CAPITOL STREET

November 30, 2025

'26 Home Health Severe Proposed Cuts Mitigated to -1.3%

Almost 500 bps Improvement; Positive for Agencies As Temp & Permanent Adjustments Mitigated

Relevant Companies

Our Take & Next Up

Home health in CY26 will face a significantly smaller pay decrease (490 bps improvement) than proposed, with free-standing for-profits to be paid -1.6% (versus -6.5% proposed). We had said that the -6.5% reduction would be mitigated or spread out over several years (here). Facility-based for profits will see a -2.1% (versus -7.1% proposed) pay update.

Late Friday of Thanksgiving weekend, CMS released the final 2026 home health agency (HHA) policy & pay regulation (here). CMS estimates Medicare payments to all agencies will decline by –1.3% (and -1.6% for free-standing proprietary agencies).The final rule adopted most other non-payment proposed policies, including updates to quality reporting measures and face-to-face encounter requirements. CMS modified the temporary and permanent payment adjustments that HHAs have worked to kill for years, and new DME provisions. These pay policies take effect Jan 1, 2026.

Key Points

The puts and takes of the vastly improved -1.3% update starting Jan 1, 2026. Proprietary home health agencies' (HHAs) payments are projected to decline -1.6%. The -1.3% update reflects the effects of the final 2026 home health payment update of +2.4% ($405 M increase), -0.9% from the effects of the final permanent adjustment ($150 M decrease), -2.7% that reflects the effects of the temporary adjustment ($460 M decrease), and an estimated -0.1% decrease from an update to the fixed-dollar loss ratio ($15 M decrease).

The agency is scaling back certain temporary and permanent adjustments under the patient-driven groupings model (PDGM), a win for industry, but the '27 outlook remains murky. Instead of the proposed combined reduction of -9%+ (-4% permanent, -5% temporary), the final rule implements a total -4% combined reduction (-1.023% permanent, -3% temporary). CMS notes that they plan to exclude the CY 2026 temporary adjustment from the 2027 base rate calculation, but may impose additional temporary adjustments in 2027 or later years as needed.

CMS recognized that some behavior changes were influenced by factors unrelated to the PDGM, such OASIS-E (outcome and assessment information set - version e) and expanded value-based purchasing. We had said previously (our take here) that we expected mitigation in the final rule. CMS explained that stakeholder and industry feedback highlighted concerns that external factors and overly steep cuts could compromise beneficiary access to home health services.

OTHER: DME COMP BIDDING, PROVIDER SCRUTINY & QUALITY MEASURE REMOVAL

The agency is tightening oversight of Medicare provider enrollment for fraud, waste and abuse prevention. Providers can now be revoked retroactively if they were noncompliant, allowing CMS to reclaim payments made since the start of noncompliance. Providers may also be revoked if beneficiaries report they didn't receive claimed services. Additionally, physicians and practitioners who haven't ordered or certified services for 12 consecutive months will have their Medicare billing privileges deactivated.

For 2026, CMS updated PDGM case-mix weights, functional impairment levels, comorbidity subgroups, and LUPA (low utilization payment adjustment) thresholds using CY 2024 claims data. These updates ensure Medicare payments better reflect patient care needs, complexity, and actual resource use. Functional levels are based on OASIS assessments, comorbidity subgroups account for secondary conditions, and LUPA thresholds adjust payments when patients receive very few visits. Overall, the changes keep PDGM payments accurate and aligned with current home health practice.

Final changes to the face-to-face encounter policy, expands the types of providers who may perform the required encounter for Medicare home health eligibility. Under the rule, physicians, nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), and certified nurse-midwives may conduct the encounter, regardless of whether they are the certifying provider or were involved in the patient's recent hospital or post-acute care stay.

CMS removes certain social determinant and related quality measures starting in 2026. The agency will remove the COVID-19 % of Patients Who Are Up to Date measure and corresponding OASIS measure. They will also remove four assessment items (1) Living Situation, (2) Food Runs Out, (3) Food Doesn't Last, and (4) Utilities. CMS is implementing a revised HHCAHPS (home health consumer assessment of healthcare providers and systems) survey beginning with the April 2026 sample month to improve patient experience measurement while reducing survey burden.

Durable medical equipment (DME) policies were finalized as well; see below for a quick take with more detail on manufacturer impact in our note forthcoming today. In short, CMS will move ahead with competitive bidding, as we previewed here and here. We said that specific DME categories and locations would be forthcoming in a subregulatory guidance – CMS notes this will be the case – but that and that CGM and insulin pumps will be included. The agency will pay for them on a monthly rental basis. Other key changes include revising single payment amounts (SPAs) using the 75th percentile of winning bids, applying annual inflation updates, adjusting bid limits, and establishing policies for remote item delivery.

- CMS is working to finalize DME comp bidding updates, and will start with furnishing class II continuous glucose monitors (CGMs) and insulin pumps.
- A new DME exemption for prior authorization based on 90% claim approval rate will be final.
- DME accreditation is final under the rule, as suppliers must be accredited by a CMS-approved accrediting organization (AO) to bill Medicare.

Ipsita Smolinski
Managing Director I Capitol Street
ipsita@capitol-street.com

202.250.3741 I www.capitol-street.com

900 19th St NW 6th Fl
Washington, D.C. 20006

CAPITOL STREET