Home health, hidden basis, points, pricing of hospital level care

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Abstract

Short version of what follows:

• CMS finalized the 2026 home health rule with a headline 2.4 percent payment update, a permanent behavior adjustment of a bit over negative 1 percent, and a year temporary reduction of about 3 percent, which nets out to roughly a 1.3 per aggregate cut in Medicare home health spend compared to 2025.

• Under the hood, CMS rebuilt the PDGM case mix weights using very fresh cla data linked to OASIS, refreshed functional impairment levels, expanded comorb subgroups well into the triple digits, and reset LUPA thresholds across the grou

• At the same time, the 2026 outpatient and ASC final rule hikes OPPS and ASC payment rates by 2.6 percent, sets a new conversion factor around the low ninety dollar range, and expands the ASC covered procedures list by hundreds of codes

including cardiac ablations, advanced endoscopy, and other historically inpatien HOPD dominated work.

• Put together, you have hospitals with capital constraints, home health agencies facing mild pressure, and a policy environment actively steering more care out o hospital footprint.

• For anyone investing in RPM, tele rehab, home infusion, DME logistics, or AS infrastructure and tooling, these rules are basically a fresh term sheet for where hospital-level revenue is going to land by 2026.

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Why home health suddenly matters again

Hospitals are not abandoning inpatient towers, but financially many of them pro wish they could. They are getting a 2.6 percent bump on outpatient and ASC payments in 2026, which looks fine on paper until you place it next to wage infla consumable inflation, and the pleasure of financing capital projects in a rate

environment where money still costs real money. At the same time, a good chunk procedures that used to be glued to inpatient settings can now be done in ASCs hospital outpatient departments under the refreshed criteria. When CMS adds hundreds of codes to the ASC list, including serious work like certain cardiac ablations or advanced GI procedures, the message is basically that inpatient is n longer the default.

Demand is not politely waiting, either. Aging demographics, Medicare Advantag penetration, and risk based payment models keep pushing more responsibility o post acute settings. Home health agencies end up in the middle of that shift. The either be low margin vendors of short visits or the chassis that hospital level acu rides on when beds are scarce or economics tilt in favor of sending patients hom sooner. In a roundabout way, CMS is saying it is open to the latter path if the ma holds.

For investors, the 2026 rules shift the implied value of the care continuum. OPP ASC get a straightforward rate bump plus more procedures. Home health takes modest net negative adjustment but avoids a much steeper cut that was on the ta From a direction-of-travel standpoint, CMS is effectively saying home health is central, not peripheral, to the next iteration of federal care delivery incentives. F anyone underwriting virtual care, hybrid home models, care logistics, or non physician home services, this is not noise. It is where the revenue ceiling is being redrawn.

What CMS just did to the home health math

The headlines do not explain why operators were sweating the proposed rule ear The granularity changes inside the new rule are the real story.

Start with the basic rate mechanics. CMS sets a national standardized 30 day bas rate, then applies case mix weights, wage index, outlier logic, and LUPA rules. F 2026, the base rate receives a 2.4 percent update, then gets hit with a permanent prospective behavior adjustment just above negative 1 percent plus a temporary

year 3 percent adjustment tied to PDGM behavior corrections. Net that all out a home health agencies land around a 1.3 percent aggregate cut relative to 2025. It not ideal, but it is far better than what was proposed earlier.

The PDGM internals are where things really move. CMS rebuilt case mix weight using recent claims and OASIS data, capturing true agency behavior rather than PDGM era patterns. That means coding interactions, functional levels, and visit distributions all get refreshed. The functional impairment levels are tightened, a the comorbidity grid expands meaningfully, with roughly twenty low comorbidit groups and close to a hundred high groups. LUPA thresholds are reset across all clinical groupings.

There are also adjustments to face to face encounter requirements and home hea quality reporting, which matter because they change the overhead and documen burden for agencies partnering with tech vendors.

If you zoom out, the environment is a mild rate headwind combined with a heavy classification overhaul. That means the winner's circle is defined by documentat accuracy, OASIS execution, and visit planning. PDGM is becoming more of a dat workflow puzzle and less of a rote billing exercise. Agencies that treat PDGM m like revenue science will outperform those running on gut instinct. This is exact kind of regulatory complexity that startups can arbitrage if they know what they doing.

Modeling high acuity episodes at home

Investors love to hear about the future of high acuity care at home. Analysts love talk about bending inpatient curves. Patients mostly want to stay out of hospital question is always whether the payment rules will support it.

Under PDGM, every 30 day period sits in a clinical group, functional impairmen level, and comorbidity tier. Each combination gives you a case mix weight. LUPA thresholds then determine how many visits you need to escape per visit payment hit the full 30 day rate. For high acuity work like advanced heart failure, oxygen

dependent COPD, or post joint replacement, you tend to surpass LUPA threshol but the mix of disciplines you use changes the economics.

If you are backing companies that insert RPM, virtual cardiology, virtual pulmo rehab, or intensive tele rehab, the trick is knowing whether your product shifts episode into a different and better reimbursed PDGM cell or prevents it from fa into a low utilization pattern that nukes revenue. The 2026 recalibration is base real data, so gaming the grid is harder, but optimizing within it is easier if your product actually influences visit timing and documentation.

For example, a heart failure RPM program might catch early decompensation an prompt skilled nursing visits earlier in the period. That not only helps keep pati out of the hospital; it also increases the likelihood the episode stays above LUPA it may justify a more complex comorbidity tier if the documentation lines up. Bu the product adds work for agencies without reliably moving the episode classific it is just margin erosion dressed up as innovation.

Joint replacement is another case where 2026 rules matter. More joints are movi outpatient or into ASCs. That means home health or hybrid virtual rehab is the primary post acute care environment. If you are modeling a business built on outpatient joints, you must know the 2026 case mix weights and thresholds cold combination of outpatient or ASC index stays plus PDGM governed home recov the new baseline. It has nothing to do with historical DRG assumptions and everything to do with how agencies get paid for therapy heavy episodes.

In short, if a startup cannot walk you through PDGM math with actual numbers 2026, not theoretical grids from 2020, they probably are not ready for prime tim

Value based purchasing and the tech R problem

Home health value based purchasing is now nationwide and sticks around in the rule without major structural changes. The performance periods, scoring, and payment adjustments create a long tail on ROI for tech that improves outcomes.

value based purchasing is noisy. It relies on measures that only partially reflect v agencies can control, and it pays out with delay.

So tech vendors pitching VBP upside must show a revenue bridge that includes PDGM improvements and VBP improvements, not just vague promises about qu Agencies will be extremely sensitive in 2026 because they are absorbing a net pa cut. If something does not produce a sharp and obvious PDGM gain or a clear reduction in avoidable acute events, it is a tough sell.

The added twist is that CMS tweaked some of the quality reporting elements. Anything that adds documentation friction becomes more expensive for agencie a startup says it will improve VBP, it also has to prove it will not create new wor headaches that reduce PDGM efficiency.

In reality, the best positioned startups are those that solve for both revenue inte and clinical performance. They must know the specific measures that matter in and show how their intervention moves those measures, not just claim "better outcomes."

DMEPOS, logistics, and the messy hom based stack

Nobody gets excited about DMEPOS policy unless they have lived through it. It deeply unglamorous part of home based care, but it determines whether high ac home actually works. The 2026 home health rule touches DMEPOS accreditatio enrollment, and documentation rules, and these changes land on top of years of fraud policy tightening.

This creates real friction. High acuity home care needs equipment like oxygen concentrators, non invasive ventilation, wound vacs, infusion pumps, and a doze other devices. Getting them to the home, getting them set up correctly, and keep them running is not easy.

From an investor perspective, the opportunity sits between documentation, logis and compliance. Smaller DME suppliers struggle with accreditation and audit ri Large suppliers struggle with responsiveness and workflow integration. Home h agencies often have zero visibility into equipment timing and failures, which me they shoulder the clinical risk.

Startups that can bridge that gap with real operational capabilities, not just a ni app, have a shot. You want companies that can get equipment delivered in hours days, integrate with agency documentation, and make the whole episode compli The 2026 rule essentially raises the bar for DME documentation alignment with health visits. That friction is an opportunity for companies that can take comple off operators' plates.

OPPS, ASC, and the site of care migrat lever

The 2026 OPPS and ASC rule is essentially a migration policy hiding in plain sig 2.6 percent payment rate increase is not trivial, but the real story is the scope of procedures that can now be performed in ASCs. The ASC list grows by hundred codes, including cardiac ablations, advanced GI procedures, and surgeries previ scoped as inpatient only. The inpatient only list continues its slow phase out.

This is reshaping where procedures start and therefore where the downstream c pathways go. If an ablation moves into an ASC, a lot of follow up shifts into hom virtual environments. If joints move outpatient, the entire post op rehab pathwa becomes a hybrid of home health, tele PT, and occasional in person visits.

Private equity backed ASC platforms will absolutely capitalize on the expanded procedure list. Hospitals will push cases into ASCs and outpatient suites to relie inpatient capacity and improve financials. Payers will expect downstream saving they will scrutinize post acute spend more tightly when the index stay is no long inpatient DRG.

Investors need to track which procedure families are migrating and what their downstream clinical profiles look like. Cardiology procedures require rhythm monitoring and med management. GI procedures need follow up for bleeding ri motility. Ortho needs rehab and fall risk monitoring. Each of those creates open for specialized hybrid care companies.

If a founder cannot explain the economic difference between an inpatient ablati episode and an ASC based ablation episode under 2026 rates, they probably have done enough homework.

How this all looks from an angel invest seat

Looking across inpatient, outpatient, ASC, and home health, the 2026 rules reas margin and risk across the clinical continuum. Inpatient stays remain lucrative i absolute dollars but face steady encroachment. OPPS and ASC continue to rise a default settings for a growing slate of procedures. Home health becomes more d and operations heavy and slightly less well funded, but still central to the government's strategy for managing chronic and postoperative care.

For early stage investors, the opportunity lies in anticipating how operators will adapt. Hospitals will seek to push more cases outpatient. ASCs will expand scop Home health agencies will tighten operations and chase revenue integrity. Risk bearing entities will push more responsibility down to whoever touches the pati most frequently, which is often home health or hybrid home virtual care models.

The worst investment you can make in this environment is a general purpose toc is not grounded in the actual payment mechanics. The best investments tend to very specific wedges built around regulatory complexity. Examples include toolir that makes PDGM classification more accurate at scale, post procedure follow u programs tied to newly migrated ASC procedures, or DME logistics platforms th guarantee setup windows tight enough to actually avoid hospitalizations.

The main risk is founders who treat policy as background noise. If a team canno explain the sign of the 2026 home health adjustment or cannot name a single cat of procedure that just gained ASC eligibility, you are underwriting a long and expensive education.

A few concrete theses and things I wou actually fund

Here are some directions that seem investable in the world shaped by the 2026 r

First, high acuity home health enablement built on PDGM arithmetic. Not vagu coordination products. Tools that change PDGM classification and LUPA avoida rates in high value clinical groups. The 2026 environment rewards operators wh understand the grid. Products that make the grid work for them, not against the will be sticky and defensible.

Second, DME logistics plus compliance with real field ops. The gap between pol demands and actual equipment performance at home is wide. Companies that ca deliver, service, and document equipment setups in hours, not days, and can inte that data into home health workflows will win.

Third, ASC centric episode platforms focused on specific procedures. Do not try build the everything platform for ASCs. Pick one or two types of procedures tha newly viable in ASCs, build the end to end follow up and monitoring pathways, a tie your unit economics to the actual differential between inpatient and ASC payments.

Fourth, analytics tools that treat inpatient, OPPS, ASC, and home health as a portfolio. Hospitals need to plan capacity, capital spending, and service mix acro four settings. Tools that forecast margin and volume under the 2026 rules can gu real investment decisions.

The thread across all these ideas is that CMS effectively rewrote a large chunk o revenue architecture for post acute care and outpatient migration. If you back

founders who treat these rules as constraints to design within, you get companie
align naturally with policy and financial tailwinds. If you ignore these rules and
with generic healthcare pitches, you are basically underwriting hope.

The broader point is that home health is no longer the supporting act. It is part
new chassis for hospital level care in a world where inpatient capacity is constra
and outpatient migration is accelerating. The 2026 rules do not blow up the syst
but they quietly change the margin structure just enough that a lot of care will
reorganize around them. Investors who know how to read that shift will have an
advantage.

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