

National Home Health Update

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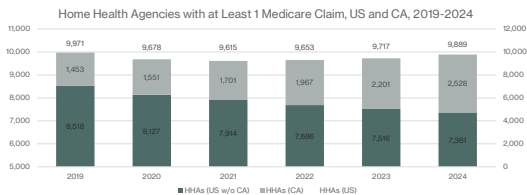

1

CARE IN THE HOME

2

Home Health Agency Supply Decreasing Over Time

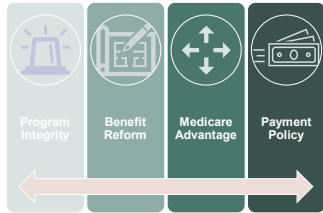
Claims data indicate a net 14% decline in Home Health agencies with at least one Medicare claim outside of CA since the inception of PDGM



Source: Dobson DiWanzo & Associates analysis of 2024 CMS Home Health Claims

3

Key Home Health & Hospice Issues in Washington



7

Oversight – 119th Congress

- February 3, 2026: House Energy and Commerce Committee, Oversight & Investigations Subcommittee - *Common Schemes, Real Harm: Examining fraud in Medicare and Medicaid*
- March 17, 2026: House Energy and Commerce Committee, Oversight & Investigations Subcommittee - *Protecting Patients and Safeguarding Taxpayer Dollars: The Role of CMS in Combatting Medicare and Medicaid Fraud*
 - Witness – Kim Brandt, Deputy Administrator and Chief Operating Officer, Centers for Medicare & Medicaid Services
- March 24, 2026: House Oversight Committee launches investigation into California hospice fraud
- April 21, 2026: House Ways & Means Committee hearing: *Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud*

8

Future CRUSH Proposed Rule

- CMS issued a Request for Information for Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH) on February 27, 2026. Comments due March 30, 2026
- As mentioned previously, CMS has been focused on non-hospice spending during hospice election, so that could be the subject of some of the proposals in an upcoming rule
- Alliance member listening sessions were held in March and members provided thoughtful input to help the Alliance formulate its response to the RFI

9

Fraud Task Force

- Headed by Vice President JD Vance
- West Coast Healthcare Fraud Strike Force
- multi-district enforcement initiative uniting the Division's Health Care Fraud Section with the U.S. Attorney's Offices for the District of Arizona, District of Nevada, and Northern District of California



10

Anti-fraud Activities

- Beyond PPEO and EPR**
- CMS Payment Suspension
 - 447 hospices, 23 home health agencies
 - California

Suspension versus Revocation



11

CMS Announces Nationwide Home Health & Hospice Moratorium

6 months duration May be extended	Medicare only CMS leaves Medicaid/CHIP moratoria to State discretion	May 13, 2026 Moratorium effective date for home health and hospice
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WHAT IT DOES

- Halts enrollment nationwide of newly enrolling Medicare home health agencies and hospices
- Applies only to Medicare
- CMS offering states/territories opportunity to consult on prospect of implementing Medicaid/CHIP moratorium
- In States that require Medicare certification as a Medicaid qualification, the moratorium effectively reaches Medicaid

WHAT IT DOES NOT APPLY TO

- Changes in practice location (unless moving from outside to inside the moratorium area)
- Changes in provider/supplier information (e.g., phone number, address)
- Changes in ownership except CHOWs of HHAs or Hospices that would require an initial enrollment
- Enrollment applications already received by the MAC before the effective date of the moratorium (May 13, 2026)

CMS Q&A Guidance | <https://www.cms.gov/files/document/hh-hospice-moratorium-faqs.pdf>
 CMS indicates the moratorium **will not impact** the existing telehealth flexibility for hospices face-to-face recertification encounters. Hospices already enrolled may continue to use telehealth to conduct recertification encounters.

12

Home Health Review Choice Demonstration & Audits

- Extended through May 31, 2029
 - Florida, Illinois, North Carolina, Ohio, Oklahoma, Texas
- HHAs select from three initial choices:
 - Pre-claim review
 - Post-payment review
 - Minimal post-payment review with a 25% payment reduction
- PRA Listing
 - September 19, 2025 – Palmetto can expand to all 16 states in jurisdiction

13

PEPPER

- PEPPER – Program for Evaluating Payment Patterns Electronic Report
- Site went down end of 2023
- CMS paused PEPPER until "Fall 2024"
- Anticipated home health release date: Summer 2026?

14

CY 2026 Home Health Final Rule

- CY 2026 30-day payment rate - in response to public comments:
 - CMS did not include data from 2023 or 2024 in calculating the permanent and temporary payment adjustments (cuts)
 - CMS signaled that it was finished with permanent payment adjustments with the implementation of a final 0.9% reduction for 2026
 - CMS began to implement temporary adjustments to recoup \$4.7 billion in overpayments
- CMS finalized changes for to the face-to-face encounter, provider enrollment, the Home Health Quality Reporting Program, and Home Health Value-Based Purchasing (HH VBP) Model.

15

Fraud in Home Health

Payment calculations based on data inclusive of fraudulent providers

Number of home health agencies in CA doubled 2019 – 2024

- 2% of Medicare beneficiaries in LA County, 6% of home health users
- 9% of Medicare home health expenditures

16

Home Health Face to Face (F2F) Encounter

- Section 3708 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act modified who may conduct the Face-to-Face (F2F) encounter for the Medicare home health care certification
- CMS finalized conforming regulations to allow physicians, in addition to NPs, CNSs, and PAs, to perform the face-to-face encounter *regardless* of whether they are the certifying practitioner or whether they cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner.
- Retains all other requirements for the home health F2F encounter and certification

17

Home Health Face-to-Face Encounter

Original intent:

- Home health benefit relies on patient's physician or allowed practitioner to determine eligibility
- Physician or allowed practitioner conducting the F2F encounter is the most knowledgeable practitioner and has firsthand information of the patient's current clinical condition
- Reminder
 - Effective Date
 - Applicable to Medicare traditional FFS
 - MAC

18

18

Home Health Rule Estimated Impacts 2026

Proposed	Final
<p>Estimated \$1.136 billion decrease (-6.4%) to payments in 2026. This reflects:</p> <ul style="list-style-type: none"> ➢ Statutorily-required payment update of 2.4% (\$425 million increase) ➢ 3.7% decrease due to the permanent adjustment (\$655 million decrease) ➢ 4.0% decrease due to the temporary adjustment (\$815 million decrease) ➢ 0.5% decrease due to an updated FDL (\$90 million decrease) 	<p>Estimated \$220 million decrease (-1.3%) to payments in 2026. This reflects:</p> <ul style="list-style-type: none"> ➢ Statutorily-required payment update of 2.4% (\$405 million increase) ➢ 0.9% decrease due to the permanent adjustment (\$150 million decrease) ➢ 2.7% decrease due to the temporary adjustment (\$460 million decrease) ➢ 0.1% decrease due to an updated FDL (\$15 million decrease)

This reflects a difference of approximately \$900 million in aggregate payments to home health agencies in CY 2026 alone

19

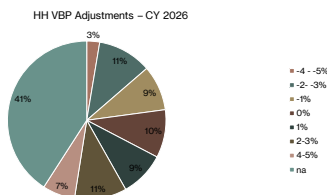
Expanded HH Value-Based Purchasing Model

Quality Measure	Current Measure Weights (CY 2025)		Measure Weights Beginning CY 2026		Measure Weights Beginning CY 2026	
	Larger Volume	Smaller Volume	Larger Volume	Smaller Volume	Larger Volume	Smaller Volume
Quality-based Measures						
Discharged in Community	6.9%	6.3%	-	-	-	-
Improvement in Progress	6.9%	6.3%	6.0%	6.3%	7.0%	6.9%
Improvement in Management of Oral Medications	6.9%	6.3%	9.0%	12.0%	11.0%	13.1%
Total Normalized Composite Change in Quality (TNC: Quality)	6.7%	12.3%	-	-	-	-
Total Normalized Composite Change in Self-Care (TNC: Self-Care)	6.7%	12.3%	-	-	-	-
Discharge Function Score (DC: Function)	-	-	20.0%	20.5%	15.0%	16.3%
Improvement in Safety	-	-	-	-	3.0%	4.3%
Improvement in Legible Body Charting	-	-	-	-	1.7%	2.1%
Improvement in Care Plan Charting	-	-	-	-	1.7%	2.1%
Rate of OASIS-based Measures	35.0%	50.0%	35.0%	50.0%	40.0%	50.0%
Volume-based Measures						
Acute Care Hospitalization (ACH)	25.2%	37.0%	-	-	-	-
Emergency Department Use Without Hospitalization (ED Use)	6.7%	12.0%	-	-	-	-
Home Health Utilization: Potentially Preventable Hospitalization (PHH)	-	-	20.0%	37.1%	15.0%	16.7%
Change in Continuity - Post Acute Care (PIC/PAC)	-	-	9.0%	12.0%	10.0%	10.7%
Medicare Spending per Beneficiary - PAC (MSP/PAC)	-	-	-	-	10.0%	12.0%
Rate of Volume-based Measures	35.0%	50.0%	35.0%	50.0%	40.0%	50.0%
HHVBP Agency-based Measures						
Care of Patients	0.0%	0.0%	0.0%	0.0%	-	-
Communication Between Providers and Patients	0.0%	0.0%	0.0%	0.0%	-	-
Specific Care Issues	0.0%	0.0%	0.0%	0.0%	-	-
Overall Rating of Home Health Care	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%
Willingness to Recommend the Agency	0.0%	0.0%	0.0%	0.0%	10.0%	0.0%
Rate of HHVBP Agency-based Measures	30.0%	0.0%	30.0%	0.0%	20.0%	0.0%
Sum of All Measures	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

20

Expanded HH Value-Based Purchasing Model

HHVBP does not provide adjustments to over 40% of participating agencies



Source: Alliance analysis of 2026 HHVBP data

21

Medicare Advantage and Home-Based Care

MA Prior Authorization & Utilization Management

- Prior authorization can frequently delay or deny access to care
- Fragmented prior authorization processes and delays
- 13% of MA prior authorization denials met coverage rules (HHS OIG, 2022)
- 16x higher post-acute care (PAC) denial rate by MA plans vs non-PAC (Sen. PSI Majority Report, 2024)
- 17% of MA initial claims denied, with >50% overturned on appeal (Vabson et al., 2025)

MA Impact on Home Health Access

- 10-percentage point larger increase in MA penetration associated with 11.5% decline in HHAs (Marr et al., 2026)
- MA enrollees significantly less likely to receive care from high-quality HHAs (Schwartz et al., 2019)
- Unfulfilled MA home health referrals linked to higher mortality rates (Gada, et al., 2024)

MA Network Adequacy & Payment

- Payments often lower than FFS
- HHAs excluded from MA time-and-distance network adequacy standards
- MA plans do not need to specifically contract with a certain number of HHAs to satisfy network adequacy requirements

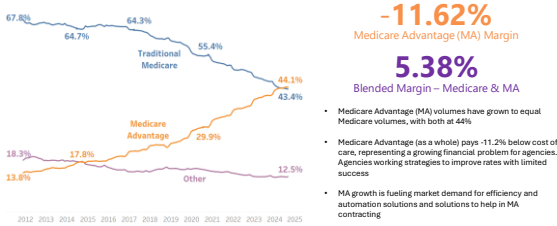
Hospice Medicare Advantage Carve-In

- MedPAC previously recommended a hospice MA carve-in
- Beneficiaries could face restricted networks & MA utilization management tools
- Payment could shift from per diem to per service and be significantly lower than FFS
- May not include full hospice benefit
- Risk of inappropriate steering of beneficiaries toward or away from hospice

22

Home Health Agency Margin Pressures

Medicare Advantage (MA) patients are reimbursed below the cost of care. With payor mix continuing to shift from Medicare to MA, this represents a growing margin compression issue for Home Health Agencies.



23

CY 2027 HH Proposed Rule

Potential Policies

- Hopeful that CMS will confirm no more permanent adjustments
- Likely that CMS will propose to continue with temporary adjustments
- Potential for HHAs that are non-compliant with HHQRP to be ineligible for positive adjustment under HHVBP
- Alliance met with CMS in Jan/Feb and pushed for several deregulatory actions/changes

24

24



25
