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INSIGHTS

Calendar Year 2026
Home Health
Prospective
Payment System
Final Rule

Calendar Year 2026 Home Health Prospective Payment System Final Rule

On November 28, 2025, the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2026 Home Health Prospective Payment System [Final Rule](#). A CMS fact sheet can be found [here](#). The 60-day comment period under the Administrative Procedure Act (APA) for the CY26 Home Health Final Rule ends on January 27, 2026.

UPDATES TO HOME HEALTH AGENCY PAYMENT RATES

The Bipartisan Budget Act (BBA) of 2018 directed CMS to create the Patient-Driven Groupings Model (PDGM), intended to improve reimbursement for all patients eligible for home health benefits and to remove perceived incentives to over-provide therapy services. As part of this system, CMS applies two types of “behavioral adjustments” to ensure budget neutrality and prevent “gaming” that increases payments:

- Prospective adjustments are based on past conduct but are meant to prevent future overpayments. To assess the need for such adjustments, CMS calculates whether the actual expenditures (from two years prior) deviated from the agency’s estimate of what expenditures would have been under the pre-BBA system. CMS has made annual cuts since the start of PDGM. However, the magnitude of those cuts has been such that CMS has typically phased them in over 2 years. This has resulted in a dynamic in which CMS often implements cuts that were partially delayed from the year prior, as well as new cuts to account for “newly discovered” deviations from two years prior.
- Retrospective adjustments are intended to claw back overpayments already made when past conduct led to higher-than-expected payments (i.e., CMS’s prospective adjustments were not sufficient to prevent overpayments relative to the pre-BBA system). Since the start of PDGM, CMS has been keeping a running tally of overpayments, which currently totals ~\$5.3b (through CY24; that figure is likely to grow once CY25 and CY26 – the final two years of the PDGM phase-in – are complete).

For CY26, CMS proposed an aggregate -6.4% cut to home health agency payments relative to FY25. Of this, 2.4% represented the CY26 home health market basket update. With respect to the PDGM adjustments, CMS first proposed a permanent prospective behavioral adjustment of -3.7% (-1.8%) attributable to a lingering phased-in cut from CY25 (projected based on CY23 spending) and -1.9% representing a new cut (projected based on CY24 spending). CMS then proposed – despite prior assurances it would not pursue prospective and retrospective cuts simultaneously – an incremental retrospective cut of -4.6% (accounting for ~15% of the amount that needs to be recouped). Finally, CMS proposed a fixed dollar loss (FDL) ratio adjustment of -0.5%.

In the final rule, CMS finalized policies resulting in an overall -1.3% (-\$220m) cut to aggregate Medicare payments to home health agencies for CY26 compared to CY25. The net rate update is based on the following:

- 2.4% home health market basket update (unchanged from proposed rule).
- -0.9% permanent prospective PDGM cut (rather than phasing the cut over multiple years as in prior rules, CMS achieved softening by excluding CY23 and CY24 claims data from the permanent adjustment calculation and relying solely on CY20–22 data).
- -2.7% temporary retrospective PDGM cut (softened, but not abandoned, out of concern for provider impact)
- -0.1% FDL ratio cut (softened based on updated claims data)

Although CMS significantly softened the CY26 impact by reducing the permanent behavioral adjustment and lowering the temporary recoupment amount, the deferred over-expenditures from 2023 and 2024 remain outstanding and will need to be addressed in future years. This continues the pattern of recent rules in which significant adjustments are repeatedly deferred rather than fully implemented, causing the cumulative amount owed under PDGM budget-neutrality requirements to grow. Absent Congressional intervention to waive or reform the behavioral offset provisions (as requested by industry stakeholders), these deferred cuts will eventually translate into larger permanent rate reductions or extended temporary recoupments in the out-years, creating ongoing payment uncertainty for home health agencies.

HOME HEALTH QUALITY REPORTING PROGRAM (HH QRP)

The HH QRP is an initiative that requires certified home health agencies to submit standardized data, primarily through the Outcome and Assessment Information Set (OASIS) instrument, to measure and improve the quality of care provided to patients. This program ties data submission compliance to annual payment updates, imposing a 2% reduction in the home health market basket percentage increase for non-compliant agencies, which can result in lower payments than the prior year under certain conditions. The HH QRP aims to enhance care quality, increase transparency for consumers, and promote better health outcomes.

For CY26, CMS proposed removing the COVID-19 Vaccine: Percent of Patients Who Are Up to Date measure and its associated OASIS item 00350, effective for assessments on or after the final rule's publication date, with the item fully removed from OASIS by April 1, 2026. CMS also proposed eliminating four social determinants of health assessment items related to living situation, food, and utilities, effective for patients discharged on or after April 1, 2026. Additional proposals included revising the reconsideration process for data noncompliance to allow requests demonstrating full compliance and limited extensions for extraordinary circumstances; and updating the Home Health Consumer Assessment of Healthcare

Providers and Systems (HHCAHPS) survey with new questions, removals, and adjustments starting with the April 2026 sample month.

CMS finalized the HH QRP proposals without modification.

HOME HEALTH VALUE-BASED PURCHASING (HHVBP) MODEL

The HHVBP Model is a program that adjusts payments to certified home health agencies based on their performance on a set of quality measures, aiming to improve the quality of care provided to beneficiaries. Under this model, agencies receive a total performance score derived from measures in categories such as OASIS-based outcomes, claims-based utilization, and patient experience surveys, which determine payment adjustments ranging from -5% to +5%. The HHVBP Model encourages agencies to enhance care delivery, reduce unnecessary hospitalizations, and promote better patient outcomes by rewarding high performers.

For CY26, CMS proposed updates to the HHVBP Model's measure set, including the removal of three HHCAHPS survey-based measures (Professional Care of Patients, Communications Between Providers and Patients, and Specific Care Issues) due to planned revisions in the HHCAHPS survey. CMS also proposed adding four new measures: three OASIS-based measures (Improvement in Grooming, Improvement in Toileting Hygiene, and Improvement in Feeding or Eating) and one claims-based measure (Medicare Spending Per Beneficiary-Post-Acute Care Home Health). Additional proposals included adjustments to the weights of measures/categories to reflect the updated set, as well as the addition of a new measure removal factor for measures that are not feasible to implement.

CMS finalized the HHVBP Model proposals without changes from the proposed rule.

FACE-TO-FACE ENCOUNTER REGULATIONS

The face-to-face encounter regulation requires a certifying physician to conduct an encounter with the patient to certify eligibility for Medicare home health services and to establish or review the plan of care. This encounter must occur within specified timeframes, be related to the primary reason the patient requires home health services, and include documentation explaining how the patient's clinical condition supports homebound status and the need for skilled services.

For CY26, CMS proposed – in compliance with CARES Act revisions enacted by Congress – revising the language at 42 CFR 424.22(a)(1)(v)(A) to allow the face-to-face encounter to be performed by a physician, nurse practitioner, clinical nurse specialist, physician assistant, or certified nurse midwife. CMS also proposed removing 42 CFR 424.22(a)(1)(v)(C), which had limited the encounter to the certifying practitioner or to a physician or non-physician practitioner who cared for the patient in an acute or post-

acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner.

CMS finalized the proposed changes to the face-to-face encounter regulations without modification.

FRAUD, WASTE, & ABUSE REFORMS

CMS and stakeholders have expressed significant concerns about waste, fraud, and abuse in the home health industry, including vulnerabilities to improper payments, abusive billing practices, and unqualified providers entering the program (concerns validated by recent GAO and OIG investigations showing unusually high improper payment rates in home health agencies, particularly in states such as California, Pennsylvania, and Texas). To that end – and given the Trump administration’s intense focus on reducing wasteful federal spending – CMS proposed several revisions to Medicare provider enrollment regulations to strengthen program integrity and address fraud, waste, and abuse, including:

- Expanding the grounds for revocation or denial of enrollment to cover abusive billing patterns, beneficiary attestations that services were not furnished, and modifications to language around prescribing authority for Medicare-covered drugs.
- Expanding the retroactive effective dates for revocations to the onset of noncompliance in additional scenarios, such as lapsed liability insurance for independent diagnostic testing facilities, failure to report required changes, or abusive billing, to enable recovery of improper payments from that date.
- Other reforms, such as requiring providers and suppliers to report adverse legal actions within 30 days, deactivating billing privileges for physicians and practitioners who have not ordered or certified services in 12 consecutive months, and making technical corrections to related regulatory text.

CMS finalized the Medicare provider enrollment provisions as proposed, without modification.

AGENCY REPLIES TO REQUESTS FOR INFORMATION (RFIS)

The proposed rule included four Requests for Information (RFIs) related to the Home Health Quality Reporting Program (HH QRP) and the expanded Home Health Value-Based Purchasing (HHVBP) Model, and the final rule summarized the public comments received. An overview of those RFIs is below.

- Data Submission Deadlines for HH QRP: Commenters generally supported reducing the deadline from 4.5 months to 45 days after the end of the reporting period to enable more timely public reporting and decision-making, though some suggested phased implementation, pilot programs, or alternatives like 60 or 90 days; concerns included increased administrative burden, potential errors, and financial pressures on smaller agencies.

- Digital Quality Measures for HH QRP: Commenters expressed strong support for transitioning to digital quality measures using standards like Fast Healthcare Interoperability Resources to reduce burden and improve quality, with recommendations for phased implementation, funding, technical assistance, APIs, and training; concerns focused on varying IT readiness among agencies and the lack of HITECH-like funding for home health.
- Future HH QRP Quality Measure Concepts: Commenters supported concepts in interoperability (e.g., national standards and federal funding, with barriers like low IT adoption noted), cognitive function (e.g., emphasis on maintenance rather than improvement and limitations of existing OASIS tools), well-being (e.g., evidence-based tools, process measures, and caregiver input, with concerns about scope in short stays), and nutrition (e.g., validated tools like the Malnutrition Composite Score and process measures, though some opposed due to complexity and short timeframes).
- Future HHVBP Measure Concepts: Commenters supported a respecified Falls with Major Injury measure using multiple data sources but raised concerns about reporting accuracy, episodic care, and unintended penalties; for HHCAHPS changes, there was opposition to achievement-only scoring and single-item additions, with preferences for full improvement points and patient-reported outcomes.

We trust you found this summary useful. Please reach out to [us](#) with any questions.

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