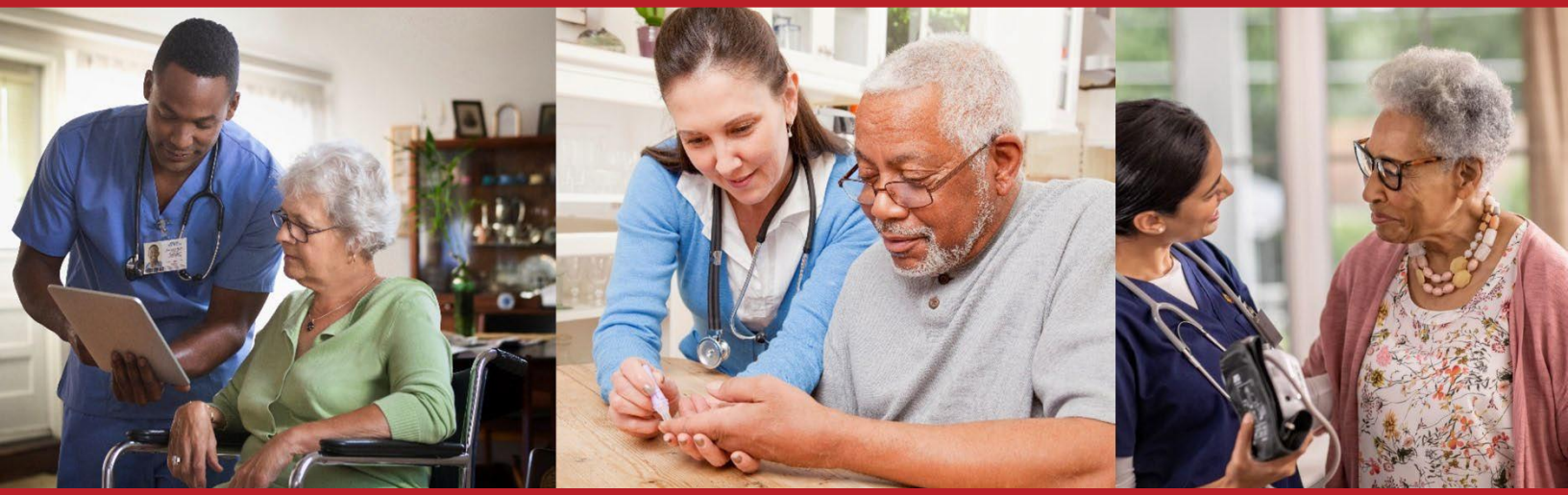
Expanded Home Health Value-Based Purchasing (HHVBP) Model

Frequently Asked Questions (FAQs)



December 2025

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List of Exhibits

Technical Assistance and Help Desks

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

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

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

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

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

Exhibit 2. HHQRP and HHCAHPS Help Desks' Contact Information

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

Introduction

About the Frequently Asked Questions (FAQs)

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

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

FAQ Numbering System

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

[1] HH PPS final rules impacting the expanded HHVBP Model are: 1) CY 2022 HH PPS final rule; 2) CY 2023 HH PPS final rule; 3) CY 2024 HH PPS final rule; and 4) CY 2026 HH PPS final rule.

New and Updated FAQs

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

New FAQs

Q5009. Is the HHVBP adjustment applied to Medicare Secondary Claims?

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

Q7005. Where can I find more information about expanded HHVBP Model changes that were finalized in the CY 2026 Home Health Prospective Payment System (HH PPS) final rule?

The "Expanded HHVBP Model Web-Based Training: Changes to the Applicable Measure Set Beginning in CY 2026", is located on the CMS Expanded HHVBP Model webpage in the Quality Measures section at Expanded HHVBP Model CY26 Post Acute Care Training.

All information regarding changes to the expanded HHVBP Model in the calendar year (CY) 2026 Home Health Prospective Payment System (HH PPS) final rule is available in the Federal Register at https://www.federalregister.gov/public-inspection/2025-21767/medicare-and-medicaid-programs-calendar-year-2026-home-health-prospective-payment-system-rate-update.

Q8005. Will updated HHVBP performance data be publicly reported at the same time every year?

Home health agency (HHA) performance data are reported annually for each HHA based on the data for the applicable performance year. Each year, CMS will follow the same approximate timeline for publicly reporting the HHVBP performance data. For example, the CY 2024 performance year data are anticipated to be released in January 2026 and made available in the Provider Data Catalog.

Updated FAQs

Q2004.2 Will cohort assignments change during a performance year?

A home health agency's (HHA's) cohort assignment is based on the number of its unique beneficiaries. For the purposes of identifying cohorts in the expanded HHVBP Model, unique beneficiaries is defined by the number of unique beneficiaries served by an HHA with a completed quality episode in the calendar year prior to the performance year. The smaller-volume cohort is the group of competing HHAs that had fewer than 60 unique beneficiaries in the calendar year prior to the performance year. The larger-volume cohort is the group of competing HHAs that had 60 or more unique beneficiaries in the calendar year prior to the performance year.

For the calendar year (CY) 2025 performance year, cohort assignment is based on CY 2024 beneficiary counts. For the CY 2026 performance year, the cohort assignment will be based on CY 2025 beneficiary counts. Because the beneficiary counts can change year to year, so can the cohort assignment.

The cohort assignment is updated every July based on the most recent full calendar year.

It is possible that the assigned cohort for an HHA will change from year to year depending on the beneficiary count during the applicable CY. For example, an HHA with a beneficiary count 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.

Q3001.1 How do HHAs submit the measure data required under the expanded HHVBP Model?

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

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

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

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

- Acute Care Hospitalization During the First 60 Days of Home Health (ACH)

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

The measure set for CY 2025 performance year includes the following two (2) claims-based measures derived from claims data submitted to CMS for payment purposes:

- Discharge to Community – Post Acute Care (DTC-PAC)
- Potentially Preventable Hospitalization (PPH)

The measure set for CY 2026 performance year includes the following three (3) claims-based measures derived from claims data submitted to CMS for payment purposes:

- Discharge to Community – Post Acute Care (DTC-PAC)
- Potentially Preventable Hospitalization (PPH)
- Medicare Spending per Beneficiary – Post Acute Care (MSPB-PAC)

Q3007.1 Are the claims-based measures included in the expanded HHVBP Model measure set risk-adjusted? Where can HHAs find more information on the risk-adjustment methodology for these measures?

The claims-based measures are risk adjusted. The data sources for risk-adjustment may include information found in Medicare's eligibility database as well as fee-for-service (FFS) claims.

For further information on the risk adjustment methodology for the claims-based measures, please see the *Downloads* section of the CMS Home Health Quality Measures webpage. For questions related to the claims-based measures, please email: homehealthqualityquestions@cms.hhs.gov.

Q3016.1 What OASIS-based, claims-based, and HHCAHPS Survey-based data is included in the quality measures reported in the calendar year (CY) 2025 Annual Performance Report (APR)?

The CY 2025 APR includes the following data from the CY 2024 performance year:

- OASIS-based measures – quality episodes ending in CY 2024.
- Claims-based measures – home health stays that begin during CY 2024. The time period for the claims-based measures is 60 days following the start of the home health stay.
- HHCAHPS Survey-based measures – HHCAHPS surveys completed for eligible patients seen by home health agencies during CY 2024.

Q4004.4 What benchmarks apply to the expanded HHVBP Model and when will the final benchmarks used to calculate the Total Performance Score (TPS) be available?

Note that the HHA baseline years listed in **Exhibit 7** refer to the first ***possible*** baseline year for an HHA. An HHA must have sufficient data to establish a baseline year for each quality measure. If an HHA does not have sufficient data to create a measure score in the first possible baseline year, the following year(s) may qualify to become the HHA baseline year if the HHA has sufficient data. For more information on sufficient data for the TPS calculation, refer to

Q4001.2. CMS sets all benchmarks and achievement thresholds for each quality measure by cohort, based on all home health agencies' (HHAs') performance data in the designated baseline year cited in the most current Home Health Prospective Payment System (HH PPS) final rule.

The CY 2024 HH PPS final rule cites that CY 2023 is the Model baseline year used to calculate benchmarks and achievement thresholds beginning with the CY 2025 Performance Year. CMS provided the preliminary achievement thresholds and benchmarks beginning with the CY 2025 Performance Year in July 2024. Please note that the Performance Years, Model Baseline Years and HHA Baseline Years for Discharge to Community – Post Acute Care (DTC-PAC) and Medicare Spending per Beneficiary - Post Acute Care (MSPB-PAC) are two years.

Q5007.3 What is the billing process for the expanded HHVBP Model?

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

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

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

1. The HHA submits a final claim as usual. There is no change in this process.
2. The Medicare claims processing system reviews the claim, calculates payment, and applies the APP to the claim.
3. The Medicare Administrative Contractor (MAC) pays the claims and returns the remittance advice with the claim. Please note, while the HHVBP adjustment amount is not separately identified on the remittance advice, a QV code may be visible in the MAC's online claim history. The QV code, or value-based purchasing adjustment amount, is the dollar amount of the difference between the HHA's value-based purchasing adjusted payment and the payment amount that would have otherwise been made. This adjustment is a positive or negative amount that adjusts the payment based on performance in the expanded HHVBP Model.

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

Q6002.4 How often will HHAs receive an Interim Performance Report (IPR)?

The Interim Performance Report (IPR) is published quarterly. For the CY 2023 performance year, only active HHAs that were Medicare-certified prior to January 1, 2022, and meet the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year received an IPR.

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

For the CY 2025 performance year, only active HHAs that were Medicare-certified prior to January 1, 2024, and meet the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year received an IPR.

Q6005.1 I use vendor reports for my quality data and the report values on their reports are different from those on the Interim Performance Report (IPR). Why? Should I use the vendor reports?

There could be multiple possible reasons for differences in measure values, including, but not limited to, the following:

- Time frame covered by the data,
- Risk adjustment and risk-adjustment model used,
- Data sources used (e.g., OASIS assessments vs. Medicare claims),
- Timeframe when the data are extracted,
- Completeness of the data, and
- Inclusion/exclusion of Medicare Advantage patients, other measure-specific exclusions, such as whether certain hospitalizations are excluded for the Potentially Preventable Hospitalization measure, and/or the formulas and rounding rules used when calculating values.

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

Q6021.2 When will HHAs receive expanded Model reports? What data will each report include?

Exhibit 10 shows the timelines for report timing through October of 2027, by report and measure category. The measure performance period for each report covers 12 months of performance data for each 1-year quality measure and 24 months of performance data for each 2-year quality measure. Note that data collection periods differ among the types of measures, resulting in differences in data availability by measure category.

Exhibit 10. Timeline for by Report Type, Measure Category, and Data Period

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

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

Q6032.1 Our agency did not receive an Annual Performance Report (APR). We have received Interim Performance Reports (IPR) this year and do not understand why our agency did not receive an APR.

Active Home Health Agencies (HHAs) were eligible to receive the CY 2025 APR and an annual payment percentage if the agency was Medicare certified prior to January 1, 2023, and had sufficient data for at least five (5) quality measures to calculate a TPS. If an agency did not have sufficient data for at least five (5) quality measures, they did not receive an APR even if they received IPRs previously. HHAs that were Medicare certified prior to January 1, 2023 and met the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year received a January 2025 and April 2025 IPR. HHAs that were Medicare certified prior to January 1, 2024 and met the minimum threshold of data for at least one (1) quality measure in the quarterly reporting period for the performance year received a July 2025 IPR.

Section One: Expanded HHVBP Terms, Acronyms, & Definitions

Exhibit 3 contains the list of common terms, acronyms, and definitions used specifically in the expanded HHVBP Model and referenced throughout this document.

Exhibit 3. Expanded HHVBP Model Glossary of Terms, Acronyms, and Definitions

Terminology	Definition
Achievement Score (Also referred to as achievement points)	During the performance year data period for each applicable measure, an HHA will receive an achievement score, quantifying the HHA's performance relative to other HHAs within the respective volume-based cohort in the Model baseline year. An HHA can earn between zero (0) and 10 achievement points for each measure. Achievement points are calculated for each measure by dividing the difference between an HHA's performance score and the achievement threshold by the difference between the benchmark and the achievement threshold, multiplying the resulting quotient by 10, and rounding to the third decimal point. The formula for calculating an HHA's achievement score is: $\text{Achievement Score} = 10 \times \left(\frac{HHA\ Performance\ Score - Achievement\ Threshold}{Benchmark - Achievement\ Threshold} \right)$ For additional information on the Achievement score please see the **Expanded HHVBP Model Guide: Section 5.2**. Source data used to calculate an achievement score are derived from iQIES. The achievement score for each measure with sufficient data will be available in the Interim Performance Report (IPR) and the Annual Performance Report (APR).
Achievement Range	A scale between the achievement threshold and the designated benchmark, along which an HHA 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 that is 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 fee-for-service (FFS) claim submitted with a payment episode "through date" in the corresponding expanded Model payment year.
Baseline Years	**HHA Baseline Year:** The year(s) used by CMS to compare an HHA's reporting period performance score for each applicable performance measure to its own performance in the specified measure during the HHA Baseline Year. CMS uses the HHA baseline year to calculate an HHA's improvement threshold for each quality measure. An HHA's baseline year for each quality measure is determined by: 1) Sufficient data to establish a baseline year for a particular quality measure, and 2) the HHA's Medicare-certification date. If an HHA does not have sufficient data to create a measure score in the first possible baseline year, the following year(s) may qualify to become the HHA baseline year if the HHA has sufficient data.

SECTION ONE: EXPANDED HHVBP TERMS, ACRONYMS, AND DEFINITIONS

Terminology	Definition
	Model Baseline Year: The year against which CMS calculates the achievement thresholds and benchmarks values for each quality measure by cohort. Please note that the HHA Baseline Years and Model Baseline Years for Discharge to Community – Post Acute Care (DTC-PAC) and Medicare Spending per Beneficiary (MSPB) are comprised of two years of data.
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 the achievement points or improvement points for each measure with sufficient data reported in the Interim Performance Report and Annual Performance Report.
CCN	An HHA's six (6)-digit (all numeric) CMS Certification Number.
Claims-based Measures	For the expanded HHVBP Model, the utilization measures calculated using Medicare fee-for-service (FFS) claims data. Claims-based utilization measures provide information related to the use of health care services (e.g., hospitals, emergency departments, etc.) resulting from a change in patient health status. These measures use healthcare utilization data to indicate whether patients achieved a successful outcome of care or, instead, whether they have unresolved care needs.
Cohort	The group in which an HHA competes. HHAs compete nationally in one (1) of two (2) volume-based cohorts, as defined by the number of unique HHCAHPS Survey-eligible beneficiaries for each HHA in the year prior to the performance year. • Smaller-volume cohort: the group of competing HHAs that had fewer than 60 unique beneficiaries in the calendar year prior to the performance year. This grouping is based on the definition of HHAs that are exempt from participation in the HHCAHPS survey in accordance with §484.245. • Larger-volume cohort: the group of competing HHAs that had 60 or more unique beneficiaries in the calendar year prior to the performance year. This grouping is based on the definition of HHAs participating in the HHCAHPS survey in accordance with §484.245.
Competing Home Health Agency (HHA)	A home health agency that has a current Medicare certification and is receiving payment for home health care services from CMS.
Composite Measure	A combination of two (2) or more individual measures that results in a single measure and score.
CY	Calendar year. The period from January 1 through December 31.
Home Health Prospective Payment System (HH PPS)	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount, specific to home health agencies. The payment amount for a particular service is derived based on the classification system of that service. More information on the HH PPS is available on CMS.gov.
HHA	A home health agency.
HHA Performance Score	The risk adjusted value for an applicable measure based on the HHA's performance in a given performance year data period.
Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)	A publicly reported survey that measures the experiences of people receiving home health care from Medicare-certified home health agencies. For the HHCAHPS Survey-based measure category, there are five (5) individual components that each serves as single measure under the expanded Model. Details on the HHCAHPS Survey scoring methodology are available on the HHCAHPS website.

Terminology	Definition
Improvement Range	A scale between an HHA's performance during the HHA baseline year and the benchmark along which an HHA will receive improvement points for a given measure.
Improvement Score (Also referred to as improvement points)	During the performance year for each applicable measure, an HHA will receive an improvement score, quantifying the HHA's performance relative to its own performance in the HHA baseline year. An HHA can earn between zero (0) and nine (9) improvement points for each applicable measure. An HHA's performance score on each applicable quality measure during the HHA baseline year is also known as the improvement threshold. The improvement score is calculated for a given quality measure by dividing the difference between an HHA's performance score and the improvement threshold by the difference between the designated benchmark and the improvement threshold and multiplying the resulting quotient by nine (9). The formula for calculating the improvement score is: $\text{Improvement Score} = 9 \times \left(\frac{HHA\ Performance\ Score - HHA\ Improvement\ Threshold}{Benchmark - HHA\ Improvement\ Threshold} \right)$ The Interim Performance Report (IPR) and the Annual Performance Report (APR) include an HHA's improvement points for each measure with sufficient data. For additional information on the Achievement score please see the **Expanded HHVBP Model Guide: Section 5.3.**
Improvement Threshold (Also referred to as the baseline year score)	An individual competing HHA's performance on an applicable measure during the HHA baseline year.
Internet Quality Improvement Evaluation System (iQIES)	iQIES serves as the only access site for all HHVBP performance feedback reports for the expanded HHVBP Model. Only iQIES users authorized to view an HHA's OASIS Quality report can access HHVBP reports. If an HHA needs to register a user or experiences trouble locating or downloading reports, please contact the QIES/iQIES Service Center at (800) 339-9313 or by email at iqies@cms.hhs.gov.
Interim Performance Report (IPR)	A performance feedback report is available to HHAs in iQIES only. These quarterly reports contain information on the quality measure performance based on the 12 most recent months of data available. The IPR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. The IPR provides HHAs with the opportunity to assess and track their performance relative to their 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 the **Expanded HHVBP Model Guide: Appendix D. Measure Weights by Performance Year**.
Outcome and Assessment Information Set (OASIS)	A data collection instrument incorporated within a home health patient comprehensive assessment.
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.

SECTION ONE: EXPANDED HHVBP TERMS, ACRONYMS, AND DEFINITIONS

Terminology	Definition
Percentile Ranking	A percentile ranking compares competing HHA's performance to those of other HHAs within the same cohort.
Performance Year(s)	The calendar year(s) during which OASIS-based, claims-based, and HHCAHPS Survey-based measure data are used for the purpose of calculating an HHA's Total Performance Score (TPS).
Pre-Implementation Year	CY 2022 was the pre-implementation year to allow HHAs time to prepare for implementation of the expanded HHVBP Model. During this time, CMS provided education and support to competing HHAs. HHAs used this time to assess their performance on the set of quality measures used in the expanded Model.
Quality Episode	Used in the calculation of the quality measures. Quality episodes are different from payment episodes. A quality episode begins with either a SOC (start of care) or ROC (resumption of care) and ends with an End of Care (EOC) assessment (transfer, death, or discharge) for a patient regardless of the length of time between the start and ending events. This is relevant for OASIS-based measures.
Quality Measure Set	The quality measures included in the expanded HHVBP Model consist of OASIS-based, claims- based, and HHCAHPS Survey-based measures. See the **Expanded HHVBP Model Guide: Section 4. Quality Measures** for the current list of measures.
Recalculation Request	An HHA may submit this request if it wishes to dispute the calculation of the following: (i) interim performance scores, (ii) annual performance scores, or (iii) application of the formula to calculate annual payment adjustment percentages. Recalculation requests are available for each quarterly Preliminary IPR and for the Preview APR using instructions provided by CMS. An HHA may only submit a recalculation request within 15 calendar days after CMS publishes the HHA-specific Preliminary IPR or Preview APR to iQIES, if the HHA has evidence there may be an error in the calculation.
Reconsideration Request	An HHA may request a reconsideration of the Preliminary APR if it disagrees with the results of a recalculation request presented in the Preliminary APR. HHAs can submit a reconsideration request and supporting documentation via instructions provided by CMS within 15 calendar days after CMS issues the Preliminary APR. Only HHAs that submit a recalculation request may submit a reconsideration request. Per the CY 2024 HH PPS final rule, an HHA may request an Administrator review of a reconsideration decision within seven (7) calendar days from CMS' notification of the outcome of the reconsideration request.
Total Normalized Composite (TNC) Change in Mobility	Please note that as of the CY 2025 performance year set the TNC Change in Mobility OASIS-based quality measure has been retired from the expanded HHVBP Model applicable measure set. This measure captures the magnitude of change (positive change, no change, or negative change) in home health patients' mobility between the Start or Resumption of Care (SOC/ROC) and the End of Care (EOC). It is a composite of three (3) OASIS items related to mobility (i.e., M1840, M1850, and M1860). CMS calculates the risk-adjusted Total Normalized Composite (TNC) Change in Mobility measure from the observed difference in patient mobility between SOC/ROC and EOC in eligible home health quality episodes ending with a discharge from the agency during the reporting period, except for those meeting the exclusion criteria. For more information, please refer to the "Technical Specifications for the Total Normalized Composite Change Measures – October 2021" and "Technical Specifications for the Total

Terminology	Definition
	Normalized Composite Change Measures – April 2023" and the "Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures" document, available on the Expanded HHVBP Model webpage.
Total Normalized Composite (TNC) Change in Self-Care	Please note that as of the CY 2025 performance year set the TNC Change in Self-Care OASIS-based quality measure has been retired from the expanded HHVBP Model applicable measure set. This measure captures the magnitude of change (positive change, no change, or negative change) in home health patients' self-care between the Start or Resumption of Care (SOC/ROC) and the End of Care (EOC). It is a composite of six (6) OASIS items related to self- care (i.e., M1800, M1810, M1820, M1830, M1845, and M1870). CMS calculates the risk-adjusted Total Normalized Composite (TNC) Change in Self-Care measure from the observed difference in patient self-care between SOC/ROC and EOC in eligible home health quality episodes ending with a discharge from the agency during the reporting period, except for those meeting the exclusion criteria. For more information, please refer to the "Technical Specifications for the Total Normalized Composite Change Measures – October 2021", "Technical Specifications for the Total Normalized Composite Change Measures – April 2023", and "Calculating Episode-Level Observed Values for the Total Normalized Composite (TNC) Change Measures" documents, available on the Expanded HHVBP Model webpage.
Total Performance Score (TPS)	The numeric score awarded to each qualifying HHA based on the performance scores for each applicable measure. CMS determines the TPS by multiplying the care points by the applicable measure weight and summing the weighted measure points. A qualifying HHA will receive a numeric score ranging from zero (0) to 100. An HHA must have sufficient data to allow calculation of at least five (5) applicable measures in the expanded Model measure set in the baseline year and performance year. The following is the minimum threshold of data an HHA must have for each applicable measure to receive a measure score: • For OASIS-based measures, 20 home health quality episodes per reporting period. • For claims-based measures, 20 home health stays per reporting period. For the HHCAHPS Survey-based measures, 40 completed surveys per reporting period
Weighted Measure Points	The Interim Performance Report (IPR) and the Annual Performance Report (APR) include an HHA's weighted measure points on the Measure Scorecard tab. The Total Performance Score (TPS) is the sum of the weighted measure points.

Exhibit 4. 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

SECTION ONE: EXPANDED HHVBP TERMS, ACRONYMS, AND DEFINITIONS

Acronym	Term
CMMI	CMS Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CoPs	Conditions of Participation
CY	Calendar Year
DTC-PAC	Discharge to Community – Post-Acute Care (claims-based measure)
ED Use	Emergency Department Use
EOC	End of Care
FAQ	Frequently Asked Question
FFS	Fee-for-Service
HH	Home Health
HH PPS	Home Health Prospective Payment System
HH QRP	Home Health Quality Reporting Program
HHA	Home Health Agency
HHCAHPS	Home Health Consumer Assessment of Healthcare Providers and Systems
HHVBP	Home Health Value-Based Purchasing
HIPAA	Health Insurance Portability and Accountability Act
IPR	Interim Performance Report
iQIES	Internet Quality Improvement and Evaluation System
LEF	Linear Exchange Function
MSPB	Medicare Spending Per Beneficiary
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
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

Section Two: Frequently Asked Questions (FAQs)

I. General Information

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

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

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

The first performance year for the expanded Model was CY 2023, beginning January 1, 2023. HHA performance during CY 2023 determined payment adjustment amounts CMS applied during the first payment year, CY 2025.

Q1001. When did the expanded HHVBP Model begin?

The expanded HHVBP Model began on January 1, 2022.

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

The first performance year for the expanded Model was CY 2023, beginning January 1, 2023, determined payment adjustment amounts during the first payment year, CY 2025. **Exhibit 5** illustrates the timeline for the expanded Model.

Exhibit 5. Timeline for the Expanded HHVBP Model by Performance Year/Payment Year through CY 2028

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

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

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

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

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

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

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

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

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

Q1006.1 Are small HHAs required to participate? How does the expanded HHVBP Model impact agencies that provide services to a small number of Medicare patients (e.g., 10 cases/year)?

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

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

For HHAs that provide services to a small number of patients, the number of patients they serve may affect the number of applicable measures with sufficient data to create a baseline year score or performance score. HHAs must have sufficient data to allow calculation of at least five (5) of the applicable measures to receive a Total Performance Score (TPS). Therefore, some small HHAs may not receive a TPS and a corresponding payment adjustment. See **Q3004**.

Q1007.2 Which payers does CMS include in the expanded HHVBP Model?

CMS applies the payment adjustment percentage to Home Health Prospective Payment System (HH PPS) Medicare claims, which are only available for Medicare fee-for-service (FFS) beneficiaries. Please note that this does not preclude other non-Medicare FFS payers from utilizing an agency's HHVBP annual payment adjustment. Questions related to non-Medicare FFS payers should be directed to that payer. For calculating performance scores and public reporting, the expanded HHVBP Model includes the following payers for each measure category:

Exhibit 6. Payers Included in the Expanded HHVBP Model

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

*Although HHAs are required to collect and submit OASIS data on all patients, regardless of payer effective 7/1/2025 (with a voluntary phase-in period of 1/1/2025 – 6/30/2025), the OASIS-based quality measures in the expanded HHVBP Model will continue to report only data for Medicare FFS, Medicare Advantage (Medicare managed care), Medicaid, and Medicaid managed care. CMS will monitor the all-payer OASIS data and will notify providers when decisions are made for future uses for quality or payment purposes, including if, when or how non-Medicare/non-Medicaid OASIS data will be used for the expanded HHVBP Model.

Q1009.4 What can HHAs do to further understand the expanded HHVBP Model and stay up to date with expanded Model requirements?

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

- Review the HH PPS final rules for: CY 2022; CY 2023; CY 2024; and CY 2026. See the table of contents for each rule to locate information specific to the expanded HHVBP Model.
- Visit and bookmark the Expanded HHVBP Model webpage.
- Review each resource on the Expanded HHVBP Model webpage.
- Subscribe to the Expanded HHVBP Model listserv by entering your email address on the contact form, then selecting "Home Health Value-Based Purchasing (HHVBP) Expanded Model" from the *Innovations* list. To ensure you receive expanded Model communications via email, please add "cmslists@subscriptions.cms.hhs.gov" to your email safe sender list.
- Confirm agency access to Internet Quality Improvement and Evaluation System (iQIES). Review all identifying agency information (e.g., name, address, CCN) in the expanded HHVBP Model reports for accuracy. If information is incorrect, please contact the iQIES Help Desk: iQIES@cms.hhs.gov or 1 (800) 339-9313. For more information, please review the QIES Technical Support Office webpage for HHA Providers.
- Access and review the reports available in iQIES in the "HHA Provider Preview Reports" folder.
- Review the quality measures in the expanded HHVBP Model. See the Expanded HHVBP Model Guide: Section 4. Quality Measures for information.
- Contact the CMS HHVBP Model Help Desk, HHVBPquestions@cms.hhs.gov, with questions.

Q1010.1 Are there exclusions to participation for an HHA, such as excluding patients that are dual beneficiaries (Medicare skilled nursing, Medicaid personal care) from expanded HHVBP quality measures?

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

Q1011.1 How will CMS differentiate between public reporting under the expanded HHVBP Model and public reporting under the Home Health Quality Reporting Program (HH QRP)?

Publicly reporting performance data under the expanded HHVBP Model will enhance the current home health public reporting processes, as it will better inform the public when choosing a home health agency (HHA), while also incentivizing HHAs to improve performance. Publicly reporting performance data under the expanded Model is also consistent with the CMS practice

of publicly reporting performance data under other value-based initiatives such as the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) and Hospital Value-Based Purchasing (HVBP) Programs.

Public reporting of performance data for the expanded Model began with the calendar year (CY) 2023 performance year/CY 2025 payment adjustment. CMS made this information available to the public on the CMS Provider Data Catalog (PDC) website in January 2025.

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

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

The expanded HHVBP Model payment adjustment percentage is applied based on the quality of the home health agency's (HHA's) performance represented by the quality measure scores for all Medicare and Medicaid patients. CMS applies the payment adjustment percentage to Home Health Prospective Payment System (HH PPS) Medicare claims, which are only available for Medicare fee-for-service (FFS) beneficiaries. The Home Health Quality Reporting Program (HH QRP) collects quality measure data from the same payer sources as the expanded Model, including Medicaid. Please see **Q1007.2** for the payers included in each expanded Model measure category.

To minimize provider documentation burden and improve care, the expanded Model quality measure set aligns with data already submitted via the OASIS Instrument, Medicare FFS claims, and HHCAHPS Surveys. Quality measures used in the expanded Model are calculated using data from all Medicare and Medicaid payers (health care insurances).

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

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

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

For additional assistance, HHAs may submit questions related to HH QRP exception and

extension requests to: HHAPUReconsiderations@cms.hhs.gov.

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

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

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

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

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

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

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

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

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

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

1. Complete form CMS-855A in PECOS with the updated demographic information, url:

https://pecos.cms.hhs.gov/pecos/login.do#headingLv1. If you need assistance, contact your Medicare Administrative Contractor (MAC).

2. Contact your State OASIS Automation Coordinator (OAC) or State OASIS Education Coordinator (OEC) and request an update of your demographic data in iQIES. A list of OAC/OECs and their contact information can be found here: CMS Quality, safety, and oversight- General information, OASIS Coordinators webpage.

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

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

II. Cohorts

Under the expanded HHVBP Model, cohorts are the group in which an HHA competes. HHAs compete nationally in one (1) of two (2) volume-based cohorts, as defined by the number of unique beneficiaries served by an HHA with a completed quality episode in the calendar year prior to the performance year. This approach allows for the grouping of HHAs that are of similar size and more likely to receive scores on the same set of measures, for purposes of setting benchmarks and achievement thresholds and determining payment adjustments. The definition of the beneficiary-based cutoff used to define the two cohorts is derived from the HHCAHPS requirement allowing HHAs that serve fewer than 60 unique HHCAHPS Survey-eligible beneficiaries to request an exemption from participating in the HHCAHPS survey for a given Annual Payment Update (APU) period based on agency size.

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

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

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

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

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

For the expanded Model, CMS proposed and finalized to establish cohorts prospectively and with sufficient HHA counts to prevent the need to combine multiple cohorts retrospectively. To reliably define cohorts prospectively and to avoid regrouping multiple states, territories, or the

District of Columbia into a single cohort retrospectively based solely on their lower HHA counts, CMS estimated that a minimum of 20 HHAs in each cohort is necessary to ensure that attrition and variation in episode counts do not lead to insufficient HHA counts at the end of the performance year.

Q2007.1 If an HHA's beneficiary count changes each calendar year so that an HHA's cohort size changes, how is the improvement threshold determined?

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

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

For more information about the improvement threshold, please see **Q4002.4** and **Q4004.4**.

III. *Quality Measures*

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

For the applicable measures per calendar year, please refer to the **Expanded HHVBP Model Guide: Section 4. Quality Measures**.

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

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

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

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

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

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

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

Q3005.2 Do all the measures have the same weight when calculating each HHA's Total Performance Score (TPS) for the calendar year (CY) 2023 and CY 2024 and CY 2025 performance years?

For the CY 2023 and CY 2024 and CY 2025 performance years, the OASIS-based, claims-based, and HHCAHPS Survey-based measures categories are weighted 35%, 35%, and 30%, respectively, for the larger-volume cohort, accounting for 100% of the Total Performance Score (TPS). For the smaller-volume cohort, the OASIS- based and claims-based measure categories each have a weight of 50%. For more information on weighting, please refer to the **Expanded HHVBP Model Guide: Appendix D. Measure Weights by Performance Year**.

Q3006.2 Why are the data in the expanded HHVBP Model performance feedback reports different from other home health reports available on the Internet Quality Improvement Evaluation System (iQIES)?

While there are similarities in the measures used in the expanded HHVBP Model, the Home Health Quality Reporting Program (HH QRP) and the Quality of Patient Care (QoPC) Star Rating use a specific measure set. For calendar year (CY) 2023 and 2024 (12 measures) and CY 2025 (10 measures) performance years See the **Expanded HHVBP Model Guide: Section 4. Quality Measures**.

Additionally, while measures in the HH QRP, QoPC Star Rating, and expanded Model use the same measure specifications, each may use different data collection time periods for the measures.

Differences in individual quality measure scores between the HH QRP and the expanded Model performance feedback reports are most likely due to differences in the time periods for the data included in the analyses. As a result, CMS does not expect measure results to be identical and the ability to compare is limited.

Q3008.1 How are the two (2) OASIS-based TNC measures, Total Normalized Composite Change in Mobility (TNC Mobility), and Total Normalized Composite Change in Self-Care (TNC Self-Care) defined, and where can HHAs locate additional information for these two (2) measures?

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

Total Normalized Composite Change in Self-Care (TNC Self-Care) measures the magnitude of change (positive change, no change, or negative change) based on normalized total possible change across six

(6) OASIS-based Activities of Daily Living (ADL) items: M1800 Grooming, M1810 Upper Body Dressing, M1820 Lower Body Dressing, M1830 Bathing, M1845 Toileting Hygiene, and M1870 Eating.

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

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

Please note that as of the CY 2025 performance year set the TNC Change OASIS-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

Q3009.3 When will the claims-based measures, Acute Care Hospitalization During the First 60 Days of Home Health (ACH) and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (ED Use), be replaced with the measure Home Health Within Stay Potentially Preventable Hospitalization (PPH)?

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

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

The list of expanded HHVBP Model applicable measure sets for CY 2023, CY 2024, CY 2025, and CY 2026 are available in **the Expanded HHVBP Model Guide.**

Please note that as of the CY 2025 performance year set the TNC Change OASIS-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

Q3010.2 What factors are included in the calculations of the quality measures included in the expanded HHVBP Model for the CY 2023 and CY 2024 performance years?

Information on each quality measure included in the expanded HHVBP Model for the CY 2023 and CY 2024 performance years is available in **the Expanded HHVBP Model Guide**.

For additional information related to the:

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

Please note that as of the CY 2025 performance year set the TNC Change OASIS-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

Q3011.3 Do the measures used in the expanded HHVBP Model address maintenance patients where the goal is to stabilize, but not necessarily show improvement? What about patients who are likely to decline?

Every home health agency (HHA) serves a different patient population, commonly referred to as

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

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

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

For questions related to risk adjustment for the:

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

Q3012.1 Does the claims-based acute care hospitalization measure include hospitalizations at 60- days or 30-days after home health admission? What is the definition of a stay for the Acute Care Hospitalization During the First 60 Days of Home Health and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health claims-based measures?

For the calendar year (CY) 2023 and CY 2024 performance years, the two (2) claims-based measures included in the expanded HHVBP Model are "Acute Care Hospitalization During the First 60 Days of Home Health (ACH)" and "Emergency Department Use without Hospitalization During the First 60 days of Home Health." For these two measures, a home health stay is calculated as a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

Information on each quality measure in the expanded Model, including links to technical specifications, is available in the **Expanded HHVBP Model Guide: Appendix C. Applicable Measures for the Expanded HHVBP Model**.

For more information on the claims-based measures, please refer to the Home Health Quality Measures Outcome Measures Table located in the download section of the Home Health Quality

Measure webpage. For questions related to claims-based measures in the expanded Model, email: homehealthqualityquestions@cms.hhs.gov.

Please note that as of the CY 2025 performance year set ACH and ED Use claims-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

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

Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) respondents are sampled or selected from sample months during the 12-month performance year data period. HHCAHPS Survey participants are selected or sampled from all eligible patients receiving services from a home health agency (HHA) during a sample month and the month immediately preceding the sample month. HHCAHPS Survey participants can include patients discharged during the sample month, as well as those continuing to receive services. To reduce respondent burden, after a patient has been included in a sample, they are not eligible to be included in the sample for the next five (5) months.

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

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

Q3014.2 Are there risk adjustment models for the quality measures included in the expanded HHVBP Model? Is risk adjustment calculated at the HHA parent level or at the branch level?

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

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

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

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

For more information on risk adjustment and the description of risk factors, please see the Risk Adjustment Technical Steps and Risk Factor Specifications, 2025 document on the CMS Home Health Quality Measures webpage.

The risk adjustment process for HHCAHPS Survey-based measures is different from the process described above. Please refer to the document titled Patient-Mix Adjustment Factors for Home Health Care CAHPS Survey (HHCAHPS) Results Publicly Reported on Care Compare in April 2025 on the HHCAHPS website that outlines the risk adjustment process for HHCAHPS measures in detail.

Information on each quality measure included in the expanded HHVBP Model is available in the **Expanded HHVBP Model Guide: Appendix C. Applicable Measures for the Expanded HHVBP Model.**

For questions related to risk adjustment for the:

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

Q3015.1 How is the HHA-level predicted score calculated for the two (2) Total Normalized Composite (TNC) Change measures that are part of the applicable measure set for the CY 2023 and CY 2024 performance years?

Predicted values are obtained from a regression model using a set of risk factors, as cited in the "Technical Specifications for the Total Normalized Composite Change Measures - April 2023" and "Technical Specifications for the Total Normalized Composite Change Measures – October 2021" documents, available on the Expanded HHVBP Model webpage.

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

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

Please note that as of the CY 2025 performance year set the TNC Change OASIS-based quality

measures have been retired from the expanded HHVBP Model applicable measure set.

Q3017.1 How do the Total Normalized Composite (TNC) Change Measures for the CY 2023 and CY 2024 performance years consider individuals who may not have goals for improvement?

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

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

Please note that as of the CY 2025 performance year set the TNC Change OASIS-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

Q3018.1 If a home health patient is hospitalized twice in the first 60 days of home health, are both hospitalizations counted in the claims-based measure, Acute Care Hospitalization During the First 60 days of Home Health (ACH)? Would it make a difference if the patient is transferred or discharged in terms of calculating the HHA performance score for this quality measure?

For the calendar year (CY) 2023 and CY 2024 performance years, the Acute Care Hospitalization During the First 60 days of Home Health (ACH) measure reports the percentage of home health stays in which patients were admitted to an acute care hospital during the 60 days following the start of the home health stay. The numerator for this quality measure includes the number of home health stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital in the 60 days following the start of the home health stay. A home health stay is a sequence of home health payment episodes separated from other home health payment episodes by at least 60 days.

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

Please note that as of the CY 2025 performance year set ACH and ED Use claims-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

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

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

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

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

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

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

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

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

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

Note that for the Discharged to Community measure, quality episodes in which patients were transferred to an institutional hospice (M2410 = 4) and with a M0906 Discharge/Transfer/Death Date of 1/1/2023 or later are also excluded from the measure.

The *Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 3.0,* available on the Home Health Quality Measures webpage, contains additional information about the Home Health Quality Reporting Program measure calculation.

Expanded HHVBP Model TNC Measures: Note that the *Home Health Quality Reporting Program Measure Calculations and Reporting User's Manual Version 3.0* does not have specifications for the TNC Change measures, as these measures are unique to the expanded Model. Resources specific to the TNC Change Measures are available on the Expanded HHVBP Model webpage under "Quality Measures."

Please note that as of the CY 2025 performance year set the TNC Change OASIS-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

Q3021.2 How is risk adjustment for the TNC Change measures calculated for a patient admitted to an HHA using OASIS-D1 and discharged using OASIS-E?

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

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

Please note that as of the CY 2025 performance year set the TNC Change OASIS-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

Q3022.3 Does discharge to a non-institutional hospice negatively impact the OASIS- based Discharged to Community measure that is included in the CY 2023 and CY 2024 applicable measure set?

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

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

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

- Transfer to an inpatient hospice (M0100 Reason for assessment - RFA 6 or 7 Transferred, and M2410 Inpatient Facility response is 4 hospice) and with a M0906

Discharge/Transfer/Death Date of 1/1/2023 or later, or

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

Please note that as of the CY 2025 performance year set the DTC OASIS-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

Q3023.1 What changes cited in the calendar year (CY) 2024 Home Health Prospective Payment System (HH PPS) final rule relate to the expanded HHVBP Model applicable measure set for the CY 2024 performance year?

Changes cited in the CY 2024 HH PPS final rule apply to the applicable measure set for the CY 2025 performance year and do not apply to the applicable measure set for the CY 2023 or CY 2024 performance years. For the list of applicable measures, and For more information about impacts to the expanded HHVBP Model finalized in the CY 2024 HH PPS final rule, please see **the Expanded HHVBP Model Guide**.

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

As finalized in the CY 2023 HH Final Rule, CMS is ending the suspension of OASIS data collection as part of the comprehensive assessment requirement for patients with non-Medicare and non-Medicaid payers. The CY 2023 rule specifies that starting July 1, 2025, OASIS data must be collected on all patients, regardless of payer, with some exceptions: patients under the age of 18, patients receiving maternity services, patients receiving only personal care, housekeeping services, or chore services. At this time, the OASIS-based measures used in the expanded HHVBP Model will continue to be calculated using only data from skilled Medicare and Medicaid patients that includes Medicare fee-for-service (FFS), Medicare Advantage, Medicaid, and Medicaid Managed Care.

Q3025.1 Since the Discharge to Community – Post Acute Care (DTC-PAC) measure reports two years of baseline data, what is the HHA baseline year for this measure?

For the calendar year (CY) 2025 performance year, CY 2022 and CY 2023 are used as the HHA Baseline Year for Discharge to Community – Post Acute Care (DTC-PAC), whereas CY 2023 is used for all other measures. Please note that because the DTC-PAC measure is reported as a two-year measure, improvement thresholds for this measure are only established for HHAs with 24 months of data (i.e., Medicare certification dates before January 1, 2022) and at least 20 home health stays that end in the two-year reporting period.

Q3026. Our agency has successfully completed and submitted several Start of Care (SOC) OASIS assessments for our commercially insured (non-Medicare/non-Medicaid) patients during the voluntary phase of all-payer OASIS data collection. Is CMS going to use patient data from these voluntary assessments in the measure calculation for the HHVBP measures? If not, what indicator(s) will CMS use to identify non-Medicare/non- Medicaid OASIS assessments that were completed on voluntary patients so that their OASIS information doesn't impact our Total Performance Score (TPS) for HHVBP?

CMS will monitor the all-payer OASIS data and will notify providers when decisions are made for future uses for quality or payment purposes, including if, when or how non-Medicare/non-Medicaid OASIS data will be used for the expanded HHVBP Model.

It is **not** intended that voluntary OASIS data will be used in the measure calculation of the HHVBP measures or in the HHVBP reports.

CMS uses Start of Care (SOC) data from 1) M0090 – Date Assessment Completed and 2) M0150 – Current Payment Sources to identify voluntary patient assessments in the phase-in and mandatory periods. Voluntary assessments can be identified as any OASIS assessment (including any time point) collected on a patient who has a M0090 date for their SOC on or between 1/1/2025 and 6/30/2025, and the SOC M0150 coding does not include responses 1 – Medicare (traditional fee-for-service), 2 – Medicare (HMO/managed care/Advantage plan), 3 – Medicaid (traditional fee-for-service), or 4 – Medicaid (HMO/managed care). Note that collection and submission of voluntary assessments could include all subsequent time points for a non-Medicare/non-Medicaid patient with a SOC M0090 date in the phase-in period, including those assessments occurring on or after 7/1/2025.

Q3027. Are the Home Health Within-Stay Potentially Preventable Hospitalization (PPH) and Discharge to Community - Post Acute Care (DTC-PAC) claims-based measures calculated using home health stays that begin or end in the performance period?

The Home Health Within-Stay Potentially Preventable Hospitalization (PPH) measure includes home health stays with an **end date** during the 12-month performance period. The Discharge to Community – Post Acute Care (DTC-PAC) measure includes home health stays with an **end date** during the 24-month performance period. Please note this approach is different from the specifications used for the Acute Care Hospitalizations (ACH) and Emergency Department Use (ED Use) claims-based measures. That is, the ACH/ED Use measures include home health stays with a **start date** during the 12-month performance period.

IV. Total Performance Scoring Methodology

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

Q4001.2 What is the Total Performance Score (TPS)?

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

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

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

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

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

Q4002.4 In the expanded HHVBP Model, what are the Model baseline year and the HHA baseline year, and how are these used in calculating the Total Performance Score (TPS)?

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

Model Baseline Year(s):

The *Model baseline year(s)* is used to measure an HHA's performance within their applicable

size cohort, smaller-volume HHAs or larger-volume HHAs, using benchmarks and achievement thresholds based on the most recent data available. For the purposes of calculating the benchmarks and achievement thresholds in the expanded HHVBP Model:

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

HHA Baseline Year:

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

Exhibit 7 summarizes the Model and HHA baseline years by Medicare certification date. CMS may consider changes for the expanded Model through future rulemaking.

Exhibit 7. Model and HHA Baseline, Performance and Payment Years based on Medicare certification date

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

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

Q4005.1 What is the minimum amount of measure data needed for an HHA to receive a TPS and be subject to a payment adjustment?

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

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

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

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

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

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

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

The HHA baseline year(s) is the calendar year(s) used to determine the improvement threshold for each measure for each individual competing HHA. CMS determines an HHA's baseline year(s) by the HHA's Medicare-certification date. If a change in ownership (CHOW) results in the use of a new CCN, neither the baseline nor the performance year score would transfer to the new CCN. If the agency continues to use the same CCN, then the baseline and the performance year scores transfer to the new owners.

Q4009.1 Why are the measures Acute Care Hospitalization During the First 60 Days of Home Health (ACH) and Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (ED Use) weighted higher than other measures? Do the ACH and ED Use measures take into account planned admissions or elective procedures?

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

For more information on the claims-based measures, please refer to the Home Health Quality Measures Outcome Measures Table located in the download section of the Home Health Quality Measure webpage. For questions related to claims-based measures in the expanded HHVBP Model, email: homehealthqualityquestions@cms.hhs.gov.

Please note that as of the CY 2025 performance year set ACH and ED Use claims-based quality measures have been retired from the expanded HHVBP Model applicable measure set.

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

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

Q4011.2 How are an HHA's weighted measure points calculated?

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

For more information on weighting per calendar year please refer to the **Expanded HHVBP Model Guide: Appendix D. Measure Weights by Performance Year.**

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

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

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

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

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

Q4016.1 If our HHA does not receive any completed HHCAHPS surveys for one or more quarters during the performance year, how will the HHCAHPS Survey-based measures be calculated for the performance year?

The expanded HHVBP Model Annual Performance Report (APR) calculations are based on the number of completed HHCAHPS surveys received during the 12-month reporting period and are not based on the number of completed HHCAHPS surveys an HHA receives each quarter. For the APR published in August 2025, HHCAHPS Survey-based measure performance is based on HHCAHPS surveys completed in CY 2024. To receive Care Points on the APR, the HHA must have a minimum of 40 completed surveys in the performance year data period.

In the expanded HHVBP Model performance reports, there are 10 quality measures in the expanded Model quality measure set for the calendar year (CY) 2025. The measures include three (3) OASIS-based measures, two (2) Medicare Fee-for-Service (FFS) claims-based measures, and five (5) HHCAHPS Survey-based measures. The OASIS-based, claims-based, and HHCAHPS Survey-based measure categories are weighted 35%, 35%, and 30%, respectively. If an HHA is missing all measures from one (1) measure category, the weights for the remaining two (2) measure categories are redistributed so that the proportional contribution remains consistent with the original weights. These redistributed measure categories sum to 100% of the HHA's TPS. For example, if a smaller-volume cohort HHA has sufficient data for OASIS-based and claims-based measures, then the OASIS-based and claims-based measures each count for 50%. If two (2) measure categories are missing, the remaining category is weighted at 100%.

Q4017.1 Why did our HHA receive zero (0) achievement points and zero (0) improvement points for some of the quality measures listed on our HHA's Model Performance Report?

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

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

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

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

Note that for one of the claims-based measures to be added to the Model measure set beginning with the CY 2025 performance year, Discharge to Community, higher scores reflect better performance. See the Glossary for the terms "Achievement Score" (also referred to as achievement points) and "Improvement Score" (also referred to as improvement points).

Q4018.1 For a newly certified HHA, when will their OASIS data begin to be used in the expanded HHVBP model and reported on HHVBP reports?

For a newly certified HHA, data from the first full calendar year after the agency received Medicare certification will be used to calculate the agency's HHA baseline for each of the Model measures. Data from the second calendar year after Medicare certification are used to calculate the agency's performance on the quality measures included in the Model. See the example table below. Note: For an agency's baseline (HHA baseline) and measure performance to be calculated for an applicable measure, they must have sufficient data in both the baseline and performance years. See **Q4001.2** for more information on sufficient data requirements.

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

Q4019.1 Our home health agency (HHA) has been Medicare certified since 1985 but has only provided services for pediatric patients until this year. What is our baseline year for the calendar year (CY) 2025 applicable measure set?

For a home health agency (HHA) that was Medicare certified in 1985 but began to serve adult Medicare and/or Medicaid patients in 2025, it is possible that calendar year (CY) 2025 could be the HHA baseline year for a measure if there is sufficient data. The following is the minimum threshold of data an HHA must have for each applicable measure to receive a measure score:

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

Q4020. Why does an agency need to have numeric values for both achievement points and improvement points to receive care points?

Care points are defined as the higher of the achievement points or improvement points for a given quality measure. Therefore, reported numeric values for both achievement and improvement points are required for determining care points. To generate achievement points and improvement points for a home health agency (HHA), the agency must have sufficient data to create an improvement threshold (i.e., baseline year score) and a performance year score. This requirement allows for a more equitable comparison of an HHA's Total Performance Score (TPS), which is defined as the sum of weighted care points. This approach also permits comparison of performance that considers both improvement and achievement for all HHAs in the cohort versus comparing only achievement for some HHAs in the cohort.

V. *Payment Adjustments*

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

Q5001.3 What level of payment adjustment can an HHA expect?

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

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

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

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

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

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

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

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

The linear exchange function (LEF) is used to translate a home health agency's (HHA's) Total

Performance Score (TPS) into a percentage of the value-based payment adjustment earned by each HHA. Performance measurement is based on a LEF which only includes competing HHAs.

Under the expanded HHVBP Model, payment adjustments will be made to the Home Health Prospective Payment System (HH PPS) final claim payment amount as calculated in accordance with HH PPS regulations at §484.370 using a LEF, similar to the methodology utilized by the Hospital Value-Based Purchasing (HVBP) Program (76 FR 26533). For more information on the LEF for the expanded Model, including step-by-step calculations, please refer to the CY 2022 HH PPS final rule.

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

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

Additional information is provided in **Q5001.3** and **Q5003.1**, and the resource *"How the Total Performance Score (TPS) Becomes the Final Payment Adjustment,"* located on the Expanded HHVBP Model webpage.

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

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

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

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

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

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

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

VI. Reports

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

HHAs are encouraged to review their IPRs to gain insights into their performance across a range of quality measures compared to their peers, consider the drivers of performance, and identify opportunities for improvement. HHAs have an opportunity to compare data in the quarterly IPRs to assess performance throughout each performance year. There are quality improvement resources designed to support HHAs with improving performance in the expanded HHVBP Model. These resources are available on the Expanded HHVBP Model webpage under the "Quality Improvement" category.

The second report is the Annual Performance Report (APR). The APR provides HHAs with information on their measure performance in the expanded Model, based on data from the prior calendar year. Like the IPR, the APR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds.

Additionally, the APR includes the HHA's payment adjustment percentage for the upcoming CY, an explanation of when the adjustment will apply, and how CMS determined the adjustment relative to HHA performance scores. The APR includes an average TPS for the cohort on the Annual Payment Adjustment tab. CMS issues three (3) versions of the APR – preview, preliminary, and final. For all reports, the home health episodes or patients included vary according to measure category as shown in **Exhibit 8**.

Exhibit 8: Data Included in Expanded Model Quality Measure Categories

Measure Category	Data Included
OASIS-based	OASIS quality episodes that ended during the 12-month performance year data period, determined from the date of the OASIS end of care assessment
Claims-based	Home health stays are constructed through analysis of Medicare fee-for-service claims. PPH: Home health stays with an end date during the 12-month performance period. DTC-PAC and MSPB: Home health stays with an end date during the 24-month performance period.
HHCAHPS Survey-based	HHCAHPS Survey respondents sampled or selected from sample months during the 12-month performance year data period. HHCAHPS Survey participants are selected or sampled from all eligible patients receiving services from an HHA during a sample month and during a 60-day lookback period. HHCAHPS Survey participants can include patients discharged during the sample month, as well as those continuing to receive services. To reduce reporting burden, patients are not asked to participate in the HHCAHPS Survey more than once every six (6) months.

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

Q6001.5 Will CMS notify HHAs when the Interim Performance Reports (IPRs) and Annual Performance Reports (APR) are available? How will HHAs access the reports?

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

Expanded HHVBP Model reports are available to home health agencies (HHAs) only via iQIES, in the "HHA Provider Preview Reports" folder, by the CCN assigned to the HHA. If a provider has more than one (1) CCN, a report will be available for each CCN. Only iQIES users authorized to view an HHA's reports can access the expanded HHVBP Model reports. Access Instructions are available on the Expanded HHVBP Model webpage under "Model Reports."

Reports Replaced in iQIES

- The **preview** version of the APR will be replaced with the **preliminary** version when available.
- The **preliminary** version of the APR will be replaced with the **final** version of the APR when available.
- The **preliminary** version of the IPR will be replaced with the **final** version of the IPR when available.

Final Reports Retention Period in iQIES

The final version of expanded HHVBP Model performance feedback reports will be retained and available in iQIES for 730 days after publication. When the report retention changes are implemented, final versions of the IPRs and APRs that are older than 730 days will be permanently deleted by the iQIES system and will no longer be provided to HHAs by CMS. The number of days the report will be available in iQIES is directly related to the date when the report was generated or made available in your CCN's My Report folder in iQIES.

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

Q6003.1 What does the Interim Performance Report (IPR) include?

The quarterly Interim Performance Report (IPR) contains information on quality measure performance based on the 12 most recent months of data available (24 months for DTC-PAC and MSPB-PAC). The IPR provides feedback to home health agencies (HHAs) about performance

relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. The IPR provides HHAs the opportunity to assess and track their performance relative to peers in their respective cohort. Each IPR includes the following information:

- Quarterly update on the HHA's Total Performance Score (TPS)
- Percentile rankings that reflect the agency's performance relative to the performance of other HHAs in their cohort
- Scorecard information that will support HHAs with understanding how each individual measure contributes to their TPS

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

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

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

Q6006.2 What can an HHA do if we think there may be an inaccuracy in the Interim Performance report (IPR)?

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

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

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

hhvbp_recalculation_requests@abtglobal.com.

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

- The provider's name, address associated with the services delivered, and CMS Certification Number (CCN).
- The basis for requesting recalculation to include the specific data that the HHA believes is inaccurate or the calculation the HHA believes is incorrect.
- Contact information for a person at the HHA with whom CMS or its agent can communicate about this request, including name, email address, telephone number, and mailing address (must include physical address, not just a post office box).
- A copy of any supporting documentation, not containing PHI, the HHA wishes to submit in electronic form.
- **Note**: When submitting recalculation and reconsideration requests:
- CMS asks HHAs to only include one CCN per request.
- If you are submitting a recalculation request due to a suspected discrepancy between measure values reported in your IPR and measure values calculated internally or by your HHA's vendor, please consider providing a copy of the internal/vendor report used to generate the internal data to assist CMS with investigating your HHA's request.
- If possible, confirm whether 1) your internal data are risk-adjusted and 2) the data source used to generate your internal measure values (e.g., OASIS data, claims data).
- **Please do not include any PHI/PII.**

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

Q6007.1 When does CMS make the Annual Performance Report (APR) available?

CMS provides the preview version of the Annual Performance Report (APR) in August of each applicable year. The Preliminary APR will be made available in September/October and the Final APR in December.

An HHA will receive an APR if they were Medicare-certified in the calendar year prior to the performance year and had sufficient data to allow calculation of at least five (5) measures to calculate scores in the baseline year(s) and performance year(s).

Q6008.1 What does the Annual Performance Report (APR) include?

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

adjustment relative to the HHA's final Total Performance Score (TPS).

Each competing HHA will receive three (3) confidential versions: a Preview APR, a Preliminary APR (if applicable), and a Final APR. The 2025 APR is based on the CY 2024 performance year (January 1, 2024 to December 31, 2024) with the payment adjustment applied to each HH PPS final claim payment amount as calculated in accordance with HH PPS policies as codified at §484.370 for Medicare fee-for-service claims with through dates between January 1, 2026 and December 31, 2026.

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

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

An HHA may request a*n Administrator review* of a reconsideration decision within seven (7) calendar days from CMS' notification of the outcome of the reconsideration request.

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

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

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

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

Q6013.1 On the TNC Change Reference tab, does the list of OASIS items refer only to the OASIS items or also to measures?

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

Exhibit 9: TNC Change Reference Tab

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

Performance Summary for TNC Change Measures [a]

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

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

Please note that as of the October 2025 IPRs the TNC Change Reference tab has been removed from the model reports as the TNC Change measures have been retired from the Expanded HHVBP Model applicable measure set.

Q6014.1 What is the relationship between HHA performance under the expanded HHVBP Model and performance for Star Ratings? How can the Star Ratings help HHAs understand current opportunities for improvement?

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

These reports contain details on agency performance on a variety of quality measures, including those included in the expanded HHVBP Model.

These reports in iQIES can inform current quality assurance and performance improvement (QAPI) programs as required under the Conditions of Participation (CoPs) §484.65.

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

- The TPS combines results from OASIS-based, claims-based, and HHCAHPS Survey-based measures**.** The TPS weighs points earned specific to the measure and measure category.

Star Ratings are computed separately for the Quality of Patient Care and Patient Survey domains.

- An HHA's TPS is compared to other agencies within the respective cohort—smaller-volume or larger- volume nationwide. For the Star Ratings, an HHA's ratings are compared at the national level only.
- The TPS offers an opportunity for HHAs to earn points for both improvement and achievement. Star Ratings recognize quality measure HHA performance in a specified time period, without reference to past performance.
- The time periods for the HH QRP data used for TPS and Star Ratings may not align.

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

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

Q6015.1 Is any of the data on the Total Normalized Composite (TNC) Change Reference tab in the Interim Performance Report (IPR) and Annual Performance Report (APR) risk-adjusted?

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

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

Please note that as of the October 2025 IPRs, the TNC Change Reference tab has been removed from the model reports as the TNC Change measures have been retired from the Expanded HHVBP Model applicable measure set.

Q6017.2 Does the information on the iQIES Review and Correct Report impact expanded HHVBP Model reports?

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

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

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

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

The values shown in the "Your HHA's Performance Year Measure Value" column and "Your HHA's Cohort Statistics" values are risk adjusted. Risk adjustment accounts for differences in patient case mix among different home health agencies (HHAs) that affect performance on outcome measures. For more information on risk adjustment in the expanded HHVBP Model, please refer to **Q3014.2.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

On the **Measure Scorecard Tab**, the values in the *Your HHA's Care Points* column carry over from the **Care Points Tab**. See **Q4017.1**.

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

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

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

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

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

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

Q6027.1 Can I access patient-level data in the expanded HHVBP Model performance feedback reports?

At this time, CMS does not provide any patient-level data in the expanded HHVBP Model performance feedback reports. HHAs should refer to their iQIES reports or internal databases to track how each patient performed at End of Care (EOC) relative to Start of Care/Resumption of Care (SOC/ROC).

Q6029. On our agency's Annual Performance Report (APR), the Annual Payment Adjustment tab, Step 6 (C7) TPS-Adjusted Payment Percentage has a value greater than five (5) percent. However, in Step 8 (C8), the Final TPS-Adjusted Payment Percentage is a much lower value. Why do we have two (2) different TPS-Adjusted Payment Percentages on this report?

CMS will apply a payment adjustment that ranges from minus five (5) percent to plus five (5) percent in payment year CY 2025 based on an HHA's performance in CY 2023. Step 7 (C8) *Final TPS-Adjusted Payment Percentage* is a result of normalizing the TPS-Adjusted Payment Percentage by subtracting the maximum payment adjust of five (5) percent and redistributing the excess that is above five (5) percent across all eligible HHAs in the cohort. The percentage in Step 7 (C8) Final TPS-Adjusted Payment Percentage indicates the adjustment that will be applied to that agency's Medicare fee-for-service claims with a "through date" in the HHVBP payment year.

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

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

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

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

An HHA must have sufficient data for both the baseline year **AND** the performance year for an applicable measure's achievement points, improvement points, and care points to be calculated in

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

Q6033. Why did our home health agency's (HHA's) Total Performance Score (TPS) increase but our adjusted payment percentage (APP) decrease when comparing the preliminary Annual Performance Report (APR) to the final APR?

A home health agency's (HHA's) Total Performance Score (TPS) and adjusted payment percentage (APP) may change from their preliminary Annual Performance Report (APR) to their final APR. Changes in TPS and APP can occur if there are changes in the underlying data. Applying your HHA's TPS in the linear exchange function (LEF), which reflects the relative performance of your HHA within your cohort, can result in an HHA's final TPS-adjusted payment percentage in the final APR increasing, decreasing, or remaining the same.

An HHA's performance relative to the performance of its cohort is a key factor in determining the linear exchange function (LEF) that works as another driver in the calculation of each HHA's payment adjustment. The amount of each HHA's payment adjustment, a maximum of five percent upward or downward depends on **both** the HHA's TPS **and** the performance of other HHAs in the assigned cohort.

Q6034. Which Interim Performance Report (IPR) will include the calendar year (CY) 2025 performance data for the Home Health Within-Stay Potentially Preventable Hospitalization (PPH) claims-based quality measure?

The July 2026 Interim Performance Reports (IPRs) will provide agencies with Home Health Within-Stay Potentially Preventable Hospitalization (PPH) quality measure data for the full calendar year (CY) 2025 (1/1/2025 – 12/31/2025).

Please note: The quarterly IPRs contain information on quality measure performance based on the 12 most recent months of data available (24 months for the DTC-PAC measure).

- The October 2025 IPR will be the first performance report that calculates an agency's Total Performance Score (TPS) based on the CY 2025 measure set. This IPR will include PPH measure performance based on home health stays with an end date during 4/1/2024 – 3/31/2025.
- The January 2026 IPRs will include PPH measure performance based on home health stays with an end date during 7/1/2024 – 6/30/2025.
- The April 2026 IPRs will include PPH measure performance based on home health stays with an end date during 10/1/2024 – 9/30/2025

VII. Public Reporting

Q8001.1 What information will CMS publicly report for the expanded HHVBP Model?

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

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

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

The Provider Data Catalog (PDC) is a CMS website that is a companion to the Care Compare website.

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

While the Care Compare website has consumer-focused content, the PDC is designed for innovators and stakeholders who are interested in detailed CMS data. Those looking for data related to the expanded HHVBP Model are encouraged to review the interactive and downloadable datasets for Home Health agencies, which CMS made available in January 2025 on the PDC.

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).