Illinois Health and Hospital Association

RULE SUMMARY

AUGUST 2026

MEDICARE HOME HEALTH PPS PROPOSED RULE

Overview and Resources

On July 1, 2026, the Centers for Medicare & Medicaid Services (CMS) released its calendar year (CY) 2027 proposed rule for the Medicare Home Health Prospective Payment System (HH PPS). The proposed rule includes updates to the Medicare fee-for-service (FFS) HH PPS payment rates based on changes set forth by CMS and those previously adopted by the US Congress. Among the proposed updates are:

- Recalibration of the Patient-Driven Groupings Model (PDGM) case-mix weights, low utilization payment adjustment (LUPA) thresholds, functional levels, and comorbidity adjustment subgroups;
- Payment adjustments to reflect the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate payment expenditures under the HH PPS;
- Updates to the HH Quality Reporting Program (QRP);
- Strengthening policies related to Medicare and Medicaid provider enrollment; and
- Updates to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) related policies.

Proposed program changes would be effective for discharges on or after January 1, 2027, unless otherwise noted. CMS estimates the overall impact of this proposed rule to be an increase of $420 million in aggregate payments to HH Agencies (HHAs) in CY 2027 over CY 2026, which includes a $370 million increase due to the proposed HH payment update and a $50 million increase due to the proposed fixed-dollar loss (FDL) amount for outlier payments.

A link to this proposed rule and other resources related to the HH PPS are available on the CMS website.

An online version of this proposed rule is available here.

Comments on this proposed rule are due to CMS by August 31, 2026 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "CMS-1844-P."

HH PPS Payment Rates

The following table shows the proposed CY 2027 30-day period standard payment rate compared to the final CY 2026 30-day standard payment rate:

	Final CY 2026	Proposed CY 2027	Percent Change
30-Day Period Standard Payment Rate	$2,038.22	$2,092.27	+2.65%

The following table provides details for the proposed annual updates to the HH 30-day period standard payment rate for CY 2027. The net temporary behavior adjustment accounts for both the removal of the final CY 2026 adjustment factor of 0.9700 and the inclusion of the proposed CY 2027 adjustment factor of 0.9700.

Proposed CY 2027 Update Factor Component	Change to 30-Day Period Standard Rate
Market Basket (MB) Update	+3.10%
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-1.0 percentage points (PPTs)
Wage Index and Labor-Related Share Budget Neutrality	+0.09%
Case-Mix Weights Recalibration Budget Neutrality	+0.45%
Net Temporary Behavior Adjustment	0.00%
Net Rate Update	**+2.65%**

The proposed market basket update percentage is based on IHS Global Inc.'s 1Q 2026 forecast with historical data through 4Q 2025.

Behavioral Assumptions and Adjustments

Since CY 2020, CMS has been required by the Bipartisan Budget Act of 2018 to use a 30-day period of care as the unit of payment in place of the prior 60-day episode of care. Part of this statute requires CMS to make assumptions about behavior changes that could occur as a result of implementing a 30-day unit of payment and case-mix adjustment factors that eliminated the use of therapy thresholds when calculating the CY 2020 standard payment amount.

The Consolidated Appropriations Act (CAA) of 2023 requires CMS to determine the impact of differences between assumed and actual behavior on estimated aggregate expenditures, beginning with CY 2020 and ending with CY 2026, and apply permanent and temporary adjustments as necessary through notice and rulemaking. CMS is also required to provide both the data sets underlying the simulated 60-day episodes and sufficient time for stakeholders to make comments on the development of the HH PPS payment rate. The methodology to determine these estimated expenditures was finalized in the CY 2023 HH PPS final rule.

After analyzing 30-day period standard payment rates for CYs 2020–2024 to account for changes in actual versus assumed behavior, CMS found that the actual rates should have been lower than the adopted rates (which were calculated using assumed behavior).

Applying this same methodology to CY 2025 claims, CMS has determined that the 30-day base payment rate for CY 2025 should have been $1,953.60 based on actual behavior, rather than the adopted rate of $2,057.35 based on assumed behaviors, including all behavior adjustments that were applied to the CY 2025 30-day base payment rate. This results in an updated total

permanent adjustment of -9.480% that needs to be applied to HH payment rates at some point to account for expenditures for CYs 2020–2025, a portion of which has already been accounted in the CYs 2023–2026 rates.

However, CMS states that there are difficulties in attributing behavior changes for CYs 2023–2025 directly to PDGM implementation and believes that the application of the permanent adjustment should be limited to data from CYs 2020–2022. As a result, CMS is proposing to not apply the permanent adjustment to the CY 2027 rate. CMS will continue to analyze data through CY 2026 claims, as required by law, to determine if any additional permanent adjustments are needed. If the permanent adjustment were to be applied for CY 2027, CMS estimates it would be -4.062%.

The same CMS analysis also found that, by updating the HH PPS payments rates for actual behaviors in CYs 2020–2025, total estimated payments for these six years were higher than they should have been. CMS estimates these overpayments to be:

- $873 million for CY 2020
- $1.211 billion for CY 2021
- $1.405 billion for CY 2022
- $835 million for CY 2023
- $430 million for CY 2024
- $152 million for CY 2025

This results in a combined $4.909 billion in temporary payment reconciliation, requiring an additional temporary adjustment to the 30-day payment rate.

For CY 2027, CMS is proposing a temporary adjustment to the CY 2027 30-day payment rate of -3.0%. This would collect approximately $500 million of the total temporary dollar amount.

National Per-Visit Amounts

CMS uses national per-visit amounts by service discipline to pay for LUPA periods of care as well as to compute outliers. LUPA payments are made when the number of visits is less than the LUPA threshold for their PDGM classification. This threshold is set at either two visits, or the 10th percentile value of visits, whichever is higher. CMS typically uses the most current utilization data available to set LUPA thresholds at the time of rulemaking.

For CY 2027 CMS is proposing to update LUPA thresholds using CY 2025 HH claims data. Of these thresholds, 396 case-mix groups would have no change in threshold, 17 groups would increase by one visit, 18 groups would decrease by one visit, and one group would decrease by 0.5 visits. A list of all proposed LUPA thresholds can be found here.

The proposed CY 2027 national per-visit rates compared to the final CY 2026 national per-visit rates are shown in the following table. These rates are not subject to the temporary adjustment or case-mix budget neutrality.

Per-Visit Amounts	Final CY 2026	Proposed CY 2027	Percent Change	Proposed CY 2027 with LUPA Add-On
HH Aide	$80.12	$81.78	+2.07%	N/A
Medical Social Services	$283.64	$289.51		N/A
Occupational Therapy (OT)	$194.74	$198.77		$342.64 (1.7238 adj.)
Physical Therapy (PT)	$193.42	$197.42		$320.32 (1.6225 adj.)
Skilled Nursing (SN)	$176.96	$180.62		$310.67 (1.7200 adj.)
Speech Language Pathology (SLP)	$210.25	$214.60		$358.30 (1.6696 adj.)

The LUPA add-on is used for OT, PT, SN, or SLP visits in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes.

Outlier Payments

Outlier payments are intended to mitigate the risk of caring for extremely high-cost cases. An outlier payment is provided whenever a HHA's cost for an episode of care exceeds a fixed-loss threshold, defined as the HH PPS payment amount for the episode plus an FDL amount.

Currently, there is a cap of eight hours or 32 units per day (one unit = 15 minutes), summed across the six disciplines of care, on the amount of time per day that will be counted toward the estimation of an episode's costs for an outlier. The discipline of care with the lowest associated cost per unit is first discounted in the calculation of episode cost, in order to cap the estimation of an episode's cost at eight hours of care per day.

The FDL amount is the HH FDL ratio multiplied by the wage index-adjusted 30-day period payment. This is added to the HH PPS payment amount for that episode. If the calculated cost exceeds the threshold, the HHA receives an additional outlier payment equal to 80% of the calculated excess costs over the fixed-loss threshold.

Each HHA's outlier payments are capped at 10% of total PPS payments. By law, a limit of 2.5% of total HH PPS payments is set aside for outliers. Based on CY 2025 claims data, CMS is proposing an FDL ratio of 0.29 for CY 2027.

Wage Index and Labor-Related Share

As has been the case in prior years, CMS proposes to use the most recent inpatient hospital wage index, which is the Federal Fiscal Year (FFY) 2027 pre-rural floor and pre-reclassification hospital wage index, to adjust payment rates under the HH PPS. The wage index would be applied to the labor-related portion of the HH payment rate. CMS previously adopted the use of a labor-related share of 74.9% for CY 2024 and onwards. The wage index and labor-related share budget neutrality factors for CY 2027 are proposed to be 1.0009 for the standard rate and 0.9997 for the per-visit rates.

In CY 2025, counties that had a different wage index value than the CBSA or rural area into which they are designated due to the adopted OMB delineation change after applying the 5% wage index cap used a five-digit wage index transition code, beginning with "50". This will be applied until the county's new CBSA-based wage index is at least 95% of the county's wage index

from the previous year and is in addition to the permanent year over year 5% stop loss on wage index previously finalized.

A complete list of the proposed wage indexes for CY 2027 is available here.

Lastly, CMS is soliciting comments on creating a HH-specific wage index using alternative data sources, such as Bureau of Labor Statistics data or HH cost reports, for potential use in future years.

Patient – Driven Groupings Model

CMS assigns HH stays into PDGM 30-day period of care groupings that are consistent with how clinicians differentiate between patients and the primary reasons for needing HH care. Case-mix adjustments for HH payments are based solely on these patient characteristics, relying more heavily on clinical characteristics and other patient information to place patients into 432 clinically meaningful payment categories.

Each year CMS recalibrates the PDGM case-mix weights in a budget neutral manner to ensure that the case-mix weights reflect current HH resource use and changes in utilization patterns. For CY 2027, CMS is proposing to recalibrate case-mix weights based on CY 2025 claims data as of March 15, 2026. Compared to CY 2026 weights, all 432 groups would see a difference between -5% and 5%. CMS is proposing a case-mix budget neutrality factor of 1.0045 to be applied to the standardized 30-day period payment rate.

The proposed case-mix weights for CY 2027 are listed in Table 24 and here.

CMS is proposing updates to functional impairment levels and functional points by clinical group using CY 2025 claims data. Tables 19 and 20 show the proposed Outcome and Assessment Information Set (OASIS) points and thresholds for functional levels by clinical group, respectively, for CY 2027.

CMS is also proposing that the comorbidity adjustment applicable to 30-day periods of care be calculated using CY 2025 HH OASIS data, which would result in 21 low comorbidity adjustment subgroups and 100 high comorbidity subgroups. These groups are listed on Tables 21 and 22, respectively.

HH Quality Reporting Program

CMS collects quality data from HHAs on processes, outcomes, and patient experience of care. HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to the market basket update for the applicable year. Measures currently in place for CY 2027 are listed in Table 31 and provided below. Measures noted with * indicate those included in the HH VBP Model.

Measures	Data Source
Improvement in Ambulation/Locomotion	OASIS
Falls with Major Injury	OASIS
Improvement in Bathing*	OASIS
Improvement in Upper Body Dressing*	OASIS

Improvement in Lower Body Dressing*	OASIS
Improvement in Bed Transferring	OASIS
Drug Regimen Review	OASIS
Discharge Function Score*	OASIS
Improvement in Dyspnea*	OASIS
Influenza Immunization Received	OASIS
Improvement in Management of Oral Medications*	OASIS
Timely Initiation of Care	OASIS
Transfer of Health Information to Provider	OASIS
Transfer of Health Information to Patient	OASIS
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury HH	OASIS
Discharge to Community-Post Acute Care (DTC-PAC)*	Claims
Medicare Spending per Beneficiary-Post Acute Care (MSPB-PAC)*	Claims
Potentially Preventable Readmission	Claims
Potentially Preventable Hospitalization (PPH)*	Claims
Communication Between Providers and Patients	HHCAHPS
Overall Rating of Care Provided by the Home Health Agency*	HHCAHPS
Care of Patients	HHCAHPS
Talk About Home Safety	HHCAHPS
Review Medicines	HHCAHPS
Talk About Medicine Side Effects	HHCAHPS
Willingness to Recommend the Home Health Agency*	HHCAHPS

Beginning with the CY 2027 HH QRP, CMS is proposing to revise the OASIS assessment data submission deadlines from the current 4.5-month deadline to approximately 45 days. Specifically, submissions and any corrections are proposed to be due to be no later than the 15th day of the second month after the end of the calendar quarter. If the 15th day of the second month falls on a Friday, weekend, or Federal holiday, the deadline would be delayed until 11:59 p.m. EST on the next business day. Table 32 shows the proposed data collection timeframes and data submissions deadlines for each quarter of CY 2027.Currently, the OASIS annual payment update (APU) has a July 1 – June 30 reporting timeframe, which differs from the timeframe used by other major CMS payment updates. These differences include the HHVBP Model and HH PPS updates, which are both based on a calendar year timeline. To improve alignment between the OASIS QRP reporting requirements and other HH payment policies, CMS is proposing to revise the OASIS APU data reporting timeframe to be on a similar calendar year cycle, January 1 – December 31. This would require a transition period in which the current reporting program timeframe is moved to the proposed reporting timeframe. Details on this transition and an example of the proposed calendar year timeline can be found in Table 33.

Similarly, the HHCAHPS APU reporting timeframe has an April 1 – March 31 reporting timeframe, which also differs from other CMS timeframes. CMS is proposing to revise the HHCAHPS APU reporting timeframe to be on a calendar year cycle, January 1 – December 31, which would also require a transition period. Details on this transition and an example of the proposed calendar year timeline can be found in Table 34.

In the CY 2026 HH PPS final rule, CMS finalized that an HHA can submit a request for an extension to file a reconsideration request to CMS via email no later than 30 calendar days from the date of the written notification of non-compliance. CMS is proposing further clarifications to this process to facilitate more timely digital transmission of information. Currently, the regulation states, *"HHAs that do not meet the quality reporting requirements under this section for a program year will receive a letter of noncompliance via the United States Postal Service and the CMS-designated data submission system"*. CMS proposes to revise this language to state that the letter of noncompliance would only be received via the CMS-designated data submission system. Other associated regulatory text, including that regarding notifications on final decisions on reconsideration requests, is proposed to be updated to reflect the notifications being sent through a CMS designated data submission system.

Request for Information (RFI) – HH QRP Measure Concepts Under Consideration for Future Years

CMS is seeking input on the importance, relevance, appropriateness, and applicability of the quality measure concepts related to advanced care planning, a continuous process that supports people in understanding and communicating goals, values, and preferences regarding future medical decisions. CMS is also seeking input on the relevant aspects of advanced care planning and measures appropriate for the HH setting.

Expanded HHVBP Model

CMS is not proposing any updates to the HHVBP model for CY 2027.

RFI – Palliative Care Services as HH Services

CMS included an RFI in the FFY 2027 Hospice Wage Index and Payment Rate Update proposed rule to solicit input on potential policies to enhance delivery of palliative care services outside of the hospice benefit. CMS is seeking comments on how to best promote access to and utilization of palliative care services under the Medicare HH benefit to expand these services.

DMEPOS Encounter Requirements For Identical Replacement Items

CMS is proposing that a new face-to-face encounter would not be required for replacement of DMEPOS items. This would only apply to replacing an item identified by the same Healthcare Common Procedure Coding System (HCPCS) code. If an item is not a replacement item identified by the same HCPCS code, then a new face-to-face encounter would be required.

Medicare and Medicaid Provider and Supplier Enrollment

CMS is proposing several changes around the existing Medicare provider enrollment regulations. These changes would apply to all Medicare provider and supplier types except where indicated otherwise. Topics included in these updates are as follows:

- Revocations and Denials of Enrollment

    - Abuse of Billing Privileges
    - False or Misleading Information
    - Extension of Revocation
    - Expansion and Reorganization of Retroactive Revocation Grounds
    - Claim Submissions After Revocation
    - New Revocation Reasons
    - Revised and New Denial Reasons
    - Reapplication Bar
    - Changes in Majority Ownership
- Preclusion List
- Temporary Moratoria
- Hospice Reactivations
- Opt-Out
- Private Equity Companies and Real Estate Investment Trusts
- Definition of "Operational"
- Signage
- Retention and Furnishing of Documentation
- Managing Employees
- Corrective Action Plans, Rebuttals, and Appeals
- Fingerprinting
- DMEPOS Accreditation
- Affiliations
- Savings, Costs, and Other Impacts Concerning the Provider Enrollment Provisions

DME Benefit Expansion For Infusion Pumps and Drugs

The Consolidated Appropriations Act (CAA) of 2026 expanded the scope of Medicare Part B for DME to include certain external infusion pumps and associated home infusion supplies, or other associated supplies that would not otherwise qualify as DME since it does not meet the "appropriate for use in the home" requirement. These DME would be treated as meeting the requirement of "appropriate for use in the home" if:

- The prescribing information approved by the FDA for the home infusion drug associated with the pump instructs that the drug should be administered by or under the supervision of a health care professional;
- A qualified home infusion therapy supplier, as defined in section 1861(iii)(3)(D) of the Act, administers or supervises the administration of the drug or biological in a safe and effective manner in the patient's home, as defined in section 1861(iii)(3)(B) of the Act; and
- The FDA-approved prescribing information instructs that the home infusion drug be infused at least 12 times per year:
    - Intravenously or subcutaneously; or
    - Infusion rates that the Secretary determines would require the use of an external infusion pump.

Since the CAA of 2026 does not define the term “health care professional”, CMS is proposing that the term refer to the following clinicians that are lawfully permitted to administer or supervise the administration of home infusion drugs: physician, clinical nurse specialist, nurse practitioner, physician assistant, or a registered nurse otherwise licensed to practice nursing in the State in which the home infusion drug is administered. The definitions of these terms would be the same as those already defined in the HH benefit. CMS is proposing that the drug must be infused at least once a month for the drug to be covered under this expanded benefit.

DMEPOS Competitive Bidding Program (CBP) – County of Origin

CMS plans to request a revision of the information collected from contract suppliers to include the country of origin for the lead items furnished during the DMEPOS CBP contract’s period of performance. This would be included in the current Form C and must also be marked on the item or included documentation of the item.

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