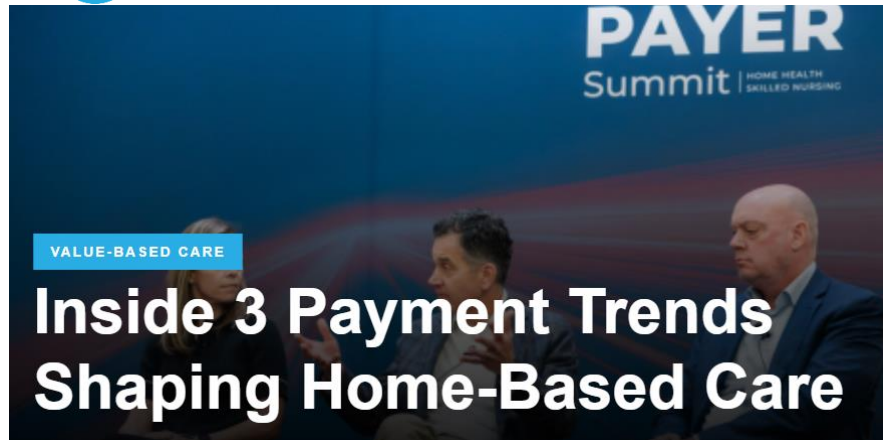




Morgan Gonzales, June 25, 2026

At last week's PAYER Summit, providers, policy experts and payer execs were largely aligned on what will separate successful home-based care organizations from the rest of the pack.

Discussions at the event, hosted by Home Health Care News and Skilled Nursing News, included commentary on some notable changes in the payment landscape that have occurred or are taking shape, including the relative importance of quality outcomes versus cost savings and the role of Medicare Advantage payers as innovation drivers.

Performance metrics shift

For years, value-based care conversations centered on proving that home-based care could reduce hospitalizations and lower the total cost of care. Those metrics remain important for providers operating within VBC frameworks, but they increasingly feel like table stakes rather than a competitive advantage. As reimbursement tightens across both Medicare Advantage and Medicaid, payers appear to be asking a different question with increasing urgency: Which providers consistently deliver measurable quality?

"Value is going to be more critical now than ever," said Allison Rizer, chief growth and innovation officer at ATI Advisory. "What I don't know is whether it's about cost savings, because I think despite us being on this many, many, many-year journey on value-based care, it hasn't really cut costs from the system writ large. I think the definition of value may shift in the coming years, where we're thinking more about quality. Are we at least getting the same or higher quality for what we're spending?"

Cost savings are, of course, still going to be top of mind for payers. But Rizer's statement and those of others at PAYER demonstrate that home-based care providers need to ensure they're looking beyond just the dollars and cents. Increasingly, the question appears to be whether providers can consistently deliver better outcomes while helping patients remain in the most appropriate setting.

Payers' influence regarding site of care may also be determined by quality, a huge tip for home-based care providers looking to help patients stay where they want to be: in the home.

"We work with providers who are receptive to value-based models, so the site-of-care decisions are almost a result of that," said Arun Dahiya, principal of skilled nursing facility (SNF) innovation and advancement strategy at OneHome.

An affiliate of Humana, OneHome acts as a payer-neutral convener and also directly provides care in the home, meaning the company has a valuable perspective on how site-of-care decisions are made and how they reflect the interests of multiple parties, including payers, providers, patients and family members.

Given that value-based models are rooted in managing the overall cost of care – with costly interventions like rehospitalization being a major obstacle – there are instances when it's preferable for an individual to be in a SNF versus at home, Dahiya noted.

"We don't nudge that process," he said, adding that it's important for providers to be financially rewarded for proper site-of-care decisions. And, again, quality is the key factor in determining the success of those decisions.

"Our north star is always: ensure that the quality of outcomes for the patient [are] always there," Dahiya said.

Data and interoperability

Providers regularly tell me that they want payers to share more data – but that desire runs in both directions. Payers want providers to share essential information that can aid in decision-making.

Almost every panel emphasized the importance of data. Without solid data, demonstrating performance metrics such as overall spend becomes nebulous, which is unlikely to encourage a payer to carve out upsides for providers.

"To the extent we're going to have success ... it's going to be able to demonstrate the data [showing] that because we got in front of this problem, we saved," said Rich Keller, CEO of PurposeCare. "We were able to demonstrate quality and value on the Medicare acute care side."

But the actual handing over of data is key. It's not just enough to track – providers have to willingly share it, making interoperability the name of the game whether in a Medicare or Medicaid managed care scenario.

"Provider organizations in the community who were able to come to the plans with data, with ideas that would help to achieve the plan's goals and ultimately the Medicaid program's goals – were open to working collaboratively to do that – were the ones that really sat at the table with the MCOs," Scott Leitz, vice president of health care programs at NORC at the University of Chicago, said. "To the extent that you're able to, demonstrate your value to the plans and the value to the state Medicaid programs through data."

Leitz has directed projects conducted on behalf of CMS, directed NORC's work to establish a Medicaid Managed Care Organization Learning Hub, served as CEO of MNsure, Minnesota's state-based health insurance marketplace and as Minnesota's Medicaid Director and Assistant Commissioner for Health Care at the Minnesota Department of Human Services. So his advice here should be a strong cue to providers.

Leitz noted that providers can bolster their cases with anecdotes to aid discussions.

CMS Medicare models drive innovation

Home-based care providers often get excited about new CMS models, and speakers at PAYER confirmed that the excitement is warranted.

"What we really have seen is that over the past decade [is] there's been a lot of innovation coming out of CMS," Devin Woodley, vice president of managed care contracting at VNS Health, said.

Woodley pointed to the Hospice Outcomes and Patient Evaluation (HOPE) model and Transforming Episode Accountability Model (TEAM) as evidence that CMS is pushing innovation in the Medicare space. He also noted that all home health agencies are now participating in home health value-based purchasing (HHVBP), further embedding value-based care into the sector.

The picture looks different, however, outside of traditional Medicare.



Devin Woodley, vice president of managed care contracting at VNS Health

“When it comes to Medicare Advantage and managed Medicaid, we’ve actually seen the opposite,” Woodley said. “There’s been significant cuts on the Medicaid side with that. In New York City, in particular, they’ve also decreased a lot of quality measures, and so when you have quality measures along the way, that’s decreasing the opportunity to do better rates. ... Some of our payer insiders have said – at some of the big payers – that they’re actually saying that they actually don’t want to share in the pie.”

Large national MA plans and managed Medicaid plans are just trying to stay afloat, Woodley said, which means there are fewer value-based opportunities for providers.

Increasingly, providers appear to see CMS as setting the pace while many MA organizations focus on navigating financial headwinds.

That doesn’t mean Medicare Advantage is becoming less important – far from it – but it reinforces the influential role that CMS continues to play in shaping the future of health care payment, even as the growth of MA has been inexorable over several years.

While providers are intensely focused on addressing the financial and administrative pressures that have arisen as Medicare Advantage has become a more dominant payer, they should not take their eyes off the ball when it comes to how they are engaged with CMS’ value-based frameworks. Indeed, providers likely will have no choice, as CMS appears to increasingly be making models mandatory, whether on a limited basis like TEAM or on a nationwide basis as in the proposed expansion of CJR.

So, the next few years may find providers balancing granular negotiations and difficult decisions about how to contract with Medicare Advantage payers, while adapting their operations to keep pace with CMS-driven innovation. Hopefully, these will prove to be complementary efforts, resulting in more data-driven, quality-focused operations that are rewarded on the payment side. A risk is that bottom-line pressures will combine with administrative burden to create serious obstacles for that more ideal scenario.

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