National Alliance for Care at Home

February 4, 2026

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

RE: Alliance Comments Following January MedPAC Meeting

Dear Chairman Chernew:

The National Alliance for Care at Home (the Alliance) respectfully submits this letter to reiterate concerns we raised in our December 2025 meeting comments that remain highly relevant following the Medicare Payment Advisory Commission's (MedPAC) January 2026 meetings.[1] While we appreciate the Commission's continued examination of Medicare's home health and hospice benefits, we believe several critical issues warrant renewed emphasis.

Home Health Payment Adequacy

We strongly oppose and remain deeply concerned about the proposed 7 percent reduction to the Medicare home health base payment rate for Calendar Year (CY) 2027. This recommendation does not adequately account for the cumulative impact of sustained payment cuts over the past decade and the resulting erosion of provider capacity and beneficiary access. The Commission's recommendation to reduce home health payments by 7 percent carries substantial fiscal implications, particularly in the confines of a broader payer market. MedPAC estimates that relative to current law, spending would decrease by between $750 million to $2 billion in a single year, and by between $10 billion to $25 billion over five years.

As we detailed in our December comments, approximately half of all U.S. counties already lost at least one home health agency between 2020 and 2024, and home health agencies in over 80 percent of counties are treating fewer Medicare fee-for-service (FFS) beneficiaries and providing fewer visits.[2,3] In 2024, over one-third of Medicare beneficiaries

[1] https://www.medpac.gov/wp-content/uploads/2025/01/Alliance-December-MedPAC-Meeting-Comment-Final.pdf
[2] CMS Market Saturation & Utilization State-County dataset, https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county
[3] https://trellahealth.com/wp-content/uploads/2024/12/Trella-Health-Special-Report-Home-Health-Accessibility-Among-Medicare-Fee-for-Service-FFS-Beneficiaries.pdf

referred for home health after hospitalization did not receive this care,[4] and approximately 10 percent of beneficiaries are waiting at least five days for a visit, with even longer wait times likely in rural areas.[5]

These access challenges are not reflected in lagging quality and access indicators. Year-after-year payment reductions have consequences: agencies are narrowing service offerings, reducing service areas, and in some cases closing altogether. We continue to question what the Commission believes will be accomplished with sustained rate reductions, besides providing less home health care to Medicare beneficiaries who depend on these vital services.

Critically, we urge the Commission to provide more emphasis on total margins as an indicator of payment adequacy rather than seemingly focusing exclusively on Medicare FFS margins. Growing evidence demonstrates that MA payment structures and utilization management practices significantly impact home health agency financial performance and service delivery. For example, a recent study found that counties with greater growth in MA penetration experienced larger declines in the number of home health agencies per 1,000 beneficiaries.[6] Adjusting for other factors, a 10-percentage point larger increase in MA penetration was associated with 0.54 fewer home health agencies per 1,000 beneficiaries—an 11.5 percent decline—and with 6.08 fewer starts of care per 1,000 beneficiaries, a 5.7 percent decline.

Another study published in Health Affairs found that MA enrollees in 2018 were nearly 24 percent less likely than FFS beneficiaries to receive multiple home-based medical visits, though MA enrollees were 31 times more likely than FFS beneficiaries to have a single home-based visit, raising concerns about use patterns that may artificially inflate risk adjustment payments without delivering comprehensive care.[7] Research published in the Journal of the American Medical Association (JAMA) found that MA enrollees were less likely than FFS beneficiaries to receive care from high-quality home health providers,[8] and had a lower likelihood of improvements in self-care and mobility function.[9] Finally, a study published in the American Journal of Managed Care in 2024 found that MA enrollees with orders to receive home health care following hospitalization may not ultimately receive these services, and those that did not receive home health had significantly higher mortality rates.[10]

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[4] https://carejourney.com/how-timely-access-to-home-health-care-impacts-cost-and-outcomes
[5] https://allianceforcareathome.org/wp-content/uploads/Trends-timeliness-home-healthcare.pdf
[6] https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.70298
[7] https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00376
[8] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2749236
[9] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2815745
[10] https://www.ajmc.com/view/unfulfilled-home-health-referrals-lead-to-higher-mortality-among-medicare-advantage-members

These findings underscore that the Commission's overemphasis on Medicare FFS margins provide an incomplete picture of home health agency financial health and fails to capture how MA payment policies are reshaping provider capacity, patient access, and even outcomes. Any assessment of payment adequacy must account for total margins to accurately reflect the financial pressures facing home health providers.

Hospice Payment Adequacy and Quality Measurement

We strongly oppose the recommendation to provide no payment update for hospice care. This recommendation fails to account for the significant cost pressures facing hospice providers, particularly persistent workforce shortages and rising labor costs that are straining providers across all care settings. Hospice care requires highly skilled clinicians who can deliver complex, interdisciplinary care in patients' homes during the most vulnerable time in their lives. Freezing payment rates while costs continue to rise will inevitably erode provider capacity and threaten beneficiary access to this vital benefit. Moreover, the hospice benefit reduces overall Medicare spending compared to traditional medical management at the end of life, while providing care that aligns with patient and family preferences. Undermining the financial sustainability of hospice providers through payment freezes risks forcing beneficiaries into more costly acute care settings and contradicts Medicare's goals of both cost containment and person-centered care.

While we appreciate the Commission's recognition that key hospice quality indicators have been generally stable or improving, we reiterate our concern that current hospice quality metrics are incomplete and must be interpreted with care. The CAHPS Hospice Survey, while valuable, faces significantly low response rates and data gaps. Two-thirds of hospices did not receive a star rating when CMS introduced ratings in 2022, and the share of unrated hospices has only grown since. We recommend that MedPAC further review these data limitations, potential biases, and risk adjustment issues before relying heavily on these measures in payment policy recommendations.

Additionally, we continue to strongly oppose MedPAC's recommendation to incorporate the hospice benefit into the Medicare Advantage benefits package. As we stated in our December comments, the current structure of the Medicare hospice benefit is working well for beneficiaries, including those that elect hospice while enrolled in Medicare Advantage. Hospice is already comprehensive, holistic managed care for patients that are terminally ill. It is unclear how allowing MA plans to administer this benefit would do anything other delay or limit access to care when patients and families need it most, similar to what we are seeing with home health care as described above.

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Conclusion

The concerns we raised in our December 2025 meeting comments remain urgent and relevant. Research has consistently shown that older adults have a strong preference for remaining in their homes as they age. While persistent staffing shortages and rising labor costs are straining providers in every setting, this is particularly acute in home-based care settings, such as home health and hospice where nurses must operate independently in the patient's home, necessitating specific competencies and skillsets to meet patient needs. We respectfully urge the Commission to reconsider its recommendations that would reduce home health payments or freeze hospice updates, as these policies threaten beneficiary access to cost-effective, high-quality care in the home setting.

We stand ready to work with MedPAC to strengthen Medicare's home-based care benefits for the millions of Americans who depend on them. If you have any questions, please feel free to contact the Alliance's Chief Government Affairs Officer, Scott Levy, at slevy@allianceforcareathome.org.

Sincerely,

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