Home Health Care News

Morgan Gonzales, Dec 5, 2025

What could've been a very dark Black Friday for home health providers ended up bringing a little sunshine.

That's because the Centers for Medicare and Medicaid Services (CMS) announced a Medicare final payment rule that was far less drastic than what it proposed this summer.

That relief is not enough to allow providers to exhale fully, however. The final rule still included a 1.3% cut to aggregate Medicare payments to home health agencies.

The real win in the final rule, however, is not that CMS backed down from the largest rate cut it's ever proposed. The most significant victory is that CMS revised the methodology that it used to generate its decision.

The methodology change shows that CMS listened to industry advocates and commenters on the proposed rule. It signals a future where final rules could be something for providers to look forward to, not dread.

In this week's exclusive, members-only HHCN+ Update, I explain why the home health final payment rule offers hope for a strained industry, offering analysis and key takeaways, including:

– What the rule says about the future of home health payment rates

– Why its revised methodology matters

– Why a brighter future doesn't outweigh a gloomier present

Tempered enthusiasm and reason for hope

I might be talking largely about hope in this Update, but I'm not missing the reality of the final rule. A cut is a cut. And the rule included a cut.

"At a time of rising labor costs, workforce shortages and increased patient complexity, these reductions seriously destabilize a benefit that millions of older adults rely on," VNS Health CEO and President Dan Savitt told HHCN. "Despite consistent evidence from hospitals, agencies, caregivers and families, the final rule fails to recognize how repeated rate cuts are worsening the shortage of home health services for Medicare patients."

So when I say CMS is listening – it's listening in the way a cat listens. It hears you, turns its ear, but largely continues what it was going to do anyway. The cat is not changing its path entirely, but it might take a few steps toward you.

Access to care will still be reduced because of this cut. Small agencies may not be able to withstand another year of rate reductions and close their doors. Rural and underserved areas will likely be even more underserved.

Still, those few steps that CMS took matter.

I started to get a sense of how much they matter when tuning into a webinar on Thursday.

“We should see from 2026 on forward, under this new payment system, authorization payment increases,” Dr. Steve Landers, CEO of the National Alliance for Care at Home, said on the webinar, hosted by law firm Polsinelli. “They’re not at the baseline level that we think they should be at. They’ve got this wrong, and it’s not supporting the American people the way they should, in terms of a cost-effective and safe home health option, but at least we’re going to be heading now in an upward direction, rather than backwards.”

Specifically, per the fact sheet, CMS revised its proposed permanent adjustment after commenters (and there were a lot of them) highlighted that behavior changes after 2022 might be because of factors other than the implementation of the PDGM, “such as the introduction of the OASIS-E assessment; expansion of home health value-based purchasing; and increased Medicare Advantage penetration.”

“The sector is not vibrant enough for any type of cut,” Landers said. “But the fact [is] that we got a billion dollars taken out of it. And the good news is, in the way they wrote this up, this wasn’t just kicking the can down the road. We actually got them finally to reevaluate a portion of their methodology and how they’re thinking about their budget neutrality calculation for 2022, and beyond.”

Of course, the problem with this win is that it will bring increases in rulemaking announced in 2026 2026 and beyond. That’s great, but it’s not now. Providers have to pay their clinicians and aides every payday throughout 2026 – an increase in 2027 won’t help that. In the meantime, smaller providers really may not be able to withstand another cut to their revenue stream.

“Without Congressional intervention, these ongoing clawbacks [in the form of temporary adjustments] will hang over the industry for years, limiting agencies’ ability to expand, invest in technology and serve those who need care,” Mollie Gurian, vice president of policy and government affairs for LeadingAge, told me in an email Monday. “It could even lead to mergers or closures. While the final rule is better than the proposed version, the aggregate 1.3% reduction and continued recoupment threaten access to care and the stability of providers nationwide.”

Investing in technology is home health’s lifeline right now. I’ve repeatedly asked providers and stakeholders how agencies can invest in innovative tech with bruised margins and the answer has always been that it’s the only way providers can survive. Even one year of limiting technology investment could seriously hinder a company’s sustainability, leading to trickle-down closures in years to come.

The methodology

Even in terms of methodology, CMS did not significantly overhaul some problematic elements.

On Monday, I heard from multiple providers that CMS needs to reopen rulemaking and exclude fraudulent data (fraud occurring in Los Angeles County, California, is the usual example I’ve heard).

“CMS has stated that it cannot exclude anomalous or fraud-tainted claims from payment calculations, allowing distorted data to continue influencing national payment rates,” AccentCare said in a statement the company shared with me on Monday. “We urge CMS to act swiftly against those exploiting the benefit and to reopen rulemaking using its time-and-manner authority to restore beneficiary access and the payment system as Congress intended.”

VNS Health CEO Savitt echoed this call, saying:

"We urge CMS to use its authority to reopen rulemaking, correct distorted data, and address abusive and exploitative behavior impacting the home health payment system."

While I plan to dive into the potential of a reopened rule in a future news story, I'll give my current (but open to change) opinion on the likelihood of the final rule: not very likely. One recent example of CMS effectively changing its course in response to industry fallout is the controversial federal staffing mandate for nursing homes. The controversial final rule was announced in April 2024 – and was rescinded in an Interim Final Rule in September 2025.

So CMS does sometimes make dramatic changes to policy, but the reversal on the nursing home staffing rule was precipitated by the political changing of the guard that happened as a result of the 2024 election.

While many call for further recalculations, industry stakeholders attributed the agency's change in methodology to the advocacy efforts of home health leaders and organizations such as LeadingAge and the Alliance. These agencies, along with home health providers, pretty unanimously say they will work with CMS and lawmakers to advocate for a strengthened home health benefit.

Perhaps industry voices will even be loud enough to drive CMS to reopen rulemaking, change its methodology and further improve the status quo for home health. For now, though, the silver lining of this final rule is plenty bright. CMS didn't act on every comment submitted on the proposal, but the sharp contrast between the proposed and final versions shows that progress can – and did – happen.

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