National Alliance for Care at Home

January 9, 2026

Michael E. Chernew, Ph.D.
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

RE: Alliance Comments on December MedPAC Meetings

Dear Chairman Chernew:

The National Alliance for Care at Home (the Alliance) appreciates the opportunity to provide our response to the Medicare Payment Advisory Commission's (MedPAC) December 2025 meetings.

The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. The Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, those with chronic and serious illnesses, and Americans at the end of life who depend on those supports.

We thank the Commission for its thoughtful examination of the Medicare home health and hospice benefits; but at the same time, we have strong concerns about draft payment recommendations. As the Commission observed, these are vital benefits that our some of our nation's most vulnerable Medicare beneficiaries depend on, and it is important to ensure that older Americans can continue to access these benefits, wherever they may call home. Recommendations to reduce the home health payment rates and to provide no payment updates for hospice care risk undermining provider capacity and patient access to services that are demonstrably cost-effective, align with patient and family preferences, and contribute to lower overall Medicare program spending.

Post-Acute Care Trends and Key Issues

The Alliance appreciates MedPAC's review of post-acute care (PAC) trends and key issues spanning home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and other settings. The Alliance agrees that differences in each PAC setting's eligibility criteria, benefit structure, and patient mix complicate direct comparisons of quality and outcomes. However, we note that PAC settings are not the same, and would urge caution about considering reforms that do not account for the individualized goals of treatment, differences in care delivery, and patient acuity and needs in each respective setting. MedPAC should consider how Medicare policies might be modernized to smooth transitions and encourage timely referral and beneficiary receipt of the most appropriate PAC setting.

Research has consistently shown that older adults have a strong preference for remaining in their homes as they age.[1] While persistent staffing shortages and rising labor costs are straining PAC providers in every setting, this is particularly acute in home-based care settings, such as home health and hospice where nurses must operate independently in the patient's home, necessitating specific competencies and skillsets to meet patient needs. Alliance members report intense competition for nurses, therapists, aides and other staff, leading to higher wages and staffing challenges even as patient demand grows. With an increasingly aging population, it is paramount to ensure that Medicare beneficiaries can continue to access and receive care at home.[2]

Any evaluation of PAC efficiency should account for workforce realities, particularly in rural and underserved areas, where staffing is particularly challenging. Further, we encourage MedPAC to assess the impact of wage index policies on PAC staffing and availability. For example, unlike hospitals, HHAs and hospice providers are unable to reclassify their wage index, which means they are at a competitive disadvantage when competing for a limited pipeline of healthcare professionals. This is particularly acute in situations where a provider is furnishing care in a rural county but pulls staffing from a metropolitan area.

We also encourage MedPAC to evaluate and compare Medicare Advantage (MA) to fee-for-service (FFS) impacts on and use of PAC. This analysis should include how patient preferences and MA prior authorization and utilization management tools, such as on hospital discharge practices, influence PAC utilization. In the home health setting specifically, emerging evidence suggests that differences in MA reimbursement structures, such as per-visit versus episodic payment models, are associated with differences in service delivery and outcomes, including shorter lengths of stay, fewer visits from certain disciplines, and higher inpatient transfer rates under more restrictive per-visit plans

[1] Geng F, McGarry BE, Rosenthal MB, Zubizarreta JR, Resch SC, Grabowski DC. Preferences for Postacute Care at Home vs Facilities. JAMA Health Forum. 2024;5(4):e240678

[2] Xiao R, Miller JA, Zafirau WJ, et al. Impact of Home Health Care on Health Care Resource Utilization Following Hospital Discharge: A Cohort Study. Am J Med, 2018 Apr;131(4):395-407.e35

compared with both traditional Medicare and episodic MA plans.[3] Similarly, we urge MedPAC to consider MA effects on the financial performance of HHAs, in addition to SNFs and IRFs. Like SNFs and IRFs, HHAs contract with Medicare Advantage Organizations (MAOs) and provide care to MA enrollees. Any comprehensive analysis of MA in the PAC setting should therefore consider home health care as well.

Home Health Payment Adequacy

Home health plays a critical role by enabling beneficiaries to receiving skilled care in the home, supporting positive care outcomes while avoiding more costly inpatient settings. The Alliance is deeply concerned that the draft MedPAC recommendation to reduce the Medicare home health base payment rate by 7 percent for CY 2027 does not reflect the cumulative impact of recent policy changes and threatens the sector's ability to meet future beneficiary needs.

While recent data may suggest relative stability across certain access and quality measures, those signals lag the operational and financial pressures now shaping provider behavior and beneficiary access on the ground. Agencies have already responded to cumulative year-after-year payment cuts by narrowing service offerings, reducing service areas, and in some cases closing altogether. Illustratively, CMS's own data show that approximately half of all U.S. counties lost at least one HHA between 2020 and 2024.[4] HHAs in over 80 percent of counties are treating fewer Medicare FFS beneficiaries and providing fewer visits.[5] In 2024, over one-third of Medicare beneficiaries referred for home health after hospitalization did not receive this care.[6] Further, approximately 10 percent of beneficiaries referred for home health are waiting at least 5 days for a visit, with even longer wait times likely in rural areas.[7]

In the last decade, the Commission has recommended payment rate reductions every year, and CMS has implemented reductions in most years. This has resulted in a sustained pattern of downward pressure on home health reimbursement (see Table 1 below). We question what the Commission believes will be accomplished with year-after-year rate reductions, besides less and less home health care provided to Medicare beneficiaries.

Table 1: MedPAC Recommendations and CMS Rate Cuts, CYs 2026-2015.

[3] Prusynski RA, D'Alonzo A, Johnson MP, Smith JM, Mroz TM. Medicare Advantage reimbursement structures impact home health delivery and outcomes. Am J Manag Care. 2025 Nov;31(11):677-685

[4] CMS Market Saturation & Utilization State-County dataset, https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

[5] https://trellahealth.com/wp-content/uploads/2024/12/Trella-Health-Special-Report-Home-Health-Accessibility-Among-Medicare-Fee-for-Service-FFS-Beneficiaries.pdf

[6] https://carejourney.com/how-timely-access-to-home-health-care-impacts-cost-and-outcomes

[7] https://allianceforcareathome.org/wp-content/uploads/Trends-timeliness-home-healthcare.pdf

Calendar Year	MedPAC Recommendation	CMS 30-day/60-day Payment Rate Cuts	Average Medicare FFS Margin	Average Total Margin
2027	-7% rate reduction			
2026	-7% rate reduction	-4.023% (-1.023% permanent adjustment, -3% temporary adjustment)	19% Projected	
2025	-7% rate reduction	-1.975% (permanent adjustment)	19% Projected	
2024	-7% rate reduction	-2.890% (permanent adjustment)	21.2%	5%
2023	-5% rate reduction	-3.925% (permanent adjustment)	20.2%	8.2%
2022	-5% rate reduction	NA	22.2%	7.9%
2021	-7% rate reduction	NA	24.9%	11.9%
2020	-5% rate reduction	-4.36% (PDGM budget neutrality adjustment)	20.2%	8.1%
2019	-5% (and rebase the rates over two years)	NA	15.8%	5.9%
2018	-5% (and rebase the rates over two years)	-0.97% (nominal case-mix reduction)	15.3%	5.3%
2017	-5% (and rebase the rates over two years)	-3.7% (0.97% nominal case-mix reduction & -2.73% rebasing adjustment)	15.2%	4.5%
2016	Eliminate payment update and rebase the rates over two years	-3.7% (0.97% nominal case-mix reduction & -2.73% rebasing adjustment)	15.5%	4.5%
2015	Eliminate payment update and rebase the rates over two years	-3.7% (0.97% nominal case-mix reduction & -2.73% rebasing adjustment)	15.6%	Not Reported

Source: MedPAC, Annual Report to the Congress: Medicare Payment Policy; and Centers for Medicare & Medicaid Services (CMS) annual final rules.

An analysis by the CMS Office of the Actuary completed for the 2025 Medicare Trustees report estimates that by 2027, 44 percent of home health providers will have negative total margins.[8] This number grows to 56 percent by 2040. The analysis is based on 2023 cost report and other data and does not assume additional cuts to payments made after that date. Given the additional permanent adjustments applied for 2024, 2025, and the permanent and temporary adjustments finalized for 2026, it is very easy to conclude, that these estimates will rise much higher.

We are also concerned with the Commission's continued focus on Medicare FFS margins, without equal weight given to all-payer financial performance, also warrants reconsideration. The persistent disparity between Medicare FFS margins and all-payer

[8] CMS Office of the Actuary, Analysis for 2025 Medicare Trustees Report, "Simulations of Affordable Care Act Medicare payment update provisions on Part A provider financial margins", June 18, 2025, https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf-0

margins reflects a structural imbalance in the home health financing environment, not excess profitability. Medicare Advantage and Medicaid underpayment increasingly shape provider decisions, workforce investment, and service capacity. Further reductions to Medicare rates risk accelerating consolidation and market exit, particularly among smaller and rural agencies, thereby weakening long-term access.

Home health administrators and clinicians report continued workforce challenges. We note that since 2015, IRFs and SNFs have received payment updates totaling 29.1 percent and 30.4 percent respectively. In contrast, home health payments have only increased by approximately 6.5% during the same time period. Between May 2015 and 2024, average hourly wages for Registered Nurses increased 40 percent and average hourly wages for Physical Therapists increased 20 percent. Hospital discharge planners and home health agency personnel alike report that lack of home health capacity, or lack of capacity to deliver specific nursing or therapy services that a patient needs, results in patients staying in the hospital longer than necessary, receive post-acute care in a more costly facility environment, or are left without a plan to receive the care they need.

We are also concerned the Commission continues to assert that access to care is mostly positive, while at the same time acknowledging that the metrics it relies on for this conclusion are flawed. The Commission largely measures access to home health care based on the number of home health agencies overall and percent of FFS beneficiaries that live in a ZIP code where a home health agency is active. As noted in previous MedPAC reports, "[t]his definition may overestimate the local supply of agencies because HHAs need not serve the entire ZIP code to be counted as serving it, and this measure does not assess the capacity of agencies relative to beneficiary demand (i.e., agencies may not have capacity to serve additional beneficiaries who require home health care)." During previous meetings with staff, we presented analysis using Medicare FFS claims data showing that over one-third of patients referred for home health care never receive it, [9] often due to capacity constraints and workforce shortages exacerbated by underfunding. For those who were referred to but did not receive home care after hospitalization, mortality rates were 43% higher, hospital readmission rates were 36% higher, and total 90-day Medicare spending was 5.4% higher.[10]

Similarly, to determine whether there are delays in care access, the Commission uses the home health patient assessment instrument data on the share of home health stays that agencies report as being initiated in a timely manner. This share has been consistently high for many years; however, analysis of claims data paints a different picture. Patients who are admitted to home health care waited a full day longer for care to start on average (3.2 days in 2024 vs. 2.2 days in 2019).[11] Currently, 10% of referrals are waiting at least 5 days to

[9] https://carejourney.com/wp-content/uploads/2025/06/Home-Health-Access_2024-Q3-_2025.02.pdf
[10] https://carejourney.com/how-timely-access-to-home-health-care-impacts-cost-and-outcomes/
[11] KNG Health Consulting, 2025, https://allianceforcareathome.org/wp-content/uploads/Trends-timeliness-home-healthcare.pdf

receive a visit, with longer wait times more likely in rural areas.[12] Year over year funding reductions to HHAs have resulted in compromised access to care as demonstrated by the data trends discussed above.

Discussion of utilization trends in California also highlights the need for more targeted, data-driven policy responses rather than nationwide rate reductions. California's experience appears to reflect a confluence of state-specific factors and rapid growth in select markets (e.g., Los Angeles). In our comment letter in response to the Calendar Year (CY) 2026 Home Health proposed rule,[13] the Alliance highlighted that rapid increases in home health agency enrollments and associated aberrant billing patterns in Los Angeles County, California are impacting CMS's rate-setting calculations and are highly indicative of fraudulent activity. We stand ready to partner with CMS to address home health fraud, waste, and abuse. We believe that refined oversight tools, enhanced analytics, and targeted enforcement are needed, rather than rather than broad payment cuts that penalize compliant providers, especially given the limitations and inconsistencies in the underlying data.

Finally, the Alliance agrees with Commissioners who raised concerns about declining visit volumes and the need to better understand quality outcomes by referral source. These trends suggest the home health benefit is already undergoing significant recalibration in response to policy and payment pressures. Before yet again advancing a recommendation of this scale, the Commission should more fully assess how ongoing payment reductions are reshaping care delivery, patient selection, and provider participation. Payment policy should reinforce value and accountability without destabilizing a benefit that is essential to beneficiary access and Medicare program efficiency.

Mandated Report: The Impact of Recent Changes to the Home Health Prospective Payment System

The Alliance appreciates the Commission's review of the Patient-Driven Groupings Model (PDGM) and its effects on home health utilization, payment, and quality. We note that the Commission highlighted several non-PDGM factors that affected utilization trends, such as the COVID-19 pandemic and workforce shortages. These factors make it challenging to isolate the effects of PDGM and underscore the importance of cautious interpretation when evaluating early trends.

[12] https://allianceforcareathome.org/wp-content/uploads/Trends-timeliness-home-healthcare.pdf
[13] https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf

As noted by the Alliance in its comment letter in response to the Calendar Year (CY) 2026 Home Health proposed rule,[14] there are several factors that resulted in behavior change throughout the measurement period (i.e., analysis of CY 2020 through CY 2024 data) that are not related to the implementation of PDGM. The Alliance stressed that CMS should not include behavior changes unrelated to the implementation of the PDGM when calculating the permanent and temporary adjustments, as this would be counter to what the law requires. CMS partially agreed with the Alliance stating that *". . . [t]here are several factors that make it difficult to determine changes resulting from the implementation of PDGM and non-PDGM-related behaviors. . . As such, we are only finalizing the remaining permanent adjustment needed to account for behavior change attributable to the implementation of the PDGM calculated using only the claims experience for CYs 2020 through 2022."* The Alliance appreciates the work of the Commission in acknowledging that non-PDGM factors also impacted CYs 2020 through 2022.

The Commission noted that recent data suggest that PDGM has had minimal adverse impact on beneficiary access or quality of care, and potentially preventable hospitalizations have improved. We support further analysis by referral source, clinical condition, and payer type to better understand care variations and inform evidence-based policy decisions. At the same time, provider sustainability remains a key concern, with ongoing workforce and operational pressures in many areas. Recommendations for payment reductions or no updates could jeopardize access to home-based care that is cost-effective, aligns with beneficiary preferences, and reduces overall Medicare spending.

Hospice Payment Adequacy

Hospice is a cornerstone of our healthcare system, and we are deeply concerned about the draft recommendation to eliminate the update to Medicare hospice payment rate for FY 2027. We respectfully urge MedPAC to reconsider this recommendation in light of thin margins and rising costs these providers continue to face across the country.

As the Commission is aware, hospice has a unique role in our healthcare delivery system, providing compassionate, holistic care that promotes the dignity and quality of life for beneficiaries at their most vulnerable time—the end of life. Through an interdisciplinary team of physicians, nurses, aides, social workers, spiritual counselors and others, such as volunteers, hospice addresses not only a patient's medical needs but their emotional, psychosocial, and spiritual needs as well.[15]

[14] https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf and https://leadingage.org/wp-content/uploads/2025/08/LeadingAge-CY2026HomeHealthProposedRuleCommentLetter-8.28.25.pdf

[15] *See* 42 CFR 418.56

This holistic approach improves patients' quality of life in their final days, emphasizing comfort and pain management. Importantly, hospice adds value to Medicare by often reducing avoidable high-cost interventions. Research has shown that hospice use is associated with lower Medicare expenditures at end of life.[16] Illustratively, an examination of cancer decedents found that longer hospice stays reduced end-of-life spending in high-expenditure regions.[17] Similarly, hospice use among patients with hepatocellular carcinoma (HCC) has been found to be associated with approximately a $10,000 decrease in inpatient expenditures and $1,300 decrease in outpatient expenditures, relative to non-hospice users.[18] Hospice delivers high-quality, person-centered care that beneficiaries and families increasingly depend on, and it does so in a manner that drives positive outcomes for patients, and savings for the Medicare program.

Given the above, it is essential that annual payment updates keep pace with rising inflationary costs, particularly the growing costs of staffing and care delivery. We are concerned that MedPAC's draft recommendation calls for no market basket update for hospice, despite evidence that hospice providers face thin margins amid a highly competitive market. It is important to note that annual payment updates in the Medicare payment system are not payment increases; rather, they are intended to allow providers to continue providing care with a level of payment that keeps pace with rising costs.

Under current law, the Medicare hospice payment rate update is tied to the inpatient market basket forecast. However, in recent years these forecasts have repeatedly underestimated actual inflation, leading to rate updates that have not kept pace with actual cost increases. Freezing rates entirely for FY 2027 would drastically worsen this gap. As the Commission has observed, many hospice providers are already operating at razor-thin margins. The elimination of an annual payment update would likely impact access to hospice care, especially in rural and underserved areas, at a time when the need for hospice is growing.

We appreciate the Commission's ongoing analysis of hospice quality trends and share the Commission's desire to ensure accountable delivery of high-quality hospice care. At the December meeting, MedPAC noted that key hospice quality indicators have been generally stable or improving. The Alliance cautions that current hospice quality metrics are incomplete and must be interpreted with care. Relevantly, hospice provides holistic care that is not always captured in claims data or existing quality measures. For example, not all hospice discipline visits are reported, such as chaplains. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Hospice Survey, while valuable for capturing

[16] https://www.norc.org/content/dam/norc-org/pdf2023/Value%20of%20Hospice%20in%20Medicare_Final%20Report.pdf

[17] Wang, S., Hsu, S., Huang, S., Soulos, P., & Gross, C. Longer Periods Of Hospice Service Associated With Lower End-Of-Life Spending In Regions With High Expenditures. Health affairs, 2018;36(2), 328-336

[18] Rice, D.R., Hyer, J.M., Diaz, A. *et al.* End-of-Life Hospice Use and Medicare Expenditures Among Patients Dying of Hepatocellular Carcinoma. Ann Surg Oncol, 2021; 28, 5414–5422

family experience, faces low response rates and data gaps.[19] When CMS introduced Hospice CAHPS star ratings in 2022, two-thirds of hospices did not receive a star rating because of inadequate data, and the share of unrated hospices has only grown since.[20] Additionally, the CAHPS survey is administered to caregivers at a time when they are most vulnerable—after the death of their loved one—often yielding low response rates and potential bias. Accordingly, we recommend that MedPAC further review and analyze the low response rates and data gaps, any potential bias in the measures, and whether they are appropriately risk adjusted. We believe that such analysis will further support the Commission in its work.

Finally, the Alliance shares MedPAC's concern about the rise of fraud and abuse in certain hotspot hospice markets, and we support efforts to root out bad actors from the Medicare program. CMS has implemented a provisional period of enhanced oversight (PPEO) for newly enrolling hospices (including changes in ownership and reactivating after a period of deactivation) in Arizona, California, Nevada, and Texas, requiring pre-payment medical review. Additionally, CMS conducted a nationwide hospice site visit project and subsequently expanded prepayment medical review to existing hospices in those four states. CMS also implemented new regulations that require hospice certifying physicians to be enrolled or opted out of Medicare, and subjecting hospices to the highest level of provider enrollment application screening. While we applaud CMS for these efforts implementing several of the hospice program integrity recommendations previously put forth by the hospice industry,[21] we note that several recommendations remain outstanding. We stand ready to partner with CMS on its work to modernize and strengthen program integrity across the Medicare and Medicaid programs.

Improving Medicare's Payment Approaches

The Alliance appreciates MedPAC's work to improve Medicare payment systems. However, we offer a few comments. MedPAC has previously recommended incorporating the hospice benefit into the MA benefits package, and revisited this recommendation in the December 5 meeting. We continue to strongly oppose this recommendation, and reiterate our prior comments raised in response to the September 2025 MedPAC meetings.[22] In those comments, we urged MedPAC to reconsider and withdraw its prior recommendation to include hospice in MA, and we reiterate that position here.

The current structure of the Medicare hospice benefit is working well for beneficiaries, and while there are certainly opportunities for improvement, folding hospice into MA would

[19] Hospices that are new or have a low patient census are exempt from CAHPS requirements.
[20] Chen AC, Grabowski DC. CMS's Hospice Star Rating System Limited By Missing Data. Health Affairs. 2025 Jun;44(6):716-721
[21] https://allianceforcareathome.org/wp-content/uploads/Hospice_Program_Integrity_Ideas_Hospice_Industry_Consensus.pdf
[22] https://www.medpac.gov/wp-content/uploads/2025/01/Alliance-MedPAC-Meeting-Comments-10.13.25.pdf

seriously disrupt this successful benefit. Indeed, the Hospice Value-Based Insurance Design (VBID) demonstration revealed significant challenges for payers, providers, and beneficiaries alike. Important to this discussion is the value to the beneficiary: how would carving hospice into MA actually help the patient?

Such an inclusion would create new complexities for a benefit that is straightforward and patient-driven, such as imposing network requirements and utilization management tools like prior authorization that could delay or limit access.

Conclusion

We appreciate your consideration of our comments. The Alliance looks forward to working with MedPAC to strengthen our Medicare program for beneficiaries across the nation receiving care at home. If you have any questions, your staff should feel free to contact the Alliance's Chief Government Affairs Officer, Scott Levy, at: slevy@allianceforcareathome.org.

Sincerely,

Steven Landers, MD, MPH
Chief Executive Officer
National Alliance for Care at Home