

Navigating the Tightrope of Home Health Technology...



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What the 2026 Home Health Regulatory Update Means for Home Health Agencies

Home health agencies are being asked to do more with less, again.

The 2026 regulatory outlook is putting reimbursement, compliance, and operational performance under a brighter spotlight. Industry commentary has focused heavily on the proposed Medicare payment reduction for home health, while software and operations leaders are warning agencies to tighten workflows, improve documentation discipline, and prepare for more pressure on margins. Alora's 2026 regulatory overview highlights the broader mix of payment, quality, and compliance issues agencies need to watch, while industry leaders like Zach Rosen have called out the financial shock of CMS's proposed payment methodology changes.

For agency owners, administrators, and revenue cycle leaders, the message is straightforward: this is not the time for revenue leakage, aging AR, coding slowdowns, or billing instability.

At **BillingDept.co**, we believe the agencies that navigate this environment best will be the ones that protect the revenue cycle first.

CMS's Proposed 2026 Home Health Payment Cut Is a Cash Flow Issue

On June 30, 2025, CMS released the CY 2026 Home Health Prospective Payment System proposed rule. CMS said the rule includes a proposed 2.4% home health payment update, but that increase is more than offset by other proposed adjustments, including a permanent behavioral adjustment and a temporary adjustment reduction tied to prior years. CMS estimated the overall impact as a **6.4% aggregate decrease** in Medicare payments to home health agencies, or about **\$1.135 billion** less than CY 2025.

That headline matters.

Even if an individual agency's exact result differs based on case mix, geography, and payer mix, a proposed aggregate cut of this size creates immediate planning pressure. Agencies do not experience these changes in a vacuum. Reduced reimbursement often collides with already-thin staffing, delayed collections, rising denial complexity, and operational strain.

That is why the 2026 update is not just a compliance story. It is a revenue cycle story.

If payments tighten, agencies need stronger discipline around:

- timely claim submission

- clean billing workflows
- coding accuracy and turnaround
- denial follow-up
- collection of aging receivables
- payer-specific AR strategy

When margins compress, unresolved AR becomes even more expensive.

Why Industry Leaders Are Alarmed

In his LinkedIn post on the proposed rule, **Zach Rosen** argued that CMS is effectively trying to recoup billions in assumed overpayments tied to PDGM-era behavior, despite those assumptions not matching how providers actually operated. His post frames the issue as a modeling problem with real-world financial consequences for agencies already trying to deliver care under difficult conditions.

Whether agencies agree with that framing or not, the concern is easy to understand. If reimbursement pressure rises because of methodology assumptions rather than operational failures at the agency level, providers still absorb the damage through lower cash inflow and tighter operating flexibility.

That makes revenue protection more urgent, not less.

The 2026 Regulatory Environment Is Bigger Than One Number

The payment discussion has taken center stage, but the 2026 regulatory environment is broader than a single percentage cut. CMS's proposed rule also includes updates tied to home health quality reporting, Home Health Value-Based Purchasing, and requests for information around data submission timelines and digital quality measurement transition.

Alora's regulatory summary similarly points agencies toward the bigger operational picture: agencies are not just responding to rate changes, but to a wider environment of compliance expectations, reporting demands, and workflow sensitivity.

For leadership teams, that means the right response is not panic. It is operational clarity.

Agencies should be asking:

- Where are claims getting delayed?
- Is coding turnaround slowing billing?

- Are denials being worked aggressively enough?

- Is AR aging because of staffing limits or broken workflows?

- Do current systems support faster reimbursement, or are they adding friction?

In a year like 2026, weak processes become expensive very quickly.

What Home Health Agencies Should Do Right Now

The most important response to the 2026 update is to focus on the parts of the business you can control.

1. Attack aging AR immediately

Old receivables are one of the clearest sources of trapped cash. In a tighter reimbursement environment, letting AR over 60, 90, or 120 days sit untouched is no longer just frustrating. It is strategically dangerous.

Many agencies already earned this revenue. The issue is follow-up capacity, payer expertise, and disciplined collections effort. That is why aging AR recovery often creates some of the fastest ROI available to an agency.

At BillingDept.co, this is one of our core specialties. We help agencies recover outstanding receivables so cash already earned does not remain stuck on the books.

2. Stabilize AR before it becomes a larger problem

Aging AR is not always just a collections issue. Sometimes it points to upstream problems in intake, authorizations, coding, documentation, claim edits, or payer follow-up. Agencies need to identify why balances are aging, not just acknowledge that they are.

This is where payer-specific expertise matters. Different payers create different follow-up realities, and generic billing approaches often miss that. A tighter 2026 reimbursement environment leaves less room for passive AR management.

3. Tighten coding turnaround and accuracy

Coding delays can quietly choke the revenue cycle. When coding is slow, inaccurate, or backlogged, claims slow with it. Under margin pressure, agencies need coding support that is fast, precise, and accountable.

BillingDept.co provides coding support at industry-low cost, and our coding is **never outsourced**. That matters for consistency, speed, and confidence.

4. Review whether your current tech stack is helping or hurting cash flow

The home health market is full of platforms, add-ons, workflow tools, and analytics promises. But technology should serve reimbursement, not distract from it.

If your system creates manual workarounds, slows handoffs, or reduces billing visibility, it is not fully optimized. The 2026 rule environment makes it even more important to evaluate whether your current stack supports the revenue cycle or quietly disrupts it.

5. Add billing support before backlog turns into lost cash

When internal teams are stretched thin, reimbursement often slips gradually before leadership fully sees the extent of the problem. Claims lag grows. Follow-up slows. Denials stay open longer. Posting and reconciliation fall behind.

The right staff augmentation or billing support can help agencies protect current production while also working through legacy AR and process strain.

Why Revenue Cycle Strategy Matters More in 2026

Regulatory changes always create headlines. But agencies do not survive on headlines. They survive on disciplined execution.

A proposed 6.4% aggregate Medicare payment reduction means agencies need more than awareness. They need a plan. CMS's own proposed-rule materials make clear that the 2026 update includes significant payment and policy changes, while industry reaction shows just how disruptive those changes could feel on the ground.

The agencies that respond well will likely do a few things better than everyone else:

- collect faster
- code more accurately
- reduce preventable lag



- strengthen payer follow-up
- stabilize billing operations
- protect the revenue cycle during change

That is exactly where BillingDept.co brings value.

How BillingDept.co Helps Agencies Respond

BillingDept.co acts as a safety net for home health and hospice agencies in rapidly changing market conditions.

We help agencies:

- **collect aging receivables** and unlock immediate ROI
- **stabilize AR** using real payer expertise
- provide **billing services and staff augmentation**
- deliver **best-in-class coding** at industry-low cost, never outsourced
- support new agencies with **start-up-in-a-box** revenue cycle infrastructure
- evaluate workflow risk without disrupting reimbursement

Our philosophy is simple: **we do not get paid unless you get paid.**

That alignment matters in an environment where every dollar, every day, and every claim cycle matters more.

Final Thoughts

The 2026 home health regulatory update is a warning sign for agencies that have tolerated revenue leakage, billing backlogs, and unresolved AR for too long. With CMS proposing an aggregate payment decrease and the industry openly questioning the logic behind parts of that reduction, agencies cannot afford weak revenue cycle performance.

This is the moment to get tighter, faster, and more disciplined.

Not by creating disruption.

By protecting the financial core of the agency.

That is what BillingDept.co is built to do.

Need help stabilizing AR, collecting aging receivables, improving coding, or supporting your billing team? BillingDept.co can help you protect cash flow when it matters most.

