2026 Home Health Final Rule

Minnesota Home Care Association

CMS Releases Calendar Year 2026 Home Health Final Rule

Late Friday afternoon the Centers for Medicare & Medicaid Services (CMS) issued the calendar year (CY) 2026 Home Health Prospective Payment System Rate and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program Updates. In past years, CMS published the HH Final Rule on or about November 1. The HH Final Rule was delayed this year due to the government shutdown.

Payment & Policy Updates

The payment rate for 2026 will change based on multiple factors:

- +2.4% HH annual payment update
- +3.2% market basket index (used to adjust the Medicaid rate in Minnesota)
- –0.9% final permanent rate adjustment
- –2.7% final temporary adjustment
- –0.1% fixed-dollar loss (FDL) ratio update for outlier payments

Overall, the aggregated payment update for 2026 results in a net decrease of 1.3%.

CMS also finalizes the following:

- Recalibration of the 432 case mix weights as CMS has done multiple times in recent years. The recalibration leads to a separate budget neutrality adjustment in the payment rates of 1.0052%.
- Updating the wage index values with more current hospital wage data leading to a budget neutrality adjustment of 1.0025%. The proposal to continue its 5% cap on any annual wage index decrease at the county level was finalized. This resulted in several counties being assigned a different classification, from urban to rural and vice versa. It will be important for HHAs to consider their wage index to understand the impact on payment rates in various regions.
- Increase the FDL ratio used to quality for outlier payments from the current 0.35 to 0.37. This proposal would decrease the number of episodes qualifying for outlier payments and result in an estimated reduction in payments to HHAs of 0.1%.

Face-to-Face

The CARES Act allows Nurse Practitioners, Certified Nurse Specialists, and Physicians Assistants to order and certify eligibility for Medicare HH and establish a plan of care. CMS has updated face-to-face encounters to now allow NPs, CNSs, PAs and physicians to perform face-to-face encounters whether or not they were the certifying practitioner or one who cared for the patient prior to home health care.

HHVBP Updates

Beginning April 2026, CMS is finalizing changes to the HHCAHPS survey. These changes affect the survey questions used to calculate three measures that are currently used in the expanded HHVBP Model. Due to the proposed changes to the HHCAHPS survey, CMS is proposing to remove these measures:

- Care of Patients
- Communications between Providers and Patients
- Specific Care Issues

CMS is adding four measures to the measure set. These include three measures related to bathing and dressing and the Medicare Spending per Beneficiary setting measure. These changes also prompted alterations to the weights of each measure and measure category, which CMS is finalizing.

The expanded model has built-in criteria for the removal of any quality measure. CMS is adding an additional criteria to the list of factors. Factor 9 reads that CMS may remove a quality measure if it is not feasible to implement the measure specifications.

Home Health (HH) Quality Reporting Program (QRP)

CMS finalizes its proposal to remove the COVID-19 Vaccine: Percentage of Patients Who Are Up to Date Measure and the corresponding Outcome and Assessment Information Set (OASIS) data element. CMS is also removing four assessment items in the standardized patient assessment: one Living Situation item, two Food items, and one Utilities item. CMS is revising the reconsideration policy to allow providers to submit a request for reconsideration of an initial determination of noncompliance if they can demonstrate compliance.

CMS finalizes its proposal to implement a revised Home Health Consumer Assessment of Healthcare Providers and Systems® (HHCAHPS) survey beginning with the April 2026 sample month.

Finally, the rule finalizes updates to the regulatory text to account for all-payer data submission of OASIS data. CMS summarized stakeholder input on a change to the final data submission deadline period from 4.5 months to 45 days.

Medicare Provider Enrollment Revocation

Currently, any provider must enroll and be approved to become a Medicare provider. CMS has the authority to both approve and revoke provider Medicare enrollment. When CMS revokes a provider's Medicare enrollment, the revocation is effective 30 days after CMS mails notification to the provider. In certain circumstances, CMS can revoke enrollment retroactively to the first date of non-compliance and consequently collect any money paid to that provider back to the retroactive date. CMS is also adding to the allowable grounds for retroactive revocation.

- If an enrolled physician or practitioner has not ordered or certified services for 12 consecutive months
- If a beneficiary attests that a provider did not actually perform the services they billed

MHCA Comments

Despite positive changes in final rule, home health leaders remain deeply concerned payment cuts will continue to impact patient access to care at home.

Kathy Messerli, MHCA's Executive Director said:

"*MHCA thanks its members for your advocacy to help achieve this substantial improvement from the Proposed Rule. We will continue to call on Congress to take further action to reform the system such that it will protect patient access to care and ensure sustainability of the Medicare home health benefit.*"

View the final rule and its wage index tables and read the CMS Fact Sheet.

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Mission: MHCA serves home care providers through advocacy, education, resources, and collaborations.
Vision: MHCA will shape the home care landscape to improve and sustain quality home care services.