CY 2027 Home Health PPS Proposed Rule

Executive Briefing

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About This Executive Briefing

Purpose

This Executive Briefing has been prepared to help home health executives, clinical and financial leaders, and other industry professionals better understand the key provisions of the CY 2027 Home Health PPS Proposed Rule and their potential financial and operational implications for Medicare-certified home health agencies.

Rather than simply summarizing the Proposed Rule, this publication focuses on explaining the issues most likely to influence strategic decision-making, financial performance, and operational planning.

This Executive Briefing is intended to provide practical insight into CMS's proposals while distinguishing between national policy changes and the potential impact on individual agencies.

Where appropriate, additional technical reference material is provided in the accompanying **Companion Reference Appendices**.

Intended Audience

- Owners
- CEOs
- CFOs
- Administrators
- DONs
- Clinical Managers
- Financial Managers
- Advisory Boards
- Reimbursement Professionals
- Investors
- Attorneys serving the home health industry

Scope

This Executive Briefing focuses primarily on Medicare reimbursement, financial, and operational provisions contained in the CY 2027 Home Health PPS Proposed Rule. It is intended as an educational resource and should not be considered legal, accounting, or reimbursement advice for any specific organization.

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Purpose of This Executive Briefing

Each year, the Centers for Medicare & Medicaid Services (CMS) issues a Proposed Rule outlining potential changes to the Home Health Prospective Payment System (HH PPS). While these proposals are often viewed primarily through the lens of reimbursement, they can also influence operational planning and strategic priorities, ultimately affecting the clinical and financial performance of Medicare-certified home health agencies.

Understanding those changes, however, requires more than merely reading the Proposed Rule.

The purpose of this Executive Briefing is to help home health executives quickly understand the financial and operational implications of the Proposed Rule, identify the issues most likely to affect their organizations, and provide context that supports informed decision-making.

Rather than attempting to summarize every provision of the Proposed Rule, this Briefing focuses on the changes that are most relevant to agency leadership. It highlights what matters most, explains why those changes merit attention, and encourages readers to look beyond the headlines to consider how national policy may translate into agency-specific outcomes.

Because no two agencies are exactly alike, the impact of a Proposed Rule can vary significantly depending on an organization's patient population, geography, staffing model, operational characteristics, and other factors. National projections provide important context, but they should never be interpreted as predictions of how any individual agency is likely to perform.

This Executive Briefing is intended to become an annual publication accompanying each Home Health PPS Proposed Rule. While each edition reflects the specific proposals for that year, the broader objective remains the same: to help agency leaders better understand the financial and operational implications of Medicare policy, encourage more informed discussion, and support better decision-making across the home health industry.

Focus of This Analysis

This Executive Briefing is authored by John Reisinger, CPA, Principal at Innovative Financial Solutions for Home Health (IFS4hh), and draws on more than three decades of experience in Medicare reimbursement, financial management, operational strategy, and executive leadership in the home health industry.

The perspective presented throughout this publication is intentionally focused on the financial and operational implications of the Home Health Prospective Payment System (HH PPS) Proposed Rule. Particular emphasis is placed on Medicare reimbursement, organizational performance, strategic planning, and the practical decisions agency leaders may need to consider as CMS policies evolve.

The Proposed Rule also includes provisions related to clinical practice, quality reporting, patient assessment, compliance, and other areas that extend beyond the primary focus of this Executive Briefing. These topics are acknowledged where appropriate and noted for readers' awareness, but they are generally discussed only to the extent that they may influence financial performance, operational effectiveness, or executive decision-making.

This publication is not intended to evaluate the clinical merits of proposed policy changes or to replace the expertise of clinicians, quality professionals, compliance specialists, legal counsel, or other subject-matter experts. Rather, it is intended to complement those perspectives by examining how proposed Medicare policy changes may affect the operations of a home health agency.

Every Proposed Rule typically spans hundreds of pages of regulatory language and supporting discussion. The objective of this Executive Briefing is not to cover every detail but to help agency leaders identify the issues most likely to affect their organizations, understand their potential implications, and make more informed decisions as they prepare for the future.

Understanding the Rule-Making Process

Why Understanding the Process Matters

Each year, CMS issues a Proposed Rule outlining potential changes to the Home Health Prospective Payment System (HH PPS). For most home health leaders, the immediate question is understandable:

"What does this mean for my agency?"

That is an important question. However, there is another question that often receives far less attention:

"How did we get here?"

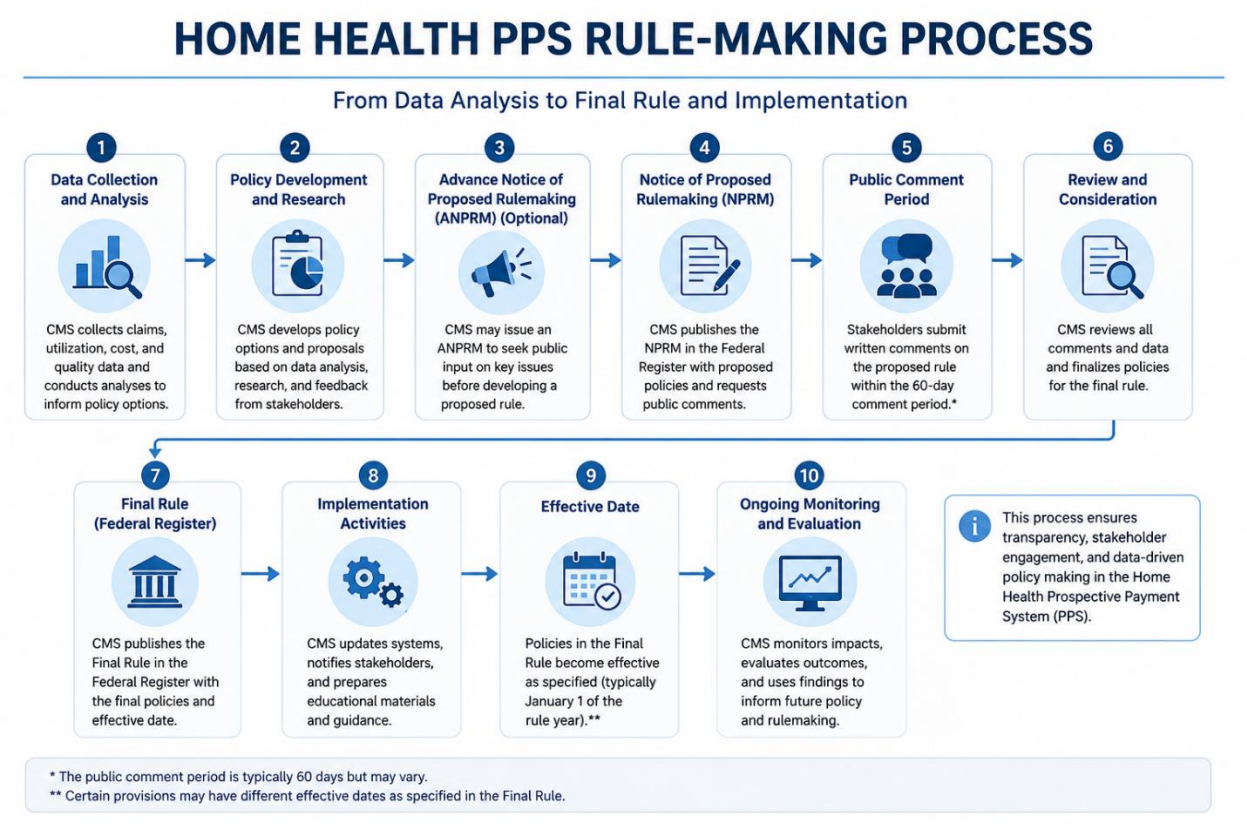
The answer matters because Medicare policy is not developed in isolation. It evolves through an ongoing process that includes legislation, research, data analysis, recommendations from advisory organizations, public input, and CMS's ongoing evaluation of how payment policies affect beneficiaries, providers, and the Medicare program.

Understanding that process provides valuable context for interpreting the Proposed Rule. It helps explain why CMS is considering specific policy changes, why certain proposals vary from year to year, and why some proposals are modified—or even withdrawn—before they become final.

For many providers, the Proposed Rule is seen as a preview of what CMS intends to do next year. In reality, it serves a broader purpose. It offers CMS an opportunity to present its proposals, explain the reasoning behind them, and invite feedback from the organizations and professionals who will ultimately implement those policies. Whether or not a proposal changes before it becomes final, the comment process is an important part of how CMS evaluates the potential impact of its proposals and considers perspectives across the industry.

The Rule-Making Process is therefore more than a regulatory requirement. It is an ongoing conversation between policymakers and the providers responsible for delivering care to Medicare beneficiaries. Understanding that dialogue helps agency leaders interpret policy more thoughtfully, evaluate its potential impact more effectively, and participate more actively in discussions about the future of home health care.

The diagram below illustrates the major stages of the Rule-Making Process and highlights where stakeholder input enters the discussion. While the process itself is straightforward, understanding its purpose provides a valuable perspective for interpreting not only this Proposed Rule but also future Proposed and Final Rules.



What It Means for Agency Leaders

Should Agencies View the CY 2027 Proposed Rule as Good News?

At first glance, the CY 2027 Home Health Prospective Payment System (HH PPS) Proposed Rule appears to offer encouraging news for most home health agencies.

CMS has proposed a modest increase in Medicare home health spending for CY 2027, **no additional permanent behavioral adjustment, and continuation of the temporary behavioral adjustment through a proposed 3.0 percent reduction in the national standardized 30-day payment amount, with** relatively few structural changes compared with recent years.

For many providers, those headlines alone may suggest the industry is entering a period of greater stability after several years of significant payment policy changes.

There are certainly positive elements in this Proposed Rule.

However, the most important question is not whether the Proposed Rule appears favorable at the national level.

The more important question is:

What does the Proposed Rule mean for your agency?

That distinction is fundamental.

One of the first lessons I learned while working with Medicare reimbursement was that CMS and agency leaders often evaluate the same policy from two very different perspectives. CMS must evaluate policy at the national level, while agency leaders must make decisions at the agency level. Understanding the difference between those perspectives is essential to understanding any Proposed Rule.

Two agencies serving the same communities can experience very different financial outcomes under the same Proposed Rule. Although both agencies may be subject to the same wage index, differences in patient characteristics, case-mix, utilization patterns, and operational practices can produce markedly different financial results. National estimates provide valuable context, but they should never be mistaken for agency-specific projections.

Throughout this Executive Briefing, the focus will remain on understanding what the Proposed Rule may mean for an individual home health agency. Rather than simply describing what CMS has proposed, our objective is to examine why those proposals matter, where they may have the greatest operational and financial implications, and which questions agency leaders should ask as they evaluate the potential impact on their organizations.

What It Means for Agency Leaders

Why Won't Every Agency Experience the Same Result?

One of the most common misconceptions about the annual Home Health PPS Proposed Rule is the belief that CMS's national payment estimates accurately predict the financial impact an individual agency should expect.

They do not.

National projections are not agency projections.

Since the Home Health Prospective Payment System was implemented in 2000, CMS's published payment estimates have consistently reflected projected changes for the home health industry as a whole—not for individual agencies.

CMS's estimates describe the expected impact on the home health industry, based on national assumptions, aggregated claims data, and projected changes across thousands of agencies.

However, individual agencies operate under very different circumstances.

Every home health agency serves a distinct patient population and operates under a unique combination of clinical, operational, and financial circumstances. These differences influence how changes in Medicare policy ultimately affect reimbursement and financial performance at the agency level.

Even agencies serving the same communities can experience very different financial outcomes under the same Proposed Rule. Although both agencies may be subject to the same wage index, differences in patient characteristics, case-mix, utilization patterns, and operational practices can lead to markedly different financial results. National estimates provide valuable context, but they should never be mistaken for agency-specific projections.

This is one reason agency-specific analysis is so important.

A national payment estimate may provide useful context, but it cannot answer the question most executives ultimately need to have answered:

"What will this Proposed Rule mean for my agency?"

That question can be answered only by evaluating an agency's own data.

Accordingly, the remainder of this Executive Briefing focuses not simply on what CMS has proposed, but on understanding how those proposals may influence the financial and operational performance of individual home health agencies.

What It Means for Agency Leaders

What Does the CMS Projected Change in Home Health Spending Really Mean?

One of the first figures most readers look for in any Home Health PPS Proposed Rule is CMS's projected change in Medicare home health spending.

For CY 2027, CMS estimates that the Proposed Rule will increase Medicare home health spending by approximately 2.4%, or about $420 million across the home health industry.

At first glance, that appears to be straightforward.

It isn't.

The challenge is that many readers naturally assume this projected change in home health spending reflects the payment change their agency should expect.

It does not.

The projected change in Medicare home health spending reflects CMS's estimate of the overall financial impact of the Proposed Rule across the home health industry. It is a macro-level projection based on national data, national assumptions, and the expected collective effect of the proposed policy changes.

It is not an estimate of the change in Medicare payments that an individual home health agency should expect, such as a 2.4% increase for CY 2027.

That distinction is one of the most important concepts for understanding any Home Health PPS Proposed Rule.

An individual agency's financial experience will ultimately depend on how the proposed payment policies interact with its patient population, case mix, referral patterns, utilization, geographic location, wage index, and operational characteristics.

Consequently, two agencies may experience substantially different financial outcomes under the same Proposed Rule—even when they operate in the same geographic market.

The CMS projected change in home health spending should therefore be viewed as an important indicator of the Proposed Rule's overall direction, not as a prediction of how an individual agency's future Medicare revenues will change.

Understanding that distinction provides the foundation for evaluating each significant payment provision discussed throughout the rest of this Executive Briefing.



Which Proposed Changes Matter Most?

Case-Mix Weights (CMWs)

Why This Matters

Case-Mix Weights (CMWs) are among the primary factors CMS uses to differentiate Medicare payments across patient classifications under the Patient-Driven Groupings Model (PDGM). Consequently, changes to these weights can have a meaningful effect on Medicare reimbursement for individual home health agencies.

Understanding how Case-Mix Weights work—and how they change from year to year—is essential to understanding why agencies may experience very different financial outcomes under the same Proposed Rule.

Part 1 — Understanding the Mechanics

What Is a Case-Mix Weight?

Under the Patient-Driven Groupings Model (PDGM), each of the 432 Home Health Resource Groups (HIPPS Codes) is assigned a single Case-Mix Weight (CMW).

Throughout this Executive Briefing, **Case-Mix Weight** will be abbreviated as **CMW**.

John's Definition

A Case-Mix Weight (CMW) is a numeric representation of a patient's acuity level. It reflects CMS's estimate of the relative resources required to care for one patient classification compared with all other patient classifications under PDGM.

Generally, the higher the CMW, the greater the patient's relative acuity, expected resource utilization, and Medicare payment. Conversely, the lower the CMW, the lower the expected resource utilization and associated Medicare payment.

This is the author's working definition, intended to aid understanding. It is not CMS's formal definition.

Understanding the Relationship

Each of the 432 HIPPS Codes is assigned a single Case-Mix Weight. These weights are set annually by CMS and apply uniformly to all Medicare-certified home health agencies.

Although every Medicare-certified home health agency uses the same Case-Mix Weights, no two agencies have identical distributions of HIPPS Codes. That difference is one reason the financial impact of the Proposed Rule varies from one agency to another.

Because Case-Mix Weights directly affect Medicare payments, even relatively small changes can have meaningful financial implications for agencies whose patient populations are concentrated in the affected classifications.

Illustrative Excerpt

A portion of the complete national Case-Mix Weight table is shown below to illustrate the changes discussed in this section. See ***Companion Reference Appendix C – National Case-Mix Weight Changes*** *for the complete table.*

PY-CY CMW % Δs

HIPPS	Clinical Group and Functional Level	Timing and Admission Source	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	(per 2027 - P Rule) CY 2027 Weight	(per 2026 - F Rule) CY 2026 Weight	Δ	% Δ
1AA11	MMTA - Other - Low	Early - Community	0	0.9153	0.9148	0.0005	0.1%
1AA21	MMTA - Other - Low	Early - Community	1	0.9734	0.9715	0.0019	0.2%
1AA31	MMTA - Other - Low	Early - Community	2	1.1271	1.1137	0.0134	1.2%
1AB11	MMTA - Other - Medium	Early - Community	0	0.9931	1.0031	-0.0100	-1.0%
1AB21	MMTA - Other - Medium	Early - Community	1	1.0512	1.0599	-0.0087	-0.8%
1AB31	MMTA - Other - Medium	Early - Community	2	1.2048	1.2021	0.0027	0.2%

Patient Assessment (OASIS)

⬇

HIPPS Code

⬇

Case-Mix Weight (CMW)

⬇

30-Day Medicare Payment

Part 2 — Understanding the Implications

Why Case-Mix Weight Changes Matter

For CY 2027, CMS proposes changes to 431 of the 432 Case-Mix Weights. Of those, 230 increase and 201 decrease. Together, these revisions represent CMS's proposed changes to the relative payments assigned to different patient classifications under PDGM.

Notable Case-Mix Weight Changes

Viewing all 432 proposed Case-Mix Weight changes individually can make it difficult to recognize broader patterns. One way to better understand the overall direction of the proposed changes is to examine the average Case-Mix Weight change for each Clinical Group. See the following illustration:

Illustrative Excerpt

%Δ in CMW Avgs by Clinical Grouing

	Case-Mix Weights			
	2027	2026	Δ	%Δ
MMTA - Other	1.0968	1.0938	0.0030	0.3%
Neuro	1.2348	1.2336	0.0012	0.1%
Wound	1.4830	1.5229	-0.0398	-2.6%
Complex	1.0631	1.0660	-0.0029	-0.3%
MS Rehab	1.1406	1.1295	0.0111	1.0%
Behavioral Health	1.0671	1.0707	-0.0035	-0.3%
MMTA - Surgical Aftercare	1.1022	1.1093	-0.0070	-0.6%
MMTA - Cardiac	1.0924	1.0852	0.0072	0.7%
MMTA - Endocrine	1.3490	1.3352	0.0138	1.0%
MMTA - GI/GU	1.0876	1.0834	0.0042	0.4%
MMTA - Infectious	1.1113	1.1122	-0.0009	-0.1%
MMTA - Respiratory	1.0991	1.0968	0.0022	0.2%

Δ - Change

Note:
There are 36 HIPPS Codes/CMWs in each Clinical Grouping.

The table above summarizes the average proposed changes to Case-Mix Weight by Clinical Group.

The Clinical Group summary shown above is intended to identify broad trends. Individual HIPPS Codes within each Clinical Group may change in ways that differ from the group's average.

To review the proposed changes to all 432 Case-Mix Weights, see Companion Reference Appendix C – National Case-Mix Weight Changes.

John's Observation

Although the Home Health PPS Proposed Rule is often viewed primarily as a financial document, many of its payment provisions are directly shaped by clinical classification, patient assessment, and OASIS-based patient characteristics.

The financial implications of changes to Case-Mix Weight can be quantified. However, determining whether those changes appropriately reflect patient complexity and expected resource utilization requires clinical expertise and a detailed understanding of OASIS scoring, patient assessment, and care delivery. That level of clinical analysis is beyond the scope of this Executive Briefing.

Example

Consider two agencies serving the same community.

Agency A primarily admits orthopedic patients following joint replacement or repair surgery.

Agency B primarily admits patients for wound care, diabetes management, and ostomy care.

Although both agencies operate under the same wage index and the same national payment rule, changes in Case-Mix Weights will affect them very differently because their patient populations have significantly different clinical characteristics.

Neither agency is "right" or "wrong." They serve different patient populations with distinct clinical characteristics. Examples like this illustrate why every agency should evaluate the Proposed Rule using its own patient data rather than relying solely on national payment projections.

Key Takeaway

Patient mix is one of the primary reasons national payment projections cannot predict an individual agency's financial impact.

Transition to the Next Topic

Case-Mix Weights help explain how patient characteristics influence Medicare reimbursement. The next major component affecting Medicare payment is the wage index, which adjusts payments to reflect geographic differences in labor costs. Together, these two factors account for much of the variation in payment among agencies.

Wage Index

Why This Matters

The Wage Index is one of the primary factors CMS uses to adjust Medicare payment rates to account for geographic differences in labor costs. Although every Medicare-certified home health agency operates under the same Home Health Prospective Payment System (HH PPS), the cost of employing staff can vary considerably across geographic markets.

The purpose of the Wage Index is to account for those differences.

Consequently, two agencies caring for patients assigned the same HIPPS Code may receive different Medicare payment rates—not because those patients require different resources, but because the cost of care differs across the two labor markets.

Understanding how the Wage Index works is essential to understanding why agencies in different labor markets will receive different Medicare payment rates for the same HIPPS Code under the same Proposed Rule.

Part 1 — Understanding the Mechanics

What Is the Wage Index?

CMS adjusts the labor-related portion of each Medicare home health payment to reflect geographic differences in labor costs. This adjustment uses the Medicare Wage Index for the agency's Core-Based Statistical Area (CBSA) or rural service area.

John's Definition

The Wage Index is CMS's method for adjusting the labor-related portion of Medicare payment rates to account for differences in labor costs across geographic markets. Its purpose is to help ensure that agencies receive payments that reflect local labor costs.

This is the author's working definition, intended to aid understanding. It is not CMS's formal definition.

CMS's formal description of the Wage Index appears in the ***Companion Reference Appendix D – National Wage Index Changes and CMS Definition****. The working definition above is intended to explain the concept in practical terms, not to replace CMS's regulatory language.*

Connecting Case-Mix Weights and the Wage Index

The Case-Mix Weight determines the standardized Medicare payment for a patient's HIPPS Code. The Wage Index then adjusts the labor-related portion of that payment to reflect local labor cost differences. Together, these two components account for much of the variation in Medicare payments among home health agencies.

Understanding the Relationship

Consider two patients assigned the same HIPPS Code and, therefore, the same Case-Mix Weight. From Medicare's perspective, those patients are expected to require comparable resources and would receive the same standardized Medicare payment before geographic adjustments are applied.

However, if those patients receive care in different labor markets, the final Medicare payment rates will differ because approximately 74.9% of the payment is adjusted by the applicable Wage Index for each geographic area.

CMS has determined that approximately 74.9% of each 30-day Medicare payment rate is attributable to labor-related costs. Because labor costs vary across geographic markets, this portion of the payment is adjusted by the applicable Wage Index.

The remaining 25.1% of the payment rate is classified as non-labor-related and therefore is not adjusted for geographic labor cost differences. As a result, this portion of the payment remains the same regardless of where services are provided.

Example

Consider two Medicare beneficiaries assigned the same HIPPS Code.

One patient receives home health care in **Oakland, California**.

The other receives the same services in **Rural Mississippi**.

Because both patients share the same HIPPS Code and Case-Mix Weight, they start with the same standardized Medicare payment.

The final Medicare payment rates, however, will differ because the labor-related portion of each payment is adjusted by the Wage Index for each geographic market.

The patient in Oakland is not expected to require additional visits, supplies, or more complex care than the patient in Rural Mississippi. The payment difference reflects CMS's recognition that employing staff costs more in one labor market than in another.

Illustrative Excerpt

Change in the Wage Indices per the CY 2027 HH PPS Proposed Rule:

CBSA Code	Name of CBSA/Rural Service Area:	CY 2027P HH PPS Wage Index With 5% Cap	Change in WI: Δ	Change in WI: % Δ	CY 2026 HH PPS Wage Index With 5% Cap
10180	Abilene, TX	0.9789	0.0502	5.405%	0.9287
10380	Aguadilla, PR	0.2985	0.0076	2.613%	0.2909
10420	Akron, OH	0.8213	-0.0041	-0.497%	0.8254
10500	Albany, GA	0.9029	-0.0475	-4.998%	0.9504
10540	Albany, OR	1.0476	0.0027	0.258%	1.0449
10580	Albany-Schenectady-Troy, NY	0.8453	-0.0098	-1.146%	0.8551

The excerpt above is from the complete national Wage Index table. See Companion Reference Appendix D – National Wage Index Changes and CMS Definition for the complete national Wage Index table.

Part 2 — Understanding the Implications

Why Wage Index Changes Matter

Although the Wage Index is applied uniformly across the Home Health PPS, the Wage Index assigned to a particular CBSA or rural service area may change from year to year. As a result, agencies serving similar patients may receive different Medicare payment rates simply because the labor-related adjustment for their market has changed.

Unlike Case-Mix Weights, which adjust payment based on patient characteristics, the Wage Index adjusts payment based on geographic labor costs. Together, these two components account for much of the variation in Medicare payments among home health agencies.

Distribution of Proposed CY 2027 Wage Index Changes

Viewing all proposed Wage Index changes individually can make it difficult to recognize broader patterns. One way to better understand the overall direction of the proposed changes is to examine how many CBSAs and rural service areas have experienced increases or decreases across various percentage thresholds. See the following example:

Distribution of Proposed CY 2027 Wage Index Changes

Increases	Count	Decreases	Count
> 1.0%	146	< -1.0%	229
> 2.4%	106	< -1.5%	205
> 5.0%	44	< -2.0%	177
> 7.5%	22	< -2.5%	151
> 10.0%	11	< -3.0%	129
> 15.0%	3	< -4.0%	95
> 20.0%	1	< -5.0%	42

Note: Illustrative summary of the number of CBSAs and rural service areas experiencing Wage Index increases or decreases at various percentage thresholds. See Reference Appendix D for the complete national Wage Index table.

The excerpt above is from the table in Appendix D, which lists the number of Wage Index changes exceeding each threshold identified above for 2027. See Companion Reference Appendix D – National Wage Index Changes and CMS Definition for the complete national Wage Index table.

John's Observation

Although Wage Index changes often receive less attention than payment updates, they can meaningfully affect agency reimbursement because they directly influence the labor-related portion of every Medicare payment.

Key Takeaway

Changes in the Wage Index are another reason national payment projections cannot accurately predict an individual agency's financial impact.

Understanding Two Primary Drivers of Medicare Payment

Component	Purpose
Case-Mix Weight	Reflects differences in patient characteristics and expected resource requirements.

Component	Purpose
Wage Index	Reflects differences in geographic labor costs.

Together, these two factors explain most of the variation in Medicare payments across home health agencies.

Transition to the Next Topic

Case-Mix Weights explain differences among patients, and Wage Indices explain differences among labor markets. Together, they form the foundation for understanding how CMS calculates Medicare payment rates under the Home Health PPS. The next section examines how these components—and other required adjustments—combine to determine the final standardized payment amounts proposed for CY 2027.

Standardized Payment Amounts (Payment Update)

Why This Matters

Each year, CMS publishes an updated national standardized Medicare payment amount for home health services. This payment amount is among the most closely watched figures in the Proposed Rule because it sets the foundation for Medicare reimbursement for the upcoming year.

The proposed payment amount, however, is not the result of a single adjustment. Rather, it reflects the combined effect of multiple statutory and regulatory provisions, each designed to address a different aspect of the Home Health Prospective Payment System.

Understanding **why** each adjustment is applied—and how they work together—is far more valuable than simply knowing the final proposed payment amount.

Part 1 — Understanding the Mechanics

How Does CMS Determine the Medicare Payment Amount Proposed for Next Year?

The national standardized 30-day payment amount published each year is determined through a series of required payment adjustments. Some adjustments reflect changes in the cost of providing care, while others are intended to maintain budget neutrality or implement other statutory payment policies.

The result is a single national standardized payment amount that serves as the starting point for determining Medicare payments for each 30-day payment period.

Although the calculation itself is straightforward, understanding why each adjustment is included offers much greater insight into how Medicare payment policy evolves year to year.

Why Is a Market Basket Update Applied?

The Home Health Market Basket Update is intended to reflect annual changes in the cost of providing home health services. Because inflation varies from year to year, the Market Basket Update also changes from year to year.

The Market Basket Update helps ensure that Medicare payments continue to reflect changes in the cost of delivering care.

Why Does CMS Apply a Productivity Adjustment?

Federal law requires CMS to reduce the Market Basket Update by a productivity adjustment that reflects economy-wide productivity improvements.

As a result, the annual payment update that home health agencies receive is generally less than the Market Basket Update alone.

Why Are Budget Neutrality Adjustments Applied?

Certain payment adjustments are required to maintain budget neutrality in the Home Health Prospective Payment System. These adjustments help ensure that changes to the payment methodology do not unintentionally increase or decrease overall Medicare expenditures beyond CMS's intent.

For CY 2027, these adjustments include both a Case-Mix Budget Neutrality Adjustment and a Wage Index Budget Neutrality Adjustment, which reflect the payment components discussed in the two preceding sections.

What Is CMS Proposing Regarding the Behavioral Adjustment for CY 2027?

One of the most widely discussed aspects of the CY 2027 Proposed Rule is the Behavioral Adjustment. Many summaries state that CMS is not proposing a Behavioral Adjustment for CY 2027. That statement requires clarification.

CMS is **not proposing an additional permanent Behavioral Adjustment** for CY 2027.

However, CMS is proposing to continue the temporary Behavioral Adjustment by applying a 3.0 percent reduction to the national standardized 30-day payment amount, as part of CMS's ongoing effort to recoup payments CMS has determined exceeded budget-neutral implementation assumptions under PDGM.

Understanding the distinction between permanent and temporary Behavioral Adjustments is important because both affect Medicare reimbursement, yet they stem from different policy considerations.

This distinction illustrates an important principle discussed throughout this Executive Briefing: understanding the headlines is helpful, but understanding the details is essential.

How CMS Calculates the Proposed CY 2027 National Standardized 30-Day Payment Amount

The following table summarizes the sequence of statutory and regulatory adjustments CMS uses to calculate the proposed CY 2027 national standardized 30-day payment amount for agencies that submit the required quality data.

TABLE 26: PROPOSED CY 2027 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2026 National Standardized 30-Day Period Payment Without Temporary Adjustment	CY 2027 Case-Mix Weights Recalibration Neutrality Factor	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 Proposed HH Payment Update Factor	CY 2027 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2027 Proposed National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,101.26	1.0045	1.0009	1.021	$2,156.98	0.9700	$2,092.27

The proposed CY 2027 national standardized 30-day period payment rate for an HHA

What Happens if Required Quality Data Are Not Submitted?

Federal law requires CMS to reduce the standardized payment amount for agencies that fail to submit the required quality data. For home health agencies, the required quality data include OASIS assessment data, Home Health CAHPS survey data, and applicable quality information submitted via Medicare claims.

Failure to meet these reporting requirements results in a 2-percentage-point reduction in the annual payment update.

The following table illustrates the resulting payment calculation.

TABLE 27: PROPOSED CY 2027 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA

CY 2026 National Standardized 30-Day Period Payment Without Temporary Adjustment	CY 2027 Case-Mix Weights Recalibration Neutrality Factor	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 HH Payment Update Factor Minus 2 Percentage Points	CY 2027 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2027 National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,101.26	1.0045	1.0009	1.001	$2,114.73	0.970	$2,051.29

For convenience, these tables are also reproduced in the Companion Reference Appendices (A and B).

John's Observation

Although the annual payment update receives considerable attention each year, it is only one component of the Medicare payment calculation. The financial impact on an individual agency ultimately depends on how this national payment update interacts with the agency's patient mix, geographic location, quality reporting status, and operational characteristics.

Key Takeaway

The published national standardized payment amount sets the starting point for Medicare reimbursement, not the payment an individual agency should expect to receive.

Transition to the Next Topic

The national standardized payment amount forms the basis for Medicare reimbursement. The following sections examine additional payment provisions—including Low Utilization Payment Adjustments (LUPAs) and Outliers.

Low Utilization Payment Adjustments (LUPAs)

Why This Matters

Most Medicare home health 30-day payment periods are reimbursed under the standard Prospective Payment System (PPS) methodology. However, under certain circumstances, Medicare reimburses agencies using an alternative payment methodology known as the **Low Utilization Payment Adjustment (LUPA).**

Because LUPA payment periods are reimbursed differently from standard PPS payment periods, proposed changes to LUPA Thresholds and national per-visit payment rates may affect Medicare reimbursement for some home health agencies.

Understanding when a LUPA occurs—and how it is reimbursed—is generally more valuable for executive decision-making than understanding the detailed payment calculations.

Part 1 — Understanding the Mechanics

What Is a LUPA?

A Low Utilization Payment Adjustment (LUPA) is an alternative Medicare payment methodology that applies when the number of qualifying visits during a 30-day payment period is below the LUPA Threshold for the assigned HIPPS Code.

Instead of receiving the standard Medicare PPS payment for that 30-day period, the agency is reimbursed under Medicare's LUPA payment methodology.

How Does CMS Determine When a LUPA Applies?

Each of the 432 HIPPS Codes under PDGM is assigned one—and only one—LUPA Threshold. That threshold is the minimum number of qualifying visits required during a 30-day payment period for the encounter to receive the full Medicare PPS payment.

If the total number of qualifying visits during the payment period is below the assigned LUPA Threshold, Medicare reimburses the encounter under the LUPA payment methodology rather than the standard PPS payment methodology.

Illustrative Excerpt

The excerpt below is from the complete national LUPA Threshold table. See ***Companion Reference Appendix E – National LUPA Thresholds*** *for the complete table.*

PDGM Home Health Resource Groups (HHRGs): Case-Mix Weights and					
HIPPS	Clinical Group and Functional Level	Timing and Admission Source	2027 - P LUPA Thresholds	Δ	2026 - F LUPA Thresholds
1AA11	MMTA - Other - Low	Early - Community	3	0	3
1AA21	MMTA - Other - Low	Early - Community	3	0	3
1AA31	MMTA - Other - Low	Early - Community	3	0	3
1AB11	MMTA - Other - Medium	Early - Community	4	0	4
1AB21	MMTA - Other - Medium	Early - Community	4	0	4
1AB31	MMTA - Other - Medium	Early - Community	4	1	3

Executive Summary of Proposed CY 2027 LUPA Threshold Changes

Of the **432 LUPA Thresholds** proposed for CY 2027:

- **19** increase,
- **17** decrease, and
- **396** remain unchanged.

Although relatively few LUPA Thresholds change from the prior year, even a single threshold change may alter reimbursement for certain patient classifications when utilization falls below the required visit count.

LUPA Thresholds by Visit Count:

Visit Count	2027 Proposed	2026 Final
# @ 2	123	119
# @ 3	154	165
# @ 4	141	134
# @ 5	13	14
# @ 6	0	0
	431	432

+ 1 @ 3.5 ?

*The proposed CY 2027 LUPA Thresholds range from **2 to 5 visits**, with one threshold currently set at **3.5 visits** pending CMS clarification. The complete national LUPA Threshold table is included in **Companion Reference Appendix E – National LUPA Thresholds**.*

How Are LUPA Payments Determined?

When a 30-day payment period qualifies as a LUPA, Medicare no longer pays the full PPS payment associated with the assigned HIPPS Code. Instead, payment is determined using the national discipline-specific per-visit payment rates established annually by CMS.

The LUPA payment is calculated by multiplying the number of qualifying visits provided by each discipline by the applicable national per-visit payment rate for that discipline. The resulting discipline-specific payment amounts are then combined to determine the total LUPA payment before any applicable LUPA Add-on payment is considered.

Proposed CY 2027 National LUPA Per-Visit Payment Rates

The following table summarizes the proposed national per-visit payment rates for CY 2027.

TABLE 28: PROPOSED CY 2027 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2026 Per-Visit Payment Amount	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 HH Payment Update Factor	CY 2027 Per-Visit Payment Amount
Home Health Aide	$80.12	0.9997	1.021	$81.78
Medical Social Services	$283.64	0.9997	1.021	$289.51
Occupational Therapy	$194.74	0.9997	1.021	$198.77
Physical Therapy	$193.42	0.9997	1.021	$197.42
Skilled Nursing	$176.96	0.9997	1.021	$180.62
Speech-Language Pathology	$210.25	0.9997	1.021	$214.60

CMS also publishes reduced LUPA per-visit payment rates for agencies that fail to submit the required quality data. These rates are included in ***Companion Reference Appendix F – National LUPA Per-Visit Payment Rates (Agencies Not Submitting Required Quality Data).***

What Is the LUPA Add-on?

Certain LUPA payment periods qualify for an additional Medicare payment intended to recognize the additional time and resources typically required for the initial comprehensive patient assessment.

When applicable, the **LUPA Add-on Factor** is applied only to the **first qualifying visit** of the **first eligible 30-day payment period.** Any subsequent visits during that same payment period are reimbursed using the standard LUPA per-visit payment rate applicable to the discipline providing the service.

LUPA Add-on Factors

TABLE 30: LUPA ADD-ON FACTORS

Discipline	LUPA Add-on Factors
SN	1.7200
PT	1.6225
SLP	1.6696
OT	1.7238

Example

If the first qualifying visit of an eligible LUPA payment period is performed by a **Registered Nurse**, that visit is reimbursed using the Registered Nurse LUPA per-visit payment rate multiplied by the Registered Nurse LUPA Add-on Factor. Any subsequent visits during that same LUPA payment period are reimbursed using the standard LUPA per-visit payment rate applicable to the discipline providing the service.

John's Observation

Understanding how LUPA payments are calculated is important. Understanding when they affect your agency financially is even more important.

The detailed mechanics of LUPA payment calculations are beyond the scope of this Executive Briefing. The purpose of this section is to explain the financial and operational significance of the proposed changes rather than the calculation methodology itself.

Part 2 — Understanding the Implications

Why Proposed LUPA Changes Matter

Annual changes to LUPA Thresholds and discipline-specific per-visit payment rates do not affect all home health agencies equally.

Some agencies experience relatively few LUPA payment periods and may therefore see minimal financial impact from annual LUPA updates. Others experience LUPAs more frequently due to differences in patient characteristics, referral patterns, clinical practice, or operational performance.

Consequently, the financial significance of the proposed LUPA changes depends not only on the updated payment rates themselves but also on **how often LUPAs occur within an individual agency, and which patient classifications are most commonly affected.**

COMMON MISCONCEPTION

LUPAs are not inherently "good" or "bad."

They represent an alternative Medicare payment methodology established for low-utilization payment periods. Whether LUPAs are financially favorable or unfavorable depends on the circumstances under which they occur and their overall effect on an individual agency's financial performance.

Key Takeaway

The financial impact of proposed LUPA changes depends less on the national per-visit payment rates and more on how often LUPAs occur within an individual agency.

Transition to the Next Topic

LUPAs represent one alternative payment methodology within the Home Health Prospective Payment System.

The next section examines **Outlier Payments**—a payment provision designed to address the opposite scenario: patient encounters requiring unusually high levels of care and resource utilization.

Outlier Payments: A Benefit at What Cost?

Why This Matters

The Medicare Outlier Provision is intended to provide additional reimbursement for unusually high-cost home health care encounters.

In theory, that is a reasonable goal.

In practice, however, the Outlier Provision is one of the most misunderstood components of the Home Health Prospective Payment System. Many agencies look at the Outlier payments they receive and assume the provision has benefited them financially. That may or may not be true.

The more important question is:

Outlier Payments: A Benefit at What Cost?

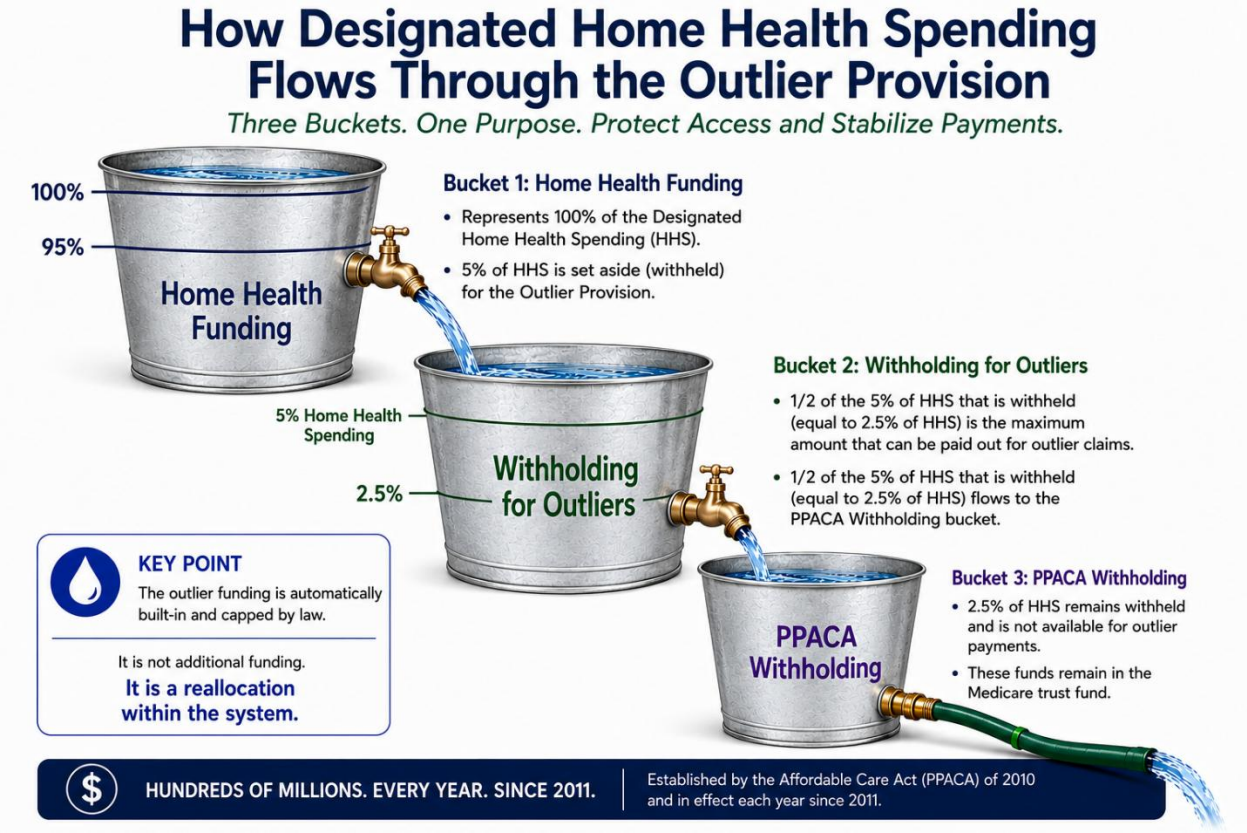
Answering that question requires understanding both **how the Outlier Provision is funded** and **how Outlier payments are calculated.**

Part 1 — Understanding the Economics

How Is the Outlier Provision Funded?

Since 2011, Medicare has reduced projected Home Health Spending by 5 percent annually to fund the Outlier Provision, while capping aggregate Outlier payments at 2.5 percent of projected spending.

This funding structure was established by Congress through the **Patient Protection and Affordable Care Act (PPACA)** beginning in 2011 and is therefore prescribed by statute rather than by CMS policy.



The estimated cumulative effect of this funding structure is shown in ***Companion* Reference Appendix G – Historical Analysis of the Medicare Home Health Outlier Funding Structure (2011 to Present).**

Because the Outlier Provision is funded by a reduction in projected Home Health Spending, every national standardized 30-day payment rate is approximately **5 percent lower** than it would be without the Outlier funding reduction.

Although agencies can readily identify the Outlier payments they receive, this reduction in payment rates is generally not apparent during day-to-day operations.

COMMON MISCONCEPTION

Receiving Outlier payments does not necessarily mean the Outlier Provision benefited your agency.

To evaluate the financial impact of the Outlier Provision, an agency must compare the Outlier payments it received with the Medicare revenue withheld from its payment rates to fund the Outlier Provision.

Part 2 — Understanding the Payment Methodology

What Is Imputed Cost?

Medicare does not use an agency's actual cost to determine whether a patient encounter qualifies for an Outlier payment. Instead, it calculates an Imputed Cost using a standardized methodology.

John's Definition

Imputed Cost is Medicare's standardized methodology for estimating the cost of resources used to provide care during a 30-day patient encounter. It is not the agency's actual cost of providing that care. Rather than using an agency's actual visits, visit costs, and chargeable medical supply costs, Medicare applies a standardized methodology based on reported 15-minute service units and estimated per-unit costs for each 15-minute unit by discipline. Consequently, Medicare's calculated Imputed Cost may differ substantially from the agency's actual cost of caring for the patient.

This is the author's working definition, intended to aid understanding. It is not CMS's formal definition.

How Does Medicare Estimate Imputed Cost?

Medicare's current Outlier methodology uses discipline-specific 15-minute service units rather than the discipline-specific visit counts used in earlier methodologies. The reported

service units for each discipline are multiplied by nationally established per-unit costs, with applicable wage adjustments, to calculate Medicare's Imputed Cost for the patient encounter.

Importantly, the Outlier methodology excludes the cost of chargeable medical supplies. For many patient encounters, that difference may not be material. For certain high-cost patient encounters—such as complex wound care, ostomy care, or other supply-intensive cases, as well as high-visit-volume encounters—the difference between Medicare's Imputed Cost and the agency's actual cost may be significant.

Further discussion of the current Outlier methodology appears in ***Companion* Reference Appendix H – Understanding the Medicare Outlier Calculation.**

COMMON MISCONCEPTION

Medicare determines Outlier payments based on the agency's actual cost of providing care.

It does not.

Medicare uses its own standardized **Imputed Cost** methodology.

When Does an Outlier Payment Occur?

An Outlier payment is made only when Medicare's calculated Imputed Cost exceeds the applicable payment amount by more than the Fixed-Dollar Loss (FDL) threshold set by CMS.

Even then, Medicare does not reimburse the full difference. The Outlier payment uses a loss-sharing methodology that covers only a portion of the amount exceeding the threshold, known as the 'Loss Sharing Ratio'.

As a result, a patient encounter may be unusually costly for the agency without generating an Outlier payment that fully offsets the agency's actual cost.

John's Observation

The Outlier Provision is often evaluated by looking only at the Outlier payments an agency receives. That is only half of the analysis. To determine whether the Outlier Provision ultimately benefited the agency financially, leadership must also evaluate the Medicare revenue withheld to fund the provision and the difference between Medicare's Imputed Cost and the agency's actual cost.

Part 3 — Why This Matters for Agency Leaders

The Outlier Provision affects agencies in two distinct ways.

First, **all agencies** are affected because the national standardized payment amount is reduced by **5 percent** to fund the Outlier Provision.

Second, **only some agencies** receive Outlier payments, and those payments are calculated using Medicare's Imputed Cost methodology rather than the agency's own actual costs.

Consequently, the financial impact of the Outlier Provision cannot be evaluated simply by reviewing the amount of Outlier payments received.

Key Questions for Agency Leaders

- **How much has your agency received in Outlier payments?**
- **How much Medicare revenue has been withheld from your agency to fund the Outlier Provision?**
- **How do Medicare's Imputed Costs compare with your agency's actual costs for high-utilization patient encounters?**

Until those questions are answered, it is difficult to determine whether the Outlier Provision has **ultimately benefited or harmed** your agency’s cash flow and profitability, or that of the home health industry.

Key Takeaway

Outlier payments received are only part of the story. The more important question is whether the Outlier Provision, when evaluated using both the funding mechanism and Medicare's Imputed Cost methodology, has ultimately benefited the agency financially.

Transition to the Next Topic

The Outlier Provision illustrates how payment policy and reimbursement methodology can produce financial outcomes that differ significantly from what many agencies expect. The next section examines another key component of Medicare reimbursement—the **Home Health Value-Based Purchasing (HHVBP) Model**—and how quality performance can affect an agency's future Medicare payments.

Expanded Home Health Value-Based Purchasing (HHVBP) Model

Why This Matters

The Expanded Home Health Value-Based Purchasing (HHVBP) Model reflects Medicare's ongoing transition toward performance-based reimbursement. Rather than paying agencies solely for the services they provide, HHVBP adjusts future Medicare reimbursement based on measured quality performance.

Although the terminology has evolved over time, the underlying philosophy is not new. For more than two decades, Medicare has pursued various forms of **Pay for Performance**, seeking to align reimbursement with quality outcomes rather than service volume. The HHVBP Model represents the current implementation of that philosophy for Medicare-certified home health agencies.

For CY 2027, CMS is **not proposing any HHVBP-specific policy changes**. Nevertheless, the HHVBP Model continues to influence Medicare reimbursement based on each agency's quality performance.

Part 1 — Understanding the Mechanics

What Is the HHVBP Model?

Eligible home health agencies are assigned to one of two national peer cohorts—**Small Cohort** or **Large Cohort**—based on the amount of qualifying data submitted to CMS.

Each agency receives a Total Performance Score (TPS) based on its performance across multiple quality measures. That score is compared with the TPS scores of all other agencies in its cohort to determine an Adjusted Payment Percentage (APP) that increases or decreases future Medicare reimbursement.

Because quality performance is measured in one period and applied to Medicare reimbursement approximately two years later, today's performance affects future Medicare revenue rather than current payment rates (Today's performance impacts tomorrow's revenues).

The **Adjusted Payment Percentage (APP)** currently ranges from approximately **–5 percent to +5 percent**, depending on an agency's relative performance within its national peer cohort.

John's Definition

Total Performance Score (TPS) is Medicare's summary measure of an agency's overall quality performance under the HHVBP Model. The TPS determines the percentage adjustment applied to the agency's future Medicare reimbursement.

This is the author's working definition, intended to aid understanding. It is not CMS's formal definition.

John's Definition

Adjusted Payment Percentage (APP) is the percentage increase or decrease applied to an agency's future Medicare reimbursement based on its Total Performance Score under the HHVBP Model (also known as a 'revenue adjustment factor').

This is the author's working definition, intended to aid understanding. It is not CMS's formal definition.

Illustrative Timeline

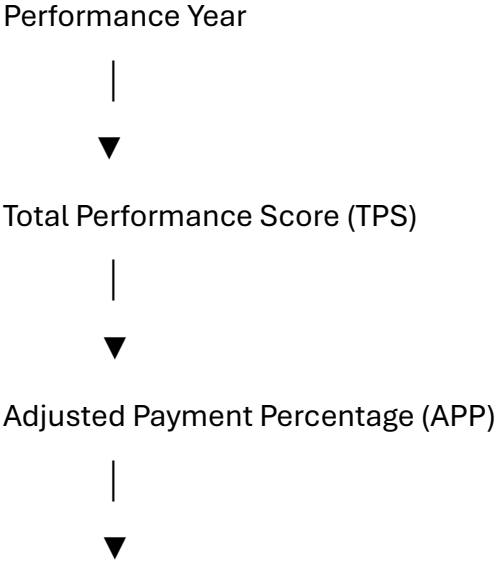


Figure X. *Illustrative timeline showing how quality performance influences future Medicare reimbursement under the HHVBP Model.*

Part 2 — Understanding the Implications

Why HHVBP Matters

Unlike the payment provisions discussed in previous sections, which affect reimbursement based on patient characteristics, geographic location, or payment methodology, the HHVBP Model adjusts Medicare reimbursement based on measured quality performance.

Consequently, two home health agencies serving the same geographic market, caring for patients assigned comparable HIPPS Codes and Case-Mix Weights, and operating under the same Wage Index may still receive materially different Medicare reimbursement due to differences in their quality performance and their respective APPs.

John's Observation

The HHVBP Model shows that Medicare reimbursement is influenced by more than patient characteristics and payment methodology. Quality performance also carries financial consequences. Consequently, improving quality should be viewed not only as a clinical objective but also as an important component of an agency's long-term clinical and operational strategy.

COMMON MISCONCEPTION

Because CMS proposes no HHVBP-specific policy changes for CY 2027, the HHVBP Model is not important this year.

It is.

Even in years without proposed policy changes, HHVBP continues to influence Medicare reimbursement through each agency's quality performance.

Key Takeaway

Even in years without proposed policy changes, the HHVBP Model continues to shape Medicare reimbursement. Consequently, quality performance remains a key strategic consideration for agency leadership.

Transition to the Next Topic

Throughout this Executive Briefing, we have examined the key factors that influence Medicare reimbursement—including patient characteristics, geographic labor costs, national payment updates, LUPAs, the Outlier Provision, and quality performance.

The next section brings these concepts together by examining why the financial impact of the Proposed Rule can vary substantially across agencies.

Agency-Level Impact

Why This Matters

At first glance, the CY 2027 Home Health PPS Proposed Rule appears to provide a national estimate of how Medicare payments are expected to change. In reality, those national estimates serve only as a starting point.

The actual financial impact experienced by an individual home health agency depends on how multiple payment components interact with that agency's unique patient population, geographic location, utilization patterns, and quality performance.

Throughout this Executive Briefing, we have examined each payment component individually. This section synthesizes those concepts to explain why agencies often see results that differ substantially from national projections—and why agency-specific analysis is essential.

Part 1 — Bringing the Pieces Together

Why National Projections and Agency Results Often Differ

To illustrate how a single payment variable can affect Medicare reimbursement, the comparison below isolates the Wage Index as the sole variable while holding all other payment variables constant. Each scenario assumes one hypothetical patient assigned to each of the 432 HIPPS Codes.

Illustrative Payment Rate Distributions Under Three Wage Index Scenarios

Payment Rate Distributions for:	CBSA A	CBSA B	CBSA C
Payment Rates Increased	432	409	221
Payment Rates Decreased	0	23	211
Payment Rates Unchanged	0	0	0
Maximum Payment Decrease	15.8%*	-2.5%	-4.9%
Average Payment Change	21.7%	2.5%	-0.1%
Maximum Payment Increase	25.8%	5.9%	3.2%
Payment Rates Increasing More Than 2.2%	432	273	7
Payment Rates Increasing More Than 3.5%	432	89	0
Payment Rates Increasing More Than 5.0%	432	6	0
Payment Rates Decreasing More Than 2.2%	0	1	33
Payment Rates Decreasing More Than 3.5%	0	0	6
Payment Rates Decreasing More Than 5.0%	0	0	0

* - CBSA A experienced no payment rate decreases.

The comparison above illustrates that the same national Proposed Rule can produce very different payment impacts depending on an agency's geographic location. Actual agency impacts will depend on the interaction of multiple factors discussed throughout this Executive Briefing.

Although these examples focus solely on the Wage Index, they illustrate an important principle. In practice, Medicare reimbursement is determined by the combined effects of multiple payment variables—including Case-Mix Weights, Wage Indices, LUPAs, Outlier payments, and Home Health Value-Based Purchasing payment adjustments. Consequently, agencies operating under the same Proposed Rule may experience markedly different financial outcomes.

John's Observation

The Proposed Rule does not determine an agency's financial future. It establishes the reimbursement framework within which agency-specific characteristics ultimately shape financial results.

Part 2 — Why Agency-Level Analysis Matters

Every home health agency serves a unique patient population, operates within a specific labor market, develops its own utilization patterns, and achieves its own quality performance. Because these characteristics vary from one agency to another, the financial impact of the Proposed Rule also varies.

Understanding how those variables interact within your organization is often far more valuable than knowing the national average payment update. Agency-specific analysis helps leadership teams move beyond national projections to evaluate how the Proposed Rule is expected to affect their agency's Medicare reimbursement for the upcoming year.

COMMON MISCONCEPTION

CMS projects that Medicare payments will increase by approximately "X%" nationally; therefore, my agency's Medicare payments should increase by approximately the same percentage.

They may— but for most agencies, that is not the case.

National projections describe the estimated impact across the Medicare home health program as a whole. Individual agencies may experience substantially different financial results depending on their patient mix, geographic location, utilization patterns, and quality performance.

Key Takeaway

National projections describe the industry. Agency-level analysis determines the expected impact on your organization. Understanding this difference is essential for informed strategic planning and better decision-making.

Transition

The CY 2027 Proposed Rule sets the reimbursement framework for home health agencies nationwide. The next step is to understand what those proposed changes mean for your organization—and to develop strategies that position your agency for long-term success.

Topics Beyond the Scope of This Executive Briefing

This Executive Briefing focuses primarily on the financial, reimbursement, operational, and strategic implications of the CY 2027 Home Health PPS Proposed Rule. The Proposed Rule also includes several important provisions affecting clinical quality reporting, patient assessment, and other regulatory requirements that may warrant separate review by individuals responsible for or with specialized expertise in those areas.

Examples include:

- Home Health Quality Reporting Program (HH QRP)
- OASIS-related updates
- Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Other clinical and regulatory provisions included in the Proposed Rule

Agencies should ensure that these provisions are reviewed by the appropriate clinical, compliance, and operational personnel as part of their overall evaluation of the Proposed Rule.

Closing Thoughts

The CY 2027 Home Health PPS Proposed Rule includes numerous policy changes that will affect Medicare reimbursement in the coming year. Some of those changes will increase Medicare payments for individual agencies, while others may reduce them. Understanding those differences begins with understanding how the Medicare payment system works—and how its components interact.

Throughout this Executive Briefing, we've examined the principal payment components individually and then explored how they work together to influence agency-specific financial outcomes. While national payment estimates provide important context, they cannot determine how the Proposed Rule will affect any single organization.

Ultimately, the value of the Proposed Rule is not found simply in knowing what changed. Its value lies in understanding what those changes mean for your agency, your patients, and the strategic decisions you will make going forward.

As Medicare reimbursement continues to evolve, organizations that develop a deeper understanding of these dynamics will be better positioned to anticipate change, assess its impact, and respond strategically.

Better understanding leads to better decisions, and better decisions help shape a stronger future for home health.

Help Shape Future Executive Briefings

One of the goals of this Executive Briefing is not simply to explain Medicare policy, but also to encourage better questions, better discussions, and ultimately better decisions throughout the home health industry.

Future editions will continue to examine the financial, operational, and strategic issues facing home health providers.

What would you like us to analyze next?

Are there Medicare reimbursement topics, operational challenges, financial questions, or regulatory issues you would like to see covered in future Executive Briefings or educational webinars?

Your suggestions will help shape future educational content and ensure that future editions continue to address the issues that matter most to home health leaders.

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Home Health Hub: Join the discussion, suggest future topics, and participate in ongoing conversations on Medicare reimbursement, home health operations, and industry trends.

About the Author

John M. Reisinger, CPA

John M. Reisinger is the founder and principal of **Innovative Financial Solutions for Home Health (IFS4hh)**, providing financial, reimbursement, operational, and strategic consulting services to **home health and hospice organizations** across the United States.

With more than three decades in healthcare reimbursement and executive leadership, John has held a wide range of roles, including Medicare auditor, Vice President of Reimbursement, **interim Chief Financial Officer**, interim Chief Executive Officer, consultant, educator, **industry advocate**, and national speaker. These experiences have given him a unique perspective and a broad understanding of the financial and operational challenges facing home health providers and the Medicare reimbursement system that supports them.

Throughout his career, John has focused on helping organizations move beyond regulatory compliance toward a deeper understanding of how Medicare policy affects operational performance, financial results, and strategic decision-making. His work emphasizes **agency- and enterprise-level analysis**, practical application, and the belief that meaningful decisions require more than information—they require understanding.

John is the creator of the **Case-Mix Planner™**, an agency decision-support system designed to strengthen the relationship between patient assessment, care planning, resource utilization, and financial performance. He has also developed numerous analytical models to evaluate Medicare reimbursement, operational productivity, Hidden Utilization Costs, and **agency-specific financial impacts associated with Medicare payment reform, particularly the annual Home Health PPS Proposed and Final Rules.**

His educational philosophy emphasizes helping healthcare leaders understand not only what Medicare policies change, but also **why those changes matter, how they interact, and why their impact can differ significantly from one organization to the next**.

John has presented educational programs on Medicare reimbursement, Home Health PPS, PDGM, Medicare cost reporting, and related financial topics for home health and hospice providers across the United States.

This Executive Briefing reflects that same philosophy: helping healthcare leaders move beyond information toward understanding so they can make better decisions and help shape a stronger future for home health.