CY 2027 Medicare Home Health Final Rule

Executive Summary

Released November 4, 2026

Final rule: https://public-inspection.federalregister.gov/2026-22750.pdf

1. Medicare Payment Update: Aggregate Payments Increase 2.4%

CMS estimates that Medicare payments to home health agencies (HHAs) will rise 2.4%, or approximately $415 million, in CY 2027 relative to CY 2026. This reflects a 2.1% home health payment-rate update, worth about $365 million, plus an estimated 0.3% or $50 million increase associated with recalibrated outlier payments. The final overall increase is essentially unchanged from the proposed 2.4% increase, although its dollar estimate declined from approximately $420 million to $415 million. These are national aggregate estimates; individual agencies may experience different results because of their case mix, geography, utilization, and outlier experience.

2. Additional 3% Temporary PDGM Reduction

CMS finalizes a negative 3.0% temporary adjustment to the CY 2027 national standardized 30-day payment rate, continuing the 3% temporary adjustment implemented in 2026. Its purpose is to recover retrospective Medicare overpayments attributable to the shift to 30-day payment periods and the Patient-Driven Groupings Model (PDGM). The temporary reduction is already reflected in the estimated aggregate payment impact above and should not be deducted a second time from the 2.4% estimate.

CMS does not impose a new permanent behavior adjustment for 2027. The agency concludes that claims patterns beginning in 2023 may reflect other influences—not solely PDGM-induced behavioral changes—including case-mix recalibration, OASIS-E implementation and previous rate reductions. Nevertheless, CMS continues to analyze historical spending and states that future temporary adjustments may be necessary to complete recovery of past overpayments. Thus, continued payment pressure remains a longer-term concern even with the positive 2027 aggregate update.

3. PDGM, LUPA, Wage Index and Outlier Changes

CMS recalibrates the case-mix weights across the 432 PDGM payment groups using 2025 utilization data and updates functional-impairment levels, comorbidity adjustment subgroups and low-utilization payment adjustment (LUPA) thresholds. The rule also updates geographic wage indices and national per-visit payment rates. The final fixed-dollar loss (FDL) ratio for outlier eligibility is 0.29; the statutory target caps estimated aggregate outlier payments at 2.5% of total home health payments. These technical changes can materially alter agency-level revenue despite the positive national average.

4. Medicare Enrollment and Program Integrity: Broad New Authorities

One of the rule's most consequential provisions extends well beyond home health. CMS finalizes authority to make Medicare enrollment revocations retroactive under all revocation grounds, rather than requiring certain revocations to take effect 30 days after notice. Consequently, where CMS determines that noncompliance began earlier, Medicare payments made during the intervening period may be subject to recovery. CMS estimates roughly $82 million in annual taxpayer savings from its broader enrollment integrity changes.

The rule also adds or broadens grounds for enrollment denial and revocation. Among them are failures by home health agencies, hospices and DMEPOS suppliers to reenroll and undergo required surveys or accreditation following specified changes in majority ownership; and certain license or program suspensions involving owners and managing personnel or organizations. The expanded rules strengthen CMS oversight of ownership, management and eligibility and create potential financial exposure across Medicare provider and supplier categories—not simply for HHAs.

5. Quality Reporting: Faster Data Submission and Public Reporting

Beginning with the CY 2027 Home Health Quality Reporting Program (HH QRP), CMS shortens the Outcome and Assessment Information Set (OASIS) data-submission deadline from 135 days to 45 days. CMS expects this to make public quality information available as much as three months sooner, while reporting that approximately 98% of agencies already submit within 45 days. Agencies that rely on the previous longer deadline will need tighter assessment and submission workflows.

CMS also aligns OASIS and Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) annual payment update reporting periods to a January–December calendar year and refines electronic transfer procedures for reconsideration requests. Agencies failing to meet applicable HH QRP submission requirements remain subject to the statutory two-percentage-point reduction in the annual payment update. CMS describes possible future coordination between the HH QRP and expanded Home Health Value-Based Purchasing (HHVBP) Model, but does not finalize HHVBP-specific policy changes in this rule.

6. Palliative Care Within the Home Health Benefit

CMS acknowledges that eligible beneficiaries with serious or progressive illness may receive appropriate palliative services through the Medicare home health benefit and intends to publish examples through subsequent subregulatory guidance. The rule does not establish a separate palliative-care payment benefit or eliminate existing eligibility rules. This discussion may help home health agencies and referring clinicians distinguish covered home health services from hospice care and assess appropriate care planning for patients with complex needs.

7. Home Infusion: Expansion of Covered DME

Effective April 1, 2027, the rule implements the Consolidated Appropriations Act, 2026 expansion of the Medicare Part B durable medical equipment benefit to certain external infusion pumps, associated home infusion drugs and supplies even when they would not otherwise satisfy the traditional "appropriate for use in the home" DME criterion. Coverage requires, among other factors, FDA-approved labeling specifying administration by or under supervision of a health professional, administration or supervision by a qualified home infusion therapy supplier in the home, and sufficiently frequent infusion. Notably, CMS finalizes "at least 12 times per year" instead of the proposed once-per-month threshold, allowing greater scheduling flexibility. CMS does not narrowly

define which eligible health professional may supervise administration, subject to scope-of-practice requirements.

8. DMEPOS Replacements and Supplier Reporting

For an identical replacement DMEPOS item falling under the same HCPCS code, CMS clarifies that a new comprehensive face-to-face encounter is not required solely for replacement. The original face-to-face encounter and medical-necessity documentation must remain available to substantiate claims, particularly during audits. A different item required because of a changed clinical condition does not qualify as an identical replacement under this clarification.

CMS also describes changes to DMEPOS Competitive Bidding Program information collection under which contracted suppliers report the country of origin of lead items furnished. The information is intended to appear in the Medicare Supplier Directory after the relevant approval and implementation process; it should not be treated as an immediately operative requirement based solely on this final rule.

9. Issues Deferred Rather Than Finalized

CMS solicited input on a potential home-health-specific wage index based on sources such as Bureau of Labor Statistics data, but did not finalize a new wage-index methodology. The agency likewise sought views on future quality measures, including advance care planning, without adopting a new measure in this rule. No change specific to the expanded HHVBP Model was finalized. These issues warrant monitoring but should not be mistaken for new CY 2027 compliance obligations.

Executive Implications

For home health organizations, the principal near-term effects are a modest national increase in total payments, continued PDGM recoupment through a 3% temporary rate adjustment, and case-mix and outlier changes that produce variation among agencies. The broader Medicare sector should pay particular attention to retroactive enrollment revocation and ownership-related compliance provisions. Home health operators should also be prepared for the 45-day OASIS deadline, while home infusion providers and referral partners assess the expanded Part B benefit effective April 2027.

Sources: CMS-1844-F, final rule (Federal Register public-inspection version); CMS fact sheet, November 4, 2026; CMS-1844-P proposed-rule fact sheet, July 1, 2026.