



CY 2026 Home Health Rule Finalizes Smaller Permanent Adjustment and Sets One-Year Temporary 3.0% Rate Reduction

On November 28, 2025, the Centers for Medicare & Medicaid Services (CMS) released the [Calendar Year \(CY\) 2026 Home Health Prospective Payment System](#) final rule for home health agencies (HHAs). CMS released a [fact sheet](#) accompanying the proposed rule.

The rule updates Medicare home health payment rates for CY 2026 and includes behavioral adjustments, recalibration of case-mix weights, and changes to low-utilization payment adjustment (LUPA) thresholds. It also updates requirements for the face-to-face encounter policy, the Home Health Quality Reporting Program (HH QRP), and the expanded Home Health Value-Based Purchasing (HHVBP) Model, as well as technical updates to conditions of participation for home health agencies.

Policies related to payment and accreditation requirements for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers and the Competitive Bidding Program are summarized in a separate summary document.

This rule is scheduled for publication in the Federal Register on December 2, 2025.

PERMANENT AND TEMPORARY ADJUSTMENTS TO CY 2026 HOME HEALTH RATES

FINALIZED WITH MODIFICATION- Page 63 of the Unpublished Rule

The Home Health Prospective Payment System (PPS) provides standardized, case-mix and area wage-adjusted payments for 30-day periods of care.

In this rule, CMS significantly scales back its behavior-related cuts to account for differences between assumed and actual provider behavior changes under the Patient-Driven Groupings Model (PDGM). **Instead of the proposed 4.059% permanent reduction, CMS finalizes a**



1.023% permanent reduction to the CY 2026 30-day base payment rate. Rather than using CY 2020-2024 data as proposed, CMS uses only CY 2020-2022 claims (the years the agency believes clearly reflects behavior change due to PDGM and the 30-day unit of payment) to determine the payment adjustment. CMS does not apply any permanent adjustment based on 2023 or 2024 data at this time, but will continue to monitor claims through 2026 and may propose additional permanent adjustments later if they can clearly tie post-2022 behaviors to the PDGM/30-day payment model.

In addition to the permanent adjustment, CMS finalizes a temporary 3.0% reduction to the CY 2026 home health payment rate to begin recoupment of approximately \$4.76 billion in retrospective overpayments from CYs 2020–2024. This decrease represents a reprieve from the originally proposed 5.0% temporary reduction. This one-year, prospective reduction (equivalent to a 0.9700 temporary adjustment factor) is expected to recover roughly \$471 million in CY 2026, based on an estimated 7.7 million 30-day periods.¹ The temporary adjustment does not carry forward into CY 2027 payment rates, but CMS indicates that additional temporary adjustments in future years are likely to reconcile the remaining overpayment balance and any further amounts identified for CYs 2025–2026 once data become available.

MARKET BASKET AND PAYMENT RATE UPDATES

FINALIZED AS PROPOSED- Page 120 of the Unpublished Rule

CMS finalizes a 2.4% payment update for agencies that report quality data, based on a 3.2% home health market basket increase reduced by a 0.8% productivity adjustment.² Agencies that do not meet quality reporting requirements will receive only a 0.4% update. The updated 30-day base payment rate for CY 2026 is \$1,933.61 for compliant HHAs and \$1,895.85 for non-compliant HHAs.

LUPA THRESHOLDS FOR CY 2026

FINALIZED WITH MODIFICATION- Page 71 of the Unpublished Rule

LUPA thresholds determine whether a 30-day home health period is paid as a full episode or on a per-visit basis, depending on whether the required visit count is met. In the final rule, CMS updates the CY 2026 low-utilization payment adjustment (LUPA) thresholds using CY 2024

¹ Proposed: 5.0% temporary reduction to the CY 2026 payment rate to begin recoupment of ~\$5.3B in cumulative overpayments from CY 2020-2024

² Per-visit rates, used for LUPAs, are also updated by 2.4% (or 0.4% for non-compliant HHAs), but excluded from the permanent and temporary PDGM payment adjustments.

claims data, consistent with the agency’s annual recalibration policy. CMS reports that visit patterns in 2024 were largely unchanged from 2023, with **18 case-mix groups experiencing a one-visit decline in their LUPA threshold**.³ CMS finalized the updated thresholds as proposed, reaffirming that utilization data—rather than clinical evidence—appropriately drive these annual adjustments.

FUNCTIONAL IMPAIRMENT LEVELS AND COMORBIDITY ADJUSTMENTS FOR CY 2026

FINALIZED WITH MODIFICATION- Pages 71-76, 86 of the Unpublished Rule

For CY 2026, CMS updates functional impairment levels and comorbidity adjustment subgroups under the PDGM using CY 2024 claims data. Functional levels (low, medium, and high) are determined by a scoring system based on responses to OASIS items related to activities of daily living and hospitalization risk. CMS updates the point values and thresholds for each clinical group using the same methodology as in prior years.

CMS also finalizes 20 low comorbidity subgroups and **98 high comorbidity interaction subgroups**,⁴ reflecting diagnoses with statistically significant resource use impacts.⁵ CMS asserts that these updates better align payment with patient complexity and care needs.

PDGM CASE-MIX WEIGHTS

FINALIZED WITH MODIFICATION- Page 111 of the Unpublished Rule

CMS finalizes updates to the case-mix weights used in the Patient-Driven Groupings Model (PDGM) for CY 2026 using CY 2024 home health claims and OASIS assessments. These updates are part of CMS’s annual recalibration process, designed to ensure that payment weights reflect current patient characteristics and resource use. Under the PDGM, patients are classified into one of 432 case-mix groups based on clinical condition, admission source, episode timing, functional impairment level, and comorbidity adjustment.

Using a fixed-effects regression model, CMS recalculated weights by estimating the relationship between these factors and actual resource use, measured via cost-per-minute plus non-routine supply costs. Functional scores and comorbidity adjustments were updated based on statistically significant associations with resource use. CMS updates the weights in a budget-

³ Proposed: 15 case mix groups experiencing a one-visit decline in their LUPA threshold

⁴ Proposed: 100 high comorbidity adjustment interaction subgroups.

⁵ Identified in Table 11 on page 78 of the unpublished final rule.

neutral manner **using a recalibration neutrality factor of 1.0052**,⁶ to ensure that overall spending remains unchanged when applied to CY 2024 data.

The final updated case-mix weights and methodology are outlined in Table 13 of the unpublished rule.⁷

WAGE INDEX AND OUTLIER PAYMENT ADJUSTMENTS

FINALIZED WITH MODIFICATION- Pages 130-131, 146 of the Unpublished Rule

CMS finalizes its proposal to continue to use hospital wage data (updated with OMB Bulletin 23-01) and apply a 5% cap on wage index decreases, applicable to both counties and CBSAs. Areas without hospital data (e.g., rural Puerto Rico, Northern Mariana Islands, American Samoa) will continue to receive special wage index proxies.

To comply with the statutory 2.5% cap on total outlier payments, **CMS increases the Fixed Dollar Loss (FDL) ratio from 0.35 to 0.37**,⁸ while maintaining the loss-sharing ratio at 0.80. These technical adjustments help ensure outlier payments remain within budgeted limits while accounting for high-cost cases.

EXPANDED FLEXIBILITY FOR HOME HEALTH FACE-TO-FACE ENCOUNTER REQUIREMENTS

FINALIZED AS PROPOSED- Page 155 of the Unpublished Rule

CMS finalizes its revisions to the face-to-face encounter requirement for Medicare home health services to allow more provider types to conduct the encounter, addressing long-standing stakeholder concerns and aligning with the CARES Act. Under current regulations, the encounter must be performed by the certifying physician, an allowed non-physician practitioner (NPP), or—in specific circumstances—a provider with hospital privileges who treated the patient prior to home health admission. Stakeholders have argued that this narrow definition creates operational barriers, especially when a different clinician within the same group practice performs the encounter.

To reduce confusion and improve access, CMS amends 42 CFR § 424.22(a)(1)(v)(A) to permit any physician, nurse practitioner, clinical nurse specialist, physician assistant, or certified nurse-

⁶ Proposed: a recalibration neutrality factor of 1.0051.

⁷ Table 13 can be found on page 93 of the unpublished final rule.

⁸ Proposed: an FDL of 0.46.

midwife⁹ to perform the face-to-face encounter. CMS also removes the current paragraph (v)(C), which restricts the encounter to a more limited set of circumstances when the certifying practitioner did not perform it.

HOME HEALTH QUALITY REPORTING PROGRAM UPDATES

FINALIZED AS PROPOSED

Under the Home Health Quality Reporting Program (HH QRP), home health agencies (HHAs) must submit specified data used to assess care quality. Agencies that fail to comply face a 2-percentage-point reduction in their annual payment update.

COVID-19 and SDOH Measure Removals

Pages 162, 167, 206 of the Unpublished Rule

CMS finalizes removal of the “COVID-19 Vaccine: Percent of Patients Who Are Up to Date” measure, citing declining COVID-19 case rates and high provider burden. Additionally, CMS finalizes removal of four social determinants of health (SDOH) assessment items from the Outcome and Assessment Information Set (OASIS)—one related to Living Situation, two to Food, and one to Utilities—also citing high provider burden. These items will no longer need to be collected for patients beginning in CY2026, with public display for the COVID-19 vaccine measure to end after the January 2026 CareCompare refresh.

Technical Updates to Reconsideration Policy and All-Payer Reporting

Pages 170, 172, 175 of the Unpublished Rule

CMS finalizes its clarifications to the HH QRP reconsideration policy and makes technical corrections to the OASIS All-Payer Data Submission requirements, emphasizing that current reporting standards apply to all patients regardless of payer.

HHCAHPS Survey Revisions and Reporting Methodology

Page 187 of the Unpublished Rule

Following extensive testing initiated in 2022, CMS finalizes revisions to the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS®) Survey. The new version is shorter, includes new questions based on stakeholder feedback, and removes lower-priority items.¹⁰ CMS also finalizes proposed updates to the case-mix and mode adjustments and new quality measures tied to the revised survey. The updated survey will take effect with the April 2026 sample month.

⁹ As defined in regulation and authorized by state law

¹⁰ For a full list of changes to the question set, see Table C-20 on page 177 of the unpublished rule.

Feedback on Future Quality Measure Concepts

Page 195 of the Unpublished Rule

CMS provides a summary of stakeholder input shared in response to the request for information included in the proposed rule on four potential future measure concepts: interoperability and IT capacity, cognitive function, well-being, and nutrition. CMS will use comments to inform future measure development.

Public Comments on Shortening Data Submission Window

Page 199 of the Unpublished Rule

CMS thanks stakeholders for their input on whether to shorten the current 4.5-month data submission window to 45 days to reduce the lag between data collection and public reporting. CMS will use the feedback to inform future rulemaking.

Advancing Digital Quality Measurement (dQM)

Page 205 of the Unpublished Rule

CMS thanks stakeholders for sharing information on efforts to advance digital quality measurement in home health, particularly using Fast Healthcare Interoperability Resources (FHIR®) for interoperable reporting of patient assessment data. CMS received feedback on current integration levels, implementation challenges and opportunities, and the potential use of interoperability as a future quality measure concept. Comments will be considered to inform future measure development.

OVERVIEW OF THE HOME HEALTH VALUE-BASED PURCHASING MODEL

The expanded Home Health Value-Based Purchasing (HHVBP) Model, finalized in the CY 2022 HHA final rule, requires participation from HHAs nationwide. The model adjusts payments by up to 5% based on agency performance on selected quality measures.

CMS Finalizes New Measure Removal Criterion

Page 209 of the Unpublished Rule

CMS currently evaluates measures for removal using eight established factors. This year, CMS finalizes a ninth criterion: "It is not feasible to implement the measure specifications." This will allow CMS to remove measures when revisions to data collection instruments prevent required data from being collected.

Significant Changes to HHVBP Measure Set for CY 2026

Page 212, 219, 225, and 228 of the Unpublished Rule

CMS finalizes its proposed updates to the expanded HHVBP Model for CY 2026 to align with proposed survey changes, improve functional measurement, and promote cost-effective care.

Three HHCAHPS Survey-based measures (Care of Patients, Communication Between Providers and Patients, and Specific Care Issues) will be replaced with the following measures: the Medicare Spending Per Beneficiary – Post-Acute Care (MSPB-PAC) measure to assess cost efficiency during and after home health episodes, and three OASIS-based functional measures (Improvement in Bathing, Upper Body Dressing, and Lower Body Dressing) to capture patient recovery more comprehensively. These function measures build on existing OASIS data.

CMS also finalizes its proposed adjustments to measure weights. For larger-volume HHAs, OASIS-based and claims-based measures will increase from 35 percent to 40 percent of the Total Performance Score, while HHCAHPS-based measures will drop from 30 to 20 percent. Weights for smaller-volume HHAs remain unchanged.¹¹

CMS Gathers Stakeholder Feedback on Potential HHVBP Model Changes

Page 232 and 235 of the Unpublished Rule

CMS thanks stakeholders for their feedback, which will be taken into consideration for future rulemaking. CMS requested feedback on several changes to improve performance measurement and reduce provider burden. Topics included: (1) the adoption of broad, outcome-focused measures aligned with ASPE, RAND, and IMPACT Act guidance that also assesses appropriateness, overuse, and value; (2) revision of the Falls with Major Injury measure using claims, encounter, and OASIS data to improve accuracy; and (3) updates to the HHCAHPS survey to initially score new measures based on achievement only, beginning in CY 2028, while retaining three safety-related items as standalone, weighted measures.

TECHNICAL UPDATES TO HHA Conditions of Participation

FINALIZED AS PROPOSED- Page 238 of the Unpublished Rule

CMS finalizes technical changes to the Home Health Agency Conditions of Participation (CoPs), replacing the term “beneficiary” with “patient” to align with the all-payer OASIS reporting requirements finalized in previous rules.¹² This change clarifies that OASIS data submission applies to all patients receiving skilled services, not just Medicare beneficiaries. The change does not alter existing assessment timelines, data elements, or exemptions for certain patient groups, such as those under 18 or receiving only non-skilled services.

This Applied Policy® Summary was prepared by Meghan Basler with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at mbasler@appliedpolicy.com or at 908-752-9875.

¹¹ For a full breakdown of new measure weights, see Table D-22 on page 226 of the unpublished rule.

¹² Sections § 484.45(a) and § 484.55(d)(1)(i)