CY 2026 Home Health PPS & DME Final Rule

CMS-1828-F | Effective January 1, 2026

https://public-inspection.federalregister.gov/2025-21767.pdf

I. Overview

CMS updates Medicare home health payment rates, the Home Health Quality Reporting Program (HH QRP), and the expanded Home Health Value-Based Purchasing (HHVBP) Model. The rule also strengthens DMEPOS competitive bidding, supplier accreditation, prior authorization, and Medicare/Medicaid provider enrollment.
(Pages 1–14)

II. Home Health Prospective Payment System (HH PPS)

(Pages 8–14, 21–35)

A. Core Payment Updates

- **CY 2026 payment update: +2.4%**
- **Permanent behavior adjustment: –1.023%**
- **Temporary 2026-only adjustment: –3.0%**
- **Outlier policy:** Fixed Dollar Loss ratio updated to maintain outliers at **2.5%** of spending.

B. Case-Mix, LUPA, and Functional Adjustments

CMS finalizes recalibrated PDGM case-mix weights, updated LUPA thresholds, functional impairment levels, and comorbidity groupings.
(Pages 10–11)

C. Face-to-Face Encounter Policy

CMS aligns F2F encounter requirements with CARES Act telehealth flexibilities by revising 42 CFR 424.22(a)(1)(v).
(Page 11)

III. Home Health Quality Reporting Program (HH QRP)

(Pages 11–13)

A. Measures Removed Beginning CY 2026

- COVID-19 Vaccine “Up-to-Date” measure
- Four OASIS items removed (Living Situation, two Food items, one Utilities item)

B. Revised HHCAHPS Survey

A modernized HHCAHPS survey begins with the **April 2026** sample month.

C. Reconsideration and Compliance Updates

HHAs may request reconsideration if they can demonstrate compliance; limited extensions allowed for extraordinary circumstances (e.g., cyberattack, natural disaster).

D. OASIS All-Payer Submission Requirements

Rules clarified to require reporting for **all skilled-care patients**, not only Medicare beneficiaries.

E. RFIs and Future Quality Strategy

CMS summarizes feedback on reducing the OASIS submission window (from 4.5 months to 45 days), transitioning to digital quality measurement, FHIR adoption, and potential future measures on cognition, nutrition, interoperability, and patient well-being.

IV. Expanded Home Health Value-Based Purchasing (HHVBP) Model

(Pages 13–14)

A. Measure Set Changes

CMS finalizes:

- **Removal of three HHCAHPS measures**
- **Addition of four new measures:**
    1. Medicare Spending per Beneficiary – Post-Acute Care (MSPB-PAC)
    2. Improvement in Bathing
    3. Improvement in Upper Body Dressing
    4. Improvement in Lower Body Dressing

B. New Measure-Removal Factor

A ninth measure-removal factor is added to allow retiring measures that are no longer feasible.

C. Updated Weighting

Measure and category weights updated to reflect the revised measure set.

V. Home Health Conditions of Participation (CoPs)

(Page 14)

CMS makes technical corrections to §§484.45 and 484.55 to align terminology and ensure CoPs match the all-payer OASIS submission requirement.

VI. Provider Enrollment & Program Integrity Changes

(Pages 14–15)

CMS strengthens Medicare & Medicaid enrollment oversight:

- Expanded grounds for **denials, revocations, and deactivations**
- Expanded use of **retroactive effective dates**
- Providers and suppliers must report **adverse legal actions within 30 days** (reduced from 90 days)
- Clarifies wording in Medicaid rule §455.416

Estimated financial impact: **~$2.2B per year** in transfers to the federal government.

VII. DMEPOS Policy Changes

A. DMEPOS Supplier Accreditation Overhaul

(Pages 15–18)

Significant updates to accreditation and AO oversight:

- **Annual** accreditation surveys (vs. every 3 years)
- Standardized oversight requirements across accrediting organizations
- Greater CMS oversight and reporting requirements

Financial effects:

- ~$128M annual cost to suppliers/AOs
- ~$165M in annual AO fees
- ~$664M in annual transfers to CMS due to revocations

B. Prior Authorization Reforms

(Pages 15–16)
CMS finalizes criteria for granting and withdrawing exemptions from prior authorization requirements for DMEPOS suppliers.

Estimated savings: **~$2.5M annually.**

C. Competitive Bidding Program (CBP) Modernization

(Pages 16–20)

1. SPA Methodology

- Lead-item bid prices based on **75th percentile** of winning bids
- Non-lead items based on **local** 2015 fee schedule ratios rather than national averages

2. Inflation Adjustments

SPAs will receive an annual inflation factor beginning in contract year 2.

3. Bid Limits & Award Conditions

- Contracts may be awarded if payment amounts are **≤110%** of otherwise payable amounts
- Updated bid limits for new and previously bid items

4. Remote Item Delivery (RID) CBPs

CMS can create national or regional remote-delivery (mostly mail-order) bidding areas for items furnished from distant supplier locations.

5. Continuous Glucose Monitors & Insulin Pumps

Shift to **bundled monthly rental payments**, enabling more frequent upgrades and eliminating the 5-year replacement rule.

6. Tribal Exemption

IHS and Tribal suppliers can serve beneficiaries as non-contract suppliers within CBAs.

7. PHE Contract Termination Authority

CMS may terminate/modify CBP contracts during public health emergencies to address access problems.

VIII. Economic & Regulatory Impact Summary

(Pages 21–22)

- **Home Health PPS:** –$220M net payment change for 2026
- **HH QRP burden reductions:** $17.8M
- **HHVBP:** ~$3.376B estimated Medicare savings (2024–2027)
- **DMEPOS accreditation:** ~$128M annual cost; ~$833M in annual financial transfers
- **Provider enrollment changes:** ~$2.2B annual transfers to government

IX. Bottom Line

The CY 2026 rule continues CMS's multi-year recalibration of PDGM payments, advances quality modernization, significantly strengthens DMEPOS oversight, and expands Medicare program integrity authority. Home health agencies will experience modest baseline updates offset by substantial permanent and temporary downward adjustments, while DMEPOS suppliers face broad new compliance obligations.