CAPITOL STREET

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Positive Home Health 2027 Pay Proposal

Rates +2.4% With No Permanent PDGM Adjustment For First Time In 4 Years; Temporary Adjustment -3.0% Persists

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Our Take & Next Up

In a tailwind for home health agencies (HHAs), CMS proposes a +2.4% Medicare pay increase in 2027 (here), with no permanent PDGM adjustment. The update reflects a +2.1% MB increase and a +0.3% outlier payment update. CMS does not propose an additional permanent PDGM behavioral adjustment.

CMS retains the existing -3.0% temporary adjustment to continue recouping historical overpayments. We said that the pending HH rule would likely avoid major negative adjustments, with CMS more probably leaning on a modest temporary behavioral adjustment to preserve budget neutrality rather than layering in a new permanent cut.

The rule also includes several provider enrollment and fraud, waste, and abuse (FWA) provisions following heightened scrutiny of the sector (our take here). Comments are due August 31, 2026, with a final rule expected around November 1, 2026. Policies would take effect January 1, 2027.

Key Points

The +2.4% payment update reflects several offsetting policy changes. CMS projects a net +2.4% (+$420 M) increase in Medicare home health payments, consisting of a +2.1% home health payment update (+3.1% MB less a -1.0% productivity adjustment), no incremental impact from either the permanent or temporary behavioral adjustments (CMS is not proposing a new permanent adjustment and retains the existing -3.0% temporary adjustment), and a +0.3% increase from updating the fixed-dollar loss (FDL) ratio for outlier payments. Payments to proprietary HHAs are projected to increase +2.3%.

Positively, for the first time since 2022, CMS provides no incremental permanent PDGM behavioral adjustment. CMS is not proposing an additional permanent behavioral adjustment to the CY 2027 base payment rate because it concluded that recent differences between assumed and actual payments are primarily driven by routine payment recalibrations and coding changes, rather than provider behavioral changes attributable to PDGM. CMS will maintain the existing -3.0% temporary adjustment to continue recouping historical PDGM-related overpayments.

The agency promotes community-based palliative care, which differs from hospice. CMS proposes policies intended to promote beneficiary access to community-based palliative care under the existing Medicare home health benefit. While the proposal does not create a new payment pathway, CMS clarifies how palliative care services may be furnished under current benefit rules.

FWA (FRAUD, WASTE AND ABUSE) PROVIDER ENROLLMENT

CMS is proposing to expand its authority to apply retroactive revocations of Medicare enrollment in certain circumstances. CMS proposes allowing Medicare enrollment revocations to take effect on the date the underlying noncompliance occurred, rather than when CMS issues the revocation. The agency estimates the policy would recover roughly $82 M annually in improper payments. Under current policy, most revocations become effective 30 days after CMS issues notice, allowing providers to continue billing Medicare until the revocation takes effect. CMS proposes to close this gap by making most revocations effective as of the date the underlying noncompliance began. While relatively few HHAs are revoked, affected providers could be required to repay Medicare payments received after the violation began.

CMS is also proposing to add & expand several criteria for denying or revoking Medicare enrollment to strengthen program integrity. The agency proposes new and expanded criteria for denying or revoking Medicare enrollment, including providers operating in fraud-prone geographic areas and those with certain misdemeanor convictions involving sexual assault or financial misconduct. The proposal also expands CMS's authority to impose re-enrollment bars following enrollment denials or revocations.

The provider enrollment change aligns with the broader CMS-wide FWA crackdown. CMS's Fraud Defense Operations Center (FDOC), launched June 2025, has already stopped over $2B in improper payments across home health, hospice, and DME, part of a shift from "pay and chase" to "stop and cop," using AI to flag high-risk claims before payments are issued. CMS is also building a 50-state Medicaid program integrity playbook to standardize oversight nationally. CMS leadership has specifically named HH and hospice, alongside genetic testing and DME, as top fraud-risk areas, and is likely to continue scrutiny of HHAs this year.

OTHER PROVISIONS

- **CMS is proposing several routine payment methodology updates for CY 2027.** These include recalibrating PDGM case-mix weights, updating the fixed-dollar loss (FDL) ratio for outlier payments, and revising low utilization payment adjustment (LUPA) thresholds to better align payments with current utilization patterns.
- **RFI: home health specific wage index:** CMS is seeking stakeholder feedback on the potential development of a home health-specific wage index. The agency is requesting input on whether replacing the current hospital wage index with one based on home health labor market data would more accurately reflect workforce costs and improve payment accuracy across geographic areas.
- **HH quality reporting program (HH QRP):** CMS proposes cutting the OASIS data submission deadline from 4.5 months to ~45 days, speeding up public quality reporting by up to 3 months starting with CY 2027. It also standardizes reporting to a calendar-year window, makes minor digital-transfer updates for reconsiderations, and seeks input (RFI) on future measures like advance care planning. No expected change in reporting burden.
- **DMEPOS: face-to-face encounter for replacement items:** Clarifies that a new face-to-face encounter is not required for replacement of a DMEPOS item under the same HCPCS code (distinct from replacing

with a different item due to a changed medical condition).

- **DME benefit expansion, infusion pumps and drugs:** Implements CAA 2026 amendment to the DME definition, expanding Part B DME coverage to certain external infusion pumps and associated home infusion drugs/supplies, items currently only covered in outpatient settings. The agency projects an estimated ~$800K/year in Medicare savings. Conditions include a prescribing requirement of at least 12 infusions/year (monthly) via IV or subcutaneous route.

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