APPLIED POLICY®

CMS Finalizes Net 2.4% Increase in CY 2027 Home Health Payments, Temporary PDGM Recoupment Cut, and Medicare-Wide Provider Enrollment Safeguards

On November 4, 2026, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2027 Home Health Prospective Payment System final rule for home health agencies (HHAs). CMS released a fact sheet and a press release accompanying the final rule.

The rule finalizes updates to Medicare home health payment rates for CY 2027 and:

- Includes a temporary behavioral adjustment, recalibration of case-mix weights, and changes to low-utilization payment adjustment (LUPA) thresholds;
- Finalizes changes to the Home Health Quality Reporting Program (HH QRP) and summarizes initiatives to improve alignment between the HH QRP and the expanded Home Health Value-Based Purchasing (HHVBP) Model; and
- Discusses home health palliative care services, including a summary of and reactions to responses received from the Request for Information (RFI) on potential development of a home health-specific wage index.

In addition, CMS finalizes several Medicare-wide provider enrollment and program integrity policies that apply broadly across provider and supplier types, not only to HHAs, including:

- Expansions to CMS's ability to recover payments following enrollment revocations,
- Added or expand bases for denying or revoking Medicare enrollment; and
- Strengthened oversight of ownership changes, licensing and program actions, and managing employees or organizations.

Final Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers and the Competitive Bidding Program requirements are summarized in a separate summary.

This final rule is scheduled for publication in the Federal Register on November 9, 2026.

CMS FINALIZES 2.1% HOME HEALTH PAYMENT UPDATE

FINALIZED AS PROPOSED

Pages 82-89 of the unpublished rule

CMS finalizes a 2.1 percent home health payment update for agencies that submit required quality data, based on a 3.1 percent home health market basket increase reduced by a 1.0 percentage point productivity adjustment. Agencies that do not meet quality reporting requirements would receive only a 0.1 percent update, reflecting the required 2 percentage point reduction.

Overall, CMS estimates that the CY 2027 home health payment policies increase aggregate Medicare payments to home health agencies by $415 million, or 2.4 percent, compared to CY 2026.[1] This projected increase is driven by the 2.1 percent home health payment update, which increases payments by approximately $365 million, and an additional estimated 0.3 percent increase from the proposed update to the fixed-dollar loss (FDL) ratio for outlier payments, which would increase payments by approximately $50 million.[2]

This policy will modestly increase overall Medicare payments to home health agencies in CY 2027. However, the positive update may be viewed as limited by agencies facing rising labor and operating costs, especially given separate CMS policies to apply a temporary behavioral adjustment reduction.

CMS FINALIZES A ONE-YEAR HOME HEALTH PAYMENT REDUCTION WHILE PAUSING ADDITIONAL PERMANENT PDGM CUTS

FINALIZED AS PROPOSED

Pages 17-43 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.

CMS finalizes a proposal not to apply a permanent adjustment to the CY 2027 30-day base payment rate, despite illustrative calculations based on preliminary CY 2025 claims data. CMS explains that behavior changes in CYs 2023 through 2025 are difficult to attribute directly to PDGM and the 30-day unit of payment due to confounding factors, including case-mix and

[1] In the proposed rule, CMS estimated the total CY 2027 home health payment impact would increase payment by $420 million.
[2] In the proposed rule, CMS estimated payments would increase by $370 million.

LUPA recalibration, Outcome and Assessment Information Set (OASIS)-E implementation, prior payment reductions, ICD-10-CM coding changes, and the expanded HHVBP Model. As a result, CMS continues limiting permanent adjustments to claims data from CYs 2020 through 2022.

CMS does, however, finalize a temporary 3.0 percent reduction to the CY 2027 national, standardized 30-day payment rate to continue recouping retrospective overpayments associated with differences between assumed and actual behavior changes under PDGM. The temporary adjustment applies only for CY 2027 and will not be built into the CY 2028 base payment rate, although CMS may propose additional temporary adjustments in future rulemaking.

This policy is a continuation of CMS's effort to reconcile home health payments under PDGM, but it reflects a more moderate approach than last year because CMS is not proposing a new permanent payment cut for CY 2027. However, the one-year 3.0 percent temporary reduction would lower payments and create ongoing financial uncertainty for home health agencies as CMS continues to recoup prior overpayments.

CMS FINALIZES CY 2027 LUPA THRESHOLD UPDATES BASED ON LATEST HOME HEALTH UTILIZATION DATA

FINALIZED AS PROPOSED

Pages 44-49 of the unpublished rule

Low-Utilization Payment Adjustment (LUPA) thresholds determine whether a 30-day home health period is paid as a full episode or per-visit, based on the number of visits delivered. For CY 2027, CMS finalizes the proposal to update the PDGM LUPAs using more complete CY 2025 home health claims utilization data as of July 14, 2026, consistent with its policy to annually recalibrate case-mix weights and update LUPA thresholds, functional impairment levels, and comorbidity subgroups. CMS states that CY 2025 LUPA visit patterns were similar to CY 2024, with 18 case-mix groups decreasing by one visit and two case-mix groups increasing by one visit.

CMS FINALIZES UPDATES TO FUNCTIONAL IMPAIRMENT LEVELS AND COMORBIDITY ADJUSTMENTS FOR CY 2027

FINALIZED WITH MODIFICATION

Pages 49-61 of the unpublished rule

For CY 2027, CMS updates the PDGM functional impairment levels using CY 2025 claims data and the same previously finalized methodology. The functional impairment level is based on

selected OASIS items related to activities of daily living and hospitalization risk, which are scored and used to classify home health periods into low, medium, or high functional impairment levels by clinical group. CMS finalized updated OASIS functional points and updated functional impairment thresholds by clinical group as proposed, using updated CY 2025 claims data.

CMS also finalized updates to the PDGM comorbidity subgroups using CY 2025 home health data linked to OASIS data. Under the policy, CY 2027 would include 22 low comorbidity adjustment subgroups and 103 high comorbidity adjustment interaction subgroups. CMS states that these updates are intended to continue aligning comorbidity adjustments with clinically and statistically significant secondary diagnoses associated with higher resource use.

CMS UPDATES THE CY 2027 PDGM CASEMIX WEIGHTS

FINALIZED WITH MODIFICATION

Pages 59-81 of the unpublished rule

CMS finalizes updates to the case-mix weights used in the Patient-Driven Groupings Model (PDGM) for CY 2027 using the most recent complete data—CY 2025 home health claims and OASIS assessments. This update is a 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 finalizes the proposal to implement the updated weights in a budget-neutral manner using a recalibration neutrality factor of 1.0047 for CY2027, ensuring overall spending remains unchanged when applied to CY 2025 data.[3]

The updated case-mix weights and methodology are outlined in Table 11 of the unpublished rule,[4] and will be finalized after review of more complete CY 2025 data. CMS finalizes its proposal to implement the changes to the PDGM case-mix weights in a budget neutral manner by applying a case-mix budget neutrality factor to the CY 2027 national, standardized 30-day period payment rate.

---

[3] CMS proposed implementing the updated weights in a budget-neutral manner using a recalibration neutrality factor of 1.0045 for CY 2027.

[4] Table 11 can be found on page 69 of the unpublished rule.

WAGE INDEX AND OUTLIER PAYMENT ADJUSTMENTS

FINALIZED AS PROPOSED

Pages 96-101 and 111-118 of the unpublished rule

CMS continues to use hospital wage data (updated with OMB Bulletin 23-01) and apply a 5 percent cap on wage index decreases, applicable to both counties and CBSAs. CMS finalizes the proposal that the wage index would not take into account any geographic reclassification of hospitals. Areas without hospital data (e.g., rural Puerto Rico, Northern Mariana Islands, American Samoa) would continue to receive special wage index proxies. Home health wage indices are available to download here.

Home health payments are adjusted for outliers to account for unusually high amounts or types of medically necessary care. To comply with the statutory 2.5 percent cap on total outlier payments, CMS finalizes a Fixed Dollar Loss (FDL) ratio of 0.29, which is a decrease from the CY 2026 FDL of 0.37. These technical adjustments help ensure outlier payments remain within budgeted limits while accounting for high-cost cases.

While a lower FDL ratio means that each payment will be lower, CMS believes that there is a tradeoff where more periods can qualify for outlier payments.

CMS FINALIZES HH QRP CHANGES, INCLUDING REVISED DATA SUBMISSION DEADLINES AND REPORTING TIMEFRAMES

FINALIZED AS PROPOSED

Pages 131-154 of the unpublished rule

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.

CMS Finalizes Initiatives to Improve Alignment Between HH QRP and Expanded HHVBP Model

CMS finalizes initiatives to improve alignment between the HH QRP and the expanded Home Health Value-Based Purchasing (HHVBP) Model, citing that differences in measure sets, reporting periods, and performance assessment processes could create unnecessary complexity and administrative burden for HHAs. Specifically, CMS:

- Aligns the expanded HHVBP Model and HH QRP Quality of Patient Care (QoPC) Star Ratings measure sets and reporting periods;

- Aligns the HH QRP annual payment update (APU) and expanded HHVBP Model annual payment reporting periods;
- Expands HHVBP Model Interim Performance and HH QRP QoPC Star Rating Reports;
- Aligns the timeframe of appeals review processes for the expanding HHVBP Model and HH QRP; and
- Updates scoring methodology to incorporate HH QRP APU penalties in expanded HHVBP Model payment adjustments and factoring HH QRP Quality Assessments Only (QAO) values into QoPC Star Ratings Scoring.

CMS Revises HH QRP Data Submission Deadlines

Beginning in calendar year (CY) 2027, CMS requires HHAs to complete their data submissions and make corrections to their OASIS data no later than the 15th day of the second month after the end of the calendar quarter. CMS also finalizes a policy that similar calendar year data submission deadlines would apply to future years' payment determinations. In response to public comments, CMS finalizes to require that HHAs submit their OASIS assessments and make corrections to their OASIS assessment data where necessary no later than the 15th day of the second month after the end of the calendar quarter beginning with the CY 2027 HH QRP.

CMS Revises OASIS APU and HHCAHPS APU Reporting Timeframes

CMS finalizes the proposal to revise the OASIS APU data reporting timeframe to January 1 through December 31, the calendar year, citing that the current OASIS Annual Payment Update (APU) reporting timeframe differs from that used for other major CMS payment updates. CMS believes this update would align Home Health pay-for-reporting policies with other Home Health payment policies.

CMS also finalizes the revision of the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) APU reporting timeframe to a calendar year format, noting that the current HHCAHPS APU reporting timeframe differs from that used for other annual HH CMS payment updates.

CMS Sought Feedback on Future Quality Measure Concepts

CMS is evaluating the overall value and relevance of the quality measure concepts related to advance care planning, while prioritizing evidence-based outcome measures that promote person-centered care practices. CMS sought feedback on relevant aspects of advance care planning and measures appropriate for the HH setting.

CMS signals a shift to improve alignment between the Home Health Quality Reporting Program (HH QRP) and the expanded Home Health Value-Based Purchasing (HHVBP) Model by finalizing revisions to data submission deadlines and reporting timeframes.

REQUESTS FOR INFORMATION

Pages 118-130 of the unpublished rule

CMS summarizes and responds to comments received on two RFIs:

1. **Ways to Enhance Palliative Care Services as Home Health Services:** CMS sought feedback on how to improve access to and use of palliative care services, including whether beneficiaries who meet home health eligibility requirements and have an order from an allowed practitioner could receive these services under the home health benefit. CMS issued a similar RFI in the FY 2027 Hospice Wage Index and Payment Rate Update proposed rule (91 FR 17359). CMS plans to add palliative care examples to the Medicare Benefit Policy Manual and to issue Medicare Administrative Contractor (MAC) instructions to enhance consistent implementation after publishing the CY 2027 HH PPS final rule and seeks comments on concerns or suggestions for expanding palliative care.
2. **Construction of a Home Health Specific Wage Index**: CMS currently uses the Inpatient Prospective Payment System (IPPS) wage index to adjust home health payments. In response to stakeholder feedback, including from the Medicare Payment Advisory Commission (MedPAC), CMS is considering developing a home health-specific wage index. CMS sought input on potential area wage data sources, occupation mix weights, a methodology for calculating the index, labor market areas and geographic delineation, and an appropriate transition policy. CMS noted responses will inform future development of a home health specific wage index and potential future rulemaking.

CMS FINALIZES MEDICARE-WIDE PROVIDER ENROLLMENT SAFEGUARDS TO STRENGTHEN OVERSIGHT AND RECOVER IMPROPER PAYMENTS

FINALIZED AS PROPOSED

Pages 159-337 of the unpublished rule

Although included in the CY 2027 Home Health PPS rule, CMS's provider enrollment proposals would apply broadly across Medicare provider and supplier types. CMS states that the policies are intended to strengthen program integrity, reduce improper payments, and improve its ability to address noncompliant providers and suppliers. CMS estimates that the provider enrollment provisions would generate approximately $82 million in annual savings.

A central policy would expand CMS's ability to make Medicare enrollment revocations retroactive. Under current regulations, some revocations take effect prospectively, while others are effective back to the date the provider's noncompliance began. CMS finalizes making all

revocation grounds retroactive, which would allow the agency to seek recovery of payments made after the date of noncompliance, regardless of the basis for revocation.

CMS also finalizes the proposal to add or expand several bases for denying or revoking Medicare enrollment. These include authority to deny or revoke enrollment where a provider or supplier presents a high risk of fraud, waste, or abuse because it is located in a limited geographic area with an excessive number of providers or suppliers. CMS also finalizes the proposal to deny or revoke enrollment based on certain misdemeanor convictions related to sexual assault or financial misconduct within the past 10 years.

In addition, CMS finalizes targeted enrollment safeguards related to ownership and oversight. For example, CMS would be able to deny or revoke enrollment if a home health agency, hospice, or DMEPOS supplier violates existing requirements to reenroll and undergo survey or accreditation following certain changes in majority ownership. CMS also expands existing denial and revocation authorities tied to program or license suspensions or terminations so they apply not only to the provider or supplier, but also to certain owners and managing employees or organizations.

These policies represent a significant Medicare-wide program integrity package rather than a home health-specific payment policy giving CMS broader authority to recover payments from noncompliant providers and suppliers, scrutinize ownership and management arrangements, and remove higher-risk entities from Medicare. Providers and suppliers may face increased enrollment scrutiny and compliance exposure.

***

This Applied Policy® Summary was prepared by Lexi Hartranft with support from the Applied Policy team of health policy experts. If you have any questions or need more information, please contact her at lhartranft@appliedpolicy.com or at 202-558-5272.