determined appropriate by the Secretary, to CMS in the form, manner, and at a time specified by the Secretary, and subject to any exceptions or extensions CMS may grant to home health agencies for the Public Health Emergency as defined in § 400.200 of this chapter.

(c) Competing home health agencies in selected states will be required to collect and report such information as the Secretary determines is necessary for purposes of monitoring and evaluating the HHVBP Model under section 1115A(b)(4) of the Act (42 U.S.C. 1315a).

[80 FR 68718, Nov. 5, 2015, as amended at 81 FR 76796, Nov. 3, 2016; 84 FR 60646, Nov. 8, 2019; 85 FR 27628, May 8, 2020; 86 FR 62422, Nov. 9, 2021]

§ 484.320 Calculation of the Total Performance Score.

A competing home health agency's Total Performance Score for a model year is calculated as follows:

(a) CMS will award points to the competing home health agency for performance on each of the applicable measures excluding the New Measures.

(b) CMS will award points to the competing home health agency for reporting on each of the New Measures worth up to ten percent of the Total Performance Score.

(c)(1) For performance years 1 through 3, CMS will sum all points awarded for each applicable measure excluding the New Measures, weighted equally at the individual measure level to calculate a value worth 90 percent of the Total Performance Score.

(2) For performance years 4 and 5, CMS will sum all points awarded for each applicable measure within each category of measures (OASIS-based, claims-based and HHCAHPS) excluding the New Measures, weighted at 35 percent for the OASIS-based measure category, 35 percent for the claims-based measure category, and 30 percent for the HHCAHPS measure category when all three measure categories are reported, to calculate a value worth 90 percent of the Total Performance Score.

(d) The sum of the points awarded to a competing HHA for each applicable measure and the points awarded to a competing HHA for reporting data on each New Measure is the competing HHA's Total Performance Score for the calendar year.

[80 FR 68718, Nov. 5, 2015, as amended at 81 FR 76796, Nov. 3, 2016; 83 FR 56630, Nov. 13, 2018]

§ 484.325 Payments for home health services under Home Health Value-Based Purchasing (HHVBP) Model.

CMS will determine a payment adjustment up to the maximum applicable percentage, upward or downward, under the HHVBP Model for each competing home health agency based on the agency's Total Performance Score using a linear exchange function. Payment adjustments made under the HHVBP Model will be calculated as a percentage of otherwise-applicable payments for home health services provided under section 1895 of the Act (42 U.S.C. 1395fff).

§ 484.330 Process for determining and applying the value-based payment adjustment under the Home Health Value-Based Purchasing (HHVBP) Model.

(a) *General.* Competing home health agencies will be ranked within the larger-volume and smaller-volume cohorts in selected states based on the performance standards that apply to the HHVBP Model for the baseline year, and CMS will make value-based payment adjustments to the competing HHAs as specified in this section.

(b) *Calculation of the value-based payment adjustment amount.* The value-based payment adjustment amount is calculated by multiplying the Home Health Prospective Payment final claim payment amount as calculated in accordance with § 484.205 by the payment adjustment percentage.

(c) *Calculation of the payment adjustment percentage.* The payment adjustment percentage is calculated as the product of: The applicable percent as defined in § 484.320, the competing HHA's Total Performance Score divided by 100, and the linear exchange function slope.

§ 484.335 Appeals process for the Home Health Value-Based Purchasing (HHVBP) Model.

(a) *Requests for recalculation*—(1) *Matters for recalculation.* Subject to the

limitations on review under section 1115A of the Act, a HHA may submit a request for recalculation under this section if it wishes to dispute the calculation of the following:

(i) Interim performance scores.

(ii) Annual total performance scores.

(iii) Application of the formula to calculate annual payment adjustment percentages.

(2) *Time for filing a request for recalculation.* A recalculation request must be submitted in writing within 15 calendar days after CMS posts the HHA-specific information on the HHVBP Secure Portal, in a time and manner specified by CMS.

(3) *Content of request.* (i) The provider's name, address associated with the services delivered, and CMS Certification Number (CCN).

(ii) The basis for requesting recalculation to include the specific quality measure data that the HHA believes is inaccurate or the calculation the HHA believes is incorrect.

(iii) 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).

(iv) The HHA may include in the request for recalculation additional documentary evidence that CMS should consider. Such documents may not include data that was to have been filed by the applicable data submission deadline, but may include evidence of timely submission.

(4) *Scope of review for recalculation.* In conducting the recalculation, CMS will review the applicable measures and performance scores, the evidence and findings upon which the determination was based, and any additional documentary evidence submitted by the home health agency. CMS may also review any other evidence it believes to be relevant to the recalculation.

(5) *Recalculation decision.* CMS will issue a written notification of findings. A recalculation decision is subject to the request for reconsideration process in accordance with paragraph (b) of this section.

(b) *Requests for reconsideration*—(1) *Matters for reconsideration.* A home health agency may request reconsideration of the recalculation of its annual total performance score and payment adjustment percentage following a decision on the home health agency's recalculation request submitted under paragraph (a) of this section, or the decision to deny the recalculation request submitted under paragraph (a) of this section.

(2) *Time for filing a request for reconsideration.* The request for reconsideration must be submitted via the HHVBP Secure Portal within 15 calendar days from CMS' notification to the HHA contact of the outcome of the recalculation process.

(3) *Content of request.* (i) The name of the HHA, address associated with the services delivered, and CMS Certification Number (CCN).

(ii) The basis for requesting reconsideration to include the specific quality measure data that the HHA believes is inaccurate or the calculation the HHA believes is incorrect.

(iii) 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).

(iv) The HHA may include in the request for reconsideration additional documentary evidence that CMS should consider. Such documents may not include data that was to have been filed by the applicable data submission deadline, but may include evidence of timely submission.

(4) *Scope of review for reconsideration.* In conducting the reconsideration review, CMS will review the applicable measures and performance scores, the evidence and findings upon which the determination was based, and any additional documentary evidence submitted by the HHA. CMS may also review any other evidence it believes to be relevant to the reconsideration. The HHA must prove its case by a preponderance of the evidence with respect to issues of fact.

(5) *Reconsideration decision.* CMS reconsideration officials will issue a written determination.

[81 FR 76796, Nov. 3, 2016]

HHVBP MODEL COMPONENTS FOR COMPETING HOME HEALTH AGENCIES (HHAS) FOR HHVBP MODEL EXPANSION—EFFECTIVE JANUARY 1, 2022

SOURCE: 86 FR 62422, Nov. 9, 2021, unless otherwise noted.

§ 484.340 Basis and scope of this subpart.

This subpart is established under sections 1102, 1115A, and 1871 of the Act (42 U.S.C. 1315a), which authorizes the Secretary to issue regulations to operate the Medicare program and test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under Titles XVIII and XIX of the Act.

§ 484.345 Definitions.

As used in this subpart—

Achievement threshold means the median (50th percentile) of home health agency performance on a measure during a Model baseline year, calculated separately for the larger- and smaller-volume cohorts.

Applicable measure means a measure (OASIS- and claims-based measures) or a measure component (HHCAHPS survey measure) for which a competing HHA has provided a minimum of one of the following:

(1) Twenty home health episodes of care per year for each of the OASIS-based measures.

(2) Twenty home health episodes of care per year for each of the claims-based measures.

(3) Forty completed surveys for each component included in the HHCAHPS survey measure.

Applicable percent means a maximum upward or downward adjustment for a given payment year based on the applicable performance year, not to exceed 5 percent.

Benchmark refers to the mean of the top decile of Medicare-certified HHA performance on the specified quality measure during the Model baseline year, calculated separately for the larger- and smaller-volume cohorts.

Competing home health agency or agencies (HHA or HHAs) means an agency or agencies that meet the following:

(1) Has or have a current Medicare certification; and

(2) Is or are being paid by CMS for home health care services.

HHA baseline year means the calendar year used to determine the improvement threshold for each measure for each individual competing HHA.

Home health prospective payment system (HH PPS) refers to the basis of payment for HHAs as set forth in §§ 484.200 through 484.245.

Improvement threshold means an individual competing HHA's performance level on a measure during the HHA baseline year.

Larger-volume cohort means the group of competing HHAs that are participating in the HHCAHPS survey in accordance with § 484.245.

Linear exchange function is the means to translate a competing HHA's Total Performance Score into a value-based payment adjustment percentage.

Model baseline year means the calendar year used to determine the benchmark and achievement threshold for each measure for all competing HHAs.

Nationwide means the 50 States and the U.S. territories, including the District of Columbia.

Payment adjustment means 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.

Payment year means the calendar year in which the applicable percent, a maximum upward or downward adjustment, applies.

Performance year means the calendar year during which data are collected for the purpose of calculating a competing HHA's performance on measures.

Pre-Implementation year means CY 2022.

Smaller-volume cohort means the group of competing HHAs that are exempt from participation in the HHCAHPS survey in accordance with § 484.245.

Total Performance Score (TPS) means the numeric score ranging from 0 to 100 awarded to each competing HHA based