliminary IPR and HH QRP PPR Reporting

Reporting Period		Preview Reports (HH QRP/HHVBP)			Medicare.gov Compare Tool (HH QRP only)				
Start Date	End Date	Preliminary IPR	PPR (HH QRP)		Final IPR (HHVBP)*	Suppression Request Deadline		Release Date	
		Current	Current	New	Current	Current	New	Current	New
4/1/23	3/31/24	7/20/24	10/4/24	7/20/24	8/20/24	11/1/24	8/18/24	1/15/25	10/23/24
7/1/23	6/30/24	10/26/24	1/8/25	10/26/24	11/24/24	2/7/25	11/24/24	4/23/25	1/15/25
10/1/23	9/30/24	1/24/25	4/2/25	1/24/25	2/24/25	5/2/25	2/24/25	7/16/25	4/23/25
1/1/24	12/31/24	4/30/25	7/9/25	4/30/25	4/30/25	8/8/25	5/30/25	10/22/25	7/16/26

* No HH QRP equivalent exists for Final IPRs.

Summary of TEP Feedback

TEP members strongly supported moving toward faster and more aligned public reporting for HH QRP and HHVBP. They agreed that releasing HH QRP reports three months earlier to align with HHVBP would be valuable, because it would allow providers to get information confirmed by CMS sooner. They also supported the suggestion to use the same reporting periods for all components of both programs. The TEP also suggested that CMS investigate the feasibility of quarterly (rather than annual) claims-based measure updates for HH QRP, to further increase alignment.

Although the TEP supported taking steps to facilitate unified reporting, such as reducing the length of the HH QRP Review and Correct period, the TEP noted that some providers, especially small agencies, might struggle to meet a shorter correction timeline. However, according to CMS data, more than 99 percent of all OASIS assessments were submitted within 45 days. The TEP recommended that CMS ensure all rollout communications are clear to minimize disruptions for small agencies.

Scoring Rule Proposals

While HHVBP and HH QRP are both intended to promote high-quality home health care, there are differences in how performance is calculated, reported, and incentivized. As discussed in the preceding sections, proposals to align measure sets and reporting periods are intended to reduce these inconsistencies and establish a more comparable foundation across the two programs.

Building on those proposed alignments, four scoring rules were presented for TEP discussion to further strengthen coordination between the two programs. These scoring rules are designed to clarify incentives, reinforce complete and accurate data submission, and improve the consistency and interpretability of performance results across programs. The following sections describe each scoring rule in detail and summarize TEP feedback.

Scoring Rule 1: Single, Composite HH QRP Overall Star Rating

The TEP was asked to provide feedback on the potential introduction of an Overall Star Rating on the [Medicare.gov](https://www.medicare.gov) compare tool, which would provide a single, composite score reflecting all dimensions of an HHA’s quality of care by combining performance metrics used in the existing QoPC Star Ratings and the Patient Survey Star Ratings. The addition of a single, composite Overall Star Rating could improve usability of the [Medicare.gov](https://www.medicare.gov) compare tool by creating a consolidated metric reflecting HHA performance across multiple dimensions of quality of care. **Exhibit 5** summarizes the two potential options for a single, composite HH QRP Overall Star Rating, which were presented to the TEP for feedback.

Exhibit 5. Scoring Rule Options for Scoring Rule 1

Scoring Rule Option	Description
1A. Add a single, composite Overall Star Rating in addition to the existing QoPC and Patient Survey Star Ratings	The Medicare.gov compare tool would continue to display the QoPC and Patient Survey Star Ratings separately and would add a third, single composite Overall Star Rating summarizing an HHA’s performance across domains of quality of patient care and patient satisfaction. The Overall Star Rating would be a composite score reflective of many different aspects of the provider’s quality performance. While this option preserves detailed information, it may create uncertainty for consumers about how to interpret multiple ratings.
1B. Replace the existing QoPC and Patient Survey Star Ratings with a single, composite Overall Star Rating	The Medicare.gov compare tool would only display a single, composite Overall Star Rating that incorporates both QoPC and Patient Survey data. This option simplifies presentation for consumers but reduces transparency into the specific drivers of performance.

Summary of TEP Feedback

Overall, TEP members favored Option 1A (“Add a single, composite Overall Star Rating in addition to the existing QoPC and Patient Survey Star Ratings”). Some TEP members highlighted the importance of keeping QoPC and Patient Survey Ratings separate from each other because they do not measure the same aspect of provider quality. Other TEP members

felt that consumers would prefer streamlined quality information, which would be provided by a single, composite HH QRP Overall Star Rating but also stressed that CMs should provide clear documentation on how Star Ratings are calculated and interpreted to support consumers' decision-making.

One TEP member warned about a potential high correlation between the proposed HH QRP Overall Star Ratings and the existing QoPC Star Ratings and Patient Survey Star Ratings and suggested analyzing the relationships between these metrics before introducing a new single, composite HH QRP Overall Star Rating. TEP members suggested that CMS examine how different weighting methodologies would impact rating distributions that could inform a future TEP discussion about measure weights.

One TEP member raised concerns about frequent patient misunderstanding of the HHCAHPS Survey-based measure "Overall Rating of Care Provided by the Home Health Agency" and thus providing conflicting survey responses compared to other survey questions. This TEP member encouraged further analysis of the survey question's wording, response scale, and potential participant confusion related to the item as its weight increases.

Some TEP members questioned how the proposed single, composite Overall Star Rating would impact low-volume HHAs without HHCAHPS data. They noted that HHAs with fewer than 60 patients eligible to submit HHCAHPS surveys are exempt from the survey data requirement. These HHAs receive a QoPC Star Rating but no Patient Survey Star Rating. After further discussion, the TEP recommended that HHCAHPS-exempt HHAs receive an Overall Star Rating, along with clear notation indicating that no Patient Survey Star Rating is due to no or insufficient HHCAHPS data.

Scoring Rule 2: Limit HHVBP Payment Adjustments for HHAs that Fail APU

In some cases, HHAs fail the pay-for-reporting requirement (enforced via the APU) by submitting insufficient OASIS or HHCAHPS data and still receive high positive HHVBP payment adjustments. This represents a misalignment between HH QRP's pay-for-reporting (via APU) and pay-for-performance incentives in HHVBP. Approximately one-third of HHAs failing the 2026 APU requirements were also eligible for HHVBP payment adjustments, and about half of those received negative adjustments, but a subset received positive payment adjustments despite failing to submit complete data. Note that this scoring rule depends on aligned reporting periods between HHVBP and HH QRP.

One proposed approach to improve alignment between payment incentives is to establish a new scoring rule that directly links an HHA's compliance with the APU requirements to its HHVBP payment adjustment. This scoring rule would reinforce complete and accurate data submission in both programs. **Exhibit 6** summarizes the two proposed options for implementing this scoring rule, which were presented to the TEP for feedback.

Exhibit 6. Scoring Rule Options for Scoring Rule 2

Scoring Rule Option	Description
2A. Cap HHVBP payment adjustment for APU-failing HHAs at 0%	HHAs failing APU would have any positive HHVBP payment adjustment reset to 0%, while negative adjustments would remain unchanged.
2B. Reduce HHVBP payment adjustment for APU-failing agencies by a fixed percentage	HHAs failing APU would have their HHVBP payment adjustments reduced by a fixed percentage (e.g., 2%), with a floor of minus 5%.

Summary of TEP Feedback

A broad consensus favored creating a scoring rule that connects APU compliance with HHVBP payment adjustments. TEP members emphasized that HHAs should not receive substantial positive adjustments when they fail to submit complete quality data, and several described the proposal as intuitive and long overdue.

While perspectives on the specific mechanism varied, many TEP members leaned toward Option 2B (“Reduce HHVBP payment adjustment for APU-failing HHAs by a fixed percentage”), noting that a uniform reduction could offer a more equitable and consistent approach. They also encouraged CMS to conduct additional analyses before selecting a final option, particularly modeling how each option would affect payment distributions, bonus and penalty amounts, the profile of HHAs that typically fail APU, and any potential unintended consequences, including penalizing agencies for technical or administrative issues rather than true performance or disproportionately affecting small or new HHAs. Alignment of the underlying reporting periods for APU and HHVBP was also viewed as a prerequisite for implementing this type of scoring rule.

TEP members further emphasized the importance of fairness, cautioning that HHAs should not be penalized for circumstances outside their control, such as EMR outages or administrative errors. They stressed that the rule should distinguish between sporadic, unavoidable technical issues and chronic underreporting.

Another theme involved the integrity of HHVBP benchmarks (i.e., cohort-level achievement thresholds and benchmarks). Some TEP members questioned whether HHAs that fail APU should continue to be included in HHVBP benchmarking, observing that incomplete OASIS submissions could distort national performance distributions.

Finally, several TEP members requested concrete examples illustrating how the cap or reduction would operate in practice, along with clarification on how budget neutrality would be maintained under each option.

Scoring Rule 3: Limit QoPC Star Ratings for HHAs that Fail Quarterly QAO

In some instances, HHAs that do not submit sufficient OASIS assessments to meet quarterly QAO submission requirements (HH QRP requires that HHAs submit at least 90% of OASIS assessments used to create quality episodes for each quarterly reporting period) still receive high QoPC Star Ratings. For these HHAs, their QoPC Star Ratings do not reflect their failing

quarterly QAO performance, which may raise concerns about the fairness and accuracy of the QoPC Star Ratings.

One proposed approach to address these concerns is to establish a new scoring rule that directly links an HHA’s QoPC Star Rating to its quarterly QAO performance. **Exhibit 7** summarizes the two proposed options for implementing this scoring rule, which were presented to the TEP for feedback.

Exhibit 7. Scoring Rule Options for Scoring Rule 3

Scoring Rule Option	Description
<p>3A. Cap QoPC Star Ratings for HHAs that fail the quarterly QAO requirements for a measure reporting period</p>	<p>CMS would adjust high QoPC Star Ratings (e.g. 4 or 5 stars to no higher than 3 stars) for HHAs that do not submit the required 90% OASIS assessments for that measure reporting period. HHAs that would otherwise receive a Star Rating lower than the capped amount would keep their Star Rating. This option would prevent HHAs from being rewarded with high ratings while submitting insufficient total OASIS data for a reporting period.</p>
<p>3B. Suppress the QoPC Star Rating for HHAs that fail QAO requirements for a measure reporting period</p>	<p>HHAs that fail the 90% quarterly QAO submission requirements would not display a QoPC Star Rating on the Compare Tool for that public reporting refresh. Instead, the Medicare.gov compare tool would display a note indicating that the HHA did not submit the minimum amount of data for a reporting period to receive a rating. This option would maintain accuracy and transparency without altering the calculated QoPC Star Ratings.</p>

Summary of TEP Feedback

The TEP expressed concerns that Option 3A (“Cap QoPC Star Ratings for HHAs that fail the quarterly QAO requirements for a measure reporting period”) would misrepresent HHAs’ quality of patient care. Several TEP members expressed concerns that adjusting QoPC Star Ratings could mislead consumers, particularly if an HHA with historically high rating were to receive a substantially lower QoPC Star Rating following the adjustment. Most TEP members supported adopting Option 3B (“Suppress the QoPC Star Rating for HHAs that fail QAO requirements for a measure reporting period”). TEP members emphasized that this option was fairer and more transparent than Option 3A for linking QoPC Star Ratings to quarterly QAO performance. They felt that this option aligned best with the principles used in other CMS programs, avoided rewarding HHAs that do not submit required data, and avoided consumer confusion through clear notation.

However, some TEP members raised concerns that consumers’ ability to make informed provider selections might be hindered by the absence of QoPC Star Ratings. To address this issue, they suggested presenting historical QoPC Star Ratings from one or more recent quarters in which the HHA met quarterly QAO requirements to provide performance-specific context and facilitate consumer choices.

The TEP also encouraged CMS to distinguish between HHAs that did not meet quarterly QAO requirements once due to unusual operational disruptions and HHAs that systematically or repeatedly do not meet their OASIS assessments. They pointed out that chronic QAO

failure could indicate structural issues in an HHA’s operations, while occasional failures may not reflect care quality.

One TEP member suggested that HHAs that fail the QAO requirements should not contribute to national benchmarking, as their scores might be based on incomplete patient populations.

Scoring Rule 4: Limit QoPC Star Ratings Based on Interim TPS Performance

In some instances, HHAs receive high performance results under one program while receiving relatively low performance under the other program. One approach to address this potential for inconsistency is to directly link QoPC Star Rating to HHVBP performance, as measured by an HHA’s Total Performance Score (TPS). **Exhibit 8** summarizes the implementation approaches presented to the TEP for feedback.

Exhibit 8. Scoring Rule Options for Scoring Rule 4

Scoring Rule Option	Description
<p>4A. Reduce QoPC Star Ratings for HHAs with TPS below the national average</p>	<p>HHAs that received a TPS below the national average would have their QoPC Star Rating adjusted downward by a fixed amount (e.g., 2 stars). This option would make QoPC Star Ratings more consistent with HHVBP performance and therefore increase alignment between programs.</p>
<p>4B. Suppress QoPC Star Ratings for HHAs with TPS below the national average</p>	<p>HHAs that receive a TPS below the national average would not have QoPC Star Rating displayed on the Medicare.gov compare tool. Instead, these HHAs would display a note indicating the inconsistency between their QoPC and HHVBP results.</p>

Summary of TEP Feedback

The TEP strongly opposed both options under this scoring rule, expressing concerns that HHAs would be penalized twice for having a below average TPS. TEP members also felt that both proposed options would be needlessly confusing for HHAs. They cited fundamental differences between the measures used in HHVBP and QoPC Star Ratings and scoring rules, pointing out that there may be valid reasons to maintain separation of these scores. For example, the HHVBP TPS considers both performance level and improvement while QoPC ratings are based only on performance level and do not consider improvement. They also expressed a need for additional analyses of the prevalence of HHAs receiving high TPS scores and low QoPC Star Ratings or low TPS scores and high QoPC Star Ratings.

Conclusions and Next Steps

Across the scoring rules discussed, the TEP provided clear direction on which approaches would best advance alignment between HH QRP and HHVBP. TEP members showed strong support for:

- Updating the HH QRP and HHVBP measure sets to get as much alignment in measures as possible.
- Aligning the HH QRP OASIS and HHCAHPs APU reporting periods with the HHVBP APR reporting period
- Aligning HH QRP quarterly PPRs with HHVBP IPRs
- Adding an Overall Star Rating while retaining the existing QoPC and HHCAHPS ratings (Option 1A),
- Linking APU compliance to HHVBP payment adjustments (Scoring Rule 2, with interest leaning toward Option 2B), and
- Suppressing QoPC Star Ratings when agencies fail quarterly QAO requirements (Scoring Rule 3B).

These preferred options reflect the TEP's desire for improved consistency across programs, clearer incentives for complete and accurate data submission, and more transparent reporting for consumers and providers.

As a next step, CMS will use this input to prepare formal scoring rule proposals for inclusion in future notice and comment rulemaking, ensuring that the favored options are presented clearly for public comment. This work will include refining policy language, conducting the additional analyses requested by the TEP, and drafting regulatory text where needed.

Advancing some proposals through rulemaking, as deemed necessary, will allow CMS to gather broader stakeholder feedback and further evaluate implementation considerations before finalizing any changes.

Appendix A. TEP Member Biographies

The following biographies describe the professional backgrounds and relevant expertise of the 2025 TEP members.

- **Alicia Arbaje, MD, PhD, MPH, FACP** is a geriatrician, health services researcher, and Associate Professor of Medicine/Director of Transitional Care Research at the Johns Hopkins University School of Medicine. She is also Medical Director for Johns Hopkins Care at Home, the HHA affiliated with Johns Hopkins Medicine. She applied to the TEP to bring attention to issues relevant to the needs of older adults, their caregivers, and the home-based providers that serve them.
- **Dawnita Brown, MA, MS, CCC, CCE, CCF** is a family caregiver in Maryland and founder of caregiver-centered initiatives supporting family caregivers nationwide. She serves on the CMS Expanded Home Health Value-Based Purchasing (HHVBP) Model Technical Expert Panel, is a Commissioner on the Maryland Commission on Caregiving, and is a Doctor of Public Health (DrPH) student at the Johns Hopkins Bloomberg School of Public Health. Her work advances caregiver well-being, health equity, and quality of care.
- **April Coxon, RN, CLHP** is the Executive Vice President of Quality at an HHA, Healing Hands Healthcare, in Wichita Falls, Texas. She applied to the TEP because of her commitment to the improvement of healthcare payment models to ensure effective quality of patient care across all home care service lines.
- **Shekinah Fashaw-Walters, PhD, MSPH** is an Assistant Professor in the Department of Medical Ethics and Health Policy at the Perelman School of Medicine at the University of Pennsylvania. She is a senior fellow at the Leonard Davis Institute of Health Economics and a research associate at the Penn Population Aging Research Center. As a health services researcher, she has a focus on equity in the home health setting. She applied to the TEP because it aligns with her goals to advance health equity for Medicare beneficiaries seeking services at home and in the community.
- **Cindy Krafft, PT, MS, HCS-O** is a physical therapist with over 25 years of home health experience. She is the owner/founder of K&K Health Care Solutions. She applied to the TEP because of her interest in how functional outcomes are measured and supporting better alignment with patient performance for assessments of quality of care in home health.
- **Terri Lindsey, RN, BSN, COS-C, CPHQ** is an RN with 40 years of experience. She previously served as Quality Outcomes Specialist at Bon Secours Mercy Health Home Health and Hospice in Richmond, Virginia. She applied to the TEP because of her clinical and quality improvement experiences, as well as because of the firsthand family caregiver perspective that she brings.
- **Trudy Mallinson, PhD, OTR/L, FACRM, FAOTA, NZROT** is an occupational therapist, Professor with Tenure, and Director of Doctoral Research at the School of Medicine & Health Sciences at George Washington University. As a health services researcher, she has expertise in quality measures development in post-acute care. She

applied to the TEP because of her involvement as a member of the TEP for the original HHVBP Model, relevant research focuses, and personal experiences with family caregiving.

- **Molly McDonald, PT, DPT, MBA, CHC, COS-C** is the Chief Quality and Compliance Officer at Frontpoint Health, with extensive experience in the home health industry. She focuses on the importance of aligning clinical practice, quality outcomes, and financial performance to optimize agency operations. She has been actively involved in the Home Health Value-Based Purchasing (HHVBP) program at the agency level since its 2016 pilot and continues to support the integration of accurate patient assessment with high-quality care delivery.
- **Tracy Mroz, PhD, OTR/L, FAOTA** is an occupational therapist and Professor in the Division of Occupational Therapy, Department of Rehabilitation Medicine, School of Medicine at the University of Washington. She applied to the TEP to contribute input on the expanded HHVBP Model, bringing perspectives from her research and as an occupational therapist.
- **Dana Mukamel, PhD, MS** is a Distinguished Professor of Medicine, Public Health and Nursing and the Director of the iTEQC Research Program (Program of Research in Translational Technology Enabling High Quality Care) at the University of California, Irvine. She has expertise in quality measures for long-term care providers and investigating the impact in terms of behavior, quality, and cost. She applied to the TEP because of her involvement as a member on the TEP for the original HHVBP Model and other relevant TEPs, and to contribute her expertise and experience.
- **Zainab Toteh Osakwe, PhD, RN, NP, FAAN** is a nurse practitioner and Associate Professor in the College of Nursing and Public Health at Adelphi University. She has extensive experience in home healthcare nursing and has served as director of both a long-term home healthcare organization and a certified home healthcare program. Her research focuses on developing clinical decision-support pathways that help home healthcare nurses deliver goal-concordant care, while also improving the care experiences of patients and family caregivers. She applied to the TEP to offer input on potential refinements to the expanded HHVBP Model based on her clinical, leadership, and research expertise.
- **Steven Pamer, PT, MPA, CGS** is the Administrator and Director of Rehabilitation Services at Cleveland Clinic Home Health Care in Ohio. He applied to the TEP to provide input based on his experience with value-based care delivery, understanding of methods of evaluation of quality care, and exposure to health equity.
- **Madeline Sterling, MD, MPH, MS** is a primary care doctor and an Associate Professor of Medicine at Weill Cornell Medicine in New York, NY. She is the Inaugural Director of the Initiative on Home Care Work at Cornell University in Ithaca, NY. She joined the TEP to provide input based on her clinical experience in primary care and research expertise in home health care.

Appendix B. Acronym List

This appendix provides a list of acronyms that are used in this report with their expansions, arranged in alphabetical order.

Acronym	Expansion
APR	Annual Performance Report
APU	Annual Payment Update
CA	California
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DC	Discharge
D.C.	District of Columbia
DTC-PAC	Discharge to Community – Post Acute Care
FFS	Fee-for-service
GA	Georgia
HHA	Home health agency
HHCAPHS	Home Health Consumer Assessment of Healthcare Providers and Systems
HH QRP	Home Health Quality Reporting Program
HHVBP	Home Health Value-Based Purchasing
IPR	Interim Performance Report
iQIES	Internet Quality Improvement and Evaluation System
MD	Maryland
MSPB	Medicare Spending Per Beneficiary
NY	New York
OASIS	Outcome and Assessment Information Set
OH	Ohio
PA	Pennsylvania
PAC	Post-acute care
PDC	Provider Data Catalog
PPH	Potentially preventable hospitalization
PPR	Provider Preview Report
QAO	Quality Assessment Only
QoPC	Quality of Patient Care
QM	Quality measure
QRP	Quality Reporting Program
TEP	Technical Expert Panel
TPS	Total Performance Score
TX	Texas
VA	Virginia
VBP	Value-Based Purchasing
WA	Washington