Texas Association for Home Care & Hospice (TAHC&H)

2026 Federal Legislative Priorities

Ensure appropriate and adequate reimbursement for Medicare home health services

CMS made methodological improvements in the CY2026 Home Health PPS Final Rule but still finalized another net cut to home health services for a total of 13.4% over the last 4 years that will worsen home health closures and access challenges. Texas has already seen a 24% decline in beneficiaries served and a 36% decline in agencies offering services to patients since 2019, with disproportionate harm across ~200 rural areas; more than one-third of referred patients cannot obtain services. The CY2026 HH PPS rule extends temporary adjustments that will continue each year totaling $4.7B, compounding the damage to home health agencies. The final rule relies on data tainted by fraudulent activity—especially concentrated in Los Angeles County—skewing national rates, hurting legitimate providers and undermining access for patients. **TAHC&H calls on Congress to engage CMS so that forthcoming CY 2027 rulemaking will:**

- **Reset national payment rates** using fraud-adjusted datasets and anomaly-robust methods so tainted claims do not drive policy.
- **Provide adequate annual updates** that reflect real inflation to stabilize the workforce and preserve beneficiary access.
- **Deploy targeted program-integrity** actions (e.g., an immediate California statewide moratorium, Review Choice Demonstration nationwide, enhanced claims monitoring in areas of high fraud activity).
- **Leverage state licensure and accreditation surveys** for program integrity by directing State Survey Agencies and Accrediting Organizations to perform standardized fraud-red-flag checks (e.g., verification of bona fide practice locations; identification of multiple agencies using the same address; ownership anomalies) and to document and refer suspected fraud using uniform CMS protocols (e.g., referrals to UPICs/MACs/OIG/MFCUs within defined timelines).

Medicare Advantage — ensure fair, timely payment and remove barriers to home health access

Home health agencies continue to face below market rates, prior-authorization delays, opaque denials, unaffordable co-pays for patients and late or inaccurate payments from MA plans—barriers that delay or prevent medically necessary care. Evidence also shows MA beneficiaries often receive fewer home health visits than in traditional Medicare, and MA reimbursement designs that tightly restrict visit patterns are associated with higher inpatient transfers during a home health episode. CMS strengthened MA rules for 2024 to align coverage criteria with traditional Medicare and limit prior authorization, but provider experience shows gaps in compliance and enforcement that continue to harm access. T**AHC&H asks Congress to:**

- **Support and pass H.R. 5454 — Medicare Advantage Prompt Pay Act.** Requires MA plans to pay at least 95% of clean claims within 14 days (electronic) or 30 days (other), with interest and penalties for noncompliance and plan-level reporting—reducing cash-flow strain and administrative churn.
- **Support and pass H.R. 4559 — Prompt and Fair Pay Act.** Requires payment parity so MA plans pay providers no less than traditional Medicare rates and establishes enforceable prompt-payment and transparency standards, improving predictability and access.
- **Exercise oversight to enforce the 2024 MA rule** (coverage-criteria parity with NCD/LCDs, limits on prior authorization, 90-day transition protections, UM committee requirements) and ensure these protections are applied in home health.
- **Require MA Plans to Improve data transparency** on rates, denials, and appeals outcomes so policymakers and providers can identify and correct plan behaviors that impede timely in-home care.

Protect Rural Veterans' Home-Based Care — Restore VA HHA/Homemaker Rates and Hours

a. The FY2026 VA fee schedule imposes a 43% cut to the "Rest of Texas" locality (on top of a 10% cut in FY2025), dropping rates a combined 49% since 2024 – threatening provider participation across 247 of 254 counties and access for ~1 million rural veterans in that locality. Providers report they were not included in discussions, and the locality approach focuses on fewer than 10 counties. Neighboring New Mexico ($54/hr.) and Oklahoma ($67/hr.) pay substantially more than the FY2026 "Rest of Texas" locality rate ($38/hr.), for the same service, despite Texas' longer travel and workforce challenges. Further challenges in care delivery stem from variability in Care Coordination (CC), which affects the Standardized Episodes of Care (SEOC) through Case Mix Index Assessments (CMI). This variability can lead to inequitable access to medically necessary services. Since mid-2024, the VA's transition from annual to semi-annual authorization processes has increased the assessment workload for care coordination. The addition of unnecessary screening questions has resulted in reduced approved hours for veterans, creating undue burdens and, in some cases, contributing to avoidable hospitalizations. **TAHC&H calls on Congress to direct VA to:**

- **Maintain FY2025** rates now for "Rest of Texas Locality"
- **Require transparent**, rural-sensitive rate-setting,
- **Ensure** that the SEOC is applied consistently and
- **Align CCN** NextGen with on-the-ground realities, so Texas veterans aren't left without timely in-home care.

b. Different regions of Texas are reimbursed at varying rates for skilled nursing and therapy services by the VA. Similar to MA plans, home health agencies in parts of Texas receive below-market reimbursement for skilled services provided to VA patients. These rates limit access to care for veterans, particularly those living in rural areas of Texas. **TAHC&H calls on Congress to direct VA to:**
   - **Standardize reimbursement rates for skilled nursing and therapy services so that they align with the episodic payment methodology and fee schedule utilized by Medicare.**

Keep Hospice Out of Medicare Advantage

Preserve the long-standing hospice carve-out so beneficiaries retain barrier-free access and Medicare maintains a benefit that works for patients and providers. Hospice is already a comprehensive, risk-based, managed-care model that prioritizes dignity, comfort, and family choice at the end of life; inserting MA plans creates a middleman that limits provider choice, delays or denies care, and threatens small and rural hospices through lower rates and payment delays. The VBID hospice carve-in (2021–2024) demonstrated significant operational and access challenges and was terminated effective December 31, 2024, underscoring that a carve-in creates more problems than solutions. **TAHC&H calls on congress to:**

- **Oppose integrating** ("carving-in") hospice into Medicare Advantage and sign the **Dunn (R-FL)–Bera (D-CA)** letter to congressional leadership.

Ensure permanent telehealth flexibility in the home health and hospice benefit

Telehealth (including telephonic, telemonitoring, and video conferencing) enables providers to deliver care safely and effectively. Currently, home health agencies are allowed to accept orders from a physician, nurse practitioner or physician assistant for home health after a face-to-face visit has been completed either in person or using telehealth. The administrative component of the certification process ensures timeliness of services for Medicare beneficiaries in need of these medically necessary services. Additionally, COVID era flexibilities extended the face-to-face component to Hospice agencies as well, ensuring these critical services can be delivered to beneficiaries in their last days of life. We appreciate Congress' continued extension of these flexibilities, which currently expire on December 31, 2027; however, we urge these flexibilities be permanently extended as they have proven to improve the quality and efficiency of care, **TAHC&H supports legislation making these flexibilities permanent.**

Ensure any Medicaid reforms do not limit patient access to HCBS services

a. In April 2024, CMS finalized a rule requiring that states ensure at least 80% of all Medicaid HCBS payments are spent on compensation for direct care workers, such as nurses, home health aides, and others who directly support Medicaid beneficiaries in activities of daily living at home. The remaining 20% of the payments are expected to cover all the other HCBS operating expenses. TAHC&H opposed this "80/20 Rule" being finalized and remains concerned about the lack of data from CMS to support the need for the rule, potential exacerbation of existing workforce shortages, especially in small and rural communities, and adverse impacts on affordability, among other issues. In 2024, Rep. Kat Cammack (R-FL) introduced a bill to prohibit CMS from implementing the 80/20 Rule that was cosponsored by several members of Congress from Texas. **TAHC&H supports legislative or regulatory efforts to prohibit CMS from implementing the 80/20 requirement.**

b. Medicaid Home and Community-Based Services (HCBS) offer essential state and federally funded services to help Medicaid enrollees with complex care needs get the support they need to continue living in their homes in lieu of more costly institutional settings. As Congress continues to assess policy options that may further reduce federal spending, **we support policies that prioritize ensuring access to the high-value and cost saving home and community-based programs that have proven to reduce overall health care spending in Medicaid.**