HOME HEALTH CARE SERVICES PAYMENT SYSTEM

paymentbasics

Revised: October 2026

Beneficiaries who are generally restricted to their homes and need skilled care (e.g., from a nurse or a physical or speech therapist) on a part-time or intermittent basis are eligible to receive certain medical services at home. Home health agency (HHA) personnel visit beneficiaries' homes to provide:

- skilled nursing care;
- physical, occupational, and speech therapy;
- medical social work services; and
- home health aide services.

Telehealth services, such as remote patient monitoring and virtual visits, are also covered under the home health benefit.

Medicare's home health benefit originally had restrictive coverage standards such as requiring a prior hospital stay or limiting the number of visits allowed. These limitations were later eliminated, so a beneficiary can receive covered home health services for an unlimited period of time as long as they meet the other coverage criteria. Beneficiaries are not required to make any copayments or other cost sharing for these services.

About 2.7 million beneficiaries used home health care in 2024. Medicare pays for home health care with both Part A and Part B funds; in 2024, total payments were $16.0 billion. Over 12,000 agencies participated in the program in 2024.

The policies discussed in this document were current as of September 30, 2026. This document does not reflect proposed legislation or regulatory actions.

Defining the care Medicare buys

Medicare's home health prospective payment system (PPS) pays a predetermined rate intended to cover the operating and capital costs of furnishing a 30-day period of home health care, including skilled nursing care; physical, occupational, and speech therapy; medical social work services; and aide services.

Setting the payment rates

Payments to HHAs are determined by adjusting a base payment amount (the amount that would be paid for a typical home health patient residing in an average market area) to reflect differences in patient characteristics (case mix) and in the the level of market input prices in the geographical area where services are delivered (Figure 1). The base payment amount for 2026 is $2,038.22.

CMS uses a home health case-mix system, the Patient-Driven Groupings Model (PDGM), to adjust payment for differences in patient characteristics (Figure 2). The PDGM categorizes each period into 432 home health resource groups (HHRGs) based on:

Period timing—A newly initiated home health period (with no home health services in the preceding 60 days) is classified as "early," while periods that are immediately preceded by a 30-day period are classified as "late."

Referral source—Early periods that are preceded by a stay at an inpatient hospital, long-term care hospital, inpatient rehabilitation facility, or skilled nursing facility are classified as institutional periods. Early periods that are not preceded by a stay in one of those facilities are classified as community-admitted periods. Later periods are classified as institutional if they are preceded by a hospital stay; otherwise they are classified as community-admitted periods.

Clinical category—Patients are assigned to 1 of 12 clinical categories based on their reported conditions or treatments.

Functional impairment—Patients are assigned to one of three functional impairment levels based on reported cognitive and physical functioning information.

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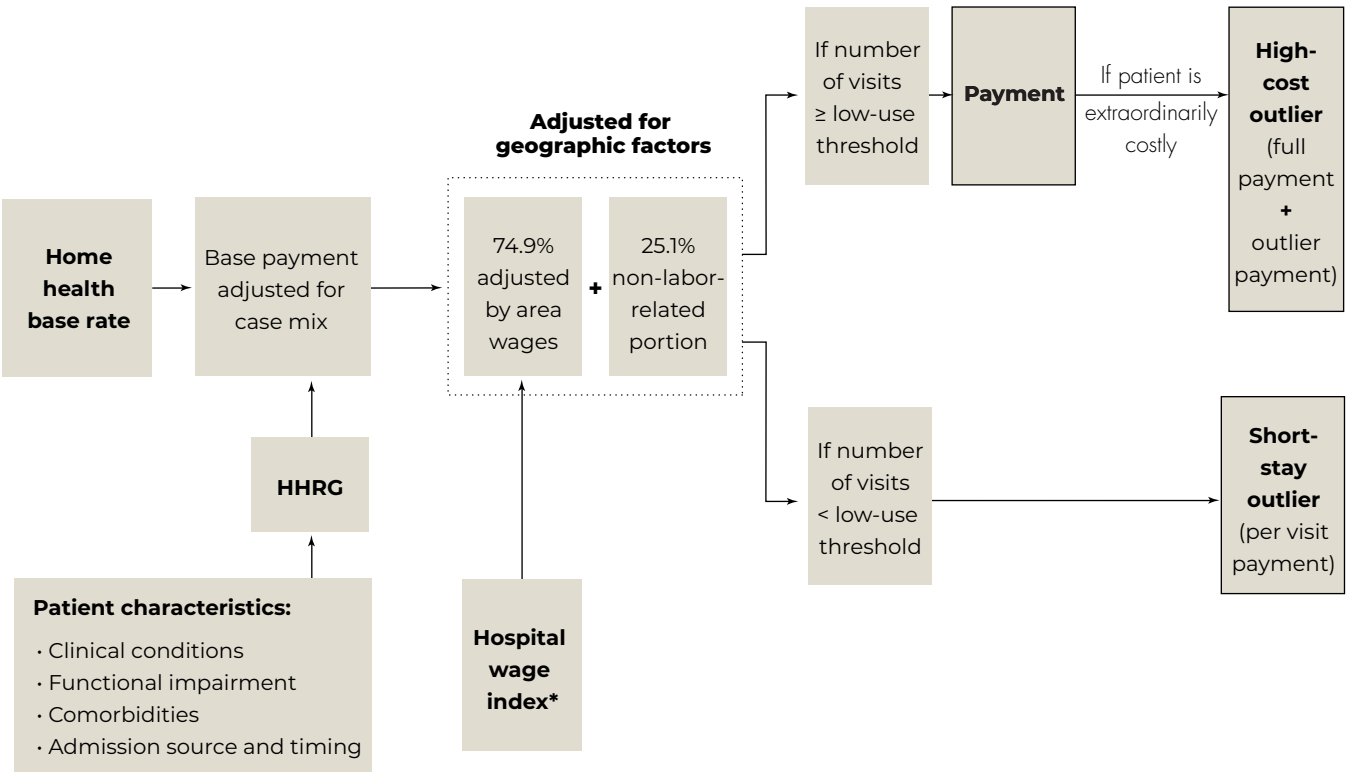
Figure 1 Home health care services prospective payment system, 2026



Note: HHRG (home health resource group). The low-use threshold varies by payment group and ranges from two to six visits.
* The home health care services prospective payment system uses a version of the hospital wage index called the "pre-floor, pre-classification hospital wage index."

Presence of comorbidities—The case-mix system also includes a three-tiered adjustment for selected comorbidities.

Each HHRG has a national relative weight reflecting the average relative costliness of patients in that group compared with the average Medicare home health patient.

To adjust for geographic factors, the per period payment rate is divided into labor and nonlabor portions; the labor portion—74.9 percent—is adjusted by a version of the hospital wage index to account for geographic differences in the input-price level in the local market for labor-related inputs to home health services. Unlike most other Medicare payment systems, the local-area adjustment for home health services is determined by the beneficiary's residence rather than the provider's location. The total payment is the sum of the adjusted labor portion and the nonlabor portion.

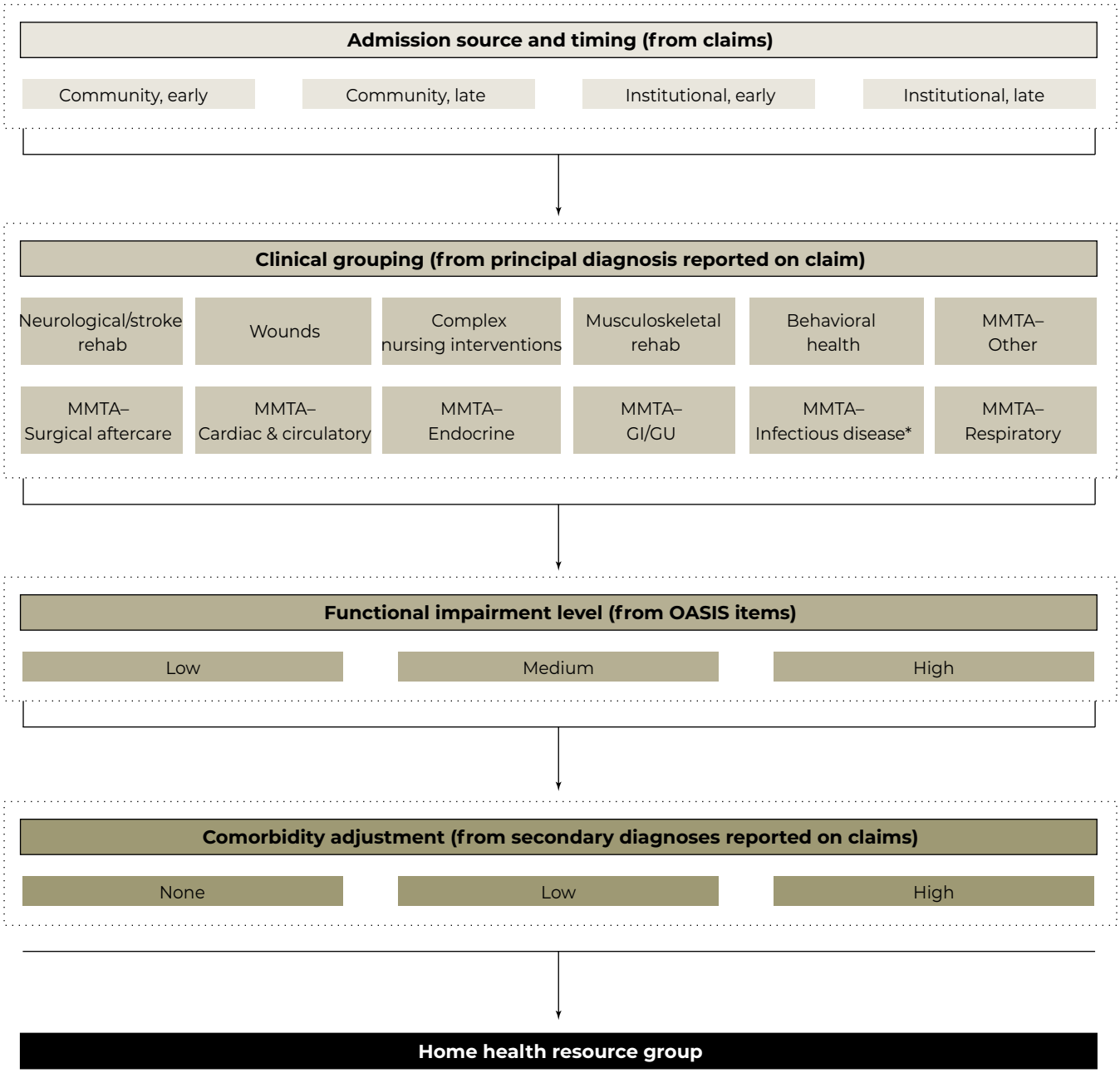
Low-use periods

Low-use periods (periods with relatively few visits) are paid on a per visit basis. The threshold for the low-use payment adjustment varies from two to six visits, depending on the payment group to which a period has been assigned. Periods above the threshold receive the full case-mix-adjusted 30-day payment under the PDGM.

High-cost outliers

When a patient's period of care involves an unusually large number or a costly mix

Figure 2 The home health Patient-Driven Groupings Model, 2026



Note: MMTA (medication management, teaching, and assessment), GI/GU (gastrointestinal tract/genitourinary system), OASIS (Outcome and Assessment Information Set).
* Includes neoplasms and blood-forming diseases.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026. Medicare program; calendar year 2027 home health prospective payment system rate update; requirements for the home health quality reporting program and the expanded home health value-based purchasing model; Medicare provider enrollment, durable medical equipment, and DMEPOS policies. *Federal Register* 91, no. 127: 41216–41327.

of visits, the HHA may be eligible for an outlier payment. To be eligible, imputed period costs must exceed the payment rate by a certain amount set annually by CMS.[1] The total cost of a period is determined by multiplying the minutes of patient care for each covered service by a standardized per minute cost factor. When these estimated costs exceed the outlier threshold, the HHA receives a payment equal to 80 percent of the difference between the period payment with the threshold and the period's estimated costs.

Payment for quality reporting and performance

The home health prospective payment system has two programs intended to improve quality. The first is a pay-for-reporting program under which HHAs must report quality-of-care data to avoid a 2 percentage point reduction in their annual market basket update.

Additionally, in 2025 Medicare implemented a nationwide value-based purchasing program. The program adjusts HHAs' Medicare payments (upward or downward) based on their performance on a set of five quality, outcome, and patient-experience measures. The size of any bonus or penalty varies according to performance. Quality bonus payments are funded through a payment withhold.

Payment updates

The base rate is updated annually. The update is based on the projected change in the home health market basket, which measures changes in the prices of goods and services bought by home health agencies. The update for 2026 was 2.4 percent, though this update was offset by a 4.0 percent adjustment required by the Bipartisan Budget Act of 2018.[2] ■

1 The amount equals 0.37 times the standard base payment amount in 2026 adjusted by the wage index.

2 The 2026 adjustment included a 1.023 percent permanent reduction and a 3.0 percent temporary reduction required by the Bipartisan Budget Act of 2018.