2026 ANNUAL CONFERENCE & EXPO

Celebrating 60 Years

Then. Now. Next.

Elite-Level Outcomes for Home Health

Winning in a Value Driven Era, the HH Moratorium, Finding Future Success

June 22, 2026

Presenters

- HH Post-Acute Consulting Firm –Post-Acute Outcomes
- Arnie Cisneros PT – President, SURCH Developer
- Kimberly McCormick RN BSN – Exec Clinical Director
- UR Mgmnt Model for HH PDGM & VBP Reforms – SURCH
- PAC PPS Trials w PIONEER ACO – Value-Based Models
- Deliver VBP-Level HH Outcomes in Value Era
- HH Operational model replicates Medicare Part A success
- Objective, real-time care production & delivery mgmnt
- Elite-Level HH Operations and Outcomes

CMS Announces Aggressive Nationwide Crackdown on Fraud with 6-month Home Health Moratorium

CMS Nationwide 6-month HH Moratorium Fraud Initiative

The moratorium is a temporary suspension or halt on the enrollment of new providers in specific categories or geographic areas. CMS implements moratoria as a program integrity measure to prevent fraud, waste, and abuse (FWA) by stopping, for example, the enrollment of new providers in geographic areas where there is significant potential for FWA.

CMS Nationwide 6-month HH Moratorium Fraud Initiative

Home Health fraud, waste, and abuse has been a severe problem for over two decades. Based on our experience, low start-up costs and the home-based nature of the services – with little direct supervision of the persons performing them – help make the HHA arena ripe for fraud. Indeed, HHAs have long been among the highest-risk Medicare provider/supplier types in terms of program integrity.

CMS Nationwide 6-month HH Moratorium Fraud Initiative

We've seen systemic and deeply troubling fraud in the HH space, with bad actors exploiting some of our most vulnerable Medicare patients & stealing money from the American taxpayer. "Today we're shutting the door on fraud – preventing new bad actors from entering Medicare while we aggressively identify, investigate, and remove those already exploiting them. This is about protecting patients, restoring integrity, and safeguarding taxpayer dollars."

CMS Administrator Dr. Mehmet Oz

Areas of Concern for HH Fraud, Waste, & Abuse

Areas of Concern for HH Fraud, Waste, & Abuse

- CMS is seeking Value-based Care Programs from ALL Part A Providers
- Progressive Care Development and Management for Medicare beneficiaries
- ALL Part A Providers manage care from Admission – Discharge via QA/UR
- Acute Care – manages DRGs thru "Documentation for Coverage" model (DFC)
- MD, Nursing, Therapy notes read daily for qualified care and POC mgmnt
- Inpatient Rehab Facility (IRF) – 3 hours/day Therapy required for admission
- Daily Utilization Review (UR) of therapy notes in DFC mode
- Sub-Acute Rehabilitation – occurs in Skilled Nursing Facilities
- SNF LOS managed via Minimal Data Set (MDS) – Medicare Post-Acute UR

Areas of Concern for HH Fraud, Waste, & Abuse

- MDS – Minimal Date Set – CMS-developed UR program for rehab/nursing
- MDS based on Medicare Post-Acute UR philosophies for qualified care
- MDS Example – Therapy Evals – DAY 1 ------- DAY 6-7 ---------- DAY 13-14
- Home Health lacks controls seen in ALL other Medicare Part A Providers
- CMS FWA Home Health efforts related to lack of these management controls
- HH PPS Volume Identity has lingered – PDGM Value model un-installed
- Most HH Supervisory – Clinical staff unaware of PDGM V2V change
- Reflected in lacking Value content – MVs, Readmits, Non-compliance, Falls
- HH lack of management of clinical staff delivering care

Areas of Concern for HH Fraud, Waste, & Abuse

- Failure to transition to Value model limits HH potential
- Focus on payment rates limits success in VBP P4P model
- HH Care Initiatives align Care Episodes with contemporary programming
- PART A practices from Providers outside of HH address current issues
- These practices address successful management of CMS HH model
- From timely care to accurate admissions, rights and responsibilities
- Management of skill & homebound status, POC development/management
- In-Episode Control, Compliance, Value-based Outcomes, HH model compliance

Specific Areas of Concern for HH Fraud, Waste, & Abuse

Specific Areas of Concern for HH Fraud, Waste, & Abuse

- Medicare developed and evolved the Home Health benefit
- Initial identity as Post-Acute Provider has expanded x 20 years
- CMS – MED PAC plans to shift significant care programming to HH
- Covid effect – further impetus to reduce inpatient care programs
- Inpatient - significant costs plus infections, death, etc.
- Home Health has struggled to change identity despite PDGM, VBP, etc
- HH retro-active Model puts us behind the 8-ball compared to other Part A
- Unable to perform or compete in Value model on retro-active basis

Specific Areas of Concern for HH Fraud, Waste, & Abuse

- Clinician-led model also impedes Value Era success
- Bring Care Control from clinician's cars-patient homes to agency to manage
- Assure SOC OASIS accuracy – 72% OASIS accuracy (Scrubbers don't improve)
- Timeliness – particular HH weakness based on scheduling/productivity issues
- HH POC development – by front-line staff in HH, not done in any other Part A
- In-Episode Care Management – required for success w PDGM Capitated Model
- Care Intrinsics – Rights/Resp, MVs, Compliance, Skill, Homebound
- Discharge Management – assure program completion, Post-DC, HHAHCPS

What's on the other side of the HH Moratorium?

Preparing for the Future of HH

What's on the other side of the HH Moratorium?

- Pending HH reforms outline a steeper Value Path ahead
- Future reforms build on Value-Based success model
- Further VBP Expansion w greater Payment portion connected to outcomes
- PAC PPS – we're headed toward Post-Acute Bundling for ALL HH patients
- CJR National Expansion slated for 10/1/27 installation - Joint Replacements
- PAC PPS Bundled Payment for Care Improvement (BPCI) 2018 HHSM DMC
- Performed for Center for Medicare/Medicaid Initiatives (CMMI)
- Significant savings seen for >13,000 Post-Acute patients
- PAC PPS – 90-day Bundle with Hospital as Convener

What's on the other side of the HH Moratorium?

- PAC PPS Initiative requites Bundle collaboration with Convener
- Quality Outcomes required for Bundle participation – Star Ratings, Readmits
- Timeliness, Falls Management, Value-Based POC, Compliance, MVs, etc.
- Financial disclosures required – HH spending and Fiscal health (MSPB)
- Full Clinical Control required with In-Episode Control for rapid outcomes
- Ongoing Convener Management – assures ongoing care improvements
- Bundle rosters are traditionally prospective – ongoing roster evolution
- Post-Acute Providers removed/added as basic Bundle Management
- Significant HH Opportunity – HHSM Bundles with > 60% SAR-SNF reduction

Utilization Review for Management of efficient Medicare Programming

Utilization Review (UR) Process Part A Management

Utilization Review (UR) is a systemic process used by hospitals, health insurers, and other healthcare Providers to ensure that medical services are medically necessary, provided in the most appropriate setting, and delivered efficiently. The goal is to balance high-quality care with cost control, ensuring patients receive the right care at the right time. All Medicare Part A Providers outside of Home Health manage care development and content through use of realtime, UR-based care management.

A Home Health Rewire to Establish a Value-Based Operational HH Model for Elite-Level Success

HH Rewire for Value-Based HH Operational Model

- HH Operations based in the PPS HH Era when they were developed
- HH Operations - PPS-era philosophy that fails to support PDGM
- Focus is Agency and front-line staff – independence, clinician satisfaction
- Clinical staff often leads in area of Admit, Care, DC, Utilization, etc
- Other Medicare Providers address care targets for success
- Bring the care control from the staff cars & patient homes into the agency where it can be managed in realtime.
- Help Admin/Supervisory/Clinical Staff transition to Value-Based Care

HH Rewire for Value-Based HH Operational Model

- Key Performance Indicators (KPIs) used for objective assessment
- Care areas determined as Operational Targets based on PDGM-VBP
- Weekly KPI tracking & analysis meetings w VBP goals for staff
- Monthly clinical staff meetings to assess realtime success
- Manage HH as inpatient providers manage care and staff
- Why not 24-hr SOCs? Why under-productive staff? Falls? Readmits?
- How do we rewire our agency to address these areas for success?
- How do we raise all boats??

Connecting Clinical Operations to Value Outcomes

Connecting Clinical Operations to Value Outcomes

- Breaking down improving Clinical Quality – BREAK the HH MODEL
- Compare to Other Part A Providers – what's different
- Lead your Care – Manage your Staff – Focus on the patient
- Stop retro-active care management – costly & doesn't work
- Stop predicative software programs – all patients are different
- Admissions – 24 hours SOCs limited by admission, scheduling, Prod
- Move your care and your staff forward with regular meetings and Objective Performance data

Connecting Clinical Operations to Value Outcomes

- Follow PDGM - VBP Value Era reform changes – move close to staff
- Internalize HH PDGM – rewards rapid changes w capitation
- Rewards better care programs, delivery, best practices
- Capitation changes put mistakes on agency's dime – it costs you
- Consider routine HH elements you may have:
  - Late SOCs
  - Inaccurate OASIS
  - Non-Compliance

Connecting Clinical Operations to Value Outcomes

- Consider routine HH elements you may have:
  - Rehab FIL non-use?
  - POC development (PPS?)
  - Missed Visits (MVs)
  - Falls? Readmits?
  - Managing data for change
  - Staff issues
  - ONGOING HH changes – Updates – Reforms

Value-Based Purchasing 2026
VBP continues to Evolve

Category	Score Component	2025	2026
Functional Outcomes	Discharge Function Score	✔	✔
	Dyspnea (Risk-Adjusted)	✔	✔
	Oral Medications (Risk-Adjusted)	✔	✔
*New 2026	Bathing (Risk-Adjusted)		✔
*New 2026	Upper Body Dressing (Risk-Adjusted)		✔
*New 2026	Lower Body Dressing (Risk-Adjusted)		✔
Utilization & Safety	Potentially Preventable Hospitalization	✔	✔
HHCAHPS	Communication *Removed 2026	✔	
*Removed 2026	Care of Patient	✔	
*Removed 2026	Specific Care Issues	✔	
	Would Recommend	✔	✔
	Overall Rating of 9 or 10	✔	✔

Functional Outcomes	Discharge Function Score	✔
	Dyspnea (Risk-Adjusted)	✔
	Oral Medications (Risk-Adjusted)	✔
*New 2026	Bathing (Risk-Adjusted)	✔
*New 2026	Upper Body Dressing (Risk-Adjusted)	✔
*New 2026	Lower Body Dressing (Risk-Adjusted)	✔
Utilization & Efficiency	Potentially Preventable Hospitalization	✔
*New 2026	Medicare Spending Per Beneficiary	✔
HHCAHPS	Overall Rating of 9 or 10	✔
	Would Recommend	✔
Community & Discharge Measures	Discharge to Community	✔

VBP Outcomes Increase w/ HHSM

VBP Category	VBP 90th Percentile	Client 1		Client 2		Client 3	
		Baseline	HHSM	Baseline	HHSM	Baseline	HHSM
Discharge Function Score (VBP)	83.18	80.81	96	79.4	94.2	76.8	88.7
Improvement in Dyspnea (VBP)	99.42	88.7	99.3	75.87	100	88.05	98.51
Improvement in Mgmt. of Oral Meds (VBP)	98.75	77.9	98.4	69.89	97.5	79.5	98.89
Potentially Preventable Hospitalization (VBP)	6.3	14.12	4.3	17.6	6.5	19.4	7.1
Discharge to Community (VBP)	95.09	83.07	94.12	83.43	100	70.49	96.13
Bathing (VBP) 2026	99.26	94.8	97.35	86.8	98.76	93.9	99.2
Upper Body Dressing (VBP) 2026	98.57	93.2	97.46	90.41	96.79	94.22	98.1
Lower Body Dressing (VBP) 2026	98.21	92.5	98.1	89.13	95.79	93.24	96.4
*Medicare Spending Per Beneficiary (VBP) 2026	0.78	NA	NA	NA	NA	NA	NA
% who Rated Agency 9,10 (VBP)	94.69	81.8	96.1	86.6	94.4	85.94	94.78
% who would Recommend (VBP)	91.39	82.3	92.8	82.7	95.2	79.98	89.58
Total Performance Score (VBP)	90%	19%	98%	13%	92%	25%	94%

Operational Goals for Value-Era Home Health Success

Operational Items to address for Value-Era Success

- Rewiring Intake – Complete intake mgmnt for timely SOC
- OASIS Admit – Accurate Clinical Profiles (Scrubbers don't do it)
- POC Development – Global Programs, Value-based POC Orders
- Scheduling Control – Making scheduling work for patients, staff
- Documentation Review – Assure qualified care w required content
- In-Episode Management – Patient-specific clinical rounds replace
- Rapid Outcomes – Value-Based care seeks rapid care outcomes
- Discharge for Outcomes – DC's approved for appropriate DC - HHCAHPS

Key Performance Indicators (KPIs) to Manage Value-Era Outcomes

Drilling Down KPIs for Success in the Value Era

- Value Reform PDGM - objective, outcome-based capitated model
- VBP furthers the Value Identity of w V2V shift and P4P structure
- Value Era Operations delivers incant success to Part A Providers
- Inpatient Part A Provider structure – objective, process-based
- Managed in realtime for optimal SOCs, Productivity, missed Care reduction, Mgmnt In-Episode (content/skill/progress), documentation, DC mgmnt, HHCAHPS, VBP outcomes
- Patient-centered HH model w Care Control returned to Agency

Current Client KPI

	Baseline	Target	November 2025	December 20025
HHRG 1-30 Day	$2,696.00	$2,900.00	$2,911.08	$2,875.47
HHRG31-60 Day	$1,718.00	$1,900.00	$1,935.47	$1,894.52
Case Mix	1.037	>1.2	1.35	1.35
NTUC	20	14	6	4
LUPA 1-30 Day	5.5	3	2	1
LUPA 31-60 Day	6.6	3	1	3
Missed Visits	254*	0	310	335
Census	380	NA	480	513
Admits/Month - SOC&REC	198	>238	397	411
Episodic %	90%	>70%	91%	91%
Nursing Savings Total			$ 92,431.92	$ 196,103.91
SNV/Month	13	5	4.92	4.37
Falls	83*	0	63	52
Rehospitalization Totals	81*	<7%	72	58

VBP Analysis of Public Reported Outcomes

	Baseline	Target = 90th % VBP	November 2025	December 20025
Star Rating	4	4.5+	**5**	**5**
Timely Initiation of Care	100	100	**98.7**	**100**
Oral Meds	93.68	98.75	**97**	**97.4**
Ambulation	90.6	95.8	**95.9**	**96.1**
Bed Transfer	93.9	95.5	**99**	**96.2**
Bathing	93.9	97.4	**99.7**	**98.8**
Dyspnea	95.42	99.42	**99.2**	**99.4**
PPH	9	6.3	**5.7***	**3.4***
DFS	88.56	83.18	**85.9**	**89**
TPS	49.71	82 – 90th %	**90.05 – 96%**	**88.72 – 96%**
VBP Bonus	2.50%	5%	NA	NA

Hardwired Client KPI

	Baseline	Target	March 2025	April 2025
HHRG 1-30 Day	$1,975.00	$2,700.00	$2,784.60	$2,791.72
HHRG31-60 Day	$1,486.00	$1,800.00	$1,798.27	$1,888.20
Case Mix	1.01	>1.2	1.28	1.34
NTUC	41	29	13	8
LUPA 1-30 Day	16	3	3	1
LUPA 31-60 Day	19	3	4	2
Missed Visits	442	0	73	70
Census	484	NA	472	481
Admits/Month - SOC&REC	312	>238	316	341
Episodic %	45%	>70%	60%	67%
Nursing Savings Total			$416,000.00	$487,300.00
SNV/Month	12	5	4.09	4.07
Falls	43	0	21	16
Rehospitalization Totals	91	<7%	33	29

VBP Analysis of Public Reported Outcomes

	Baseline	Target = 90th % VBP	March 2025	April 2025
Star Rating	1.5	4.5+	5	5
Timely Initiation of Care	97	100	99.2	100
Oral Meds	77.9	98.75	98.1	98.4
Ambulation	83.7	95.8	91.4	95.9
Bed Transfer	84.7	95.5	93.4	95.7
Bathing	87.8	97.4	98.8	100
Dyspnea	88.7	99.42	96	96.4
PPH	14.12	6.3	8.3	4.3
DFS	80.81	83.18	87.05	90.6
TPS	21.98	82 – 90th %	74.3 - 76%	83.1 - 94%
VBP Bonus	-3.81%	5%	NA	NA

Thank You!

Home Health Strategic Management

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