National Alliance for Care at Home

July 28, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Proposed Permanent and Temporary Home Health Payment Adjustments in the Calendar Year (CY) 2026 Home Health Prospective Payment System (HH PPS) Proposed Rule

Dear Administrator Oz:

On behalf of home health agencies and the patients we serve, we strongly urge you to withdraw the proposed 9% cut to Medicare home health payment rates in the Calendar Year (CY) 2026 Home Health Prospective Payment System Rate and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program Updates proposed rule (CMS-1828-P). We share the Centers for Medicare & Medicaid Services' (CMS) commitment to protecting Medicare beneficiaries and taxpayer resources by eliminating fraud, waste, and abuse in the home health sector. It is deeply concerning, however, that the rule focuses on cutting payments by incorporating data from fraudulent providers' practices, which may have yielded flawed methods, instead of taking action against actors who exploit the Medicare program at the expense of vulnerable beneficiaries who need home health services most.

This proposed cut—both the permanent and temporary adjustments—would result in an estimated $1.13 billion reduction in payments to home health agencies compared to CY 2025. This reduction comes on top of nearly 9% in cuts already implemented from CY 2023 through CY 2025. Such repeated and compounding reductions are unsustainable and directly threaten patient access to critical, cost-effective home health care.

The current financial strain on the industry is already severe. Since 2020, over 1,000 home health agencies have closed,[1] Medicare fee-for-service utilization of home health care has decreased by 8%,[2] and nearly one-third of patients referred to home health care from hospitals are unable to receive services, often due to capacity constraints and workforce shortages exacerbated by underfunding.[3] Importantly, when beneficiaries are unable to access home health care, Medicare often incurs higher costs as a result of increased emergency department visits, preventable hospital readmissions, and the need for more expensive institutional care. Such a result is

[1] https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county
[2] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch7_MedPAC_Report_To_Congress_SEC.pdf
[3] https://carejourney.com/how-timely-access-to-home-health-care-impacts-cost-and-outcomes/

untenable, as it both threatens patients' ability to receive in the setting they most prefer—the home—and places unnecessary financial burden on the Medicare program.

We offer these preliminary comments to underscore our urgent concerns regarding the proposed payment cuts. We will submit a comprehensive comment letter addressing the full scope of issues raised by the proposed rule prior to the close of the comment period.

About the Alliance

The National Alliance for Care at Home (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 include over 1,500 providers representing 10,000 offices and locations, serving over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. Formed through the joint affiliation of the National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO), 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, persons with chronic and serious illnesses, as well as dying Americans who depend on those supports. In addition, the Alliance convenes an Assembly of State Associations, a collaborative body of leading state associations representing the voice of providers delivering care in the home and the patients they serve across the United States. The support of the undersigned associations reflects a broad, nationwide commitment to safeguarding home-based care.

Effects of the Proposed Payment Reductions on Access to Care

The proposed $1 billion in decreased payments to home health agencies will result in increased agency closures and significantly impair agencies' ability to maintain operations, compromising visit frequency, staffing, and patient outcomes. Indeed, we have already seen these closures occurring with alarming intensity. For example, several long-standing and highly respected agencies have recently closed or drastically reduced services due to financial strain. In 2024, Visiting Nurses Association (VNA) of Greater Philadelphia, one of the nation's oldest nonprofit home health agencies, announced its closure after more than 135 years of service.[4] Similarly, the VNA of Staten Island ceased operations after over a century of serving its community. In Maine, Andwell Health Partners—one of the state's largest home care providers—was forced to reduce its service area from 144 communities to just 58 last year, a decision driven by unsustainable payment rates.[5] These are not isolated incidents. Hundreds of agencies in other states, including,

[4] https://homehealthcarenews.com/2024/09/vna-of-greater-philadelphia-to-close-amid-unsustainable-financial-losses/
[5] https://www.modernhealthcare.com/post-acute-care/mh-medicare-home-health-rate-closures/

among others, Texas,[6] Kansas,[7] and Missouri,[8] as well as two more in New York just this spring, have also shut their doors or reduced capacity since 2023, accelerating the emergence of care deserts for vulnerable seniors and individuals with disabilities.

Home health continues to face critical workforce shortages—nurses, aides, therapists—exacerbated by rising competition from other healthcare sectors. Reduced revenue will force agencies to limit hiring, reduce wages, and shorten visits at a time when demand is only increasing. Since 2020, over 1,000 home health agencies have closed, and even more have reduced services areas in an attempt to remain financially viable. CMS Market Saturation Data show that half of all U.S. counties lost at least one home health agency between 2020–2024,[9] and over 80% of counties are treating fewer Medicare fee-for-service patients and providing fewer visits.[10] It is important to note that, unlike clinicians in other care settings, home health nurses must operate independently while managing some of our nation's most clinically complex and vulnerable patients. As a result, the impact of payment cuts on workforce shortages has a disproportionate impact on home health, where the loss of even a single nurse or therapist leaves patients at greater risk of unmet needs, adverse health consequences, and higher costs. It is also worth highlighting that since CMS released the CY 2026 Proposed Rule, the Alliance has heard from several members on the topic of increased instability among the clinical workforce who are even more uncertain about steady employment in the home health setting.

CMS analysis of home health agency cost report data from 2023, *prior to the most recent payment reductions*, indicated that over one-third of home health agencies have negative total profit margins with nearly 45% of home health agencies underwater by 2027, and nearly 60% with negative total profit margins by 2040.[11] These projections will only worsen under continued payment cuts. These steep payment reductions are likely to force the closure of rural or urban safety-net providers that already tend to have lower profit margins compared to their urban and non-safety-net counterparts, leaving patients without essential home-based options.

Home health agencies are integral to patient discharge planning and reducing hospital readmissions. Over one-third of patients referred to home health following hospital discharge did not receive it. Patients discharged from hospitals without receiving ordered home health services are 43 percent more likely to die within 90 days, 36 percent more likely to be readmitted, and 16 percent more likely to visit the emergency department.[12] Stakeholders, such as the American Hospital Association, have already expressed concern that such cuts will jeopardize continuity of

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[6] https://www.wfaa.com/article/news/health/closure-of-home-health-agency-support-center-result-in-102-layoffs/287-7d4c1006-77df-4885-9977-131abb18f781

[7] https://hospicenews.com/2024/09/20/financial-pressures-shut-down-2-hospice-agencies

[8] https://missouriindependent.com/2023/09/08/medicare-cuts-to-home-health-impede-patient-care-for-missouri-seniors/

[9] https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

[10] https://trellahealth.com/resource-center/report/home-health-accessibility-among-medicare-fee-for-service-ffs-beneficiaries/

[11] https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf-0

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

care.[13] Senator Collins (R-ME) and Senator Blackburn (R-TN) have urged CMS to pause these proposed cuts, citing the risk to fragile patient populations.[14] The proposed 9% cut to the payment rate and resulting reductions in access to home health care will increase costs to the Medicare program, put the financial strain on community health systems, and increase pressure on hospital capacity. When used, estimates show that home health care reduces costs 90-days post hospital discharge by $1.3 billion annually.[15]

This is not just a home health problem; it is a critical threat to the broader healthcare system that, if not addressed, will undermine care quality and stability across our nation's entire healthcare continuum.

Issues with the Methodology Underpinning the Proposed Payment Reductions

We continue to have concerns with the agency's approach to calculating the permanent and temporary behavior adjustments. CMS uses an approach that relies entirely on a simulation of payments under the pre-PDGM system using partial claims data from the most current year under the PDGM system. The premise that claims billed under one case-mix system—with different incentives, coding and billing rules, and units of payment—can be retrofitted seamlessly to another system accurately and without a high level of estimation error is fundamentally flawed. Notably, CMS itself acknowledged and corrected for such concerns to prevent an "overcorrection" in establishing similar adjustments under the Skilled Nursing Facility payment system for fiscal year 2023. Yet, in stark contrast, the agency disregarded similar and well-documented concerns from home health agencies about the accuracy of its approach for home health. Payment reductions resulting from this disconnect between PDGM and CMS' simulation of the former pre-PDGM payment model will continue as CMS analyzes each new year of data. The result will be subsequent unjustified cuts to home health payments and the further deterioration of patient access, care delivery, and a vital Medicare benefit.

Although CMS purports to implement Congress's instruction to measure the difference on aggregate expenditures of assumed and actual behavior changes, CMS is not accurately measuring behavior change and does not acknowledge that aggregate expenditures are decreasing year-over-year. Indeed, as Senator Collins (R-ME) and Senator Blackburn (R-TN) stated, CMS "imposed sweeping across-the-board rate reductions on HHAs that Congress never called for nor intended."[16] In fact, total Medicare fee-for-service expenditures for home health have actually *declined* by over 12 percent – from $17.9 billion in 2019 to $15.7 billion in 2023.[17] Although Congress instructed the Secretary to redistribute payments under a new case-mix adjustment methodology, move to a new 30-day unit of payment, and hold these changes budget neutral, CMS is unlawfully rebasing home health payment rates.

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[13] https://www.aha.org/lettercomment/2024-08-26-aha-comments-calendar-year-2025-home-health-prospective-payment-system-proposed-rule
[14] https://homehealthcarenews.com/2025/06/republican-senators-push-cms-to-halt-home-health-cuts-protect-medicare-hha-benefit/
[15] https://carejourney.com/how-timely-access-to-home-health-care-impacts-cost-and-outcomes/
[16] Sen. Marsha Blackburn & Sen. Susan Collins, Letter to CMS Administrator Mehmet Oz, MD (June 24, 2025)
[17] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch7_MedPAC_Report_To_Congress_SEC.pdf

In taking this approach, CMS violates the Medicare statute's plain language and arbitrarily and capriciously sets payment rates at a level that will result in substantial financial harm to numerous home health agencies across the country. Such an action is precisely the type of agency overreach and disregard for statutory limits that the Administration has sought to guard against.[18]

Fraud, Waste, and Abuse Concerns

After several years of payment rate reductions, the results indicate that these cuts have financially destabilized legitimate providers, while failing to address fraud, waste, and abuse. Furthermore, the methodology used to calculate the permanent and temporary adjustments includes claims data from fraudulent actors – potentially exacerbating the percent reductions. If this trend is not corrected, it will permanently erode the home health benefit as originally intended under Medicare, leading to care deserts and patient harm.

Since PDGM took effect in 2020, legitimate providers have struggled to survive, while criminal networks have strategically exploited the system's weaknesses to the ultimate detriment of vulnerable beneficiaries who depend on this critical Medicare benefit. The fraudulent activity driving these distortions is geographically concentrated. In Los Angeles County alone, more than 1,000 home health agencies have enrolled since 2020, despite a national reduction in home health agencies.[19] There are providers exhibiting suspect billing patterns (e.g., billing exclusively for Medicare fee-for-service beneficiaries, even in ZIP codes where Medicare Advantage penetration exceeds 60 percent). Rather than excluding these outliers, CMS includes claims data from these problematic agencies into its case-mix adjustment model and methodology used to determine the permanent and temporary adjustments. CMS further rewards some of these same suspect providers with 5 percent bonuses through the HHVBP program, even when they fail to report required quality data.

Conclusion

The proposed 9% cut to the home health payment rates for CY 2026 threatens to further destabilize an already fragile home health sector—the very setting where vulnerable Medicare beneficiaries recover, rehabilitate, and maintain independence. We strongly urge CMS to withdraw these reductions and work collaboratively with providers to address fraud, waste, and abuse while building a payment framework that sustains access, supports quality care, and invests in workforce readiness.

Thank you for your dedication to strengthening home health quality and patient access. We look forward to continued dialogue and are eager to partner in crafting equitable payment reforms.

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[18] https://www.federalregister.gov/documents/2025/05/14/2025-08384/request-for-information-rfi-ensuring-lawful-regulation-and-unleashing-innovation-to-make-american ("HHS's goal is to address regulations that are unnecessary, inconsistent with the law, overly burdensome, outdated, out of alignment with current Executive orders, or otherwise unsound.").

[19] https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

Sincerely,

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National Alliance for Care at Home

State association co-signers:

Alabama Hospice and Palliative Care Organization
Alaska Hospital and Healthcare Association
Arizona Association for Home Care
Association for Home & Hospice Care of North Carolina
California Association for Health Services at Home
Connecticut Association for Healthcare at Home
Delaware Association for Home & Community Care
Georgia Association for Home Health Agencies, Inc.
Granite State Home Health & Hospice Association
Healthcare Association of Hawaii
Home Care & Hospice Alliance of Maine
Home Care & Hospice Association of New Jersey
Home Care Alliance of Massachusetts
Home Care and Hospice Association of Colorado
Home Care Association of Florida
Home Care Association of New York State
Home Care Association of Washington
Homecare and Hospice Association of Utah
HomeCare Association of Arkansas
HomeCare Association of Louisiana
Hospice & Palliative Care Federation of Massachusetts
Hospice and Palliative Care Association of Iowa
Hospice and Palliative Care Association of New York State
Idaho Health Care Association
Illinois HomeCare & Hospice Council
Indiana Association for Home and Hospice Care
Iowa Health Care Association
Kansas Home Care & Hospice Association
Kentucky Home Care Association
Louisiana Mississippi Hospice & Palliative Care Organization
Maryland-National Capital Homecare Association
Michigan HomeCare & Hospice Association
Minnesota Home Care Association
Minnesota Network of Hospice & Palliative Care
Mississippi Association for Home Care
Missouri Alliance for Care at Home

Missouri Hospice & Palliative Care Association
Nebraska Home Care Association
Nebraska Hospice and Palliative Care Association
New Mexico Association for Home & Hospice Care
New York State Association of Health Care Providers
Ohio Council for Home Care and Hospice
Ohio Health Care Association
Oklahoma Association for Home Care & Hospice
Oklahoma Hospice & Palliative Care Organization
Oregon Association for Home Care
Pennsylvania Homecare Association
Rhode Island Partnership for Home Care
South Carolina Home Care & Hospice Association
South Dakota Association of Healthcare Organizations
Tennessee Association for Home Care
Texas ~ New Mexico Hospice and Palliative Care Organization
Texas Association for Home Care & Hospice
The Alliance for the Advancement of End-of-Life Care
Virginia Association for Home Care and Hospice
VNAs of Vermont
West Virginia Council for Home Care and Hospice
Wisconsin Association for Home Health Care