Home Health Care News

Morgan Gonzales, January 29, 2026

This week, I attended the Home Care 100 event in Phoenix, Arizona.

From panels to my interviews to hallway conversations, the new models coming out of the Centers for Medicare & Medicaid Services (CMS) Innovation Center were a frequent topic of discussion. These models are especially critical because private-sector payers are becoming less likely to innovate, according to Devin Woodley, vice president of managed care contracting at VNS Health.

"They want to see a way higher return on investment, and … it's really just cutting costs," Woodley said. "They're cutting a lot of the value-based programs. At the same time, we're seeing a lot more innovation on the CMS side. So CMMI, they're rolling out more models.

"We're actually seeing a major shift in the paradigm of where the innovation is coming from," he continued. "It's the complete opposite of what it was a few years ago."

The other paradigm shift that continually caught my attention at the conference was related to technology. Tools that stand to transform the industry may currently be too niche, too siloed and too difficult to test. But the industry stands on a precipice where these problems will be overcome, and new tech will make day-to-day operations totally unrecognizable.

These two changes were not just dominating my conversations at the event; they stand to dominate how the industry provides care and gets paid for it for the foreseeable future.

In this week's HHCN+ Update, I'll share my key takeaways from my experience at the event, including:

– The reimbursement models that have attracted providers' attention

– The technology on providers' lips

– Why uncertainty is keeping innovation in check

CMMI models

The strategy from CMS' Innovation Center, announced in May 2025, includes a focus on giving patients the ability to choose their health care path, including the choice to receive care in the home.

As part of this movement and the organization's existing work to move away from a fee-for-service status quo, more models focused on in-home care have emerged.

"Probably everybody" who was at Home Care 100 is evaluating the ACCESS model, Woodley said. This voluntary model, which stands for Advancing Chronic Care with Effective, Scalable Solutions, includes an outcome-aligned payment model with technology-supported care models. The model was praised by the advocacy organization ATA Action and offers an exciting way for patients to receive care outside of traditional venues – but it isn't yet fully understood by the industry.

"I haven't talked to anybody who's really felt that they've wrapped their arms around ACCESS and understands exactly [what] the model is and how to deliver it," Woodley said. "[At] a very high level, it feels to me like longitudinal care management. Which is great because … we're already doing advanced care planning in chronic care management codes on the original Medicare population, but this is now that we can engage more deeply with that membership, and if we can do it in a PMPM space, now you can engage with them also on a more consistent basis. And I do feel that there's a lot of benefit there."

I have plans to cover the ACCESS model in more depth, but it's exciting to watch a budding model begin to gain a foothold in providers' strategies.

Also mentioned at the conference was the mandatory bundled Transforming Episode Accountability Model (TEAM), which went into effect on Jan. 1, and the ACO REACH program (Accountable Care Organization Realizing Equity, Access, and Community Health), which will be followed by the Long-term Enhanced ACO Design (LEAD) Model after ACO REACH comes to a close at the end of this year.

These models are critical to help facilitate the industry's transition away from its fee-for-service reality – and they demonstrate Woodley's point about where innovation will come from. Providers stagnating in value-based conversations with payers should welcome the voluntary models with open arms and work to maximize their experience with the mandatory models, if they aim to catapult their businesses into the next era of home-based care.

Still, a key takeaway is just how much uncertainty is swirling around these models, given the lack of clarity around ACCESS, the fresh launch of TEAM and the still-pending transition from REACH to LEAD. Under the Trump administration, CMS does not have a great track record on communication (recall the halt on HHS external comms about a year ago). Providers may struggle to successfully prepare for and participate in these new payment models unless they gain greater clarity on these frameworks. Furthermore, some providers – including hospice and home-based care provider By the Bay Health – have backed away from CMS' Guiding an Improved Dementia Experience (GUIDE) program. After initial excitement, By the Bay determined that the financial math didn't work for the organization, and GUIDE seemed "messy and not defined" when considered alongside By the Bay's existing PACE offerings.

So, while it was exciting to hear upbeat chatter about the latest CMS payment models, I hope that the agency works productively with providers to set these models up for success – and that I'm not hearing a much different tune at Home Care 100 next year.

Tech disruptors

In off-the-record chats with provider executives, the conversation often turns to technology recommendations. Everyone wants to know who is using which technology. Who did they go to dinner with? How niche of a problem is too niche to invest in a tech solution? Is such-and-such AI solution integrating well with a particular EMR?

This was certainly the case at Home Care 100. It helped that the event was themed around the role of data, highlighting the need for providers to obtain, analyze and leverage key data points in pursuit of improved quality and more favorable reimbursement agreements. With the need for data often comes the need for tech that can collect and analyze data.

More of interest than the technology that scours data, however, were the tools that improved efficiency, quality and caregiver and client experience. Tech like remote patient monitoring tools for specific client populations, specialized transcription services and other back-end tools were all top of mind.

While providers are gung-ho about integrating these tools into their tech stacks, the problem I extrapolated from my conversations is that there are a daunting number of tools addressing such a multitude of problems.

Like how the iPhone disrupted the reign of the Blackberry and the Motorola Razr I always wanted but never got, I anticipate that some of these under-the-radar tools will be the ones that change how providers operate – but it's hard for me, and for provider execs, to determine which technology will win the market, just as the iPhone eclipsed those other smartphone models.

Linking my two key takeaways is the reality that the home-based care industry is eager to embrace innovation, while at the same time, uncertainty is constraining providers. I do believe it's inevitable that value-based and managed care models will continue to redefine how providers are paid, and that AI and other transformative technology will be widely adopted and reinvent key elements of operations and even clinical delivery. So, providers must do their best to read the signals and make smart decisions about what models and tech to invest in, while at the same time, they must remain (or become) nimble, in order to pivot if needed as they gain greater clarity on which experiments and innovations prove most durable.