National Alliance for Care at Home

August 28, 2025

VIA ELECTRONIC SUBMISSION

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1828-P
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: CMS-1828-P, Medicare Program; CY 2026 Home Health Prospective Payment System Rate and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program Updates

Dear Administrator Oz:

The National Alliance for Care at Home appreciates the opportunity to submit comments on the **Calendar Year (CY) 2026 Home Health Prospective Payment System Rate and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program Updates Proposed Rule** (Proposed Rule). The Alliance is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. Formed through the joint affiliation of the National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO), the Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, persons with chronic and serious illnesses, as well as dying Americans who depend on those supports.

Our detailed comments to the Proposed Rule are provided below.

Executive Summary: Proposed Permanent and Temporary Payment Adjustments

The National Alliance for Care at Home (the Alliance) is deeply concerned about the Centers for Medicare & Medicaid Services' (CMS) proposed 9% home health payment cut for CY 2026 and the impact of these cuts on the health and safety of beneficiaries and the function of the healthcare system. Payments to home health agencies (HHAs) are estimated to decrease by $1.135 billion in 2026 as a result of the policies in the Proposed Rule. CMS's continued cuts to home health payments are based on a fundamentally flawed approach and represent a direct threat to the care millions of Medicare beneficiaries rely on. Access to home health care has continuously eroded during the period of these misguided payment cuts, evidenced by increasing unfilled referrals, delays in care, and home health agency closures. Limited access to home health impacts the broader health care system by increasing overall Medicare costs making it harder to discharge patients from hospitals and skilled nursing facilities to their homes. This Proposed Rule, if finalized, will continue these troubling patterns.

The law directs CMS to determine the impact of differences between assumed and actual behavior change on estimated aggregate expenditures directly resulting from the implementation of the 30-day unit of payment and the new case-mix adjustment methodology without therapy thresholds (collectively referred to as the Patient Driven Groupings Model, or PDGM). The unwarranted cuts to home health are driven by CMS's flawed approach that incorrectly attributes any behavior change to PDGM, when in fact the underlying claims data reflects changes due to other unrelated policy changes. The unwarranted cuts are also related to CMS calculations made with datasets that include data from fraudulent providers, especially those that have proliferated in Los Angeles County, California in recent years, and penalizes legitimate providers and beneficiaries for these anomalies. The Alliance stands at the ready to support efforts to eliminate home health fraud and ensure all Medicare beneficiaries receive the high-quality care they deserve. Significant errors in CMS's approach are highlighted in this comment letter and must be addressed to preserve access to home health and promote a high-value Medicare system.

When the PDGM was implemented in 2020, Congress required that the transition be budget neutral. Yet the policies CMS has adopted, beginning with the original 2020 payment rate and followed by additional cuts in 2023 through 2025, have reduced total home health aggregate expenditures by more than $2 billion annually in a manner that Congress did not intend. Rather than course-correcting, CMS is now proposing a -4.06% permanent adjustment to the 30-day payment rate and a -5% temporary adjustment that would begin to recover an additional $5.3 billion in alleged overpayments. These cuts are being proposed in a payment environment where we estimate that total Medicare fee-for-service spending on home health will decline to $15 billion in 2025, down from nearly $18 billion in 2019. **This is not budget neutrality, this is a systemic defunding of the Medicare home health benefit resulting in access to care concerns throughout much of the country**.

CMS's basis for these payment cuts rests on calculations that are deeply flawed and inconsistent with what Congress intended. Key concerns with CMS's approach are summarized as follows:

- Data from 2022 and beyond reflects unrelated policy changes and market disruptions, not behavior changes due to PDGM.
- The inclusion of highly suspicious claims from Los Angeles County, California that impact CMS's calculations for the permanent and temporary adjustments as well as undermine the integrity of the payment system. CMS has taken steps to exclude fraudulent data in other programs, such as adjusting benchmarks in the Medicare Shared Savings Program to remove highly suspect and anomalous data but has failed to take similar steps for home health.
- Exclusions of large amounts of data and the assumptions used in CMS's analytical approach introduce bias, undermine the accuracy of CMS's calculations, and are unrelated to the new case-mix adjustment methodology under PDGM and the transition from a 60-day episode to a 30-day unit of payment. These include (but are not limited to):
    - Excluding roughly 20 percent of 30-day claims from the analysis;
    - Structural issues with how low-utilization payment adjustments (LUPAs), outlier payments, and changes to clinical groups are handled when 30-day claims are 'repriced' as 60-day episodes;
    - Static case-mix weights from 2019 used for repricing, even though CMS's policy was to recalibrate the pre-PDGM case-mix weights annually using the most recent data available; and
    - OASIS data for payment items used under the previous payment that are no longer collected and the assumptions CMS makes to map back to those items for its repricing approach.

We also raise several legal and technical issues in response to prior proposed rules that CMS has yet to sufficiently address. In addition to addressing our concerns regarding its calculations used for determining the permanent adjustments and temporary adjustments dollar amounts, CMS needs to adjust its calculations of the temporary adjustment dollar amounts to reflect the reduction in Medicare fee-for-service enrollment of over 11 percent between 2019 and 2024. Finally, lower payments on the fee-for-service side produce savings in Medicare Advantage through reduced benchmarks, creating a scenario where CMS collects more than the aggregate dollars it has determined for temporary adjustments. CMS must take this into account in determining the temporary adjustments.

In sum, if CMS's flawed approach is used as the basis for continued and expanded payment cuts, the consequences will be severe. HHAs, particularly small and rural providers, are already struggling to maintain operations in the face of declining margins and escalating labor costs. Further cuts would jeopardize beneficiary access, particularly for those with complex care needs who depend on home health services as an alternative to institutional care. These cuts also risk shifting costs elsewhere in the Medicare program, including hospitalizations and skilled nursing facility stays, contradicting CMS's broader value-based care goals. The approaches used by CMS are contrary to the stated goals of reducing fraud and abuse, these approaches bake fraudulent data into the payment system and punish legitimate providers while doing nothing to stop fraud. We strongly urge CMS to revise its approach and the policy rationale underlying these proposed adjustments.

Alliance Recommendations:

- The Alliance strongly recommends that CMS not finalize the proposed -4.06% permanent adjustment for CY 2026, recalculate the total permanent adjustments determined for CYs 2020 – 2024 (claims data analyzed to date) correcting for the issues identified in this comment letter, and finalize a positive permanent increase to the 30-day payment rate in 2026.

- The Alliance also strongly recommends that CMS not finalize the proposed -5% temporary adjustment in CY 2026 and recalculate the total temporary adjustments dollar amounts for CYs 2020-2024, taking into account home health expenditure decreases that already occurred due to excess permanent adjustments applied in prior years. Additionally, we recommend that CMS account for shrinking FFS enrollment and payment offsets occurring through lower Medicare Advantage (MA) benchmarks, which likely result in positive temporary adjustments. However, if CMS determines that negative temporary adjustments may still be warranted, the agency should use CMS's "time and manner" authority to pause any temporary adjustment for CY 2026 while the agency evaluates an appropriate schedule for implementing any future adjustments that do not jeopardize the ability of Medicare beneficiaries to access high-quality, legitimate home health care.

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1. The Home Health Prospective Payment System

The Alliance writes in urgent opposition to the Proposed Rule which will have devastating consequences for both beneficiaries and the home health providers that serve them. We respectfully request that CMS not finalize its proposals to impose permanent and temporary adjustments in CY 2026 and make necessary changes in its approach. The estimated total impact of the Proposed Rule is a $1.135 billion decrease in funding to Medicare-certified home health agencies (HHAs) compared to 2025, an unsustainable payment reduction impacting the viability of the Medicare home health benefit.

The proposed reductions come in the wake of nearly 9% in funding cuts imposed by CMS from 2023 to 2025 that have already caused beneficiaries to lose access to home health care as HHAs substantially reduce service areas or close altogether. According to CMS's own data, between 2019 and 2024, over 1,000 HHAs have closed, and the number of home health users has decreased by 20%.[1] The home health delivery system cannot sustain the reductions set forth in the Proposed Rule.

Even as the Alliance will demonstrate substantive flaws in CMS's calculations and corruption of the data underlying them below, the proposed reductions' cumulative effect will, if finalized, decimate the delivery system, leaving beneficiaries with essentially no viable option to receive skilled care in their homes and communities, and forcing them into higher-cost, higher-risk institutional settings at greater cost to the Medicare program.

For these reasons, and for the more detailed justifications we provide herein, we urge CMS to not finalize the proposed permanent and temporary adjustments in this Proposed Rule. Further, the Alliance urges CMS to refine its approach to make it consistent with Congressional intent. ***In our comments below, we have demonstrated that CMS's calculations contain critical flaws that overstate the permanent and temporary payment adjustments, incorrectly attributing them to provider behavior, when they are largely the result of unrelated policy changes, fraud, and technical errors in CMS's approach and use of data. As a result, CMS has overcorrected for any plausible behavior change attributed to the 30-day unit of payment and new case-mix adjustment methodology implemented on January 1, 2020, and should issue a positive permanent adjustment instead of a negative one.***

[1] https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

A. Home Health Access to Care Concerns

i. Benefits of Home Health Care

Millions of Medicare beneficiaries rely on home health care for skilled nursing and therapy services in the comfort and safety of their homes. Home health care is preferred by beneficiaries, their physicians, and their families over institutional care. As CMS itself knows, home health agencies (HHAs) provide high-quality care for beneficiaries and provide substantial savings to the Medicare program. CMS estimates that the home health value-based purchasing model (HH VBP) will result in Medicare savings of $3.4 billion for CYs 2023 through 2027 resulting from reductions in unnecessary (e.g., hospital readmissions) or avoidable service utilization (e.g., nursing home stays), and gains in functional status (87 FR 66883).

In addition to creating value for the Medicare program, the Medicare home health benefit brings clinicians to homebound beneficiaries where they live, providing personalized care needed to treat an illness, injury, or chronic disease. The availability of home health services means Medicare beneficiaries can stay in their homes and avoid costly nursing home stays, and it allows hospitalized beneficiaries to return home with the skilled care they need to recover, allowing hospitals to direct resources to more urgent and intensive care patients.

The Alliance believes that all beneficiaries eligible and with a need for home health care should be able to have access to the benefit. Unfortunately, the Proposed Rule severely compromises this important in-home care option. The Proposed Rule's unprecedented rate cuts for HHAs come at a critical juncture after years of funding reductions and dramatically increased labor costs that are not captured by Medicare's annual updates that together have left the home care delivery system severely compromised. This has resulted in reduced access and disrupted care transitions that have unnecessarily driven overall system costs up,[2] and increased beneficiary mortality.[3]

[2] When HHA services are delivered promptly and consistent with Medicare coverage criteria, estimates show that home health care reduces costs in the 90 days following a hospital discharge by $1.3 billion annually. https://carejourney.com/how-timely-access-to-home-health-care-impacts-cost-and-outcomes/

[3] *Id*. Beneficiaries discharged from hospitals without receiving ordered home health services are 43 percent more likely to die within 90 days, 36 percent more likely to be readmitted, and 16 percent more likely to visit the emergency department.

ii. Significant Declines in Home Health Access

The Alliance has observed its member HHAs confront substantial and unreconcilable challenges in attracting and retaining skilled labor due to the continued payment cuts and as actual labor price trends for nurses and therapists far outpace CMS's annual market basket updates. As a result of the current adverse reimbursement environment, HHAs have been forced to limit their service areas or closed altogether, creating major obstacles to beneficiary access in many areas of the country. According to the National Alliance for Caregiving,[4] "many homebound Medicare beneficiaries are already not receiving the professional care they need and are entitled to under their benefits. These proposed cuts will exacerbate this access crisis, leaving even more of the 55% of caregivers performing medical tasks without professional support."[5]

Although the Medicare Payment Advisory Commission (MedPAC) states that access to home health care is good,[6] this is simply not the case. As noted previously, the number of HHAs has declined by over 1,000 in the last five years. Additionally:

- Half of all U.S. counties lost at least one HHA between 2020 and 2024.[7]
- Over 80% of counties are treating fewer Medicare fee-for-service beneficiaries and providing fewer visits.[8]
- We estimate that over 1.5 million fee-for-service Medicare beneficiaries have lost access to home health care between 2020 and 2024, based on 2019 home health utilization rates.[9]

Reductions in access to the Medicare home health benefit have accrued over time and are widely documented in Medicare claims data and in published and gray literature. Direct observations include:

- Over one-third of patients referred for home health care never receive it, often due to capacity constraints and workforce shortages exacerbated by underfunding.[10]

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[4] https://www.caregiving.org/

[5] Comment Letter of the National Alliance for Caregiving, CMS-1828-P: Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies (Aug. 28, 2025).

[6] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch7_MedPAC_Report_To_Congress_SEC.pdf

[7] https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

[8] https://trellahealth.com/wp-content/uploads/2024/12/Trella-Health-Special-Report-Home-Health-Accessibility-Among-Medicare-Fee-for-Service-FFS-Beneficiaries.pdf

[9] https://data.cms.gov/summary-statistics-on-use-and-payments/program-integrity-market-saturation-by-type-of-service/market-saturation-utilization-state-county

[10] https://carejourney.com/wp-content/uploads/2025/06/Home-Health-Access_2024-Q3-_2025.02.pdf

- For those who were referred but did not receive home care after hospitalization, mortality rates were 43% higher, hospital readmission rates were 36% higher, and total 90-day Medicare spending was 5.4% higher.[11]
- Patients who are admitted to home health care waited a full day longer for care to start on average (3.2 days in 2024 vs. 2.2 days in 2019). Currently, 10% of referrals are waiting at least 5 days to receive a visit, with longer wait times more likely in rural areas.[12]

These trends align with the concerns raised by the American Hospital Association about timely access to post-acute home health.[13] These issues are present in both Traditional Medicare[14] and Medicare Advantage.[15]

As home health agencies lose capacity, acute-care hospitals lose their ability to discharge patients to care, forcing them to board patients ready for discharge, driving up hospital costs, and minimizing the capacity to admit new patients. Issues for rural hospitals are especially acute when there are difficulties discharging patients to post-acute care. Over 700 rural hospitals (one-third of all rural hospitals) are at risk of closing in the near future – a problem that will be compounded by a lack of discharge partners.[16]

Year over year funding reductions to HHAs have resulted in compromised access to care as demonstrated by the data trends discussed above. In the past, CMS has recognized the clear connection between payment rate cuts and access to care.[17] CMS should not finalize further Medicare payment rate reductions set forth in the Proposed Rule and, as outlined in this comment letter, we believe that CMS should instead increase payments to HHAs.

iii. Workforce Challenges Compounded by Rate Cuts

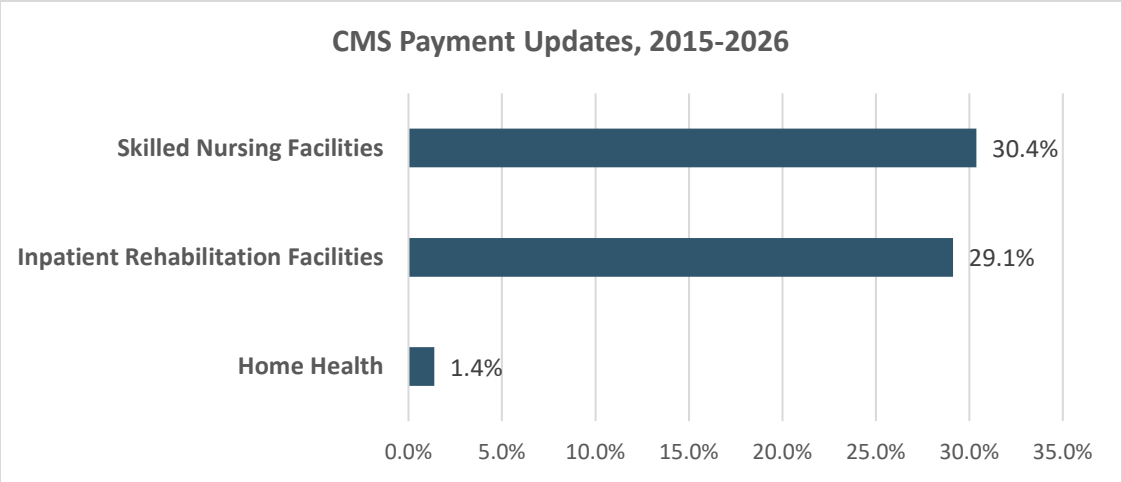
HHAs serving the Medicare population have continued to experience labor constraints that have catalyzed HHA closures or forced them to limit service access. Actual industry wage growth for nursing staff rose by 3.0% in Q1 2025, compared to Q1 2024, according to Bureau of Labor Statistics data. The labor-related share is by far the most expansive and

[11] https://carejourney.com/how-timely-access-to-home-health-care-impacts-cost-and-outcomes/
[12] https://allianceforcareathome.org/wp-content/uploads/Trends-timeliness-home-healthcare.pdf
[13] https://www.aha.org/lettercomment/2024-08-26-aha-comments-calendar-year-2025-home-health-prospective-payment-system-proposed-rule
[14] https://pubmed.ncbi.nlm.nih.gov/33417841/
[15] https://pubmed.ncbi.nlm.nih.gov/38995829/
[16] https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf
[17] https://www.federalregister.gov/documents/2023/05/03/2023-08959/medicaid-program-ensuring-access-to-medicaid-services, CMS discusses the need for analysis when states engage in "rate reductions or payment restructurings" in order to avoid hindering access to care.

impactful component of the CMS market basket update, attributable to 74.9% of the update's value. CMS's systemic unwillingness to adjust market basket updates to reflect labor cost realities, in addition to multiple years of substantial annual rate reductions that eviscerate the market basket update and impose additional reductions on home health payments, together create a "perfect storm" of financial stress that the delivery system simply cannot survive.

Home health administrators and clinicians report continued recruitment challenges. We note that since 2015, Inpatient Rehabilitation Facilities (IRFs) and Skilled Nursing Facilities (SNFs) have received payment updates totaling 29.1% and 30.4% respectively. In contrast, home health payments have only increased by 1.4% during the same time period (see Figure 1 below). Between May 2015 and 2024, average hourly wages for Registered Nurses increased 40% and average hourly wages for Physical Therapists increased 20%. Home health agencies have lost nurses to other care settings or traveling status, where stress is lower and compensation higher. Hospital discharge planners and home health agency personnel alike report that lack of home health capacity, or lack of capacity to deliver specific nursing or therapy services that a patient needs, means patients stay in the hospital longer than necessary, receive post-acute care in a more costly facility environment, or are left without a plan to receive the care they need.

Figure 1: CMS Payment Updates, 2015-2026



Source: Alliance analysis of CMS home health, IRF, and SNF final rules for CY/FY 2015 through 2026 (proposed CY 2026 for home health).

Finally, it is important to note that, unlike skilled labor in other care settings, nurses serving beneficiaries in their homes must operate independently while managing some of our nation's most clinically complex and vulnerable patients. As a result, the impact of payment reductions, especially those of the magnitude set forth in the Proposed Rule, on

workforce shortages has a disproportionate effect on HHAs, where the loss of even a single nurse or therapist leaves beneficiaries at greater risk of unmet needs, adverse health consequences, and potentially higher out-of-pocket costs associated with institutional care settings.

iv. Margins

CMS's continued reliance on MedPAC's fee-for-service margin estimates as evidence that home health payments are adequate is misplaced. MedPAC's margin estimates fail to account for lower and inconsistent payments from Medicare Advantage, higher costs associated with hospital-based HHAs, and aberrant billing patterns in Los Angeles County and other fraud and abuse outlier areas. CMS advances a selective narrative that obscures the actual financial distress of home health providers across the nation.

An analysis by the CMS Office of the Actuary completed for the 2025 Medicare Trustees report estimates that by 2027, 44% of home health providers will have negative total margins.[18] This number grows to 56% by 2040. The analysis is based on 2023 cost report and other data and does not assume additional cuts to payments made after that date. Given the additional permanent adjustments applied for 2024, 2025, and proposed permanent and temporary adjustments for 2026, it is reasonable to conclude, that these estimates will rise much higher, and most HHAs will be financially underwater within a few years.

MedPAC is consistent in reporting to Congress that the fee-for-service margin performance of HHAs is excessive.[19] The Alliance strongly disagrees with these public reports and considers them overstated and misleading, particularly in light of contradictory findings by the CMS Office of the Actuary.

v. Safeguarding Program Integrity and Protecting Patients

In addition to jeopardizing access for millions of beneficiaries served by high-integrity providers committed to compliance with CMS standards, eligibility rules, billing criteria, and conditions of participation, the Alliance is troubled that the Proposed Rule perpetuates a broken payment system that allows unscrupulous HHAs to enroll in the Medicare program with relative ease and to bill for services that do not meet Medicare

[18] https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf-0
[19] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch7_MedPAC_Report_To_Congress_SEC.pdf, Table 7-11

coverage criteria, bill for services not provided at all, and engage in other fraudulent billing activities that harm the integrity of the Medicare program and waste taxpayer dollars.

CMS's proposed rate setting methodology and the precise level of its proposed permanent adjustment for 2026 – about 37% of which can be mathematically tied to CMS's inclusion of highly suspect claims data from discrete areas of the country – allows for a minority segment of flawed data to undermine the entire payment system and benefit. This punishes good faith HHAs with payment reductions that arise from the unlawful behavior of illegitimate ones which in turn results in reduced care resources and access for beneficiaries. Accordingly, the Alliance urges CMS to address underlying issues in the data used to calculate the permanent and temporary adjustments and strongly supports the Agency undertaking additional program integrity efforts to root out fraud, waste, and abuse in high fraud home health areas of the country. We support Dr. Oz's vision of "identifying and eliminating fraud, waste, and abuse to stop unscrupulous people who are stealing from vulnerable patients and taxpayers."[20]

B. Proposed CY 2026 Reductions and Other Changes to CY 2026 Payments

While the move to the Patient Driven Groupings Model (PDGM) under the Home Health Prospective Payment System (HH PPS) promised a renewed focus on the total care needs of beneficiaries while maintaining a stable and budget neutral reimbursement environment to ensure access to high quality home care, the implementation of successive years of payment rate reductions has only undermined those goals. As the evidence presented in the previous section demonstrates, beneficiaries are facing reduced access to care as HHA payments are reduced and fail to keep pace with inflation including the cost of labor and other critical resources. We demonstrate below that the technical approach taken by CMS deviates from its authorizing legislation and fails to meet its stated intent in the rulemaking.

Current and past policy decisions continue to destabilize the economics of the home health sector and combine to reduce payments to unsustainable levels. These serious flaws include: technical errors that systematically bias the results of the calculations for determining permanent and temporary adjustments; annual payment updates that, according to the Office of the Actuary's own data, fail to accurately reflect price growth for home health care; failure by CMS to control for the proliferation of significant fraud in areas of the country that has corrupted CMS's data and rate setting; and most importantly, an aggressive and ill-advised policy over the past several years by CMS aimed at cutting

[20] https://www.cms.gov/newsroom/press-releases/dr-mehmet-oz-shares-vision-cms

payment and benefits that reflects no understanding of the challenges and true economics of home health care delivery and payment under Medicare.

The Alliance believes that Medicare payments should be accurate, predictable, and support access to high quality home health care. However, based on the data and serious concerns presented in this comment letter, and the experience of our member providers across the country, we believe that CMS policies result in a home health benefit that is failing patients, providers, and the Medicare program.

CY 2026 would be the fourth consecutive year that CMS applies a permanent adjustment to significantly reduce payments to HHAs. In addition, CMS now proposes to apply for the first time in CY 2026, a temporary adjustment to further reduce payments resulting in a one-year net reduction of 6.4% or $1.135 billion in payments compared to 2025. This is tantamount to a 9% rate cut less the statutory market basket increase. These rate cuts are not sustainable and will cause significant harm to the home health care delivery system and beneficiaries it serves. This is the case not solely in Medicare fee-for-service, but also in Medicare Advantage, and under CMS's innovation models that promote use of home care.

Home health industry stakeholders have raised issues with CMS's approach resulting in inappropriate and unwarranted cuts to the payment system for years. To this point, merely pointing to the existence of flaws in comments and public meetings has not elicited serious, policy and quantitative consideration by the agency. To that end, the Alliance, in its first comment letter in response to CMS's home health rulemaking activities, has pursued a detailed quantitative assessment of the impact of several, identified flaws in CMS's approach and calculations used to determine the permanent and temporary adjustments.

In the section below, we discuss various aspects of the payment system and PDGM that the Alliance believes should be addressed by CMS to ensure accurate payments that support access to high quality home health care. Based on our recommendations below, we encourage CMS to take immediate action to not finalize these harmful cuts, correct the many significant flaws enumerated here, and work to ensure the payment system supports a sustainable reimbursement structure and a viable home health care delivery system for beneficiaries that rely on this critical Medicare benefit.

i. Permanent and Temporary Adjustments

The CY 2026 Proposed Rule would apply an additional permanent –4.059% permanent adjustment to the 30-day payment rate and an additional -5% temporary adjustment – a

9% rate reduction. Combined with the annual payment update, this results in an average estimated net -6.4% overall payment impact for HHAs.

For the fourth straight year, the rule would apply a payment reduction to the 30-day rate that results in a cut of unprecedented magnitude with the application of a -5% temporary adjustment. Tables 1 and 2 below detail the level of permanent adjustments (reductions) both determined and applied/proposed by CMS to date (a 12.3% reduction). Table 3 shows this year's proposed CY 2026 temporary adjustment that is aimed at collecting approximately $786 million (or nearly 15% out of a total of $5.3 billion determined so far by CMS).[21]

Table 1: Permanent Adjustments Assessed

Data Year	Percent Reduction in Rate
CY 2020	-6.52 Percent
CY 2021	-1.42 Percent
CY 2022	-1.767 Percent
CY 2023	-1.004 Percent
CY 2024	-2.087 Percent *
Total to Date	**-12.3 Percent ****

**Proposed for CY 2026*

*** Cumulative multiplicative total*

Table 2: Permanent Adjustments Applied

Data Year	Percent Reduction in Rate
CY 2023	-3.925 Percent
CY 2024	-2.89 Percent
CY 2025	-1.975 Percent
CY 2026	-4.059 Percent*
Total to Date	**-12.3 Percent ****

**Proposed for CY 2026*

*** Cumulative multiplicative total*

[21] CMS provides two different estimates of how much a –5% temporary adjustment would recoup from HHAs. In the preamble, CMS estimates that a –5% temporary adjustment results in $786 million in reduced payments (14.8% of the total temporary adjustments dollar amounts measured to date. However, in the regulatory impact analysis section, CMS estimates that a –5% temporary adjustment would recoup $815 million.

Table 3: Temporary Adjustments – Total and Applied

Total / Applied	Percent Reduction	Dollar Value
Total through 2024		-$5,301,103,945
CY 2026	-5 Percent*	- $786,000,000**
Total to Date	**-5 Percent**	**- $786,000,000****

**Proposed for CY 2026*

*** Estimated*

The Alliance estimates the current applied and proposed permanent adjustments alone will result in aggregate cuts to home health reimbursement of $27 billion through 2030. Table 4 below details the year-by-year and cumulative impact of these harmful cuts. As noted above, the Alliance has significant concerns with the legal basis, development, application, and most importantly the impact of these cuts on beneficiaries and providers.

Table 4: Projected Impact of Behavioral Adjustments in CY 2020 through CY 2030[22]

Total Payments	Impact of CMS Permanent Adjustments
2020	($665,606,530)
2021	($692,156,154)
2022	($679,375,387)
2023	($1,268,705,896)
2024	($1,745,166,215)
2025	($2,076,189,516)
2026	($2,645,327,221)
2027	($2,692,067,937)
2028	($2,739,657,872)
2029	($2,790,740,430)
2030	($2,839,999,507)
Total Impact of Permanent Adjustments	($20,834,992,665)
Total Impact of Temporary Adjustments (CY 2020-CY 2024)	($5,301,103,945)
Total Impact of Temporary Adjustments (CY 2025-CY 2026)	($1,071,568,999)
Overall Total Impacts with Temporary Adjustments (CY2020-CY 2024)	($26,136,096,610)
Overall Total Impacts with Temporary Adjustments (CY2020-CY 2026)	($27,207,665,610)

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 71646

ii. Background

Section 1895 of the Social Security Act (the Act) requires the Secretary to calculate a standard prospective payment amount (or amounts) for 30-day units of service that end during the 12-month period beginning January 1, 2020, in a budget neutral manner,[23] and to eliminate the use of therapy thresholds in the case-mix system for CY 2020 and

[22] CMS proposed to collect $786 million of the $5.3 billion in temporary adjustments for CY 2026.

[23] https://www.ssa.gov/OP_Home/ssact/title18/1895.htm, Section 1895(b)(3)(A) of the Social Security Act.

beyond.[24] The law requires that estimated aggregate expenditures under the HH PPS during CY 2020 are equal to the estimated aggregate expenditures that otherwise *would have been made* under the PPS during CY 2020 in the absence of the change to a 30-day unit of service and a new case-mix adjustment methodology that removes the use of therapy thresholds in determining payment. In calculating the standard prospective payment amount (or amounts), the law requires the Secretary make assumptions about behavior changes that could occur as a result of the implementation of the new case-mix adjustment methodology and the change to a 30-day unit of service.

The Act also requires the Secretary to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures under the HH PPS beginning with 2020 and ending with 2026.[25] Based on this analysis, the Secretary must provide for one or more permanent increases or decreases to the home health payment amount (or amounts) for these years, on a prospective basis, to offset for these increases or decreases in estimated aggregate expenditures. Finally, the law requires the Secretary to provide for one or more temporary increases or decreases to the payment amounts for these years to offset for increases or decreases in estimated aggregate expenditures. The law requires all adjustments to be made on a prospective basis through notice and comment rulemaking in a time and manner determined by the Secretary.[26]

iii. Legal and Policy Concerns

The approach adopted by CMS does not conform with the requirements of the statute or its clear intent to ensure budget neutral payment rates going forward. Instead, CMS's approach acts to reprice payments for the years 2020 through 2024 under the pre-PDGM payment system to establish an artificial target amount or ceiling that is used to reduce future 30-day payment amounts under PDGM and establish temporary adjustments. In effect, CMS ties the current payment system inextricably to the pre-PDGM payment system, last in effect in 2019, but makes no attempt to apply the requisite adjustments to comply with authorizing legislation or the normal updates CMS would have made in absence of the change to PDGM. It does this largely by adjusting payments downward to account for changes in therapy utilization (a factor that has no impact on aggregate expenditures and is contrary to the law), changes in case-mix, and relying on distortions in the data created by CMS, such as changes in LUPA thresholds.

CMS's overall approach conflicts with the basic requirements of the statute by: (1) not measuring either assumed or actual behavior changes at all, nor calculating the

[24] https://www.ssa.gov/OP_Home/ssact/title18/1895.htm, Section 1895(b)(4)(B)(ii) of the Social Security Act.
[25] https://www.ssa.gov/OP_Home/ssact/title18/1895.htm, Section 1895(b)(3)(D) of the Social Security Act.
[26] https://www.ssa.gov/OP_Home/ssact/title18/1895.htm, Section 1895(b)(4)(B)(ii) of the Social Security Act.

difference of their impact on aggregate expenditures; (2) measuring behavior change resulting from other policy changes, not just those related to the change in the unit of payment and the removal of the therapy thresholds under a new case-mix adjustment methodology as instructed by the statute; (3) violating budget neutrality by unlawfully rebasing home health payment rates to reduce overall expenditures; and (4) by using therapy utilization as a factor in determining payment rates despite the clear command in the statute not to do so. CMS's approach for determining permanent and temporary adjustments conflicts with the basic requirements of the statute and results in significant harm to HHAs across the nation and the beneficiaries they serve.

We also remind CMS that the Administrative Procedure Act (APA), 5 U.S.C. § 551-559, requires federal agencies, including CMS, to exercise informed decision making that includes public input like that set forth in the Alliance's letter that reveal important considerations, data, and perspectives that the agency may have overlooked or not previously considered. Agencies that do not respond to stakeholder comments to proposed rules are not in compliance with the APA, fail to engage in reasoned decision making, and risk exposing the agency to judicial challenges for finalizing policy in an arbitrary and capricious manner.[27]

Most recently, and since the issuance of the CY 2025 Home Health Proposed and Final Rules, the Supreme Court in *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024) reinforced the principle that courts must exercise independent judgment to ensure agency actions are lawful and within its statutory authority. This independent judgment inherently involves scrutinizing whether an agency has engaged in reasoned decision making, including how it addressed substantive concerns raised in comments.

Loper Bright shifted the focus away from deference to agency interpretations of statutes and solidified the requirement for agencies to engage in reasoned decision making, including considering and responding to public comments, as a foundational aspect of the regulatory process. Accordingly, the Alliance expects CMS to carefully consider and respond to the considerations, data, and perspectives it sets forth herein, even as they contradict the agency's proposals and the logic supporting them. Accordingly, the Alliance recommendations regarding corrections to flaws in CMS's approach related to its calculation of the permanent and temporary adjustments are squarely within the scope of this Proposed Rule and must be addressed.

[27] In cases where agencies failed to adequately address comments, courts, including the Supreme Court in decisions like *Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Company*, 463 U.S. 29 (1983), have rejected agency action as arbitrary and capricious for failing to provide a reasoned explanation an demonstrate a connection between the facts found and the choices made.

iv. Flaws in Underlying Data and in CMS's Permanent and Temporary Adjustments Calculations

The Alliance and its members have previously commented on the flaws in CMS's calculations for determining permanent and temporary adjustments to HHA payment rates.[28] We continue to have significant technical concerns with CMS's approach that relies on a simulation of payments under the pre-PDGM payment system to establish a budget neutrality target that effectively places an artificial limit on current PDGM payments.

CMS's approach is explicitly intended to replicate what payments would have been had the agency not implemented PDGM and the 30-day unit of payment. However, the approach fails to accurately do that but rather establishes an arbitrarily low limit on current payments. Critically, CMS fails to update aspects of its model to reflect routine changes that would have been made to the pre-PDGM payment system such as recalibration of the case mix weights and updates to LUPA thresholds. CMS continues to rely on case-mix weights and thresholds developed prior to 2020 using 2017 claims data. Other concerns relating to use of the data and the misalignment between the pre-PDGM simulation model and actual PDGM payments result in bias and estimation error that are compounded year after year as these adjustments are applied.

Below, and in the attached report by Dobson Davanzo, we further detail these concerns pointing to new and serious flaws in CMS's approach (see Exhibit A). While most of our estimates below refer to an impact to the proposed -4.059% permanent adjustment for CY 2026, CMS should go back a correct for the data input and technical issues identified in our comment letter for all data years in question, CY 2020 through CY 2024.

Data from 2022 and beyond reflects unrelated policy changes, not behavior change due to PDGM.

Starting in CY 2022, CMS began annually recalibrating the PDGM case-mix weights using the most current, complete data available at the time of rulemaking. Behavior changes that occurred in CY 2022 and subsequent years were largely driven by changes in payments from the recalibration of the case-mix weights and the base rate payment cuts starting in CY 2023 – not the implementation of the 30-day unit of payment and the removal of therapy thresholds from the new case-mix adjustment methodology (collectively referred to as PDGM) two years prior.

[28] Comment Letter of the National Alliance for Care at Home, CMS-1803-P: Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System Rate Update (Aug. 26, 2024).

For CY 2022, this relied on CY 2020 data—collected during the COVID-19 pandemic—to recalibrate the PDGM case-mix weights. We note that CMS generally excluded data from the height of the COVID-19 pandemic when recalibrating case-mix weights for other payment systems and from its calculation of the Skilled Nursing Facility PDPM Parity Adjustment. Notably, the Office of the Actuary excluded COVID-19 data from its health care spending estimates stating that the data and relationships after 2019 are strongly impacted by the effects of COVID-19.[29] Perhaps most significantly, CMS chose NOT to update the low-utilization payment adjustment (LUPA) thresholds that vary by case-mix group because "*we believe that maintaining the LUPA thresholds for CY 2022 was the best approach because it mitigates potential fluctuations in the thresholds caused by visit patterns changing from what we observed in CY 2020 potentially due to the COVID–19 PHE*"(86 FR 62249).

The recalibration for CY 2022 rate-setting produced significant shifts in case-mix weights, heavily influenced by visit patterns that deviated greatly from past practice due to the COVID-19 pandemic, with changes in weights ranging from +16% to –26% across case-mix groups compared to CY 2021. These changes in payments at the case-mix group level were impacted by COVID-19 visit pattern changes and influenced how agencies modified service delivery to allow them to continue serving their communities while remaining operationally viable. Behavior changes in CY 2022 were not due to the PDGM, but rather due to the case-mix weight recalibration that incorporated known visit pattern changes impacted by the COVID-19 pandemic. CMS continued to recalibrate the case-mix weights annually in CY 2023 and beyond.

In addition, starting in CY 2023, CMS began implementing negative, permanent adjustments to the 30-day period payment rate. Each year from CY 2023 through 2025, CMS reduced the 30-day period payment rate, forcing agencies to respond in several strategic and operational ways. These changes included modifying service areas, changing the frequency of visits, aligning limited workforce resources, and changing admission and referral practices in order to sustain operations and ensure as many beneficiaries as possible had access to needed services.

Behavior changes that occurred in CY 2022 and subsequent years were largely driven by changes in payments from the recalibration of the case-mix weights and the base rate payment cuts starting in CY 2023 – not the implementation of the 30-day unit of payment

[29] https://www.cms.gov/files/document/conceptual-view-long-term-projection-methods-medicare-and-aggregate-national-health-expenditures.pdf-0

and the removal of therapy thresholds from the new case-mix adjustment methodology (collectively referred to as PDGM) two years prior. For CY 2022 rate-setting, notably the weights were based on data from CY 2020 that reflected visit pattern changes from the height of a global pandemic. The statute instructs CMS to analyze data from 2020 through 2026 and make permanent and temporary adjustments if actual versus assumed behavior changes impacted aggregate expenditures. However, it is acceptable for CMS to determine that such data reflects behavior changes that are unrelated to the implementation of PDGM and cannot be used for calculating such adjustments. Data from CY 2022 and beyond inherently reflects the influence of unrelated policy (e.g., recalibrations, payment rate cuts) and service delivery pattern changes unrelated to the implementation of PDGM. As CMS noted in response to comments in the CY 2023 Home Health Final Rule, "We reminded readers that, by law, we are required to ensure that estimated aggregate expenditures under the HH PPS are equal to our determination of estimated aggregate expenditures that otherwise would have been made under the HH PPS in the absence of the change to a 30-day unit of payment and changes in case-mix adjustment factors" (87 FR 66796). Recalibrations of the case-mix weights and payment rate cuts resulted in behavior changes that were not a result of the change to a 30-day unit of payment or to the changes in case-mix adjustment factors.

We strongly recommend that CMS not make permanent or temporary adjustments based on data from CY 2022 and beyond. Such data is not suitably appropriate for determining behavior change due to the PDGM versus other unrelated factors. We estimate that the exclusion of data from CY 2022 and beyond would result in the need for a 1% increase to the 30-day payment rate in CY 2026 and necessitate recalculating the temporary adjustment dollar amounts for CY 2020 and CY 2021 to offset the amount already collected in CY 2025 by virtue of the base rate for 2025 being set too low. However, as outlined below, we raise additional concerns with CMS's approach for calculating the permanent and temporary adjustments that should be addressed and would likely result in the need for further positive adjustments.

Inclusion of claims with aberrant billing patterns tied to suspected fraud is corrupting CMS's calculations for the permanent and temporary adjustments.

Within this comment letter and in other public documents, the Alliance and its members have raised concerns about suspicious billing patterns by potentially fraudulent actors under the home health PPS. Here, we examine Los Angeles (LA) County as an example of a geographic area where the data indicates a very high concentration of fraud. LA County has seen tremendous growth in new HHAs and fee-for-service expenditures while nearly

all other counties show a decline in both. We do not believe suspicious activities affecting the HH PPS system is limited to LA County and we must also acknowledge the many strong agencies providing appropriate and excellent care in that community.

We have focused on LA County because of the extremely aberrant patterns of provider behavior that are plainly evident in the data. We note that the county contains approximately 2% of Medicare FFS enrollees but has grown to cover some 6% of home health users and 10% of home health PPS outlays in 2024. Other notable aberrancies from the CY 2026 rulemaking HH-OASIS LDS show LA County *in aggregate* has a below 1.0 average case-mix weight, extremely low LUPA rates (2% of US) and massive outlier spending (20% of all US outlier payments).

The extent of potential fraud in the system has risen to the level where it is likely having a direct impact on the recalibration of the case-mix weights as well as the calculation of the permanent and temporary adjustments. We have identified several major impacts stemming from LA County:

- LA County agencies tend to have very low aggregate case-mix weights (< 1) in both the pre-PDGM and PDGM systems, as well as extremely low LUPA rates especially in PDGM. Overall, this leads to LA County agencies to account for about 37% of the agency-level difference in PDGM vs. Pre-PDGM payments that drive the permanent and temporary cut calculations.

Table 5: Proportion of Analytic File Payments and Differences due to LA County Agencies

	30-Day PPS Payments	60-day PPS Payments	Agency-Level Net Difference
LA County	$1,330,803,733.51	$1,147,248,519.01	$(183,555,214.50)
US	$12,729,923,516.43	$12,233,384,841.73	$(496,538,674.70)
LA County / US	10.5%	9.4%	37%

Source: Analysis of CY2026 proposed rulemaking HH-OASIS data

- LA County agencies – especially ones that began operation since 2019 – are disproportionally likely to only serve Traditional Medicare enrollees and almost exclusively with community admissions. This is a highly atypical care pattern as agencies normally work with both community and acute hospital and post-acute (e.g., SNF) referral sources.
- LA County agencies have a high proportion of community endocrine cases. This is problematic if fraudulent, because of the highly significant increases in MMTA-

endocrine codes that has occurred with case-mix weight recalibrations, increasing by 6% on average with some case-mix groups increasing by 25%. Increases in case-mix weights due to these activities would necessarily come at the expense of relatively lower weights for other case-mix groups. If it is indeed fraudulent activities that are driving these weight changes, it has the effect of stealing payment from legitimate cases, more so with each successive recalibration.

Perpetrators of fraud appear to employ a variety of tactics, and this is not the first time fraud in home health has risen to a notable level. We highlight LA County because the activity here is plainly seen in public use data. There are almost certainly other approaches to fraud than the care patterns we observe here, and there are also many legitimate providers located in LA County doing the critical work of providing home health care to Medicare beneficiaries. Importantly, the dramatic increase in agencies operating in LA County does not seem legitimate, and that increase has masked declines in agencies in most other areas of the county.

Table 6: Home Health Agencies Billing at Least One Fee-for-Service Claim per year, 2019-2024

State	2019	2020	2021	2022	2023	2024*	Percent Difference in Number of Agencies	Difference in Number of Agencies
Total	9,971	9,678	9,615	9,653	9,717	9,889	-0.8%	(82)
Total Excluding CA	8,518	8,127	7,914	7,686	7,516	7,361	-13.6%	(1,157)
California	1,453	1,551	1,701	1,967	2,201	2,528	74.0%	1,075

Source: Dobson | DaVanzo (DD) claims analysis

*2024 claims are preliminary and subject to continued run-out

For the purpose of this letter, we identify issues predominantly in 2024 claims in order to best relate impacts to the current rulemaking cycle. However, the notable and overwhelming growth of suspicious agencies seems to have escalated dramatically since 2019. Based on our observation and analysis, the extensive nature of these highly-suspect billing patterns is affecting CMS's annual rate setting – both in the recalibration of case-mix weights, outlier fixed-dollar loss ratio, and the calculation of permanent and temporary adjustments. We strongly recommend CMS examine and exclude claims data from potentially fraudulent agencies and areas with suspect billing patterns when calculating the proposed and temporary adjustments. **CMS should exclude data from LA County from its calculations from data years 2020-2024 as the data presented in this**

comment letter demonstrate that LA County is an outlier and is disproportionately impacting the permanent and temporary adjustments calculations.

Issues with exclusions and the assumptions CMS uses in its calculations introduce bias and undermine the accuracy of CMS's calculations.

The Alliance working with Dobson DaVanzo identified several concerns with CMS's approach and has conducted analyses of the CY 2026 OASIS LDS file (consisting of CY 2024 claims data) provided by CMS to quantify the impact of CMS's exclusions and assumptions on the CY 2026 proposed permanent adjustment.

Results show that changes to the calculations to address each of these concerns lead to substantial reductions in the proposed permanent adjustment. In combination, these refinements result in the elimination or reversal of the permanent adjustment proposed for CY 2026. In addition, correction of these flaws for earlier permanent adjustments based off data from CYs 2020-2023 requires that payments be made to providers to compensate for inappropriate historical cuts applied in 2023, 2024, and 2025.

A detailed discussion of each area of concern and the analyses underlying the results is included below and in the appendix. In addition, Table 9 (below summarizes the impact of each area of concern on the CY 2026 proposed permanent adjustment.

Excluded Claims

As part of the Agency's approach for the proposed permanent adjustment, the Agency uses 2024 claims data with 8,118,120 30-day periods of care, CMS applied exclusions to simulate the 60-day episodes. Following all exclusions and assumptions, the dataset used for the CY 2026 Proposed Rule analysis contained 6,433,111 actual 30-day periods of care and 3,794,744 simulated 60-day episodes for CY 2024. In total, 1,685,009 cases (representing 21% of the original dataset) were excluded from the budget neutrality assessment for CY 2024.

Excluding such a large share of cases risks introducing systemic bias if the omitted cases differ structurally from those included. Comparative analyses of the included versus excluded CY 2024 30-day cases revealed material differences in therapy provision levels, average case-mix weights, visit timing, admission sources, payment amounts, and the distribution of Complex and MS Rehab clinical groupings.

Notably, the 30-day cases retained in CMS's budget neutrality analysis had 5.45% fewer therapy visits than the full universe of CY 2024 HH PPS claims. Adjusting for this therapy visit difference increased the 60-day counterfactual budget-neutral payments, thus reducing the calculated permanent adjustment. The recalculated CY 2026 permanent adjustment is -1.88% based on this factor alone, compared with CMS's proposed permanent adjustment of -4.06%. CMS's previous assertions that excluding these claims had no effect on the permanent adjustment is not correct.

Structural LUPA Assignments

To establish the CY 2020 LUPA thresholds under PDGM, CMS used CY 2018 home health claims, splitting each 60-day episode into two 30-day periods and assigning each to one of the 432 PDGM case-mix groups. For each group, CMS calculated the distribution of in-person visits per 30-day period and set the LUPA threshold at the 10th percentile of total visits among non-LUPA periods in that group. As a result, PDGM thresholds ranged from 2 to 6 visits, replacing the uniform pre-PDGM threshold of 4 or fewer visits.

Because the prior 60-day system applied a static LUPA threshold of four or fewer visits, regrouping CY 2024 30-day periods into 60-day episodes for CMS's budget neutrality analysis produces cases priced as LUPAs under the old system that are paid the full 30-day period payment amount under PDGM thresholds. Analysis of the CY 2026 HH PPS Proposed Rule OASIS LDS file indicates that this occurs in 5.5% of simulated 60-day episodes. The LUPA rate for the simulated 60-day periods is 11.6% as compared to 8.5% in the pre-PDGM 60-day cases in CY 2019.

The differences in LUPA rates under the 60-day system are purely a structural aspect of CMS's own approach and not a behavioral change by providers. The application of a permanent adjustment that includes this structural effect is therefore arbitrary and inconsistent with the statute.

Adjusting these 5.5% of cases to receive full payments rather than LUPA payments increases the 60-day aggregate counterfactual payments and reduces the calculated permanent adjustment by 4.06 percentage points, thereby eliminating any permanent adjustment for CY 2026.

Outlier Assumptions

To estimate what aggregate payments would have been under the 60-day system without the transition to PDGM, CMS repriced simulated 60-day episodes using the payment parameters in effect under the prior 60-day model. For CY 2024 simulated claims, outlier payments were calculated by applying a static fixed-dollar loss (FDL) ratio of 0.51 (the CY 2019 FDL) to determine 60-day outlier amounts. Grouping 30-day periods into 60-day episodes under this approach resulted in only 2.0% of cases qualifying as outliers, a number substantially below the proportion of 3.6% observed in CY 2019.

By statute, the FDL ratio is intended to produce total outlier payments that do not exceed 2.5% of total HH PPS payments. CMS's approach for CY 2024 yielded outlier payments at 1.2% of total payments, well below this statutory target, thereby understating counterfactual aggregate payments under the 60-day system.

Adjusting CY 2024 simulated 60-day outlier payments to meet the 2.5% statutory threshold increases aggregate counterfactual payments and reduces the calculated permanent adjustment by 0.95 percentage points. With this adjustment to the calculations, the recalculated CY 2026 permanent adjustment would be -3.11% rather than -4.06%.

60-Day Case Mix Weights Not Recalibrated

To estimate what aggregate payments would have been under the 60-day system absent PDGM, CMS priced simulated 60-day episodes using the pre-PDGM payment parameters, adjusting for payment updates, wage index neutrality, and labor share budget neutrality factors. However, CMS did not recalibrate case-mix weights for the counterfactual 60-day system despite the fact that historically such recalibrations typically increased payment rates by 1–2%.

The omission stands in direct conflict with CMS's own approach for annually recalibrating the PDGM case-mix weights, where the agency did perform a full case-mix recalibration to set the CY 2024 PDGM case-mix weights using the most current and complete home health claims linked to OASIS. This is also in direct contrast to CMS's stated approach to calculate what payment would have been under the pre-PDGM system. Prior to PDGM, CMS's policy was to annually recalibrate the case-mix weights, something CMS has not done under its repricing approach.

Under PDGM, CMS measures resource use via a cost-per-minute plus non-routine supplies (NRS) method based on cost report data, then runs regression models across all 432 payment groups to predict resource use and derive updated case-mix weights. This

inherently accounts for changes in visit patterns, patient characteristics, and service intensity. If CMS had applied the same recalibration methodology to the simulated CY 2024 60-day claims, the resulting case-mix weights would have reflected actual resource use in that system necessitating a positive case-mix budget neutrality factor for the following reasons.

- The CY 2024 PDGM recalibration itself produced a positive case-mix weights budget neutrality factor, underscoring the likelihood that a similar factor should have been applied to the 60-day rate for the counterfactual 60-day system.
- Additionally, prior case-mix recalibration results for the pre-PDGM 60-day system (e.g., CY 2016–CY 2019 HH PPS rules) show that CMS's recalibrations almost always increased the base payment rate by ~1–2% to maintain budget neutrality.
- Analysis of CMS reported average resource use (cost per 30-day period) under PDGM for the CY 2024 HH PPS compared to the resource use under the 60-day system in the CY 2019 HH PPS showed that the portion of costs per visit type remained consistent despite the decline in the average number of therapy visits delivered under PDGM. These results are shown in the table below.

Table 7: 2016 Estimated Cost per Episode vs. 2022 Estimated Cost per Episode

	2022 Estimate 30-Day Period Costs	Proportion of Total Cost	2016 Estimated 60-Day Episode Costs	Proportion of Total Cost
SN	$677	48.3%	$1,200	47.3%
PT	$502	35.8%	$890	3.5%
OT	$139	9.9%	$245	9.6%
SLP	$29	2.1%	$56	2.2%
MSS	$14	1.0%	$31	1.2%
HHA	$42	3.0%	$117	4.6%
Total	**$1,402**		**$2,539**	

Source: DD Analysis of CY 2024 HH PPS Proposed Rule (Table B4) and CY 2019 HH PPS Proposed Rule (Table 2)

- Finally, given that the average number of therapy visits per episode decreased under PDGM relative to pre-PDGM years and pre-PDGM 60-day case-mix weights were heavily therapy-driven, if CMS used PDGM era cost-report data that reflect therapy visit volume reductions, then the recalibration would re-weight those episodes

upward, resulting in higher case mix weights for non-therapy episodes and ultimately increasing the counterfactual 60-day aggregate payments.

Applying the PDGM case-mix budget neutrality factor updates from CY 2020–CY 2024 to the 60-day payment rates increases counterfactual aggregate payments and reduces the calculated permanent adjustment by 3.67 percentage points. This single factor results in a recalculated CY 2026 permanent adjustment of -0.39%, rather than CMS's proposed -4.06%, a significant difference.

60-Day Episode Structure

The simulated CY 2024 60-day episodes differ substantially from actual pre-PDGM 60-day episodes in both volume and composition. Analyses show marked discrepancies in the total number of episodes, the share of LUPAs, partial episode payments (PEPs), outlier frequency, and overall visit patterns, indicating that the counterfactual dataset does not accurately represent the counterfactual 60-day payment system. This structural mismatch results in lower estimated aggregate payments in the counterfactual payment system. When the pre-PDGM (CY 2019) 60-day case-mix weights are applied to these simulated CY 2024 episodes (thereby aligning the payment calibration with historical visit patterns) the calculated permanent adjustment is reduced by 3.43 percentage points, shifting from -4.06% to -0.63%. Again, this one factor demonstrates that CMS's current approach materially overstates the payment reduction needed to achieve budget neutrality.

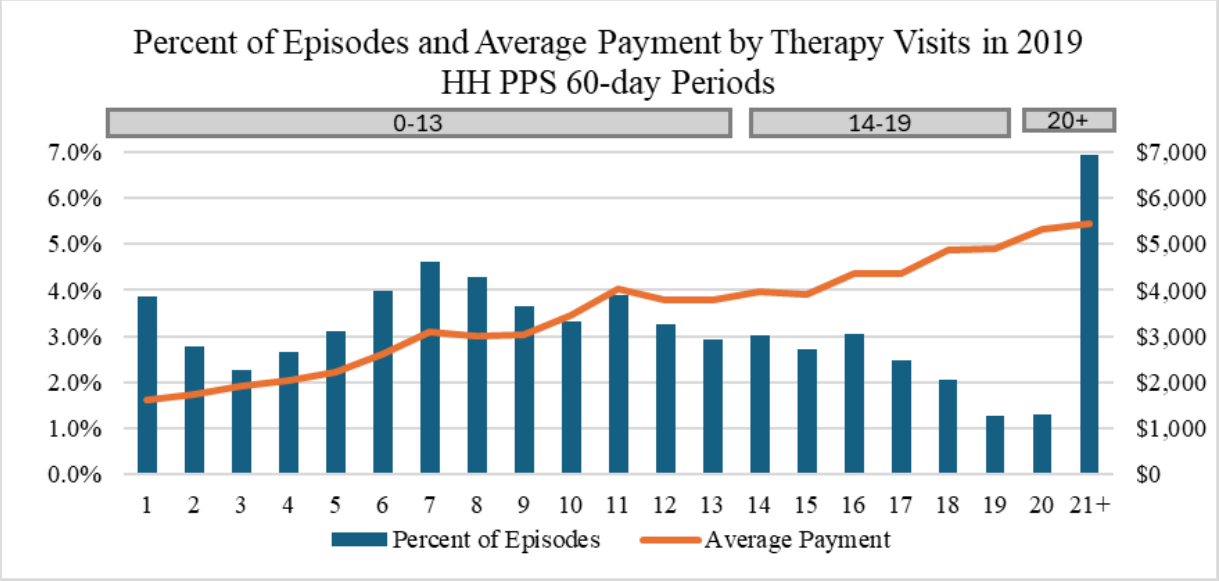
These comparisons are shown in the table and graphs below.

Table 8: Comparison of Rulemaking LDS CY 2024 simulated 60-day cases to historic 2019 claims

	Number of Simulated 60-Day Episodes	Outlier case rate	PEP case rate	LUPA rate	Average Case-Mix Weight	Physical Therapy visits	Occupational Therapy visits	Speech Language Pathology visits	Skilled Nursing visits	Medical Social Service visits	Home Health Aide visits	Average Therapy visits
CMS Rulemaking File 2024 Episodes Grouped as 60-Day Episodes	3,794,744	2.0%	0.7%	11.60%	0.9332	4.8	1.3	0.2	6.4	0.1	0.6	6.36
DD Analysis of Actual 2019 60-Day Episodes	6,053,934	3.6%	8.5%	8.50%	0.9885	5.7	1.7	0.3	8.4	0.1	1.2	7.74

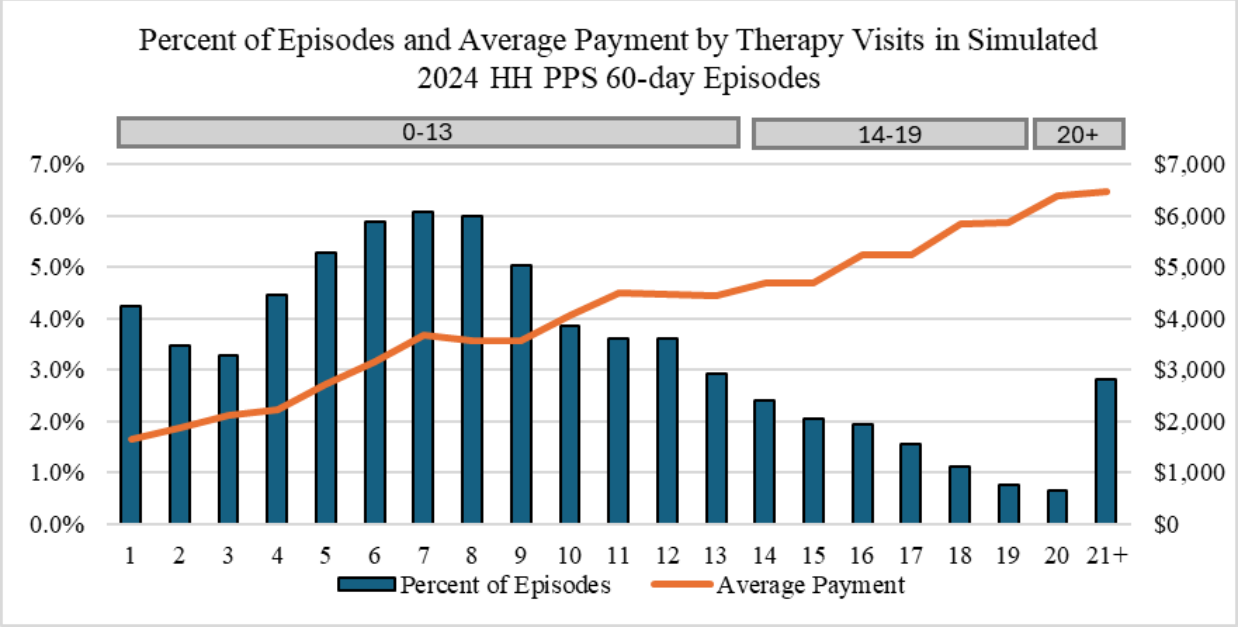
Source: DD Analysis of CY2026 proposed rulemaking HH-OASIS data and 2019 claims

Figure 2: 2019 therapy visits per 60-day period (demonstrating impact of therapy threshold policy)



Source: DD Analysis of 2019 claims

Figure 3: 2024 therapy visits per simulated 60-day period (demonstrating normalization of therapy utilization per CMS intent)



Source: DD Analysis of CY2026 proposed rulemaking HH-OASIS data

Table 9: Impact of Correcting Each Identified Area of Concern on the CY 2026 Proposed Permanent Adjustment

Assumptions	Percentage Point Impact to CY 2026 Permanent Adjustment	Re-Calculated CY 2026 Permanent Adjustment
Excluded Claims: CMS excludes roughly 20 percent of the 30-day CY 2024 claims. Yet, analyses show that there are non-negligible differences between the excluded cases and cases used in the analysis for key drivers of the 60-day payment system such as therapy visits. Excluded cases appear to have more therapy visits on average compared to included cases. Accounting for these differences lowers the permanent adjustment.	-2.18	-1.88%
Structural LUPA Assignments: Given the static LUPA threshold of 4 or less visits under the 60-day system, there are instances where cases are priced as LUPAs under the 60-day system but paid the full 30-day period payment amount under PDGM thresholds that can be as low as 2 visits. This is a structural aspect of CMS's approach, not a behavioral response from providers.	-4.06	0.00%
Outlier Assumptions: CMS applies a static fixed-dollar loss (FDL) ratio of 0.51 to calculate the outlier payments under the 60-day system. This is substantially higher than the 0.27 ratio identified in the CY 2024 HH PPS Final Rule under PDGM and results in total outlier payments falling well below the 2.5% statutory target, thereby understating counterfactual aggregate payments.	-0.95	-3.11%
60-Day Case Mix Weights Not Recalibrated: CMS does not recalibrate case mix when determining aggregate payments under the 60-Day System payment (which historically increased payment rates by 1–2%). Applying CY 2020-CY 2024 PDGM case mix updates to the 60-day payment rates increase counterfactual payments and lowers permanent adjustment.	-3.70	-0.36%
60- Day Episode Structure: Analyses show that the overall number of episodes, proportion of LUPAs, PEPs, outliers and visit patterns do not reflect the counterfactual 60-payment system episodes. Applying the 60-day case mix from pre-PDGM 2019 claims lowers the permanent adjustment.	-3.43	-0.63%

Clinical Group Assignments

In CMS's simulation, there are consecutive 30-day periods combined into a single 60-day episode where the clinical grouping changes between periods. Our analysis identified 72,602 such episodes (2.8% of all simulated 60-day episodes) where the two constituent 30-day periods fall into different clinical groups. Under CMS's approach, the primary and secondary diagnoses from the first 30-day period are applied to the entire 60-day episode,

regardless of whether the second 30-day period reflects higher-acuity conditions or greater resource needs.

This approach differs from the pre-PDGM 60-day payment system, where mid-episode changes to the HHRG group and case-mix weight were permitted when updated assessments documented materially different patient needs.[30] By ignoring such mid-episode changes, CMS's simulation structurally underrepresents higher-acuity second-period care and systematically assigns lower case-mix weights than would have been applied under the historical payment rules. These assumptions could result in lower counterfactual aggregate payments.

OASIS Assumptions

As CMS describes in the CY 2025 HH PPS Proposed Rule, under the pre-PDGM payment system (and for PDGM assessments through CY 2022) HHAs used the OASIS-D instrument. Effective January 1, 2023, CMS required reporting under the updated OASIS-E instrument.

CMS acknowledges that 13 data elements from OASIS-D, used in the 153-group system, are now collected in OASIS-E only at the start-of-care (SOC) or resumption-of-care (ROC) assessments and not at follow-up. Three additional items have been modified in OASIS-E to include more detailed questions and response options, requiring CMS to create a crosswalk to map these back to OASIS-D equivalents. Furthermore, a single pain item in OASIS-D (M1242—Frequency of Pain Interfering with Patient's Activity or Movement) has been replaced in OASIS-E with three separate items (J0510, J0520, J0530), from which CMS proposes to select the maximum severity to map back to the OASIS-D field.

While these crosswalks and substitutions allow CMS to generate variables necessary for the 153-group payment model, they introduce the potential for systematic bias in the counterfactual 60-day payment estimates. Specifically, mapping from OASIS-E to OASIS-D could:

- Understate patient severity when follow-up assessments would have captured changes in condition under OASIS-D but are now absent in OASIS-E.

[30] https://www.cms.gov/medicare/medicare-fee-for-service-payment/pcpricer/downloads/hh-users-manual.pdf. HRGs can be changed mid-episode if there is a significant change in a patient's condition (SCIC adjustment).

- Misclassify case-mix groups if differences in question specificity or coding rules shift responses relative to historical patterns.
- Reduce case-mix weights if mapped values from more granular OASIS-E items tend to yield lower severity scores than their OASIS-D counterparts.

Increasing Patient Severity

Although patient severity in the home health setting has been increasing over time, CMS's approach does not identify and account for real increases in patient severity. CMS calculated and accounted for real patient increases in severity whenever it has implemented payment rate reductions to address nominal case-mix growth under the pre-PDGM payment system. As noted in the CY 2016 Home Health Final Rule, real increases in patient severity accounted for approximately 16 percent of estimated case-mix growth (80 FR 68638). CMS should identify and quantify real increases in patient severity from CYs 2019 through 2024 and ensure that any behavior change that CMS is attributing to the PDGM does not incorrectly include real changes in patient severity. At a minimum, CMS should adjust the permanent adjustments downward by 16 percent (the historical amount of real case-mix growth in a given year).

Temporary Adjustment Concerns

CMS proposes a 5.0% reduction in CY 2026 (or a 0.9500 temporary adjustment factor) to be applied to the CY 2026 national standardized payment rate. Based on CMS's estimated volume of 7,723,632 30-day periods in CY 2026, this reduction would collect approximately $786 million, or 14.8% of the total $5.3 billion CMS has identified in temporary adjustments needed.

The proposed static percentage temporary adjustment reduction is inappropriate and inaccurate for the following reasons:

- Declining Number of Medicare FFS Home Health Users – Between 2019 and 2024, the total number of Medicare FFS 30-day periods declined by 5.3% and the number of FFS beneficiaries with at least one home health episode decreased by 18.8%, reflecting both reduced FFS enrollment and lower post-acute discharges. Overall, the number of Medicare FFS beneficiaries declined by 11.3% between 2019 and 2024 as shown in the table below.

Table 10: Trends in Medicare FFS HH Utilization

	2019	2020	2021	2022	2023	2024	Percent Difference 2019-2024
Number of Unique FFS Enrollees with at least one HH Claim	3,310,007	3,014,721	3,063,386	2,863,700	2,756,481	2,688,962	-18.8%
Total FFS Enrollees	38,577,012	37,776,345	36,356,380	35,270,914	34,582,731	32,208,709	-16.5%
Number of Unique Rural FFS Enrollees with at least one HH Claim	443,891	422,827	420,596	378,387	373,477	354,651	-20.1%
Total Number of MA Enrollees	22,937,498	25,063,922	27,536,246	29,829,632	32,590,664	34,412,866	50.0%
Number of 30-Day HH Episodes	8,744,171	9,139,449	9,318,681	8,559,023	8,337,953	8,278,250	-5.3%
Number of 30-Day HH Episodes per Enrollee	3.1	3.0	3.0	3.0	3.0	3.1	-1.3%

Source: DD Analysis of historic claims and Medicare Advantage Enrollment data

- Growth in Medicare Advantage (MA) – MA enrollment has increased nearly 50% between CY 2019 and CY 2024, further reducing the number of FFS beneficiaries. A static FFS recoupment target fails to account for this shift in coverage. Lower payments on the fee-for-service side produce savings in Medicare Advantage through reduced benchmarks creating a scenario where CMS collects more than the aggregate dollars it has determined for temporary adjustments.
- Changes in Participating Agencies – The number of HHAs billing Medicare FFS declined by 13.6% nationally between 2019 and 2024 (excluding California). In California, however, HHA counts increased by 74% (approximately 1,074 agencies). A uniform percentage cut fails to reflect these regional variations, resulting in disproportionate burdens on remaining providers, especially small or rural agencies that may be vulnerable to these cuts. These trends are shown in Table 6 above.

We recommend that CMS adjust the total temporary adjustments downward by 11.3% for the decline in Medicare FFS users. This reflects the shrinking pool of service-eligible Medicare enrollees. Additionally, CMS should further offset the temporary adjustments dollar amounts downward to account for "recoupments" that are occurring through lower FFS benchmarks used to pay MA plans.

CMS has yet to address additional, previously raised technical flaws

Multiple technical issues have been raised in past commentary by industry representative groups. These issues remain true and relevant, however have not been addressed meaningfully by the agency. We remind the agency these concerns, particularly as raised in historical comments by the Partnership for Quality Home Healthcare and WellSky in response to the CY 2024 and CY 2025 rulemaking cycles.

Impact of COVID-19: While CMS asserted that its approach appropriately controlled for the impacts of COVID-19 (see 87 FR 66800), we disagree. As noted above, CMS chose NOT to update the LUPA thresholds in the CY 2022 Home Health Final Rule. Per CMS:

> "*to mitigate any potential future and significant short-term variability in the LUPA thresholds due to the COVID–19 PHE, we proposed to maintain the LUPA thresholds finalized and displayed in Table 17 in the CY 2020 HH PPS final rule with comment period (84 FR 60522) for CY 2022 payment purposes. We believe that maintaining the LUPA thresholds for CY 2022 was the best approach because it mitigates potential fluctuations in the thresholds caused by visit patterns changing from what we observed in CY 2020 potentially due to the COVID–19 PHE*" (86 FR 62249).

At the same time, CMS did recalibrate the case-mix weights for CY 2022, stating that:

> "*we believe the COVID–19 PHE would have impacted utilization within all case-mix groups similarly. Therefore, the impact of any reduction in resource use caused by the COVID–19 PHE on the calculation of the case-mix weight would be minimized since the impact would be accounted for both in the numerator and denominator of the formula used to calculate the case-mix weight*" (87 FR 66815).

The recalibration for CY 2022 rate-setting produced significant shifts in case-mix weights, heavily influenced by visit patterns that deviated greatly from past practice due to the COVID-19 pandemic, with changes in weights ranging from +16% to –26% across case-mix groups compared to CY 2021. This demonstrates that the COVID-19 PHE did not impact utilization within all case-mix groups similarly as CMS contended. For that to be true, there would not have been much variability in the weight changes using 2020 data since CMS contends that the impacts would have been similar for each case-mix group and thus the relativity between each case-mix group would be impacted minimally. CMS also stated that its approach for calculating actual versus assumed behavior change as a result of the implementation of the PDGM controlled for COVID-19 since it used the same dataset (e.g., 2020 data) to calculate payments under the PDGM and payments under the pre-PDGM payment system (87 FR 66800). While this approach may work for calculations conducted for initial rate setting, it is not work for backward-looking tests of budget neutrality Additionally, CMS did NOT control for this once it recalibrated the case-mix weights in CY

2022 using COVID-19 data and used those weights to calculate payments under the PDGM, comparing those payments back to what it would have paid under the pre-PDGM payment system where CMS did NOT recalibrate the pre-PDGM weights to reflect changes due to COVID-19.

More generally, CMS's treatment of home health data during the pandemic shows significant methodological gaps compared to its own approach in other settings.

- *No COVID-specific exclusions*: CMS didn't remove cases with COVID-19 diagnoses from the home health analysis.
- *No control periods*: There was no effort to isolate pre- and post-pandemic data to separate policy effects from pandemic disruptions.
- *No spillover analysis*: CMS didn't consider how operational changes during the pandemic affected non-COVID patients.
- *No validation checks*: There was no confirmation that observed behavior changes were due to PDGM rather than pandemic adaptations.

This inconsistency is particularly problematic because it makes it impossible to tell whether changes were due to PDGM or pandemic-related disruptions and means that reductions in therapy may reflect appropriate clinical decisions during COVID, not payment-driven behavior.

This methodological gap undermines the validity of CMS's behavioral adjustment calculations and may result in payment reductions that fail to reflect the true cost of providing comprehensive home health services in the post-pandemic healthcare environment.

Diagnosis Items: Under PDGM, roughly 40 percent of the diagnoses previously allowed for under the former 60-day payment system are not accepted as primary diagnoses. This systematic change likely impacted the coding behavior of providers under the new system, ultimately leading to an inaccurate simulation by CMS of the clinical domain under the 60-day payment system using CY 2020, 2021, and now 2022 data. CMS also appeared to exclude a large number of claims due to differences in Outcome and Assessment Information Set (OASIS) requirements beginning in 2020 which may have biased the results.

Early v. Late Visits: Due to the difference in timing assignments under PDGM compared to the 60-day payment system, and the shortened episodes of care under PDGM, it is likely that timing assignments from the CMS simulation using CY 2020, 2021, and 2022 data overrepresent “early” visits in a 60-day system, possibly leading to CMS estimating lower

aggregate payments under the 60-day payment system than otherwise would have occurred. This distortion is obviously biased against home health providers.

Missing OASIS Items: A number of OASIS items relevant to payment under the pre-PDGM Home Health Resource Group (HHRG) model became voluntary after 2020. It is unclear how CMS assigned claims to an HHRG in its analysis when that data was not available other than by simply excluding these claims from its analysis, further biasing the results.

Therapy Thresholds: Given the existence of therapy thresholds under the pre-PDGM payment system that do not exist under the PDGM, CMS cannot plausibly use PDGM data to determine case-mix weights and aggregate payments that would have been made under the prior 60-day payment system in the absence of PDGM. In prior comments, home health providers proposed that CMS apply the PDPM parity adjustment methodology that the agency used in the CY 2023 SNF PPS Proposed and Final Rule to avoid what CMS termed an ”over correction”.

To calculate the counterfactual payments using the SNF PDPM payment parity approach in response to this year’s Proposed Rule, we used the percentage of cases in each HHRG group in CY 2019 and multiplied these percentages by the total number of CY 2024 60-day simulated episodes. We then multiplied the number of cases for each 2019 HHRG group by the CY 2024 60-day payment rate, obtained from the CY 2024 HH PPS Final Rule adjusted for case mix and wage index.

We then compared the aggregate payments under the 60-day system to the actual aggregate payments for the 30-day periods. This methodology also aligns with the notion that budget neutrality analyses should be conducted under the assumption that all else remains the same except the specific policy modeled. The use of CY 2019 data on the percentage of cases by HHRG group eliminates the need to model other behavioral shifts that occurred due to the implementation of PDGM. Using the SNF payment parity methodology, we find that CMS proposed permanent adjustment is overstated by 3.41 percentage points and the CY 2026 proposed permanent adjustment should be -0.65%.

Summary and Recommendations of the Alliance

The significant nature of these flaws and their compounding effect result in an inaccurate modeling of the difference in payments under the pre-PDGM and PDGM systems. CMS chooses to view these results as an absolute and precise calculation of this difference without any acknowledgement of estimation error or the systematic effects of its own policies that do not relate to provider behavior. The Alliance believes this is not a

reasonable policy and that CMS's choice to assert budget neutrality in this way year-after-year only compounds the significant level of error reflected in the rates resulting in inappropriately low payments to providers that are inadequate to support access to quality care. More importantly, the approach only serves to erode the viability of the home health benefit to the detriment of Medicare beneficiaries and providers.

CMS's approach contains critical flaws that overstate the PDGM permanent and temporary payment adjustments and incorrectly attributes them to provider behavior, when they are largely the result of unrelated policy changes, structural aspects of CMS's own payment system design, fraud, and technical errors. We strongly recommend that CMS not finalize the proposed -4.06% permanent adjustment for CY 2026, recalculate the total permanent adjustments determined for CYs 2020 – 2024 data correcting for the flaws identified in this comment letter, and finalize a positive permanent increase to the 30-day payment rate in 2026.

We also strongly recommend that CMS not finalize the proposed -5% temporary adjustment in CY 2026, recalculate the total temporary adjustments dollar amounts for data years 2020-2024, taking into account home health expenditure decreases that already occurred due to excess permanent adjustments applied in prior years. In addition, CMS should account for shrinking FFS enrollment and payment offsets occurring through lower MA benchmarks, which likely result in positive temporary adjustments. If CMS determines that negative temporary adjustments may still be warranted, the agency should use CMS's "time and manner" authority to pause any temporary adjustment for CY 2026 while the agency evaluates an appropriate schedule for implementing any future permanent adjustments that do not jeopardize the ability of Medicare beneficiaries to access high-quality, legitimate home health care.

C. Proposed CY 2026 Home Health Low Utilization Payment Adjustment (LUPA) Thresholds, Functional Impairment Levels, Comorbidity Sub-Groups, and Case Mix Weights

CMS proposes to recalibrate the PDGM case-mix weights, LUPA thresholds, and functional impairment levels for CY 2026 using data from 2024 claims with the aim of ensuring that the payment system accurately reflects relative resource use. According to CMS, these data are the most current and complete data available at the time of the Proposed Rule, though CMS notes that the proposed recalibrated case-mix weights will be updated based on more complete CY 2024 claims data for the Final Rule.

The Alliance generally supports annual recalibration of the case-mix system and LUPA thresholds to ensure payments reflect current trends in care delivery and are as accurate as possible. However, we are concerned that use of claims data from HHAs with suspect billing patterns and likely related to fraudulent activity may be undermining this process

resulting in inaccurate case mix weights and payments to providers, a concern we discuss at length above. In addition, we are concerned about the continued ability for the admission source variable used in the HH PPS case-mix adjustment methodology to adjust for patient acuity, particularly in light of the proposals in the CY 2026 Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule (90 FR 33476) regarding the phase-out of the Inpatient-Only (IPO) list and the expansion of procedures permitted in the ambulatory surgical center (ASC) setting.

CMS is proposing to phase-out the IPO list (1500+ services) over a 3-year period starting with the removal of 285 procedures (mostly musculoskeletal) starting January 1, 2026. CMS is also proposing to expand the number of procedures permitted in the ASC setting, adding 547 for CY 2026 (276 are the same musculoskeletal codes removed from the IPO list). These shifts are not theoretical: in 2024, 32% of inpatient stays were 2 days or less, which are the most likely to move to the outpatient or ASC settings. In its March 2025 Report to Congress, MedPAC found that between 2022 and 2023, inpatient stays have already decreased by 1.5%, whereas ASC services have increased 5.7%.[31,32]

As care continues to shift from inpatient to outpatient settings, the admission source distribution will change in ways not fully captured by historical claims.

The Alliance supports recalibration of the case-mix weights using updated data from 2024 claims; however, we recommend CMS to remove data from potentially fraudulent actors and not apply the permanent and temporary adjustments that are amplified by the payment variances resulting from changes to the case mix system and wage index.

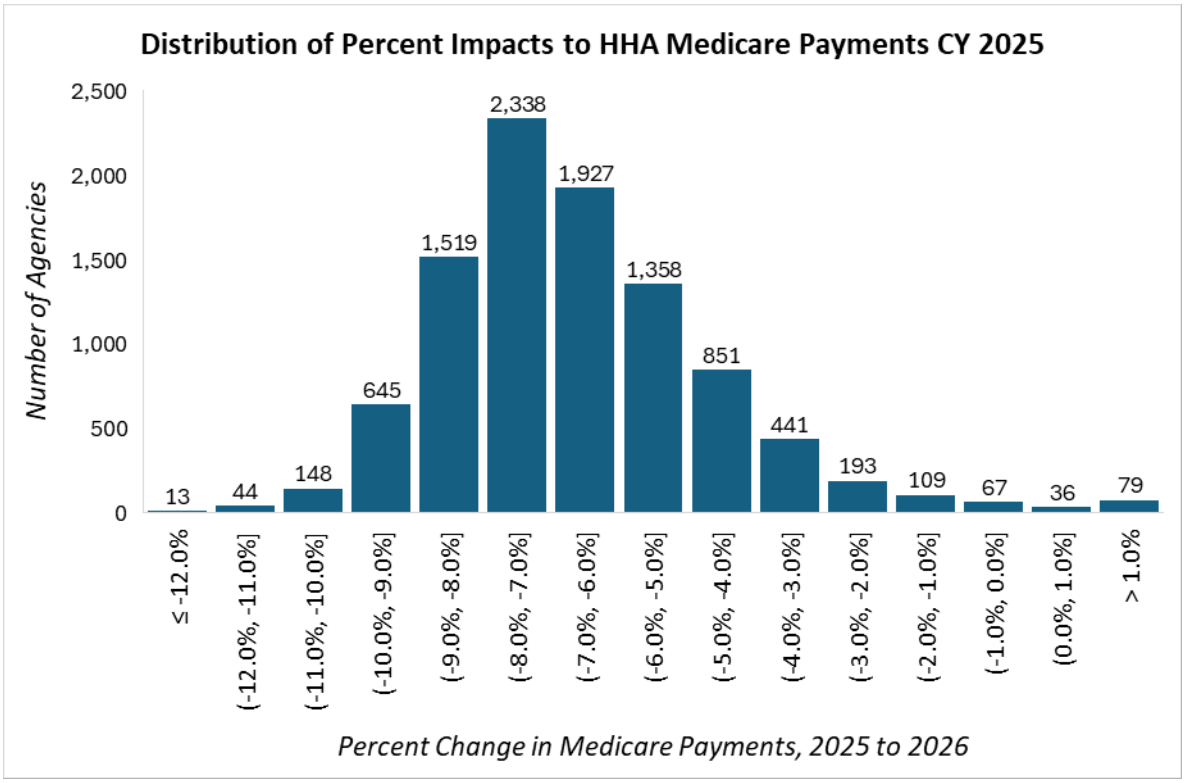
The Alliance also strongly recommends that CMS examine ways to better account for patient acuity in the case-mix adjustment methodology, especially with regards to the admission source variables, as the health care system continues to shift care from inpatient to outpatient settings.

We also note that the changes in payments that result from this process (case-mix weight recalibration) combined with the wage index update, permanent and temporary adjustments, and other proposed changes combine to produce much larger losses for many providers than the simple average (-6.5%) reported by CMS in its impact analysis for the rule. Figure 4 below shows the significant number (98.8%) of home health providers that would experience decreases in their payments because of the cumulative changes

[31] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch10_MedPAC_Report_To_Congress_SEC.pdf?utm_source=chatgpt.com#page=5.33
[32] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf#page=91.46

proposed in this rule. As shown below, this includes 7,992 providers that would experience losses of 5% or greater.

Figure 4: Distribution of Impact of Payment Changes, CY 2025 to CY 2026



Source: DD Analysis of CY2026 proposed rulemaking HH-OASIS data

D. Proposed CY 2026 Home Health Payment Rate Updates

It is critical that Medicare's payments to home health providers are adjusted annually to reflect growth in the cost of resources necessary to provide care, particularly labor which makes up three-quarters of providers' costs. However, we are concerned that, for the fourth year in a row, this year's proposed payment cuts would erase any benefit of the update for addressing the increased cost of care. In addition, we continue to be very concerned with the accuracy of the home health market basket, continued significant cumulative forecast errors in the annual updates, and the large productivity offset applied for CY 2026 that do not reflect the reality of care delivery in the home. This creates financial and workforce challenges for HHAs in hiring and retention of clinical staff that affects patient access and care delivery, as demonstrated in the analysis presented above.

i. Update Factor

The Proposed Rule provides for an annual payment update of +2.4%. This update is based on a market basket increase of 3.2% minus a 0.8% productivity adjustment. As noted above and in CMS's impact analysis for the Proposed Rule, the annual update is more than offset by the decrease associated with the proposed CY permanent and temporary adjustments for CY 2026. As a result, the 30-day period payment rate for CY 2025 of $2,057.35 decreases to $2,033.11 for CY 2026.

This policy does not align with the increased cost of skilled care experienced by our members, particularly for labor, and is inconsistent with the price trends evidenced in Bureau of Labor Statistics (BLS) data.

It is critically important that the annual payment update accurately reflect price growth in the cost of care. This helps ensure that beneficiaries needing HHA services have access to care and supports the viability of this important Medicare benefit over time. We encourage CMS to reexamine its methodology to ensure the accuracy of the market basket itself, and the forecasts used to prospectively set payment rates for each calendar year.

ii. Significant Forecast Error in the Market Basket

The accuracy of the annual payment updates is critical for ensuring that payments keep pace with the rising cost of labor and other resources that are necessary to provide high-quality patient care. Each year, the annual updates to the home health payment rates are based on forecasts of the market basket increase for the upcoming payment year and not measures of actual price growth which are not available until much later. Unfortunately, over the past four years, CMS's forecasts for the market basket have significantly under-estimated actual price growth. In effect, this has served as a second significant cut to payments on top of the already devasting permanent adjustments that CMS has applied.

Based on our analysis of the most recent data from the CMS Office of the Actuary,[33] the cumulative forecast error reflected in the home health payment rates totals -6.7% points over the period 2021 through the 2024 rulemaking. As shown in Table 11 below, there are significant forecast errors for each of these years resulting in the cumulative compounded error of -6.7%. Unless corrected, this forecast error remains in the payments rates

[33] https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

contributing to the chronic under funding of the home health benefit resulting from combined policies to cut payments.

Table 11: Market Basket Forecast Error, CY 2021 through CY 2024

MB Forecast Error Impact	CY 2021	CY 2022	CY 2023	CY 2024	Cumulative
Actual Market Basket	3.9%	6.2%	4.7%	4.0%	20.1%
Projected Market Basket (Final Rules)	2.3%	3.1%	4.1%	3.3%	13.4%
Difference	**-1.6%**	**-3.1%**	**-0.6%**	**-0.7**	**-6.7%***

*Actual cumulative compounded forecast error over the four-year period where final data is available, Data Source: CMS Office of the Actuary, July 15, 2025, 1st quarter 2025 forecast data.

The cost of providing care has grown dramatically over this period. As noted above, the experience of Alliance members is that even the market basket final actual numbers do not keep pace with the growth in labor and other costs. When CMS's projections consistently under-forecast that final actual price growth, this exacerbates the problem causing additional financial challenges. The Alliance is troubled by this "piling on" effect of permanent and temporary adjustments, a market basket that does not track with home health price growth generally, and significant forecast errors locked into providers' payments.

The Alliance believes that a one-time forecast error correction to avoid significant long-term underfunding of the home health benefit is warranted and appropriate. **The Alliance recommends that CMS finalize a one-time forecast error correction to increase the base payment rate 9.6% to account for the underestimates of the market basket for CY 2021 through CY 2024.**[34] This correction would be applied prospectively to CY 2026 payments. This one-time adjustment would account for the significant forecast error reflected in the payment rates going forward, which is unlikely to be offset by future "over-forecasts" over time. A one-time adjustment would not conflict with the prospective nature of the home health PPS going forward or generate uncertainty, concerns CMS has noted in the past. In addition, the Alliance urges CMS to explore options to improve the accuracy of its forecast model and make it transparent to the public. Finally, if CMS chooses not to make this one-time adjustment, it should acknowledge the underfunding of the payment rates caused by this forecast error and not finalize application of any proposed permanent and temporary adjustments in 2026.

[34] To arrive at the recommended 9.6% correction to the base rate, we incorporated the market basket forecast error corrections described in the above table to relevant previous payment updates. Once this is incorporated in the rulemaking base rate formulas and caried forward, the 6.7% forecast error incurs a 9.6% impact.

iii. Productivity adjustment

The Alliance recognizes that CMS, in making annual payment updates, is required by law to apply the productivity adjustment to partially offset the increase associated with the market basket. However, we are concerned that the productivity adjustment does not accurately or fairly reflect productivity gains obtainable in-home health care delivery and so simply serves as another rate cut. We encourage CMS to weigh this consideration in the context of other changes it is proposing where the agency does have the flexibility to ensure the adequacy of the payment rates.

Section 3401(g) of the Affordable Care Act (ACA) requires that the yearly payment update for home health agencies and certain other providers be reduced by a productivity factor. Specifically, the law defines this productivity adjustment as the 10-year moving average of annual growth in economy-wide private nonfarm business productivity. The Bureau of Labor Statistics (BLS) calculates this metric, formerly termed "multifactor productivity," now known as total factor productivity (TFP). In practical terms, CMS's Office of the Actuary projects the 10-year average productivity growth (using BLS data) for the upcoming year,[35] and that percentage (the TFP adjustment) is subtracted from the market basket in applying the annual payment update.

Total factor productivity is an aggregate measure of output growth attributable to technological and efficiency improvements (after accounting for labor and capital inputs). It tends to be driven significantly by advances in technology, capital investment, and process improvements common in manufacturing and other industrial sectors. Home health, by contrast, involves highly personalized, labor intensive, hands-on, one-on-one care delivered by skilled nurses, therapists, and aides in the home. This model offers limited opportunities for rapid productivity growth as measured by TFP output. This is due to the labor requirements of these fields and the fact that there are limits to how much more efficient these providers can become through technology

Innovations such as electronic health records, telehealth, and remote monitoring can result in some productivity gains in home health care, but do not have significant impact due to the intensive labor requirements of this care which limits how much more efficient these providers can become through technology. We also note that CMS details in the section of the Proposed Rule on "Monitoring the Effects of the Implementation of the PDGM[,]" these technology-centered aspects of care delivery are not utilized significantly in home health.

[35] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicareprogramratesstats/downloads/tfp_methodology.pdf

Finally, we wish to highlight language in the 2025 study[36] by the Office of the Actuary cited above that acknowledges the low productivity gains associated with home health. That study provides details on its assumptions around productivity gains and states that, for home health "productivity growth would be 0.1% per year under the achievable productivity scenario." This is far lower than the 0.8% reduction proposed for CY 2026.

Home health providers must compete in their local labor markets with hospitals, skilled nursing facilities and other health care providers to hire nurses, therapists, and aides in order to meet the increased demand for home health services. Unfortunately, these providers are facing staffing shortages and staff turnover due to the inability to maintain competitive compensation relative to other healthcare provider sectors that have not faced three consecutive years of Medicare payment rate reductions. Alliance members are already struggling to increase base pay and offer incentives to employees to meet the demands of the labor market; however, these mechanisms are unsustainable with continued cuts in reimbursement.

iv. Home Health Wage Index

The Alliance supports the annual update to wage index to reflect the most recent data on geographic wage differences across the country. For CY 2026, CMS proposes to base the Home Health Wage Index on the FY 2026 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2021, and before October 1, 2022 (FY 2022 cost report data). Based on existing regulations and policy, the proposed CY 2026 wage index would not take into account any geographic reclassification of hospitals but would include the 5 percent cap on wage index decreases established in the CY 2023 Home Health PPS Final Rule. We continue to express concerns regarding the ability for HHAs to compete with hospitals –subject to a different wage index – for the same limited pipeline of clinical and administrative staff. While we support the -5% cap on wage index decreases, any decrease in the wage index is coupled with proposed permanent and temporary adjustments and greatly impacts the stability of the home health delivery system.

v. Outlier Policy FDL and Fraud Effects on Outlier Payments

[36] https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf-0

The Alliance is troubled that proposed changes to this key factor in HHA reimbursement, designed to ensure that outlier payments remain within budgeted limits while still accounting for high-cost cases, is overstated because the underlying data used to increase the FDL ratio from 0.35 to 0.46 is corrupted by inclusion of claims from high-fraud areas, like Los Angeles County, that distort the mathematical logic to the point of creating further punitive payment policy for legitimate HHAs.

As noted above, LA County consists of 2% of FFS enrollees, 6% of HH users, 9% of HH 30-day periods,10% of payments, 20% of outliers. Although CMS did not provide an estimate of how much outliers payments were estimated to exceed 2.5% of total HH PPS payments to support its proposal for increasing the FDL ratio, we estimate that outlier payments as a percentage of total payments in CY 2024 were 2.99%. If LA County's outlier payments were proportional to its total payments (9% of outlier payments attributed to LA county rather than 20%), we estimate that outlier payments as a percentage of total payments in 2024 would have been 2.65%. Therefore, we believe that suspect billing patterns are impacting the accuracy of CMS's changs to the FDL ratio – making it harder for all HHAs to receive outlier payments as a result of a failure to account for suspicious billing activity.

According to the Proposed Rule's preamble, the proposed change would result in a 0.5% reduction in estimated aggregate payments to HHAs compared to 2025. For the same reasons we state throughout this letter, **the Alliance recommends CMS not finalize the proposed increase to the FDL ratio until it removes highly suspect claims data from its calculation and the claims data used reflect claims experience from actual care provided by legitimate HHAs.**

vi. Payment for Telecommunications Technologies

Prior to the COVID-19 pandemic, telehealth utilization was minimal, with less than 10% of the U.S. population using telehealth for clinical care. Medicare payment for telehealth is generally restricted to rural beneficiaries and specific provider types. However, the pandemic necessitated new flexibilities that lifted the geographic and originating site restrictions, triggering a dramatic expansion in telehealth utilization, with outpatient telehealth use increasing 78-fold during the early months of 2020.[37] Under the Medicare home health benefit, telecommunications technologies were used for triage, monitoring, and follow-up services that were essential for maintaining care continuity, but resulted in increased operational costs for agencies—technology infrastructure, staff training, and

[37] https://pubmed.ncbi.nlm.nih.gov/39992746/

broadband—that were not appropriately reimbursed. A 2020 study of HHAs during COVID-19 documented specific financial impacts: [38]

- 92% of HHAs reported revenue declines during the pandemic;
- Nearly two-thirds experienced revenue drops of 20% or more; and
- HHAs were required to invest in technology infrastructure, staff training, and workflow redesign to support telehealth.

While initially permitted under Section 1135 waivers during the COVID-19 pandemic, CMS finalized permanent regulatory flexibilities for the continued use of telehealth and remote patient monitoring in the CY 2021 Home Health Final Rule (85 FR 70298). On January 1, 2023, CMS began collecting data on the use of telecommunications technology used during a home health period using three G-codes reported on home health claims (telehealth, telephone calls, and remote patient monitoring).

A recent Health Services Research Issue Brief analyzed survey findings regarding the use of telehealth and remote patient monitoring by home health agencies before, during and after the COVID-19 pandemic.[39] The results showed that HHAs' use of telehealth was low prior to 2020, but that adoption spiked starting in 2020 with the COVID-19 pandemic, reaching 65% adoption by HHAs. However, 19% of HHAs adopting telehealth completely discontinued its use by 2024, reportedly due, in part, to high costs and lack of Medicare reimbursement. In the CY 2026 Home Health Proposed Rule, CMS includes several data tables showing how often these codes are included on home health claims. In CY 2024, roughly 2% of all claims included one of these three G-codes.

Collecting data on services furnished via telecommunications technology on claims allows CMS to analyze the characteristics of patients using services provided remotely. Correspondingly, HHAs report, in aggregate, the costs of telecommunication technology as allowable administrative and general costs on Medicare cost reports. However, such services are not adequately or explicitly paid for under the Medicare home health benefit. CMS should support effective use of telehealth and remote patient monitoring in home health not just by collecting data on its use, but by considering options for paying appropriately for virtual services.

[38] https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/medicare-home-health-taking-stock-covid-19-era

[39] https://connectwithcare.org/wp-content/uploads/2025/06/Health-Services-Research-2025-Mukamel-Telehealth-Use-by-Home-Health-Agencies-Before-During-and-After-COVID-19.pdf

We recommend that CMS fully analyze the services provided by HHAs via telehealth and remote patient monitoring for eventual inclusion in its rate-setting methodologies to ensure payment accuracy and adequacy of the HH PPS. Specifically, CMS should evaluate the inclusion of telehealth visits in the visit counts when updating the case-mix weights and consider establishing add-on payments for remote patient monitoring. Additionally, we recommend that CMS ensure that telecommunications technology costs are adequately captured on Medicare cost reports in a way that enables accurate rate setting. Ensuring that telehealth and remote patient monitoring are accurately included on home health claims and Medicare cost reports will subsequently increase the accuracy of future rate-setting, case-mix recalibration, and home health payment.

Recommendations:

- We urge CMS to evaluate the inclusion of telehealth visits in the visit counts when updating the case-mix weights and consider establishing add-on payments for remote patient monitoring.
- CMS should ensure that telecommunications technology costs are adequately captured on Medicare cost reports in a way that enables accurate rate setting.

2. Proposed Regulation Change to Face-to-Face Encounter

CMS proposes to codify into regulation changes to who may conduct the home health face-to-face (F2F) encounter, as required by Section 3708 of the Coronavirus Aid, Relief, and Economic Security Act of 2020 (CARES Act).

The Alliance supports the proposed regulatory changes to the home health F2F encounter. We believe these changes will significantly reduce the administrative burden on home health agencies (HHAs) and practitioners, particularly in cases where more than one practitioner is involved in the care of a beneficiary.

However, we are seeking clarification on the following paragraph from the preamble to the F2F provisions (90 FR 29171):

> We believe the regulations at 42 CFR 424.22(a)(1), in conjunction with the Medicare home health eligibility requirements at 42 CFR 424.22(c), finalized in the CY 2019 Final Rule (83 FR 56627), provide sufficient preservation of our original intent of ensuring that the home health benefit relies on the patient's physician (or subsequently, the allowed practitioner) to determine eligibility for home health services, and that the physician or NPP performing the face-to-face encounter should be a practitioner who is most knowledgeable and has firsthand information of the patient's current clinical condition when certifying the patient's eligibility for home health services and establishing a patient's plan of care.

This language appears to imply that the practitioner performing the F2F encounter must also be the certifying practitioner, and that they must have firsthand knowledge of the patient's clinical condition. We seek clarification on whether CMS intends to issue parameters to guide how HHAs and practitioners demonstrate that the F2F encounter is conducted by the "most knowledgeable" practitioner, especially in situations where care is shared among providers.

Recommendations:

- CMS should provide guidance on how HHAs and practitioners can demonstrate that the F2F encounter is conducted by a practitioner who is "most knowledgeable and has firsthand information" about the patient's condition, particularly in complex care settings where multiple practitioners are involved.
- We encourage CMS to maintain flexibility for HHAs and practitioners to determine, based on clinical judgment and care team structure, which practitioner is best positioned to perform the F2F encounter while still meeting eligibility and certification requirements.

3. Home Health Quality Reporting Program (HHQRP)

A. Proposed Removal of Quality Measures and Assessment Items

CMS proposes to remove the ''COVID–19 Vaccine: Percent of Patients Who Are Up to Date'' quality measure, along with the corresponding Outcome and Assessment Information Set (OASIS) data element. In addition, CMS is proposing to eliminate four assessment items: one Living Situation item, two Food items, and one Utilities item. The Alliance supports the removal of the COVID-19 vaccination measure and its associated OASIS data item. Given the current status of the COVID-19 pandemic, this measure is no longer as relevant or actionable as it was when originally implemented.

The Alliance also supports the removal of the social determinants of health (SDOH) items from the OASIS assessment. Home health agencies routinely assess SDOH as part of comprehensive care planning. While these factors are essential for the effective delivery of care to community-dwelling patients, they are already documented in the patient's medical record. Accordingly, including these items in the OASIS assessment tool results in unnecessary duplication and contributes to administrative burden. We appreciate CMS's continued efforts to balance the need for meaningful data collection with the imperative to reduce burden on home health agencies. Removing these items represents a thoughtful step in streamlining data requirements while maintaining a focus on patient-centered care.

Recommendations: CMS should:

- Remove the COVID-19 assessment item from the OASIS and the associated measure from the HHQRP.
- Remove the SDOH assessment items from the OASIS and explore alternative mechanisms to collect SDOH data outside of the OASIS instrument that does not duplicate clinical documentation or impose undue burden.

B. Amending the Data Non-Compliance Reconsideration Request Policy and Process

CMS proposes to amend the HHQRP non-compliance reconsideration request policy at § 484.245(d) to permit an HHA to request, and CMS to grant, an extension to file a request for reconsideration of a noncompliance determination in situations where the agency was affected by an extraordinary circumstance beyond its control during the 30-day reconsideration period, as set forth in § 484.245(d). CMS also proposes specific conditions and a time frame permitted to submit the request.

We appreciate CMS's proposal to codify this flexibility and allow agencies additional time to request reconsideration, particularly given the increasing threats from natural and man-made disasters. It is important to note that HHAs are often less resourced in contending with these events relative to larger higher-cost providers, and this proposal would provide HHAs a clear defined pathway to seek more time to contest a HHQRP non-compliance determination when unexpected events outside their control prevent timely filing.

Recommendation: The Alliance supports amending the regulations at § 484.245 to codify the extension process for requesting reconsideration of a non-compliance determination as proposed.

C. Proposed Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Survey Updates

CMS has revised the HHCAHPS survey by adding new questions that better reflect issues important to patients and removing several questions that are either less meaningful to patients or not used for public reporting. The revised survey is shorter by seven questions compared to the previous version. CMS plans to begin administering the updated survey with the April 2026 sample month.

Because the revised HHCAHPS survey significantly changes the composition of the composite measures used for public reporting, CMS proposes to delay posting the new measures on Care Compare until October 2027, after four quarters of data are collected. The revised survey will also change the measures used for public reporting, Star Ratings, and the Home Health Value-Based Purchasing (HHVBP) Model. By focusing on questions that reflect patients' priorities and eliminating items of limited value, the updated survey will yield results that are more impactful to patients while reducing the time and effort required for completion.

> **Recommendation:** The Alliance supports and appreciates CMS's efforts to revise the HHCAHPS survey that strengthens its relevance to patients while also reducing respondent burden.

D. HH QRP Quality Measure Concepts Under Consideration for Future Years

CMS is seeking feedback on four measure concepts for potential inclusion in the HH QRP:

Interoperability – CMS is seeking comments on a measure of interoperability, focusing on systems readiness and capabilities in the home health setting.
The Alliance appreciates CMS's interest in exploring quality measures related to interoperability in the home health setting. We recognize the potential of interoperable health IT systems to enhance care coordination, improve patient outcomes, and support more seamless transitions across care settings. However, we must emphasize the substantial financial and operational barriers that HHAs face in achieving interoperability.

Unlike hospitals and physician practices, HHAs were not included in previous federal funding programs, such as the HITECH Act, that subsidized the adoption and implementation of certified electronic health record (EHR) systems. As a result, HHAs have not had access to the same level of financial or technical support to build and maintain an interoperable infrastructure.

At present, there is no dedicated or sustainable funding source to support the significant investment required for interoperability in home health. Many HHAs, especially small and rural providers, operate on already narrow margins and simply do not have the resources to purchase, upgrade, or integrate advanced health IT systems that comply with evolving federal standards for data exchange.

Without a clear and stable pathway for funding, any measure that assesses readiness or capacity for interoperability would be premature and risk unfairly penalizing providers for circumstances beyond their control.

Recommendation: The Alliance urges CMS to consider the lack of funding and systemic support in the development of any interoperability-related measure. Additionally, CMS should first work with stakeholders to identify feasible pathways and funding mechanisms before proposing formal assessment or performance measures in this domain.

Well-Being – CMS is seeking feedback on a potential measure of well-being. Well-being encompasses mental, social, and physical health, integrating disease prevention and health promotion with a focus on preventative care to proactively address potential health issues. In the home health context, this approach emphasizes person-centered care by promoting the well-being of patients.

The Alliance supports the exploration of a quality measure focused on well-being and appreciates CMS's commitment to person-centered, holistic care that integrates mental, social, and physical health domains. This concept aligns closely with the values and practices of HHAs, which routinely care for individuals in their homes and often engage with the broader social and emotional aspects that influence their health outcomes. Well-being is central to successful aging in place and long-term recovery. In the home health setting, clinicians are uniquely positioned to assess and support not just medical needs, but also emotional well-being, social connectedness, and purpose—factors that are often critical to sustained health and independence.

However, implementing a well-being quality measure in home health presents several challenges that must be addressed to ensure fairness, feasibility, and effectiveness. First, we emphasize that any tools used to measure wellness must be validated for use in the home health setting. Without validation, results may be inconsistent or fail to capture relevant aspects of patient well-being.

Second, identifying issues such as loneliness or depression is only beneficial to the extent that clinicians can refer and connect patients to appropriate services and supports. Unfortunately, many HHAs, particularly those in rural or underserved areas, lack sufficient access to mental health professionals, social services, and community programs. Finally, well-being is shaped by many factors outside of an HHA's control, such as chronic mental health conditions and social determinants of health. Without robust risk adjustment and careful attribution methods, such a measure could unfairly penalize agencies that care for vulnerable populations.

Recommendations: CMS should ensure that any well-being assessment tools developed or modified are specifically designed for use with older, homebound patients who may have cognitive, sensory, or physical limitations. These tools must be validated for the home setting and be culturally sensitive, easy to administer, and accessible to individuals with varying health literacy levels. If CMS advances this measure concept, it should be constructed as a process measure rather than a performance measure—focusing on whether appropriate assessments are being conducted, rather than evaluating outcomes that may be influenced by factors beyond the control of HHAs.

Nutrition – CMS is seeking feedback on a potential measure of nutrition. Nutritional assessment in home health may include various strategies, guidelines, and practices designed to promote nutrition and ensure patients receive the necessary nutrients for maintaining their individual health needs and support overall well-being.

The Alliance appreciates CMS's commitment to exploring new quality measure concepts that promote optimal health and well-being, including nutrition. We agree that nutrition, physical activity, and other lifestyle factors such as sleep play a vital role in maintaining health and preventing avoidable complications, particularly among medically complex individuals receiving home health care.

However, we respectfully urge CMS to consider the realities that face HHAs in terms of the feasibility of implementing a quality measure on nutrition in the home health setting. Home health agencies routinely assess basic nutritional status, typically through OASIS items, patient interviews, and observation. However, most HHAs are not sufficiently staffed or funded to provide in-depth nutritional interventions. Registered dietitians are not commonly employed by HHAs, and nutrition services are often outside the scope of the reimbursed home health plan of care unless directly linked to skilled services. Without reimbursement for such services, HHAs cannot be expected to provide comprehensive nutrition counseling or treatment outside the scope of the home health plan of care.

Recommendation: Any quality measure related to nutrition should focus on identification of risk and facilitating referral or coordination with appropriate resources, rather than requiring treatment or counseling unless reimbursement models are adjusted to support those services. Consistent with our recommendations on potential well-being measures, If CMS advances this measure concept, it should be constructed as a process measure rather than a performance measure.

Cognition – CMS requests input on cognitive functioning measures that may be available for immediate use, or that may be adapted or developed for use in the HH QRP, using the Brief Interview for Mental Status (BIMS) and Confusion Assessment Method (CAM©). CMS also seeks input on the feasibility of measuring improvement in cognitive functioning during a home health stay.

The Alliance does not support the development of a quality measure aimed at improving or mitigating the effects of cognitive impairments in home health patients. It is important to note that cognitive disorders are commonly chronic and progressive, not reversible through short term home health interventions. Further, HHAs generally lack the specialized resources and expertise required to treat these conditions. Measurable improvement in these cognitive conditions during a typical home health episode of care should not and cannot be expected. While home health care can help caregivers manage patient symptoms in the home, it cannot reverse the underlying condition.

Indeed, the primary responsibility of HHAs is to support and educate caregivers on managing patients with cognitive deficits effectively. This includes helping caregivers identify behaviors that may exceed safe management within the home setting.

Given these realities, it remains unclear what meaningful or reliable performance metrics could accurately capture the quality of cognitive care provided by HHAs. Cognitive conditions vary widely in severity and progression, and outcomes are heavily influenced by factors outside the agency's control, such as the caregiver's capacity and availability of external support systems. Therefore, any proposed quality measure related to cognition must carefully consider the scope and limitations of HHAs' role and resources, focusing on caregiver education and support rather than direct clinical intervention or patient outcomes that are not readily measurable or attributable to home health services. It follows that such a measure would unfairly reflect factors entirely unrelated to the quality of home health care.

> **Recommendation:** CMS should not proceed with a cognition measure concept for the HH QRP. If CMS chooses to move forward with such a measure concept, the focus should be on realistic and actionable aspects of home health care for cognitive impairment, such as caregiver preparedness and timely referral processes, rather than holding agencies accountable for outcomes that are not feasible to influence or attributable to home health care.

E. General comments on revisions to the HH QRP

The Alliance continues to be concerned about the frequency that CMS has modified the OASIS data set over the last several years.

Since the implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014,[40] CMS has made revisions to the OASIS data set to accommodate the development of standardized assessment items and cross setting measures as required by the IMPACT Act. HHAs have had to adapt to significant OASIS updates and instruction changes in 2019, 2020, and 2023. The last revision related to the IMPACT Act requirements took effect in 2023 (OASIS E).[41] However, CMS continued to implement additional changes to the HH QRP requiring another revision to the OASIS data set, OASIS E1, effective January 1, 2025. Now, yet another version—OASIS E2—has been issued that will go into effect April 1, 2026, further adding to the cumulative burden on HHAs. Changes to the OASIS data set and instructions, even small changes, increase resource use for agencies in terms of staff training, coordination with vendors, and altered productivity associated with the learning curve required for collecting new material. The burden is magnified by increased rate cuts and a protracted workforce shortage. Also, the addition of assessment items without modifications to reduce the data set could result in a very lengthy assessment tool.

In response to the CY 2025 Home Health Rate Update Proposed Rule (89 FR 55312), the Alliance addressed the same concerns regarding the frequency of the OASIS revisions and recommended that CMS limit updates to the OASIS assessment to no more than every 4 years. In the CY 2025 Home Health Rate Update Final Rule (89 FR 88354), CMS remarked, "[a]s previously stated, CMS acknowledges that revisions to the OASIS require HHAs' time, effort, and resources, and we are committed to proposing revisions no more frequently than every two years." (89 FR 88441). However, CMS fails to fully recognize that even a two-year revision cycle places a substantial burden on home health agencies. This burden is further compounded by shrinking payment rates and sustained workforce gaps making such frequent updates unsustainable and impractical. We urge CMS to extend the OASIS revision cycle in alignment with the administration's goal of reducing regulatory burdens on providers,[42] allowing HHAs to focus on delivering care rather than repeatedly retooling operations to meet shifting reporting requirements.

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[40] https://www.congress.gov/113/plaws/publ185/PLAW-113publ185.pdf, Pub. L. 113-185.
[41] https://www.cms.gov/files/document/draft-oasis-e1-manual-04-28-2024.pdf
[42] Exec. Order 14192, 90 Fed. Reg. 9065

Recommendation: The Alliance respectfully urges CMS to extend the OASIS revision cycle to no more than once every four years to allow adequate time for implementation, staff training, and operational integration.

F. Potential Revision of the Final Data Submission Deadline

CMS is seeking feedback on a potential future change to the HH QRP that would shorten the data submission deadline from 4.5 months to 45 days following the end of the reporting period. CMS specifically requests input on how this change could improve the timeliness and actionability of HH QRP quality measures, enhance the usefulness of publicly reported data, and affect provider workflows, including any required updates to systems, processes, or staffing.

The Alliance supports limiting the time frame for reviewing and correcting OASIS data to improve the timeliness of public reporting. More current quality data benefits patients, families, and referral sources by making the information more relevant and actionable.

However, the proposed 45-day timeframe is a substantial reduction from the current submission window and could disproportionately impact certain providers, particularly small, stand-alone HHAs that operate with limited resources, manage coding and review in-house, experience high field staff turnover, or lack robust EMR or analytics systems. These agencies are more likely to encounter assessment errors and require additional time for corrections.

CMS's 2022 analysis found that only 1.3% of all OASIS assessments were submitted after the 60-day mark, with three-quarters of those (0.9% of the total) submitted between 60 days and 4.5 months. However, CMS has not provided data on how many assessments were submitted for correction within 60 days, an important factor in assessing the feasibility of a 45-day deadline. Without this information, it is difficult to evaluate whether a 60-day submission requirement might achieve similar timeliness goals while reducing the risk of unintended operational strain.

At this time, more data and analysis are needed to determine the most appropriate revised submission timeframe.

Recommendation: CMS should consider testing a reduced submission timeframe in a pilot program to evaluate operational impacts and make adjustments based on provider feedback and performance.

G. Advancing Digital Quality Measurement (dQM) in the HH QRP

CMS is issuing a request for information (RFI) to gather broad public input on the dQM transition in HHAs.

The Alliance appreciates the opportunity to provide comments on CMS's ongoing efforts to promote interoperability and health information exchange through the adoption of Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) standards. We support CMS's overarching goals of improving healthcare quality through enhanced transparency, public reporting, and more coordinated, patient-centered care. Interoperable health information technology (HIT) will be critical to achieving these aims, particularly in the context of the Home Health Quality Reporting Program (HH QRP).

However, as CMS considers future expectations for interoperability in home health, it is important to recognize the long-standing structural and financial barriers that have limited post-acute care provider access to interoperable health IT. Unlike hospitals and physician practices, HHAs were excluded from federal incentive programs established under the Health Information Technology for Economic and Clinical Health (HITECH) Act. As a result, many HHAs were unable to invest in certified electronic health record technology (CEHRT) and have been left to navigate the transition to interoperable systems without meaningful financial or technical support.

Although most HHAs utilize some form of electronic health record (EHR), these systems vary widely in their capabilities and few are ONC-certified. Should CMS require CEHRT adoption in the future, providers will face significant burdens including high costs for system upgrades or replacements, additional staff training, IT support, and vendor-driven implementation fees. In many cases, vendors serving the home health industry would also need to reconfigure their platforms to meet CEHRT criteria—costs that would inevitably be passed on to providers.

In addition to financial constraints, HHAs face infrastructure and operational barriers to interoperability. Many PAC providers—including HHAs—still receive records from hospitals, skilled nursing facilities, and community-based providers via fax, and often lack direct access to hospital or health system electronic systems. Participation in health information exchanges (HIEs) does not always ensure meaningful interoperability, especially when access is limited to only certain members of the exchange. Moreover, HHAs frequently operate in patient homes with limited or inconsistent internet access, which restricts their ability to transmit data in real-time or maintain seamless communication with other providers.

If CMS intends to move forward with policies that require the collection, sharing, or reporting of data through interoperable systems, it must ensure that HHAs have access to the resources, tools, and infrastructure necessary to comply. Without this foundational support, such policies risk further disadvantaging PAC providers and could ultimately hinder progress toward nationwide interoperability.

Recommendations: CMS should:

- Establish a dedicated funding mechanism—or advocate for one through Congress—to support HHAs and other PAC providers in purchasing, upgrading, and maintaining CEHRT systems.
- Phase in requirements over time to allow providers adequate time to adapt and plan for system upgrades.
- Ensure flexibility for rural and resource-limited providers, particularly those with internet connectivity challenges.
- Engage stakeholders and vendors early and consistently to ensure feasibility, equity, and effective implementation across diverse care settings.

4. Home Health Value Based Purchasing Model

A. Proposed Changes to the Expanded HHVBP Model's Applicable Measure Set Measures Removed

CMS is proposing to remove three measures from the current applicable measure set and add four measures starting in CY 2026. The removal of the three measures is necessary due to revisions to the HHCAHPS Survey that are proposed beginning with the April 2026 sample. While CMS could revise the HHCAHPS measures to use the proposed HHCAHPS Survey instrument changes, a full year of data with the revised HHCAHPS measures will not be available until CY 2027. Data from multiple quarters will be needed to establish benchmarks and achievement thresholds for the revised HHCAHPS Survey-based measures.

CMS will require 1 year of data to establish appropriate benchmarks and achievement thresholds for measuring HHAs' level of performance on the revised HHCAHPS. By contrast, CMS will require 2 years of data to measure improvement over time and establish improvement thresholds. Therefore, CMS seeks public comments on the possibility of initially measuring HHA performance on the future HHCAHPS Survey-based measures based solely on achievement, rather than both achievement and improvement.
A central theme consistently raised by the home health industry is frustration with the ongoing changes to the HHVBP model measure set and the associated burden of having to frequently adjust quality improvement strategies in order to remain successful under the program.

Recommendation: If CMS intends to include measures from the revised HHCAHPS survey in the HHVBP model, the Alliance recommends that both achievement and improvement measures be incorporated simultaneously to avoid additional disruption and to support a consistent and meaningful quality performance program.

B. Proposed Addition of Medicare Spending Per Beneficiary Post-Acute Care (MSPB–PAC) and OASIS-Based Function Measures to the Expanded HHVBP Model Applicable Measure Set MSPB-PAC

The Alliance does not support including the MSPB-PAC measure in the HHVBP. This item is not a measure of care quality but a measure of Medicare spending. It is unclear how CMS intends to use the MSPB measure in the HHVBP.

While the measure may be intended as a measure of efficiency, lower Medicare spending compared to the national median could reflect different realities. For example, it could mean the HHA is efficient, but it could also mean the HHA is being selective in the services it provides or the patients it serves.

If agencies believe their performance scores, and resulting payment adjustments, will be adversely affected by this measure, particularly considering ongoing CMS payment rate cuts, they may be disincentivized from serving clinically complex and higher-cost patients. These concerns are reinforced by findings in the sixth annual report for the original HHVBP model, *Evaluation of the Home Health Value-Based Purchasing (HHVBP) Model (May 2023):*[43]

> *Page 148 (emphasis added)*
>
> The overall impacts of the model in leading to fewer unplanned hospitalizations and greater improvements in functioning were not observed among Medicaid patients, resulting in a pattern of modest growth in disparities for Medicaid patients.
>
> Since patient outcomes may depend on the quality of home health care that is available, we also examined inequities in the use of lower quality HHAs. We observed overall inequities by race and ethnicity in the use of lower quality agencies that persisted under HHVBP.
>
> *Page 149*
>
> *11.2 Motivation: Potential Unintended Consequences of Value-Based Purchasing*
> The goal of VBP programs to promote overall quality improvement has potential to benefit historically disadvantaged populations through gains in quality of care and patient outcomes. However, a potential unintended consequence of VBP programs is that they may systematically penalize providers who care for patients for whom it is more difficult to achieve quality performance levels that are tied to payment. Previous research involving other care settings indicates potential for unintended consequences of VBP programs for health disparities (Joynt, 2013; Ryan, 2013; Damberg, 2015; Gilman, 2015; Qi, 2020;

[43] https://www.cms.gov/priorities/innovation/data-and-reports/2023/hhvbp-sixth-ann-rpt

> Aggarwal, 2021). One risk is that VBP programs may redistribute resources away from providers who care for historically underserved populations, which could limit investments in quality improvement and lead to worsening disparities in care and outcomes. This risk is important to evaluate in the context of HHVBP, especially as the payment adjustments grew larger over time relative to other VBP programs. . . .

Considering the HHVBP model has been expanded nationwide it is reasonable to believe that pressures on HHAs to respond to changes in the model will widen the health equity gap and leave some patient populations underserved.

> **Recommendation:** CMS should withdraw its proposal to include the MSPB -PAC measure in the HHVBP.

C. Proposed Addition of OASIS-Based Function Measures to the Expanded HHVBP Model Applicable Measure Set

CMS proposes adding three OASIS based function measures to the HHVBP applicable measure set beginning with CY 2026:

I. Improvement in Bathing (based on OASIS item M1830)
II. Improvement in Upper Body Dressing (based on OASIS item M1810)
III. Improvement in Lower Body Dressing (based on OASIS item M1820)

These measures are intended to complement the Discharge (DC) Function Score measure added to the HHVBP applicable measure set starting with CY 2025 to provide a more holistic picture of patients' functional status.

The Alliance supports including the proposed bathing and dressing measures, as they reflect activities most likely to be the focus of interventions for home health patients. However, the Alliance urges CMS to incorporate the Section GG – Functional Abilities items into the DC Function Score measure, rather than adding the M018xx items from Section G – Function Status as separate elements. HHAs have long expressed frustration that these two sections of the OASIS dataset are duplicative yet remain critical to multiple applications in home health payment and quality reporting programs. The continued use of both sections within the OASIS dataset creates unnecessary duplication, increasing provider burden without adding value. Aligning the measure with Section GG would reduce redundancy, streamline data collection, and ensure consistency across home health payment and quality reporting programs.

> **Recommendation:** CMS should eliminate the M18xx functional status items and instead incorporate the GG functional activity items into home health programs.

Aligning the measure with Section GG would reduce redundancy, streamline data collection, and ensure consistency across home health payment and quality reporting programs.

D. HHVBP Quality Measure Concepts Under Consideration for Future Years— Request for Information

Falls With Major Injury Measure (OASIS-Based and Claims-Based)

CMS is seeking information on including a claims based "respecified" Falls with Major Injury (FMI) measure into the HHVBP. A respecified measure would include other injuries not explicitly covered in the OASIS-based FMI measure, which uses a specific measure of falls with major injury that includes only bone fractures, joint dislocations, closed head injuries with altered consciousness, and subdural hematomas.

The Alliance does not support a Falls with Major Injury measure regardless of whether it is a claims based or an OASIS-based measure. The Alliance, through its legacy organization the National Association for Home Care & Hospice, has expressed its opposition to this measure during other opportunities for public comments on inclusion of the measure into the HH QRP and the HHVBP.[44, 45]

The FMI measure, whether claims- or OASIS-based, does not adequately account for the intermittent nature of home health services and relies on a flawed attribution methodology. It flags any fall resulting in injury during a home health episode, regardless of whether the agency had control over the patient's activities or the environment contributing to the fall. For instance, a fall that occurs outside the home—such as a patient tripping on an uneven sidewalk while traveling to a physician's appointment—would still be attributed to the home health agency.

Additionally, as an Improving Medicare Post-Acute Care Transformation Act of 2014(IMPACT Act) measure. An FMI measure will likely be included in cross comparison with the other post-acute care providers subject to the IMPACT Act. Those providers are facility-based settings and are staffed 24/7. This direct comparison is inappropriate and

[44] The National Association for Home Care & Hospice, Draft Specifications For The Development Of The Percent Of Patients Experiencing One Or More Falls With Major Injury During A Home Health Episode Measure, Comment letter, October 14, 2016.

[45] Comment Letter of the National Alliance for Care at Home, CMS-1803-P: Medicare Program; Calendar Year (CY) 2025 Home Health Prospective Payment System (HH PPS) Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin (IVIG) Items and Services Rate Update; and Other Medicare Policies (Aug. 26, 2024).

places home health agencies at a significant disadvantage in both measurement and benchmarking.

Furthermore, CMS provides only a cursory explanation of what a "respecified" FMI measure entails. CMS proposes to use fee-for-service claims, encounter data, and OASIS data to calculate the measure, while also broadening it to include additional injuries not explicitly captured in the OASIS-based version. The details of this approach only became clear in mid-August, when CMS released a Technical Expert Panel (TEP) report that had not previously been made public.

According to the TEP, two potential approaches were considered for integrating claims data with the existing assessment-based measure. The first would use claims to identify additional major injuries tied to falls already documented in assessment data. The second would rely more heavily on claims, using them to identify both falls and resulting injuries. Panel members were evenly split on which approach to adopt.

The TEP also reviewed refinements to the ICD-10 code lists used to define falls and major injuries. The revised specification retains fractures, dislocations, traumatic brain and includes spinal injuries, crush injuries, and organ trauma as qualifying events. There was debate over whether to include external cause codes to capture falls. Additional issues discussed included potential numerator exclusions and the appropriate measurement window.

Despite these refinements, fundamental concerns persist regarding the application of an FMI measure in the home health setting, particularly within the HHVBP model.

> **Recommendation:** CMS should not include a re-specified FMI measure in the HHVBP.

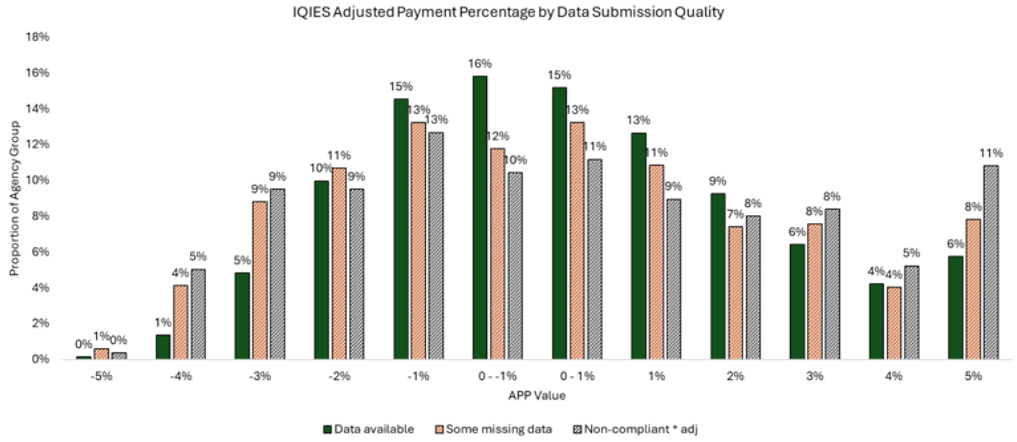
E. Concerns with Positive Payment Adjustment for HHAs that are Noncompliant with the HH QRP Requirements

The Alliance has concerns with agencies that have received pay increases under the HHVBP while non-compliant with the requirements under the HHQRP. CMS issued raw data in January 2025 for the first payment year based on data from 2023 (first performance year).

In our analysis, of all HHAs, 60% (7,161 agencies) receive a payment adjustment, while the remaining 40% (4,809 agencies) are ineligible. Within the group receiving a payment adjustment, notable gaps in data completeness remain. Specifically, 10.5% (753 agencies)

are missing some portion of the data needed to calculate either the Total Performance Score (TPS) or HHCAHPS results, and 9.4% (676 agencies) are missing data for at least one measure. Furthermore, 7.5% (537 agencies) are missing data and are also deemed non-compliant with the HH QRP as indicated by the *CY 2025 HHA Noncompliant with the APU* list. Surprisingly, 285 HHAs (7.5%) that were noncompliant still received a positive payment adjustment, including 58 HHAs (13%), that received the full +5% increase. Even more striking, noncompliant HHAs accounted for the largest share of agencies receiving a +5% adjustment compared with those having complete or partial data.

Figure 5: IQIES Adjusted Payment Percentage by Data Submission Quality



These data suggest that while a majority of HHAs are meeting eligibility requirements, a meaningful subset struggles with complete and timely data submission. However, they are eligible to receive a TPS score with many of the non-compliant agencies receiving an increase in payment.

Additionally, because the large cohort includes significantly more HHAs than the small cohort, and encompasses a wider range of sizes, defined as all HHAs serving more than 60 patients during the reporting year, it is impossible to determine whether agency size influences TPS and the resulting payment adjustment. The home health industry voiced concerns about these cohort definitions when the expanded model was first proposed, and those concerns persist today, particularly that smaller, freestanding agencies may be at a disadvantage under the expanded model.

Recommendations: CMS should:

- Conduct targeted audits of HHAs that are noncompliant with HH QRP but still receive positive payment adjustments, especially those achieving the maximum +5% increase, to assess for program integrity issues.
- Prohibit HHAs from receiving an increased payment adjustment if not compliant with the HHVBP reporting requirements per §484.355(b) during the performance year.

- Explore policy changes to ensure performance incentives are aligned with both quality reporting compliance and quality outcomes.
- Further evaluate the TPS and payment adjustments in the large cohort to assess whether the model disadvantages smaller, freestanding agencies.
- Consider introducing additional size-based stratifications or risk adjustments to account for operational differences between very large and mid-size agencies within the large cohort.

F. Evaluation Reports for the Expanded HHVBP

The Alliance requests clarification on whether the Center for Medicare and Medicaid innovation (CMMI) plans to issue annual reports on the Expanded HHVBP, similar to those provided during the original model (2016–2021). During that period, CMS issued publicly available evaluation reports for each year starting with the first payment year (2018) and continuing through 2019–2023, culminating in a final comprehensive evaluation report on the entire HHVBP.

> **Recommendation**: The Alliance urges CMS to issue annual evaluation reports for each year of the expanded model, as these reports are essential for ensuring transparency and public accountability.

5. Medicare Provider Enrollment

CMS has issued changes to several provider enrollment regulations. These changes include enhanced protections for the Medicare program by addressing areas that have been identified as potentially vulnerable to fraud and abuse.

The Alliance supports CMS's efforts to strengthen provider enrollment processes and enhance program integrity. However, we are concerned about the proposed expansion of CMS's deactivation authority under § 424.547, which would apply to physicians and nonphysician practitioners who order, certify, or refer Medicare services but have not appeared on a Medicare Part A or B claim within the past 12 consecutive months. HHAs and hospices are among several Medicare providers that will be directly affected if this proposal is finalized.

Deactivation of the certifying or ordering provider will prevent HHAs and hospices from billing Medicare for any claims that include a deactivated practitioner. Specific to hospices, there are often physicians employed by and working only for the hospice and not in a position that they would routinely or even occasionally certify a patient such as those covering some on-call hours or covering the vacations/absences of other hospice

physicians. In these instances, the on-call/covering physician may not have certified a hospice patient and, therefore, not be listed on a claim in a 12-month period.

HHAs and hospices routinely verify provider eligibility through available databases to ensure that all practitioners certifying patients for home health services are authorized to do so; therefore, the accuracy and timeliness of these databases are critical to their operations.

Moreover, because these ordering and certifying practitioners typically do not bill Medicare directly for services, they may be unaware of their deactivation status and unable to address or correct it promptly. This lack of awareness can lead to unexpected claim denials and disruptions in patient care.

Recommendations: CMS should:

- Ensure up-to-date and accurate provider enrollment databases that HHAs and other Medicare providers rely on to verify ordering and certifying practitioner eligibility.
- Exercise thoughtful discretion in determining deactivations with consideration given to physicians employed only by hospices.
- Provide targeted education and outreach to HHAs and hospices and ordering/certifying practitioners about the deactivation policy.
- Ensure the reactivation process is efficient and minimizes any delays in restoring ordering and certifying privileges for those practitioners that have been deemed eligible to certify /order home health services or hospice services.

<u>Delays in Processing Provider Enrollment Applications and Changes in Information</u>

The Alliance has heard from (HHAs) that the time frames for Medicare Administrative Contractors (MACs) to process enrollment applications, changes in ownership, and other updates to provider information have become increasingly lengthy. In some cases, MACs take many months to complete these transactions. For example, the Alliance is working with an agency for which the MAC has yet to complete a Change of Ownership (CHOW) after 11 months. Additionally, it is not unusual for MACs to request documentation that has already been submitted by the agency, creating unnecessary duplication and further delaying processing.

Recommendations: CMS should:

- Work with MACs to establish clear and reasonable processing timeframes for provider enrollment and change requests, with transparent tracking of progress.
- Require MACs to implement systems that prevent duplicate document requests and ensure that information already submitted is appropriately retained and

applied to the pending file. This would reduce administrative burden on HHAs, minimize operational disruption, and help ensure that beneficiaries have uninterrupted access to care.

- Provide flexibility for reporting changes within 30 days under §424.516(e) (1) for circumstances out of the provider's control, including delays caused by the MAC.

6. Provider Enrollment and Certain DMEPOS Accreditation Policies

The Alliance understands and appreciates the reasons for the proposals related to strengthening oversight of organizations that accredit durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers in the Proposed Rule. We have carefully considered the proposals for DMEPOS AOs and offer the following comments.

We reiterate our broader position that CMS must establish more rigorous provider screening and enrollment protocols to prevent fraudulent activity and protect Medicare beneficiaries. Ensuring appropriate oversight of DMEPOS accrediting organizations (AO) is an important part of this broader effort.

The Alliance agrees that all surveys should be unannounced, with no advance notice to the facility, and supports CMS's proposal to require AOs to conduct unannounced surveys for DMEPOS suppliers. The Alliance further supports more frequent surveys of DMEPOS suppliers; however, CMS's proposed frequency of a 12-month cycle does not take into consideration the risk level for non-compliance by a supplier. Taking such information into account when determining the frequency of surveys supports efficiency and effectiveness of the survey process. It also helps in promoting a successful rollout of more frequent surveys as AOs would need to build their surveyor workforce. Factors such as number and level of complaints and newness of the DMEPOS supplier could be part of the determination of risk level used in a weighted survey frequency system. The Alliance encourages CMS to work with the AOs and DMEPOS suppliers in the development of such a system.

CMS put forth several proposals creating stricter requirements for AOs such as addressing evidence that the AO can conduct a timely review of accreditation applications as well as carrying out accreditation activities. The AOs would not merely be required to provide information and data to CMS to evidence capabilities and actual performance but would also be required to have the data and information to provide CMS "reasonable assurance" that the AO is clearly capable of meeting these requirements. The Alliance strongly supports the intent behind these proposals which is to deter fraud, waste and abuse and protect the safety of Medicare beneficiaries.

CMS also proposes to define ‘‘reasonable assurance’’ to mean that an AO has demonstrated to CMS’s satisfaction that:

- Its accreditation program requirements meet or exceed the Medicare program requirements;
- The suppliers the AO accredits meet or exceed Medicare requirements; and
- The AO is compliant with all provisions of § 424.58.

This proposal would mirror that for AOs of Medicare certified providers of home health services and hospice services. This promotes consistency across AOs that accredit organizations providing care, services or equipment and supplies in the home setting. Some of the approved DMEPOS AOs also are approved accrediting organizations for home health and hospice services so they are familiar with reasonable assurance requirements and expectations.

Of particular interest to the Alliance are the proposals around conflict of interest. It is necessary to have robust conflict of interest policies and procedures for survey entities and surveyors. The Alliance supports requiring AOs to include in their policies and procedures detailed explanations of how conflicts—and the appearance of conflicts— will be identified, avoided, and managed for individuals who conduct surveys or participate in accreditation decisions. CMS makes numerous proposals in this area to have a more comprehensive view of how the AOs identify and handle conflicts of interest as well as require the AOs to notify CMS when there is a conflict of interest.

Specifically, CMS proposes to define the terms ‘consulting’ and ‘consulting services’ to include those services furnished by a DMEPOS AO (or by its consulting division or separate business entity (such as a company or corporation) that furnishes such services) for the review of a DMEPOS supplier’s standards, processes, policies, and functions for compliance with the AO’s standards, the DMEPOS quality standards, or other Medicare requirements through simulation of a real survey, such as a mock survey, with comprehensive written reports of findings and early intervention and action to correct deficiencies prior to an actual accreditation survey. This information is helpful in understanding what CMS considers consulting and to understand that it is a major concern of CMS if AOs conduct reviews of the supplier’s policies, processes, standards and function for compliance with the AOs standards of quality, DMEPOS quality standards, and other Medicare requirements - essentially conducting a ‘mock survey.’

CMS believes the supplier should be able to meet the quality standards independently, without coaching from the AO. The proposed definitions of ‘consulting’ and ‘consulting services’ would not be restricted to consulting that is fee-based. Because a significant component of any ‘mock survey’ is the education about the standards and expectations of applicable Medicare requirements, such activities would also fall within the definition.

Suppliers applying for DMEPOS accreditation as well as suppliers currently accredited rely on this type of education. It helps suppliers and providers to understand, interpret and comply with the requirements. If this information cannot be provided by AOs, DMEPOS suppliers will need to seek the education through consultants. Consultants typically charge a significant fee for providing this type of education whether it be specific to the DMEPOS supplier's policies, procedures, and functions or if it is more general in nature. Like many in the healthcare industry, suppliers are managing significant financial and workforce challenges and may not be able to afford education and guidance through consultants.

The Alliance recommends that AOs at least be able to provide the education on a global basis, i.e. through workshops sponsored by the AO, workshops where AO staff present, conference presentations, and webinars hosted by the AO or other entities such as national or state associations. This is not to say that the Alliance does not support the separation of consulting and accreditation activities.
In addition, CMS proposes that AOs must notify the agency when a conflict of interest is discovered. It is unclear, however, whether CMS expects the AO's report to include details on how the conflict is being addressed. It is also unclear how CMS will utilize this reported information, what actions the agency might take in response, and the timeframe within which CMS would act following notification. More information on these details is needed.

CMS proposes to define ''unannounced survey'' as meaning:[46]

- A survey conducted without any prior notice of any type (through any means of communication or forum) to the supplier to be surveyed, such that the supplier does not expect the survey until the surveyors arrive; and
- The AO schedules its surveys so that suppliers cannot predict when they will be performed.

The Alliance supports this proposed definition and agrees that all surveys should be conducted announced, with no advance notice to the facility prior to the survey team's arrival.

CMS proposes to require the AO to define the terms fraud, waste and abuse. The rationale for having the AO define these terms, rather than utilizing existing definitions of the Department of Health and Human Services (HHS) or the HHS Office of the Inspector General, is not clear. Allowing AOs to define these terms could lead to inconsistencies across AOs and within the industry. While the Alliance agrees that AOs must not disregard potential fraud, waste, or abuse, we caution against AO's being charged with the responsibility to define these terms and detect and address fraud, waste, and abuse without clear and detailed CMS guidance. It is essential for the industry and, ultimately, for

[46] https://www.federalregister.gov/documents/2025/07/02/2025-12347/medicare-and-medicaid-programs-calendar-year-2026-home-health-prospective-payment-system-hh-pps-rate, 90 Fed. Reg. 29108, 29204.

beneficiaries that there be a consistent definition of the terms and that any entity required to identify potential fraud, waste and abuse by a supplier be appropriately trained in identifying these situations and how and when to report it to CMS. The decision to refer matters to law enforcement should remain with CMS, not the AO.

Essential to the safety of beneficiaries is an avenue for them to voice their concerns about the services they did, or did not, receive. The Alliance supports CMS's proposal to require the AO to submit the following information upon receipt of a complaint:

- The steps and research the AO will undertake in its review of the complaint; and
- How the AO determines whether, in accordance with a complaint, nonadherence to a quality standard or other applicable CMS requirement exists, including the data it considers in its review and when and how it would take action against the supplier.

There are several timeframes proposed for notifying CMS of the complaint and submitting information. The AO would need to provide CMS written notice of the complaint no later than 5 calendar days after receipt. Also, in accordance with its existing policies and procedures, the AO would need to perform an initial review of the complaint to determine whether, based on the complaint and any other data, the DMEPOS supplier may be non-adherent to one or more quality standards or other applicable CMS requirement. If such non-compliance exists, the AO would need to conduct a survey of the supplier within 21 days after receiving the complaint. The AO would need to notify CMS within 10 calendar days of the result of the initial review or, as applicable, the survey. Such notice must inform CMS of any action the AO took or intends to take regarding the supplier, such as a termination of accreditation or imposition of a Corrective Action Plan.

The Alliance recommends that CMS base the timeframes surrounding reporting of complaints, their investigations, and actions taken around the priority level of the complaint with those complaints triaged at a higher level, e.g. immediate jeopardy, requiring swift action such as notification to CMS within 2 business days and an on-site investigation within 5 calendar days. Likewise, a complaint triaged at the lowest priority level may only require notification to CMS within 30 calendar days.

Conclusion

Eligible Medicare beneficiaries are entitled to receive high-quality skilled care in their home and communities, yet ample data show that access to this care is rapidly diminishing after multiple years of successive, punitive rate reductions for HHAs. If CMS's proposed permanent and temporary adjustments are finalized, delivery system diminishment will turn to decimation and beneficiaries in need of the complex clinical resources HHAs provide will no longer have access to them. CMS's approach to calculating the permanent

and temporary adjustments contains critical flaws that overstate the PDGM payment adjustments and incorrectly attribute them to provider behavior, when they are largely the result of unrelated policy changes, fraud, and technical errors. Accordingly, the Alliance urges CMS to carefully assess the current economic realities and financial performance of HHAs in 2025, not finalize its proposed permanent or temporary adjustments for 2026 and instead address the numerous issues outlined in this comment letter that likely result in a positive increase in payments to HHAs, mitigating a continued downward spiral.

Sincerely,

Steven Landers, MD, MPH
Chief Executive Officer
National Alliance for Care at Home

Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2026 HH PPS Proposed Rule

Assessing the Impact of CMS' HH PPS Proposed Rule on Home Health FFS Payments and Future Access to Home Health Services

Submitted to: National Alliance for Care at Home

Submitted by:

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August 28, 2025

Contents

Executive Summary

Dobson DaVanzo & Associates, LLC (Dobson | DaVanzo) was commissioned by the National Alliance for Care at Home (Alliance) to analyze available Medicare home health claims data reflecting the implementation of the Patient-Driven Groupings Model (PDGM) to inform the Alliance's development of comments for the CY 2026 Home Health Prospective Payment System (HH PPS) Notice of Proposed Rulemaking (NPRM or Proposed Rule). To inform our analyses and conclusions, we draw on prior work analyzing the impacts of PDGM for CY 2018 through CY 2025 HH PPS Proposed and Final Rules, and available claims data.

Outlined below are key conclusions from our analysis.

1. **CMS projects an aggregate 6.4 percent payment reduction in CY 2026 Medicare payments across all agencies, with impacts varying significantly by state and geographic region.** At the agency level, reductions range from -9.4 percent at the 95th percentile to -5.0 percent at the 5th percentile. That is, nearly all agencies will experience reductions in Medicare payments in CY 2026. Additionally, although CMS anticipates smaller reductions for rural agencies in aggregate, in 16 states rural providers are expected to face larger cuts than their urban counterparts.

2. **Home health labor supply remains constrained, with high wages and limited signs of employment recovery.** Although hourly wages remain high, data from the Bureau of Labor and Statistics (BLS) indicate that the growth in hourly nurse wages slowed in Q1 2025 as compared to Q1 2024. Employment levels for the staff most relevant to delivering home health services have increased more slowly, suggesting continued labor supply constraints. In addition, the number of home health agencies billing Medicare declined between 2019 and 2024, further underscoring system-wide capacity pressures.

3. **Overall utilization of the home health services among Medicare FFS beneficiaries continued to decline between 2019 and 2024, while patient severity appears to be increasing during the same period.** Despite a continued decreasing trend in the number of Medicare FFS beneficiaries (-12.1 percent between 2019-2024), there is a much larger reduction in the number of FFS beneficiaries using home health within the same period (-18.8 percent). However, patient severity appears to have increased with observed increases in the number of beneficiaries with one or more comorbidities and an overall increase in the average DRG weight for beneficiaries with prior hospitalization. Additionally, home health remains a prominent destination post hospitalization even post-pandemic.

4. **In the absence of any corrective action, we estimate that CMS' existing and proposed permanent and temporary behavioral adjustments could lead to a reduction of approximately $27.2 billion in home health payments between CY 2020 and CY 2030. This reduction represents more than one year's worth of home health payments.** The total $20.8 billion reduction reflects the cumulative impact of the 4.36 percent reduction due to assumed provider behaviors implemented in CY 2020, the cumulative impact of the permanent adjustment for CY 2023, CY 2024, CY 2025 and CY 2026, and a modeled $6.4 billion reduction due to the temporary reductions to reconcile CY 2020 through CY 2026 aggregate payments.

Introduction

Dobson DaVanzo & Associates (Dobson | DaVanzo) was commissioned by the National Alliance for Care at Home (the Alliance) to analyze available Medicare home health claims data reflecting the implementation of the Patient-Driven Groupings Model (PDGM) in support of the Alliance's development of comments for the CY 2026 Home Health Prospective Payment System (HH PPS) Notice of Proposed Rulemaking (NPRM or Proposed Rule). For our study, we analyzed available Medicare claims data under our Research Identifiable File (RIF) Data Use Agreement (DUA) 54757, OASIS LDS data made available by CMS for the proposed rule (DUA 71646), and the CY 2026 HH PPS Proposed Rule. We also draw from our work in prior rule making cycles. We commend CMS for making these data available.

Effective January 1, 2020, CMS overhauled the HH PPS episode and case-mix group definitions, payment weights, and base rate. PDGM is a revision of the Home Health Resource Group (HHRG) case-mix group definitions initially proposed in the CY 2018 HH PPS administrative rulemaking cycle that was refined and finalized in the CY 2019 and CY 2020 HH PPS rulemaking cycles. When implementing PDGM in the CY2020 Final Rule, CMS prospectively reduced the HH PPS base rate from the budget-neutral calculated level by 4.36 percent. CMS indicated that this rate reduction was based on analytic assumptions on how providers might change their behavior once PDGM was implemented (behavioral assumptions).

The CY 2021 HH PPS rule made limited changes to PDGM and, in the CY 2022 HH PPS rule, CMS sought comment and suggested alternative approaches to the methodology the agency used to assess budget neutrality. In the CY 2023 HH PPS Final rule, CMS finalized using the methodology first proposed in CY 2022 to assess budget neutrality. From this methodology, the agency finalized a -3.925 percent permanent adjustment to the 30-day payment rate (half of the finalized 7.85 percent adjustment, initially proposed at −7.69 percent) and sought comment on how to implement an additional temporary adjustment of approximately $2.0 billion in future years to reconcile retrospective overpayments in CYs 2020 and 2021. Using the same methodology, CMS finalized a -2.89 percent permanent adjustment (half of the initially proposed -5.653 percent) in CY 2024 and a −1.8 percent permanent behavior adjustment in CY 2025.

In the CY 2026 HH PPS proposed rule, CMS proposes an aggregate reduction of 6.4 percent, or roughly $1.135 billion to home health payments, relative to CY 2025. The proposed reductions include a 2.4 percent payment update (a 3.2 percent market basket increase less a 0.8 percent productivity adjustment), a −3.7 percent permanent behavior adjustment, a −4.6 percent temporary adjustment, and a −0.5 percent reduction from Fixed-Dollar Loss (FDL) updates. CMS proposes to begin recoupment of the retrospective overpayments for CYs 2020 through 2024 of approximately $5.3 billion using a 5.0 percent temporary reduction to the CY 2026 30-day payment rate.[1]

[1] This translates to the -4.6 percent impact to aggregate payments.

Detailed Findings

1. Impact of the CY 2026 HH PPS Proposed Rule on HHA Medicare Payments

IMPACT OF CY 2026 HH PPS PROPOSED PAYMENT RATES ON HHA MEDICARE PAYMENTS

CMS projects in the CY 2026 HH PPS proposed rule that home health agencies (HHAs) will experience an aggregate reduction of $1.135 billion million, or a 6.4 percent reduction, in payments between CY 2025 and CY 2026. This aggregate reduction includes an overall 3.7 percent reduction due to the permanent behavioral adjustment, a 0.5 percent decrease for the FDL, and a 2.4 percent increase for payment update, inclusive of the market basket update less productivity adjustment. [2]

METHODOLOGY

We examined the impacts of the CY 2026 HH PPS proposed payment rates on HHA Medicare payments by comparing current law (Dobson | DaVanzo estimated CY 2025) payments to the projected CY 2026 payments provided by CMS in the OASIS LDS files through the following steps.

Step 1: We obtained CY 2026 projected case-level payments from the CY 2026 CMS OASIS-LDS impact file dataset. We then aggregated the cases for each agency using the provider CCN and determined the CY 2026 payments for each agency.

Step 2: We modeled CY 2025 payments for each case using case mix, wage index, and visit information included in the OASIS LDS impact file. Modeled case payments accounted for the following types of episodes:

- Standard Cases: We determined CY 2025 claim-level payments by adjusting the CY 2025 standard base payment rate by case mix and the labor portion by the wage index.
- Partial Episode Payment (PEP) Cases: We proportionally adjusted the CY 2025 case payment by the length of stay of the episode.
- Outlier Cases: We estimated an outlier add-on payment using a 0.8 loss sharing ratio applied to the difference between imputed episode costs from the LDS OASIS dataset and the CY 2025 outlier threshold. We also implemented a 10 percent cap to each agency's aggregate outlier payments.
- Low Utilization Payment Adjustment (LUPA) Cases: We estimated episode payments by applying the CY 2025 per visit payments to the visit information in the LDS OASIS dataset for each agency.

Step 3: We calculated the projected revenue change by determining the difference between the modeled CY 2025 payments and the projected CY 2026 payments for each agency.

[2] As CMS notes in the CY 2026 HH PPS proposed rule, the -4.059 percent permanent reduction is applied to the base payment but after accounting for fully paid cases, LUPAs, PEP cases and outlier cases, the permanent adjustment results in a more limited 3.7 percent overall payment reduction.

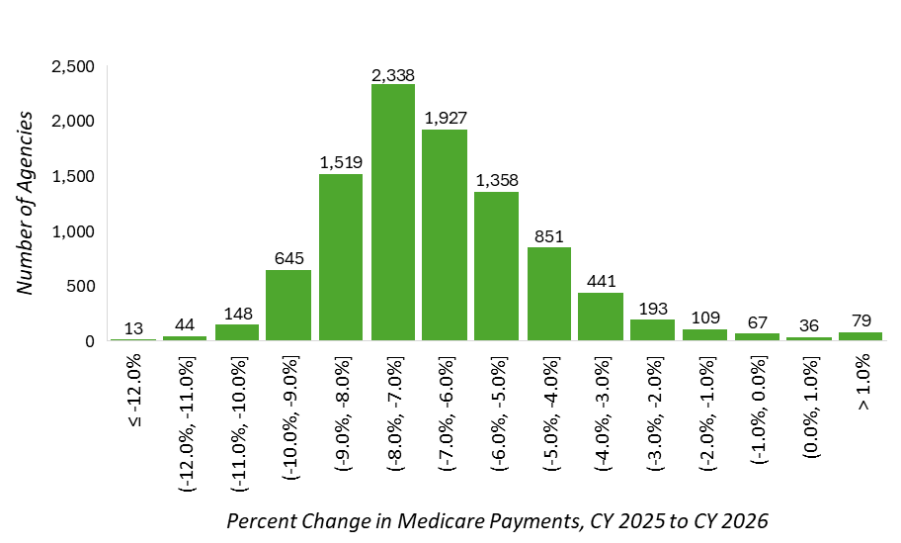
We note that the total CY 2026 payments determined from the CY 2026 CMS OASIS-LDS impact dataset were short of the projected CY 2025 payments resulting in a -$1.135 billion reduction in payments, or a -6.4 percent reduction. We calculated that CY 2026 payments of $14.87 billion and CY 2025 payments of $15.69 billion equate to a -$827 million (or a -5.3 percent) reduction in payments over the two years. We therefore applied adjustments at the agency level such that the CY 2025 and CY 2026 payment differences for each agency summed up to a $1.135 billion reduction. For each agency, we first determined the proportion of the agency's calculated payment reduction as a fraction of the overall payment reduction determined from the OASIS-LDS dataset. We then applied that proportion to the overall projected reduction of $1.135 billion to determine the adjusted payment reduction. We used the same method to adjust the CY 2025 and CY 2026 payments for each agency.

RESULTS

Agency Impacts

When comparing the percent impact (i.e., the percent change between modeled CY 2025 and projected CY 2026 payments) at the agency level, we find that home health agencies have impacts that are slightly right skewed. The percent impact for all agencies ranges between -15.5 percent to 76.8 percent with a 5th and 95th percentile range of -9.4 percent and 3.0 percent. We also estimate that roughly 60.1 percent of HHAs will have larger negative payment reductions than the average -6.4 percent. The full distribution of projected agency percentage impacts is shown in **Exhibits 1** and **2** below**.**

Exhibit 1: Distribution of Agencies by Percent Change in Medicare Payments between CY 2025 and CY 2026



Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 71646

Exhibit 2: Distribution of Agencies with Larger or Smaller than Average Percent Reduction in Medicare Payments

	Number	Percent
Number of agencies with larger than average reduction (<-6.4%)	5,874	60.1%
Number of agencies with smaller than average reduction (>=-6.4%)	3,894	39.9%
Total Number of Agencies	**9,768**	**100.0%**

Rural vs. Urban Impacts

We also examined the distribution of the percentage projected change in Medicare payments for agencies in rural versus urban areas. We found that 15 percent of agencies with approximately 13 percent of HH cases are located in rural areas and those agencies will experience a smaller negative percent reduction (-6.2 percent) compared to agencies in urban areas (-6.4 percent). These results are shown in **Exhibit 3** below. Despite the trends at the national level, rural HHAs will experience a larger negative reduction in Medicare payments compared to urban HHAs in sixteen states (results not shown).

Exhibit 3: Percent Impact between CY 2025 and CY 2026 for Agencies in Rural vs. Urban Areas

Location	Percent of Agencies	Percent of Cases	Projected 2026 Payment Impact	Payment Impact Per Case	Average Percent Impact
Rural	15%	13%	-$119,952,299	-$146	-6.2%
Urban	85%	87%	-$1,012,653,135	- $117	-6.4%

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 71646

State-Level Impacts

In **Exhibits 4** and **5** below, we show the projected changes in Medicare payments for HHAs across states. As shown, while CMS estimates an aggregate percent reduction of -6.4 percent, the top 10 states with the highest percent reduction in payments are projected to experience average percent reductions ranging from -10.6 percent to -3.3 percent—reductions that are nearly 1.7 times greater than the overall percent impact of -6.4 percent.

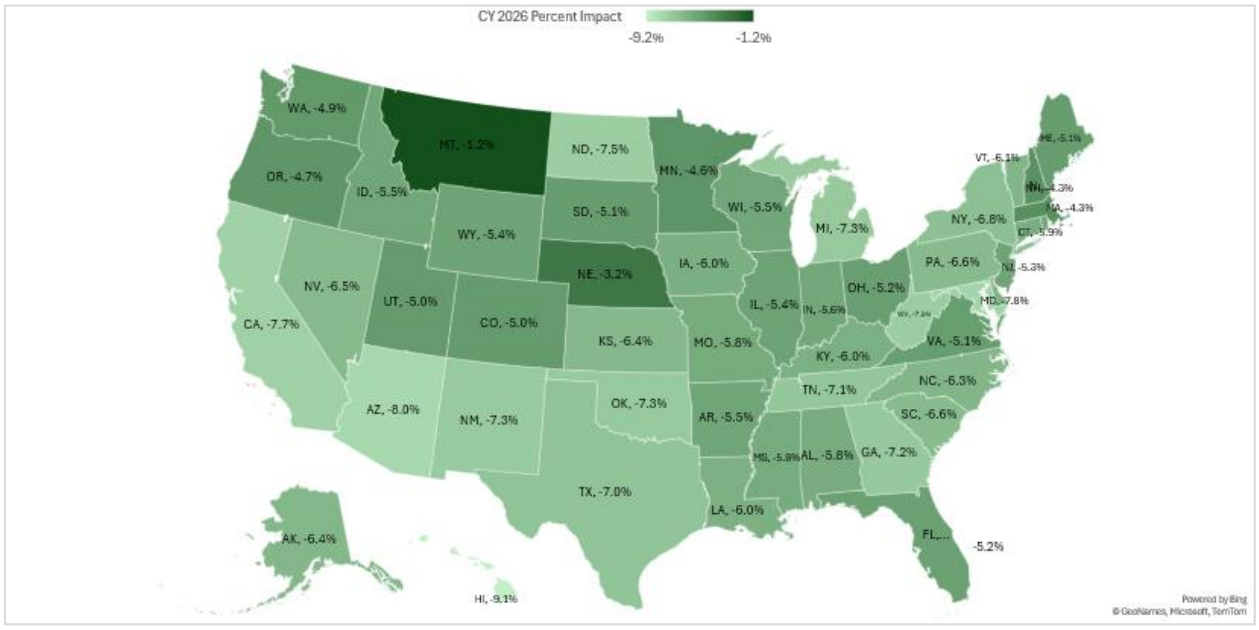
Exhibit 4: Top 10 States with Highest Projected Revenue Changes between CY 2025 and CY 2026[3]

State	Impact of 2026 Proposed Payments	Percent Impact	Range of Agency Impacts (Min – Max)	Range of Agency Impacts (5^{th} - 95^{th} Percentile)
Total	**-$1,134,052,339**	**-6.4%**	**-15.5%, 76.8%**	**-9.4%,-3.0%**
Hawaii	-$2,248,649	-9.2%	-10.6%, -5.3%	-9.1%, -5.3%
District of Columbia	-$1,652,088	-8.0%	-9.6%, -4.6%	-8.2%, -6.5%
Arizona	-$20,046,812	-8.0%	-10.4%, -0.9%	-7.9%, -5.6%
Maryland	-$26,386,869	-7.8%	-9.3%, -5.0%	-7.9%, -5.6%
California	-$280,969,961	-7.7%	-12.8%, -1.4%	-7.9%, -6.1%
West Virginia	-$6,392,306	-7.5%	-9.7%, 0.1%	-7.9%, -2.7%
North Dakota	-$1,255,558	-7.5%	-9.5%, -5.3%	-8.8%, -5.5%
New Mexico	-$6,404,219	-7.3%	-11.6%, -3.7%	-6.8%, -5.4%
Michigan	-$26,315,089	-7.3%	-11.7%, 21.5%	-7.6%, -5.6%
Oklahoma	-$28,731,660	-7.3%	-11.1%, -3.3%	-7.3%, -5.8%

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 71646

[3] Numbers may not add up due to the effects of rounding.

Exhibit 5: Distribution of Projected Medicare Revenue Changes by State, between CY 2025 and CY 2026



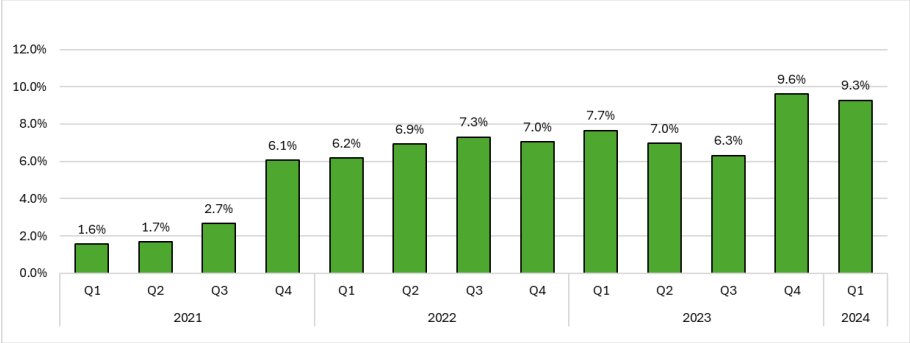
Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 71646

2. Analysis of HH Labor Trends

HH PPS MARKET BASKETS USING 2022 THRHOUGH 2024 DATA ARE NOT REFLECTIVE OF ACTUAL PRICE TRENDS IN THE HH INDUSTRY BETWEEN CY 2022 AND CY 2024

In past rulemaking cycles, CMS finalized market basket updates of 3.3 percent for CY 2024 and 2.7 percent for CY 2025 based on available data. However, these updates did not reflect actual industry price trends, as the market basket composite index relies on a four-quarter rolling average that fails to capture real-time changes specific to home health. For instance, while CMS proposed a 2.7 percent update for all of CY 2025, BLS data showed registered nurse wages increased by 8.8 percent between Q1 2023 and Q1 2024 alone. In the CY 2026 HH PPS proposed rule, CMS proposes a 3.2 percent update that aligns more closely with home health price trends, but it does not account for prior underestimates. These results are illustrated in **Exhibit 6**.

Exhibit 6: Quarterly Growth (Year-over-Year) in Nursing Staff Hourly Wages, 2020-2025



Source: Analysis of Data on BLS Wages and salaries, cost per hour worked for civilian workers in Registered Nurse Occupations[4]

TRENDS IN LABOR SUPPLY FOR RELEVANT HHA STAFFING DISCIPLINES

Despite reports of strong growth in employment in the home health industry, our analysis shows a slight decline in employment of the staff most relevant to delivering home health services between 2019 and 2024.

In the March 2024 Report to Congress[5], MedPAC presented monthly data from the Bureau of Labor Statistics (BLS) on employment for establishments classified by the North American Industry Classification System (NAICS) as home health care services (NAICS 6216). MedPAC concluded that the "broader medical home care sector[6] indicate that total employment was about 5 percent higher in July 2023 than it was in February 2020, prior to the pandemic." MedPAC further stated that the reported staffing shortages may reflect local labor conditions or other factors not observed in national labor force measures.

We conducted additional analyses of annual BLS data under NAICS 6216 to understand these trends through the following steps.

METHODOLOGY

Step 1: We obtained annual employment data for all categories under NAICS 6216 from the BLS website. Our review of the BLS data revealed that NAICS 6216 includes not only Medicare Home Health Agencies but also other services in the segment, "such as personal care services, homemaker and companion services, medical equipment and supplies, counseling, 24-hour some care, dietary and nutrition services, audiology, and other specialized care."[7]

Step 2: We replicated the MedPAC analysis by aggregating the total NAICS 6216 employment data for each year and separately identified and aggregated the employment data for categories relevant to the six home health disciplines (Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Language Therapy, Medical Social Worker and Home Health Aide).

RESULTS

Within BLS' NAICS 6216, employees in the "Home Health and Personal Care Aides" occupation category represent more than half (approximately 60 percent) of all employees for years 2019-2024 yet the "Home

[4] https://db.nomics.world/BLS/cm/CMU102000012N000D?tab=chart

[5] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch7_MedPAC_Report_To_Congress_SEC.pdf.

[6] Using a definition that includes Medicare HHAs, hospice, private duty, pediatric agencies, and other home care providers.

[7] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch7_MedPAC_Report_To_Congress_SEC.pdf.

Health Aide" discipline represents less than seven percent of visits per 30-day periods of care provided to Medicare FFS enrollees.

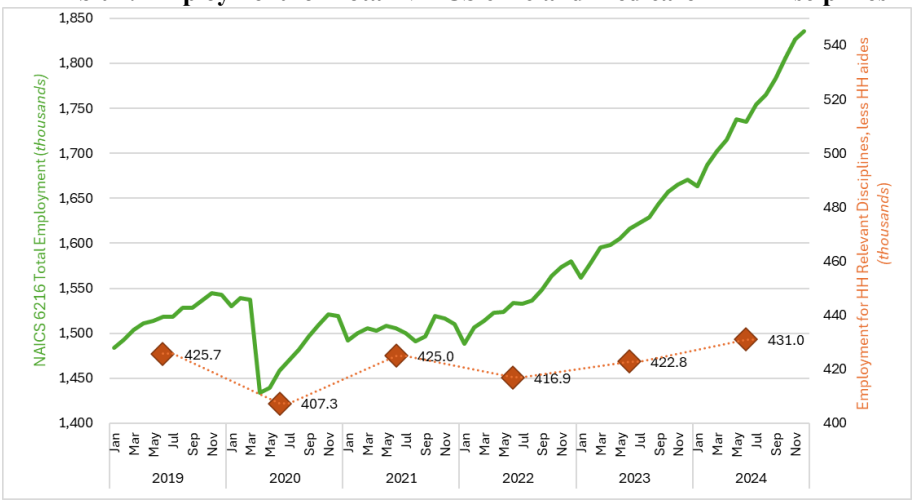
MedPAC's reported growth in total employment for the broader home health sector is largely driven by growth in "Home Health and Personal Care Aides". Within BLS NAIC 6216, the total number employees increased from 1,498,620 in 2019 to 1,713,130 in 2024, and approximately 60% of this value is attributed to the "Home Health and Personal Care Aides" category.

Our analysis constrained occupations to those most relevant to CMS Medicare FFS Home Health disciplines and excluded the "Home Health and Personal Care Aides" category. With this analysis, we observed that the number of employees increased from 425,680 in 2019 to 431,040 in 2024 (or 1.2 percent).

Exhibit 7 below shows the changes in employment for all occupations with in NAIC 6216 (as modeled in the MedPAC March 2024 report to congress) compared to changes in employment for the Medicare FFS HH disciplines less home health aides.

As shown, we observed a slight increase in employment after excluding Home Health aides and limiting the data to just Medicare FFS HH disciplines (orange line) from 2019 to 2025, despite overall increases in employment under NAICS 6216.

Exhibit 7: Employment for Total NAICS 6216 and Medicare HHA Disciplines



Source: MedPAC March 2024 Report to Congress, Dobson | DaVanzo Analysis of BLS Data Series ID CEU6562160001

TRENDS IN THE NUMBER OF MEDICARE FFS BILLING HOME HEALTH AGENCIES

We also conducted analyses to examine trends in the number of HHAs billing Medicare by year between 2019 and 2024.

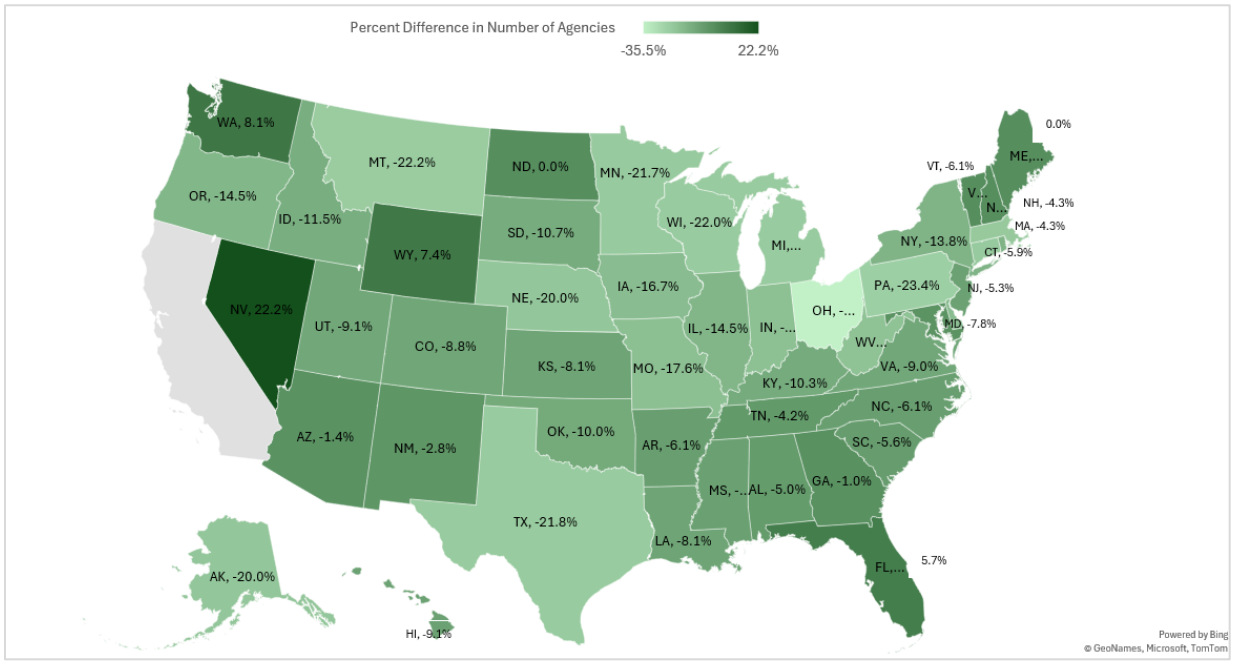
Between 2019 and 2024, the number of HHAs billing Medicare for FFS beneficiaries declined nationally by 0.8 percent (82 agencies). However, this modest overall reduction masks significant variation: excluding California, where the number of HHAs grew substantially, the decline was 13.6 percent (1,157 agencies). Further excluding states that previously had moratoriums on HHAs (Florida, Michigan, Illinois, and Texas) produced a similar decline of 13.0 percent (616 agencies), underscoring that the national trend is largely driven by growth in California. ***Exhibits 8*** and ***9*** show these results.

Exhibit 8: Top 10 States with Largest Reductions in the Number of Medicare Billing HHAs

State	2019	2024	Percent Difference
Al States	9,971	9,889	-0.8%
All States (Excluding CA)	8,518	7,361	-13.6%
All States (Excluding CA, FL, IL, MI, TX)	4,744	4,128	-13.0%
Ohio	462	298	-35.5%
District of Columbia	21	16	-23.8%
Pennsylvania	304	233	-23.4%
Montana	27	21	-22.2%
Wisconsin	100	78	-22.0%
Michigan	427	334	-21.8%
Texas	1,885	1,475	-21.8%
Minnesota	143	112	-21.7%
Connecticut	84	66	-21.4%

Source: Dobson | DaVanzo Analysis of Claims Data under DUA 54757

Exhibit 9: Percent Change in Number of FFS Medicare Billing HHAs by State, 2019-2024*



**Note that only CA, FL, NV, WA, and WY experienced increases in number of FFS Medicare billing HHAs. CA is excluded from the above map because of the anomalous growth in the number of HHAs, which would otherwise distort broader geographic trends.*
Source: *Dobson | DaVanzo Analysis of Claims Data under DUA 54757*

3. Trends in Medicare FFS Home Health Utilization

NATIONAL TRENDS IN HOME HEALTH UTILIZATION

We examined data on the utilization of home health services among Medicare FFS to explore longitudinal trends between 2019 and 2024.

METHODOLOGY

We identified the number of unique beneficiaries with at least one home health episode from the 100% Medicare claims data between 2019 and 2024. We also obtained the number of Medicare FFS enrolled beneficiaries between 2019 and 2024 from the publicly available Medicare enrollment files.

RESULTS

As shown in **Exhibit 10**, Medicare FFS beneficiaries received fewer home health services in 2024 compared to 2019. While there is a decreasing trend in the number of Medicare FFS beneficiaries, an overall 12.1 percent reduction between 2019-2024, there is a much larger reduction in the number of FFS beneficiaries using home health within the same period, a reduction of 18.8 percent. The percent of FFS beneficiaries receiving home health services declined from 8.6 percent in 2019 to 7.9 percent in 2024.

Exhibit 10: Trends in Percent of FFS HH Beneficiaries with ≥1 HH Episode, 2019-2024

Year	2019	2024	Percent Difference 2019-2024
Number of Unique FFS Benes with ≥ 1 HH Claim	3,310,007	2,688,962	-18.8%
Total Number of FFS Benes	38,577,012	33,901,001	-12.1%
Percent of FFS Beneficiaries with ≥ 1 HH Claim	8.6%	7.9%	-8.1%
Number of Unique Rural FFS Benes with ≥ 1 HH Claim	443,891	354,651	-20.1%

Sources: Dobson | DaVanzo Analysis of Claims Data under DUA 54757, CMS Medicare Monthly Enrollment PUF

We reviewed additional data to explore whether the observed reductions in home health service utilization were accompanied by changes in patient severity during the period during 2019 and 2024.

As shown in **Exhibit 11**, CMS' analysis of home health claims shows that the proportion of home health claims with a high comorbidity adjustment has increased from 10.0 percent to 15.4 percent between 2019 and 2024. Similarly, our analysis of inpatient claims for home health users with a prior hospitalization shows that the average DRG weight for those home health beneficiaries with a prior hospitalization increased from 1.89 to 1.93 between 2019 and 2024 (**Exhibit 12**).

In summary, the reduction in home health utilization does not appear to be accompanied by a decline in patient severity, suggesting that the utilization trends could be indicative of lack of access to home health services.

Exhibit 11: Distribution of 30-Day Periods of Care by Comorbidity Adjustment Category, 2019-2024

Comorbidity Adjustment	2019	2020	2021	2022	2023	2024	Percent Difference 2020-2024
None	52%	49%	50%	37%	31%	29%	-41%
Low	38%	37%	37%	48%	53%	55%	50%
High	10%	14%	14%	15%	17%	15%	10%

Source: CY 2026 HH PPS Proposed Rule

Exhibit 12: Average DRG Weight for Home Health Beneficiaries with Prior Hospitalization

	2019	2020	2021	2022	2023	2024
Average DRG Weight	1.89	1.95	1.95	1.97	1.93	1.93

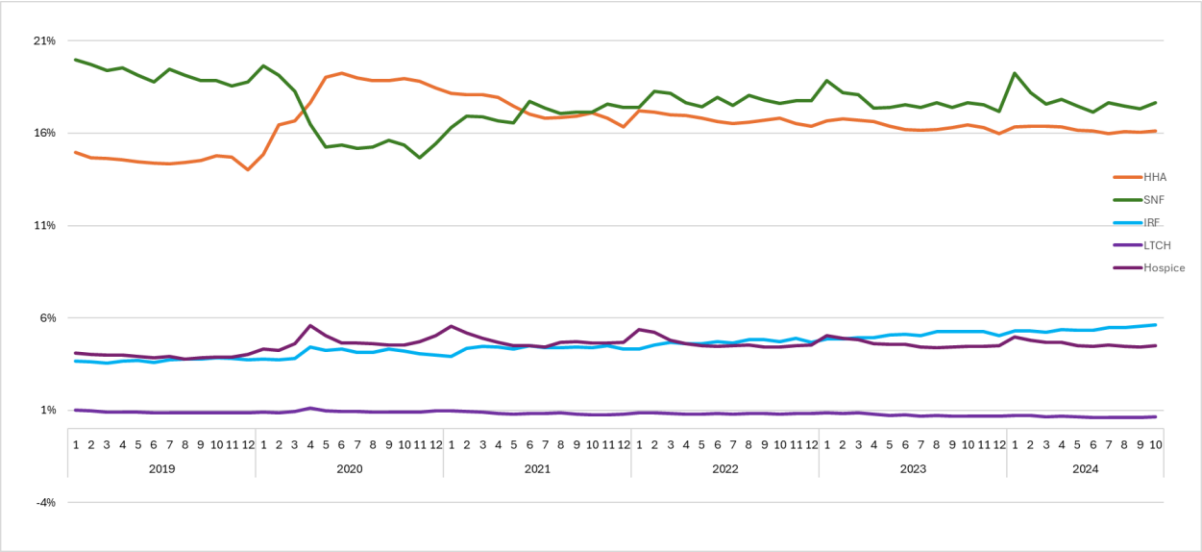
Source: Dobson | DaVanzo Analysis of Claims Data under DUA 54757

TRENDS IN HOME HEALTH UTILIZATION FOLLOWING A HOSPITALIZATION

As shown in ***Exhibit 13***, the proportion of hospital discharges to home health increased between 2019 and 2020 and started to decline between 2020 and 2024, although the proportion of discharges remained above

pre-pandemic levels. This proportion corresponds to the observed substitution effect that occurred during the pandemic months where there was a decline in SNF admissions, but the trends began to reverse between 2021 and 2024.

Exhibit 13: Trends in Hospital Discharges to Post-Acute Care Settings, 2019-2024



Source: Dobson | DaVanzo Analysis of Claims Data under DUA 54757

Exhibit 14 shows the distribution of short-term acute care hospital (STACH) discharges by post-acute care (PAC) destination as indicated by the subsequent claim after discharge. Between 2019 and 2024, overall STACH discharges declined by 26.5 percent. Even steeper reductions are observed in 1st PAC case volume for other inpatient settings (-49.2%), LTCHs (-47.5%), SNFs (-32.3%), and patients returning to the community (-29.2%). By contrast, discharges to HHAs declined more slowly (-18.5%), suggesting that home health has remained a preferred post-acute destination in the post-pandemic period and should be protected from policy changes that could be damaging.

Exhibit 14: Annual Volume of STACH Discharges by 1st PAC Destination*

Site of Service	2019	2020	2021	2022	2023	2024	Percent Difference 2019-2024
All Discharges	**8,823,723**	**7,365,087**	**6,927,626**	**6,641,479**	**6,544,774**	**6,489,358**	**-26.5%**
Other Inpatient	45,102	37,170	31,014	26,006	23,759	22,900	-49.2%
LTCH	78,685	68,698	58,054	54,384	48,845	41,343	-47.5%
SNF	1,693,095	1,207,712	1,181,712	1,180,658	1,157,656	1,147,035	-32.3%
Home (Community)	4,389,000	3,546,126	3,332,306	3,183,417	3,139,623	3,108,762	-29.2%
Hospital	660,965	536,926	494,412	463,928	469,445	474,451	-28.2%
HHA	1,282,846	1,324,362	1,198,733	1,113,825	1,072,887	1,045,517	-18.5%
Hospice	347,099	344,248	329,589	308,813	300,541	297,192	-14.4%
IRF	326,931	299,845	301,806	310,448	332,018	352,158	7.7%

Source: Dobson | DaVanzo Analysis of Claims Data under DUA 54757
** Excludes those deceased.*

4. Impact of the Existing and Proposed and Future Permanent and Temporary Reductions

OVERALL IMPACT OF CY 2026 HH PPS PROPOSED RULE REDUCTIONS AND FUTURE REDUCTIONS TO HHA PAYMENTS

In aggregate, we estimate that the payment reductions due to permanent adjustments will lead to an approximate reduction of $27.2 billion in cumulative home health-related payments in the period between 2020 through 2030. This amount includes the cumulative impacts of the CY 2020 -4.36 percent behavioral adjustment, the cumulative impacts of the CY 2023 through CY 2025 permanent adjustments, and a $6.4 billion reduction due to calculated and projected temporary adjustments for CY 2020 through CY 2026.

METHODOLOGY

We determined the impact of the assumed behavioral, permanent, and temporary adjustments on home health payments between 2020 and 2030 through the steps summarized below.

Step 1: We obtained the volume of home health episodes in CY 2020 through CY 2024 from 100% Medicare FFS claims data and estimated the volume of home health episodes in CY 2025 and beyond by adjusting the CY 2023[8] volume using the observed changes in Medicare FFS visit volume between CY 2023 and CY 2024.

Step 2: Next, we obtained the CY 2020 through CY 2026 base payment rates from the respective Final Rules and projected payment rates for CY 2027 and CY 2030 by assuming that the base payment rates in subsequent years would be inflated using CMS' forecasts of the HH PPS market basket, less assumed productivity adjustments.

Step 3: We modeled base payment rates for CY 2020 through CY 2030 without any behavioral adjustments by excluding the -4.36 percent behavioral adjustment in CY 2020 and permanent adjustments in CY 2023, CY 2024, CY 2025, and CY 2026.

Step 4: We determined the impact of the assumed behavioral, permanent, and temporary adjustments as the difference in total payments with and without any behavioral adjustments. Total payments with behavioral adjustments for CY 2020 through CY 2030 were calculated by multiplying the *Step 1* projected volume by the *Step 2* base payment rates with behavioral adjustments. Total payments without behavioral adjustments for CY 2020 through CY 2030 were calculated by multiplying the *Step 1* projected volume by the *Step 3* base payment rates without behavioral adjustments.

[8] Given that CY 2024 HH PPS claims are subject to changes due to runout, we used the CY 2023 claims to develop our projections.

RESULTS

The results of our analysis are summarized in **Exhibits 15 and 16**.

Exhibit 15: Projected Impact of Behavioral Adjustments in CY 2020 through CY 2030 [9]

Total Payments	Impact of CMS Permanent Adjustments
2020	($665,606,530)
2021	($692,156,154)
2022	($679,375,387)
2023	($1,268,705,896)
2024	($1,745,166,215)
2025	($2,076,189,516)
2026	($2,645,327,221)
2027	($2,692,067,937)
2028	($2,739,657,872)
2029	($2,790,740,430)
2030	($2,839,999,507)
Total Impact of Permanent Adjustments	($20,834,992,665)

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 71646

Exhibit 16: Proposed & Projected Temporary Adjustments, CY 2020-2026

Year	Overpayments
2020	($873,073,121)
2021	($1,211,002,953)
2022	($1,405,447,290)
2023	($971,431,113)
2024	($840,149,468)
2025 (DD estimate)	($750,111,195)
2026 (DD estimate)	($321,457,804)
TOTAL (2020-2024)	($5,301,103,945)
TOTAL (2020-2026)	($6,372,672,944)

[9] CMS proposed to collect $786 million of the $5.3 billion in temporary adjustments for CY 2026.

Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2026 HH PPS Proposed Rule

Examining CMS' Methodology for Assessing Budget Neutrality Under PDGM

Submitted to: National Alliance for Care at Home (Alliance)

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Thursday, August 28, 2025

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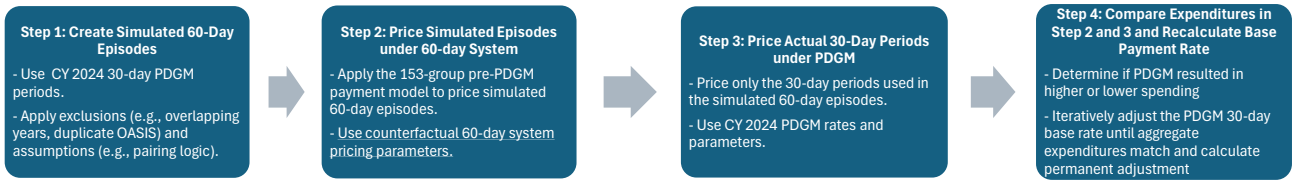
Introduction

In the CY 2026 HH PPS proposed rule, CMS evaluated whether CY 2024 payments were budget neutral by applying the methodology it finalized in the CY 2023 rule and previously used to assess budget neutrality for CY 2020 through CY 2024. Under this approach, CMS estimated what CY 2024 payments would have been under the former 153-group case-mix system and 60-day unit of payment in absence of the change to the 30-day unit of payment under PDGM. To generate these estimates, CMS applied a series of exclusions and assumptions to group CY 2024 30-day periods into simulated 60-day episodes. These episodes were then priced using the payment parameters of the prior 60-day system trended forward, and the resulting aggregate payments were compared to the payments for the same cases under PDGM's 30-day system in CY 2024. This methodology is outlined in the figure below.



CMS' results showed that actual payments made for the same set of 30-day cases in CY 2024 were higher than the estimated aggregate expenditures under the 60-day payment system. The agency then recalculated what the CY 2024 30-day base payment rate should have been to equal aggregate expenditures determined using the simulated CY 2024 60-day episodes. CMS determined that a −4.06 percent permanent adjustment to the CY 2026 base payment rate was needed to offset the increase in estimated aggregate expenditures for CYs 2020 and 2024.

As we have noted in prior years, CMS' methodology relies on assumptions and exclusions that have not been empirically tested. Our review indicates that these assumptions and exclusions create methodological flaws in how CMS combines 30-day periods to simulate 60-day episodes. These flaws introduce analytic bias into the agency's case-mix and budget neutrality calculations, producing inaccurate estimates and overstated permanent adjustments.

In this report, we present findings from our analyses of the CY 2026 OASIS LDS file (consisting of CY 2024 claims data) provided by CMS to quantify the impact of these methodological issues on the proposed CY 2026 permanent adjustment. We commend CMS for making these data available to us.

Summary of Findings

A. **CMS' assessment that CY 2024 base payments were too high is incorrect because the methodology to assess budget neutrality is critically flawed.** Dobson | DaVanzo analyses highlighted several flaws in the CMS methodology for assessing budget neutrality. We conducted analyses to assess the impact of these flaws on the CY 2026 proposed permanent adjustment and results show that adjustments to account for methodological concerns could lead to a reduction in the proposed permanent adjustment by between 4.06 and 1.40 percentage points. In fact, methodological refinements could lead to the elimination of any permanent adjustment for CY 2026. **Exhibit 1** below summarizes and quantifies the impact of each methodological issue on the proposed CY 2026 permanent adjustment.

Exhibit 1: Impact of Correcting Methodological Issues in Assessing CY 2024 Budget Neutrality on the CY 2026 Proposed Permanent Adjustment

Assumptions	Percentage Point Impact to CY 2026 Permanent Adjustment	Re-Calculated CY 2026 Permanent Adjustment
1. **Excluded Claims:** CMS excludes roughly 20 percent of the 30-day CY 2024 claims. Yet, analyses show that there are non-negligible differences between the excluded cases and cases used in the analysis for key drivers of the 60-day payment system such as therapy visits. Excluded cases appear to have more therapy visits on average compared to included cases. Accounting for these differences lowers the permanent adjustment.	-2.18	-1.88%
2. **Structural LUPA Assignments:** Under PDGM, LUPA thresholds vary by HHRG group and can be as low as 2 visits. Given the static LUPA threshold of 4 or less visits under the 60-day system, there are instances where 60-day cases are flagged as LUPAs when they are comprised of fully paid 30-day periods. This is a structural artifact of CMS' methodology rather than a behavioral response from providers. Adjusting these LUPA cases to be fully paid increases the counterfactual 60-day aggregate payments and lowers the permanent adjustment	-4.06	0.00%
3. **Outlier Assumptions:** CMS used a static fixed-dollar loss (FDL) ratio of 0.51 to calculate the outlier payments under the counterfactual 60-day system. Yet, across all payment years, this ratio is recalculated such that outliers do not exceed 2.5%. Additionally, CMS regrouping methodology results in fewer 60-day episodes flagged as outliers despite being composed outlier 30-day periods. This results in total outlier payments falling well below the 2.5% statutory target for the simulated 60-day episodes, thereby understating counterfactual aggregate payments and overstating the permanent adjustments needed.	-0.95%	-3.11%
4. **Clinical Group Assignments:** For 60-day episodes simulated using two consecutive 30-day periods with different clinical groupings, CMS assigns the first period's diagnoses to the entire episode. This methodology introduces bias if the second episode was higher-acuity and eliminates mid-episode case-mix changes allowed under the pre-PDGM system.	Not Determined	
5. **OASIS Assumptions:** Effective January 1, 2023, HHAs starting using the OASIS-E instrument for reporting assessments. Under the OASIS-E, several data elements used in the pre-PDGM 153-group system are now collected only at start-of-care or resumption-of-care, and others differ in wording and coding, requiring CMS to map responses back to OASIS-D. These mapping limitations can understate patient severity, misclassify case-mix groups, and lower case-mix weights in the counterfactual 60-day model.	Inadequate data available to quantify impact	
6. **60-Day Case Mix not Recalibrated:** CMS does not recalibrate case mix when determining aggregate payments under the 60-day payment system(which historically increased payment rates by 1–2%). Applying CY 2020-CY 2024 PDGM case mix updates to the 60-day payment rates increase counterfactual payments and lowers permanent adjustment.	-3.70	-0.36%
7. **60- Day Episode Structure**: Analyses show that the overall number of episodes, proportion of LUPAs, PEPs, outliers and visit patterns do not reflect the counterfactual 60-payment system episodes. Applying the 60-day case mix from pre-PDGM 2019 claims lowers the permanent adjustment.	-3.43	-0.63%

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646 and 100% Medicare FFS HH Claims Under DUA 54757

Note that CMS proposes a -4.06 permanent adjustment for CY 2026.

B. **Alternative approaches for assessing budget neutrality.** As CMS cannot plausibly use CY 2020 data to determine case-mix weights and aggregate payments that would have been made under the prior 60-day payment system in the absence of PDGM, we recommend that CMS apply the PDPM parity adjustment methodology described in the CY 2023 SNF PPS Proposed and Final Rule to PDGM data. Based on this approach, we found that the CY 2026 proposed permanent adjustment should be -0.65 percent instead of -4.06 percent.

C. **Proposed 5 percent Temporary Adjustment does not account for underlying changes in the industry and could have a disproportionate impacts on HHAs.** CMS proposes a 5.0 percent reduction to the CY 2026 base payment rate, intended to recover $786 million, or 14.8 percent of the $5.3 billion in temporary adjustments it has identified. However, applying a static percentage reduction to FFS payments is not equitable given recent trends in the declining Medicare FFS enrollment, declining number of FFS users of home health, and overall decline in the volume of 30-day periods of care delivered by home health agencies. Additionally, the number of HHAs billing Medicare FFS declined by 0.8 percent nationally, although some geographic areas like California saw a 74 percent increase, highlighting significant regional variation. A uniform cut fails to account for these dynamics and could have a disproportionate impact on the remaining agencies, particularly smaller and rural providers.

Findings in Detail

The methodological issues are described below in detail.

A. Impact of Budget Neutrality Methodological Flaws on Permanent Adjustments

1. EXCLUDED CLAIMS

CMS Methodology: Using the preliminary CY 2024 dataset of 8,118,120 30-day periods of care, CMS applied exclusions to simulate the 60-day episodes. Following all exclusions and assumptions, the dataset used for the CY 2026 proposed rule analysis contained 6,433,111 actual 30-day periods of care and 3,794,744 simulated 60-day episodes for CY 2024. In total, 1,685,009 cases (representing 21 percent of the original dataset) were excluded from the budget neutrality assessment for CY 2024.

Methodological Issue: Excluding such a large share of cases can introduce systemic bias if the omitted cases differ structurally from those included.

Dobson | DaVanzo Analysis: We computed the standardized mean difference of several variables across the two groups (included and excluded 30-day claims) to assess whether there were differences between the two groups. We identified cases included and excluded from the analysis using the repricing flag variable in the data provided by CMS. Results showed material differences in therapy provision levels, average case-mix weights, visit timing, admission sources, payment amounts, and the distribution of Complex and MS Rehab clinical groupings. These results are shown in **Exhibit 2** below.

Exhibit 2: Standardized Mean Difference Between Included and Excluded CY 2024 30-day Claims

Variable	Standardized Mean Difference	Interpretation
Average Case Mix Weight	0.113	Non-negligible
Visit Timing: Early	0.161	Non-negligible
Admission Source: Community	0.125	Non-negligible
Payment Amount	0.101	Non-negligible
Number of PT Visits	0.150	Non-negligible
Clinical Grouping: Complex	0.131	Non-negligible

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646

We also compared the 30-day periods included in the repricing analysis to the full universe of CY 2024 30-day claims (extracted on August 8, 2024) available to use under our DUA. Results showed that the 30-day cases used in CMS' repricing analysis had 5.5 percent fewer therapy visits than the full universe of CY 2024 HH PPS claims.

To estimate the impact of adjusting for these differences in therapy utilization from exclusion of 30-day claims, we relied on CMS' analysis from the CY 2023 HH PPS PDGM webinar, which showed that applying CY 2018 therapy distributions when assessing budget neutrality for CY 2021 produced a case-mix weight of 1.0389, compared to 0.9682 when CY 2021 therapy levels were used. We calculated that the average number of therapy visits declined by 18.8 percent between CY 2018 and CY 2024. Based on this and considering the proposed prospective adjustment of –1.44 percent from the CY 2021 claims analysis, we calculated that an 5 percent increase in the number of therapy visits should equate to each CY 2026 permanent adjustment of -1.88 percent, instead of CMS' estimate of -4.06 percent.

2. STRUCTURAL LUPA ASSIGNMENTS

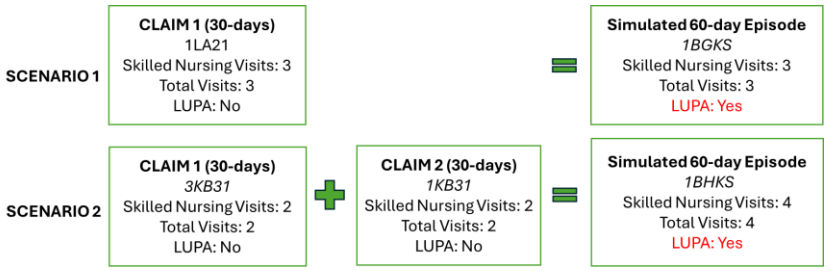
CMS' Methodology: To establish the CY 2020 LUPA thresholds under PDGM, CMS used CY 2018 home health claims, splitting each 60-day episode into two 30-day periods and assigning each to one of the 432 PDGM case-mix groups. For each group, CMS calculated the distribution of in-person visits per 30-day period and set the LUPA threshold at the 10th percentile of total visits among non-LUPA periods in that group. As a result, PDGM thresholds ranged from 2 to 6 visits, replacing the uniform pre-PDGM threshold of 4 or fewer visits.

Methodological Issue: Because the prior 60-day system applied a static LUPA threshold of four or fewer visits, regrouping CY 2024 30-day periods into 60-day episodes for CMS' budget neutrality analysis produces cases flagged as LUPAs under the old system that would have been fully paid under PDGM thresholds. The LUPA rate for the simulated 60-day periods is 11.6 percent as compared to 8.5 percent in the pre-PDGM 60-day cases in CY 2019.

Dobson | DaVanzo Analysis: We conducted an analysis of the CY 2026 HH PPS Proposed Rule OASIS LDS file to identify how often non-LUPA 30-day cases were flagged as LUPAs when grouped into 60-day episodes. We used the claim IDs to identify which single, or consecutive 30-day periods were used to form the 60-day episode. We conducted the analysis separately for single 30-day periods and consecutive 30-day periods combined to form a 60-day episode.

Results showed that 208,123 (or 5.5 percent of simulated 60-day episodes)identified as LUPA episodes were comprised of non-LUPA 30-day episodes. These identified differences in LUPA rates under the 60-day system are a structural artifact of CMS' methodology rather than behavioral change by providers. **Exhibit 3** below illustrates two such scenarios.

Exhibit 3: Illustration of Misclassified LUPA Cases



Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646

To account for these structurally induced LUPA cases, we adjusted the payments for the identified cases to receive full payments rather than LUPA payments. We found that on average LUPA case payments were $596 compared to fully paid case payments of $3,151. Our adjustments increased the 60-day aggregate counterfactual target payments from $12,233,384,718 to $12,765,315,999.

We then developed a repricing model based on CMS' repricing logic provided in the publicly available STATA programs to simulate what CY 2024 base payment rates should have been to achieve the re-calculated budget neutral target of $12,765,315,999. Our analysis showed that CY 2026 proposed permanent adjustments 4.06 percentage points less than they are, that is there should be no permanent adjustment for CY 2026. The methodology is outlined in **Exhibit 4** and results are shown in **Exhibit 5** below.

Exhibit 4: Impact of Adjusting CY 2024 Artificially Induced LUPA Payments on Aggregate Counterfactual Payments

Number of false LUPA Flags (A)	208,123
Average non-LUPA Payment (60-day Episodes) B	$3,151
Average LUPA Payment (60-day Episodes) C	$596
Impact of false LUPA flags [D= A x (B-C)]	$531,931,281
Total Budget Neutral Target (CMS calculated amount)	$12,233,384,718
Adjusted Budget Neutral Target [D + CMS calculated amount)	$12,765,315,999

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646

Exhibit 5: Impact of Adjusting CY 2024 Misclassified LUPA Payments on 30-Day Base Payment Rates and Permanent Adjustments

	Assumed 30-Day Base Payment Rate	Budget Neutral PDGM Rate (Claims Analysis)	Total Prospective Adjustment	CY 2026 Permanent Adjustment
CMS results from CY 2026 HH PPS NPRM	$1,958	$1,917	-2.13%	-4.06%
DD Adjusted Results	$1,958	$2,002	2.29%	0.00%
Difference		**$86**	**4.42%**	**4.06%**

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646

3. OUTLIER ASSUMPTIONS

CMS' Methodology: To estimate what aggregate payments would have been under the 60-day system without the transition to PDGM, CMS repriced simulated 60-day episodes using the payment parameters from the prior 60-day model. For CY 2024 simulated claims, outlier payments were calculated by applying a static fixed-dollar loss (FDL) ratio of 0.51 (the CY 2019 FDL) to determine 60-day outlier amounts. Using this approach, CMS regrouped 30-day periods into 60-day episodes and identified only 2.0 percent of cases as outliers, a number substantially lower than the 3.6 percent outlier rate observed in CY 2019. This understatement partly reflects CMS' regrouping methodology that resulted in 416,796 60-day episodes (11 percent) not flagged as outliers despite being composed of single or consecutive 30-day periods that were outliers in the repriced dataset.

Methodological Issue: By statute, the FDL ratio is intended to produce total outlier payments that do not exceed 2.5 percent of total HH PPS payments. CMS' methodology for CY 2024 yielded outlier payments equal to 1.2 percent of total payments, well below the statutory threshold amount. CMS methodology therefore understates the counterfactual outlier and overall aggregate payments under the 60-day system. Additionally, CMS methodology identifies an outlier rate of 2.0 percent for the regrouped episodes, a much lower rate than 3.6 percent observed in the CY 2019 actual claims data.

Dobson | DaVanzo Analysis: To calculate the impact of CMS' methodological flaw, we adjusted CY 2024 simulated 60-day outlier payments to meet the 2.5 percent statutory threshold. This adjustment increased the aggregate counterfactual payments from $12,233,384,718 to $12,399,948,495.

We then used the Dobson | DaVanzo-developed repricing model (used in analysis 2) to calculate what CY 2024 base payment rates should have been to equate to $12,399,948,495 in payments for the same set of cases. With this adjustment, the recalculated CY 2026 permanent adjustment should have been -3.11 percent rather than -4.06 percent (or -0.95 percentage points less than what CMS proposed for CY 2026). These findings are shown in **Exhibit 6 b**elow.

Exhibit 6: Impact of Adjusting Outlier Payments on Aggregate Counterfactual Payments

	Episodes	Total Payments	Percent of Outlier Cases	Total Outlier Payments	Percent of Outlier Payments
DD Analysis of Actual 2019 Episodes	6,053,934	$17,846,268,087	3.6%		
CMS CY 2024 Grouped 30-Day Episodes	6,433,111	$12,233,370,988	9.4%	$380,321,819	3.1%
CMS CY 2024 Grouped 60-Day Episodes	3,794,744	$12,233,384,718	2.0%	$143,434,936	1.2%
DD Adjusted CY 2024 Grouped 60-Day Episodes	3,794,744	$12,399,948,495	2.0%	$309,998,712	2.5%

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646 and 100% Medicare FFS HH Claims Under DUA 54757

Exhibit 7: Impact of Adjusting CY 2024 60-Day Outlier Payments on 30-Day Base Payment Rates and Permanent Adjustments

	Assumed 30-Day Base Payment Rate	Budget Neutral PDGM Rate (Claims Analysis)	Total Prospective Adjustment	CY 2026 Permanent Adjustment
CMS results from CY 2026 HH PPS NPRM	$1,958	$1,917	-2.13%	-4.06%
DD Adjusted Results	$1,958	$1,943	-0.75%	-3.11%
Difference		**$26**	**-1.38%**	**-0.95%**

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646

4. CLINICAL GROUP ASSIGNMENTS

CMS' Methodology: In CMS' simulation, there are consecutive 30-day periods combined into a single 60-day episode where the clinical grouping changes between periods. Under CMS' methodology, the primary and secondary diagnoses from the first 30-day period are applied to the entire 60-day episode, regardless of whether the second 30-day period reflects higher-acuity conditions or greater resource needs.

Methodological Issue: This approach differs from the pre-PDGM 60-day payment system, where mid-episode changes to the HHRG group and case-mix weight were permitted when updated assessments documented materially different patient needs.[1] By ignoring such mid-episode changes, CMS' simulation structurally underrepresents higher-acuity second-period care and systematically risks assigning lower case-mix weights than would have been applied under the historical payment rules. These assumptions could result in lower counterfactual aggregate payments.

Dobson | DaVanzo Analysis: Our analysis identified 72,602 such episodes (2.8 percent of all simulated 60-day episodes) where the two constituent 30-day periods fall into different clinical groups.

5. OASIS ASSUMPTIONS

CMS' Methodology: As CMS describes in the CY 2025 HH PPS Proposed Rule, under the prior 153-group system (and for PDGM assessments through CY 2022) HHAs used the **OASIS-D** instrument. Effective January 1, 2023, CMS required reporting under the updated **OASIS-E** instrument.

CMS acknowledges that 13 data elements from OASIS-D, used in the 153-group system, are now collected in OASIS-E only at the start-of-care (SOC) or resumption-of-care (ROC) assessments and not at follow-up. Three additional items have been modified in OASIS-E to include more detailed questions and response options, requiring CMS to create a crosswalk to map these back to OASIS-D equivalents.

[1] Per the HH PPS Price Manual Version 3.1, September 2014. Page 2: HHRGs can be changed mid-episode if there is a significant change in a patient's condition (SCIC adjustment).

Furthermore, a single pain item in OASIS-D (M1242—Frequency of Pain Interfering with Patient's Activity or Movement) has been replaced in OASIS-E with three separate items (J0510, J0520, J0530), from which CMS proposes to select the maximum severity to map back to the OASIS-D field.

Methodological Issues: While these crosswalks and substitutions allow CMS to generate variables necessary for the 153-group payment model, they introduce the potential for systematic bias in the counterfactual 60-day payment estimates. Specifically, mapping from OASIS-E to OASIS-D could:

- **Understate patient severity** when follow-up assessments would have captured changes in condition under OASIS-D but are now absent in OASIS-E.
- **Misclassify case-mix groups** if differences in question specificity or coding rules shift responses relative to historical patterns.
- **Reduce case-mix weights** if mapped values from more granular OASIS-E items tend to yield lower severity scores than their OASIS-D counterparts.

Given that the OASIS LDS file does not identify which 60 episodes required assumptions to address the changes from the OASIS-D to the OASIS-E, we cannot quantify the potential impact of CMS' methodological flaws.

6. 60-DAY CASE MIX NOT RECALIBRATED

CMS' Methodology: To estimate what aggregate payments would have been under the 60-day system absent PDGM, CMS priced simulated 60-day episodes using the pre-PDGM payment parameters, adjusting for payment updates, wage index neutrality, and labor share budget neutrality factors. However, CMS did not recalibrate case-mix weights for the counterfactual 60-day system despite the fact that historically such recalibrations typically increased payment rates by 1–2 percent.

Methodological Issue: The omission stands in direct contrast to CMS' approach for CY 2024 PDGM rates, where the agency did perform a full case-mix recalibration using the most current and complete home health claims linked to OASIS. Under PDGM, CMS measures resource use via a cost-per-minute plus non-routine supplies (NRS) method based on cost report data, then runs regression models across all 432 payment groups to predict resource use and derive updated case-mix weights. This methodology inherently accounts for changes in visit patterns, patient characteristics, and service intensity.

If CMS had applied the same recalibration methodology to the simulated CY 2024 60-day claims, the resulting case-mix weights would have more accurately reflected actual resource use in the counterfactual system. This would have required either a positive case-mix budget neutrality factor or a reweighting away from therapy-driven HHRG groups, both of which would have led to higher aggregate payments. Our reasoning is outlined below

1. The CY 2024 PDGM recalibration itself produced such a positive factor, underscoring the likelihood that a similar adjustment would have been required for the counterfactual 60-day system.
2. Additionally, prior case-mix recalibration results for the pre-PDGM 60-day system (e.g., CY 2016–CY 2019 HH PPS rules) show that CMS' recalibrations almost always increased the base payment rate by ~1–2 percent to maintain budget neutrality.

3. Analysis of CMS reported average resource use (cost per 30-day period) under PDGM for the CY 2024 HH PPS compared to the resource use under the 60-day system in the CY 2019 HH PPS showed that the portion of costs per visit type remained consistent despite the decline in the average number of therapy visits delivered under PDGM. These results are shown in the table below.

Exhibit 8: 2016 Estimated Cost per Episode vs. 2022 Estimated Cost per Episode

	2022 Estimate 30-Day Period Costs	Proportion of Total Cost	2016 Estimated 60-Day Episode Costs	Proportion of Total Cost
SN	$677	48.3%	$1,200	47.3%
PT	$502	35.8%	$89	3.5%
OT	$139	9.9%	$245	9.6%
SLP	$29	2.1%	$56	2.2%
MSS	$14	1.0%	$31	1.2%
HHA	$42	3.0%	$117	4.6%
Total	**$1,402**		**$2,539**	

Source: DD Analysis of CY 2024 HH PPS Proposed Rule (Table B4) and CY 2019 HH PPS Proposed Rule (Table 2)

4. Finally, given that the average number of therapy visits per episode fell sharply under PDGM relative to pre-PDGM years and pre-PDGM 60-day case-mix weights were heavily therapy-driven. If CMS used PDGM era cost-report data that reflect therapy visit volume reductions, then the recalibration would re-weight those episodes upward, resulting in higher case mix weights for non-therapy episodes and ultimately increasing the counterfactual 60-day aggregate payments.

Dobson | DaVanzo Analysis: We calculated and applied the PDGM case-mix budget neutrality factor updates from CY 2020 – CY 2024 HH PPS final rules to the CY 2024 60-day counterfactual payment rates. The combined CY 2020 – CY 2024 budget neutrality adjustment factors equated to a 4.24 percent increase over the time period.

Applying the 4.24 percent increase to the counterfactual 60-day base payment rate led to an increase in CY 2024 60-day counterfactual base payment rates from $3,621 to $3,775. We developed a model to simulate what 60-day counterfactual aggregate payments should have been using the adjusted counterfactual rate. Results showed that the counterfactual aggregate payments increased from $12,233,384,718 to $12,734,555,575. Using our repricing model, we find that this adjustment reduces the permanent adjustment by 3.67 percentage points and results in a recalculated CY 2026 permanent adjustment of -0.39 percent, rather than CMS' proposed -4.06 percent. Results are shown in **Exhibit 9** below.

Exhibit 9: Impact of Adjusting Outlier Payments on Aggregate Counterfactual Payments

Year	Wage Index BN Factor	Case Mix Budget Neutrality Factor	Labor Share BN Factor	Payment Update	DD Adjusted CY 2024 60-Day Payment Rate	CMS Calculated CY 2024 60-Day Payment Rate
CY 2020					$3,221	$3,221
CY 2021	0.9999	1.0000	1	1.02	$3,285	$3,285
CY 2022	1.0019	1.0396	1	1.026	$3,510	$3,377
CY 2023	1.0001	0.9904	1	1.04	$3,616	$3,512
CY 2024	1.0012	1.0124	0.9998	1.03	**$3,776**	**$3,621**
Aggregate CY 2024 60-Day Counterfactual Payments					**$12,734,555,575**	**$12,233,384,718**

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646

Exhibit 10: Impact of Adjusting CY 2024 60-Day Base Payments for Case Mix Recalibration Factors on 30-Day Base Payment Rates and Permanent Adjustments

	Assumed 30-Day Base Payment Rate	Budget Neutral PDGM Rate (Claims Analysis)	Total Prospective Adjustment	CY 2026 Permanent Adjustment
CMS results from CY 2026 HH PPS NPRM	$1,958	$1,917	-2.13%	-4.06%
DD Adjusted Results	$1,958	$1,996	1.90%	-0.39%
Difference		$79	4.03%	3.67%

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646

7. 60- DAY EPISODE STRUCTURE

CMS' Methodology: CMS relies on the visit patterns in the simulated 60-day episodes and only applies adjustments to cap the total episode length to 60 days, to determine counterfactual aggregate payments.

Methodological Issue: The simulated CY 2024 60-day episodes differ substantially from actual pre-PDGM 60-day episodes in both volume and composition. Analyses show discrepancies in the total number of episodes, the proportion of cases that are LUPAs, partial episode payments (PEPs), or outliers and overall visit patterns, indicating that the counterfactual dataset does not accurately represent the counterfactual 60-day payment system. Results comparing the 60-day episodes from the grouped 30-day claims and actual 60-day episodes are shown in **Exhibit 11** below.

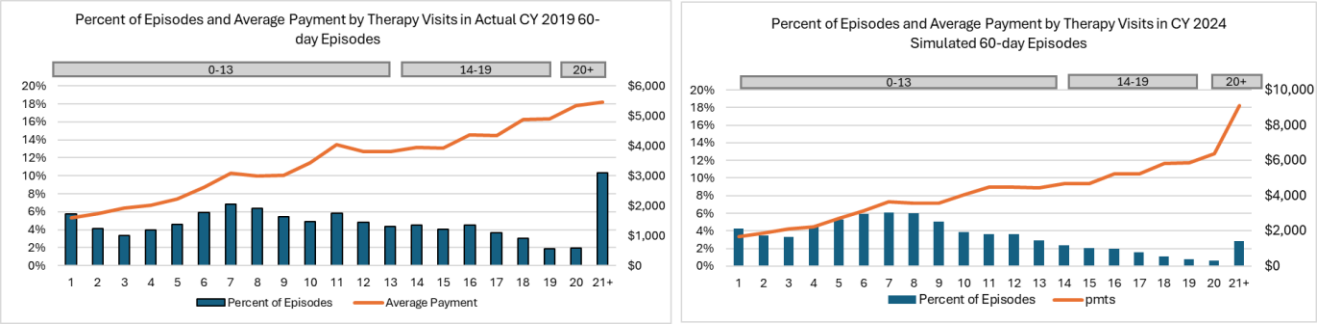
Exhibit 11: CMS Analysis of 2024 Grouped 60-Day Claims

	Simulated 60-Day Episodes	Outlier Rate	PEP Rate	LUPA Rate	Average Case-mix Weight	PT	OT	SLP	SN	MSS	HHA	Average # of Therapy Visits
CMS CY 2024 Grouped 60-Day Episodes	3,794,744	2.0%	0.7%	11.6%	0.9332	4.8	1.3	0.2	6.4	0.1	0.6	6.36
DD Analysis of Actual 2019 Episodes	6,053,934	3.6%	2.2%	8.5%	0.9885	5.7	1.7	0.3	8.4	0.1	1.2	7.74

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646 and 100% Medicare FFS HH Claims Under DUA 54757

This structural mismatch results in lower estimated aggregate payments in the counterfactual payment system especially because of the lower observed therapy utilization at the higher thresholds as shown in **Exhibit 12** below. For example, 10 percent of episodes had 21 or more therapy visits in 2019 compared to 3 percent of episodes with 21 or more therapy visits in the simulated CY 2024 60-day episodes.

Exhibit 12: Percent of Episodes and Average Payments for 2019 60-day Episodes vs. Simulated CY 2024 60-day Episodes



Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646 and 100% Medicare FFS HH Claims Under DUA 54757

Dobson | DaVanzo Analysis: To align the CMS methodology for calculating permanent adjustments with historical visit patterns, we calculated what the CY 2024 60-day counterfactual aggregate payments would have been using CY 2019 60-day case-mix weights applied to the simulated CY 2024 episodes.

We drew on CMS' analysis from the CY 2023 HH PPS PDGM webinar, which showed that applying CY 2018 therapy distributions when assessing budget neutrality for CY 2021 produced a case-mix weight of 1.0389, compared to 0.9682 when CY 2021 therapy levels were used. Based on this and considering the proposed prospective adjustment of –1.44 percent from the CY 2021 claims analysis, we estimated that the prospective adjustment for CY 2024 should have been a +1.67 percent increase. Further, the recalculated permanent adjustment for CY 2026 should have been –0.63 percent.

B. Proposed Alternative Approach for Assessing Budget Neutrality

As CMS cannot plausibly use CY 2024 PDGM data to determine case-mix weights and aggregate payments that would have been made under the prior 60-day payment system in the absence of PDGM, we propose that CMS apply the PDPM parity adjustment methodology the agency used in the CY 2023 SNF PPS Proposed and Final Rule to CY 2020 – CY 2024 PDGM data.

To assess PDMG budget neutrality for CY 2024 PDGM payments we used the SNF parity adjustment methodology outlined in the CY 2023 SNF PPS Proposed and Final Rules through the following steps.

1. ***Step 1:*** **Determine the budget neutral counterfactual aggregate payments (60-day payment system).**

   To calculate the counterfactual payments, we used the percentage of cases in each HHRG group in CY 2019 and multiplied these percentages by the total number of CY 2024 cases. We then multiplied the number of cases for each 2019 HHRG group by the CY 2024 60-day payment rate adjusted for wage index and case mix, obtained from the CY 2026 HH PPS Proposed Rule.

   We accounted for Partial Episode Payments (PEP), Outlier Cases and LUPAs by conducting separate analyses for each of these cases.

2. ***Step 2:*** **Determine CY 2024 Base Payment Rates that would have resulted in aggregate payments from Step 1.**

   We then used our repricing methodology to simulate what the CY 2025 budget neutral payment amount should have been to result in aggregate payments from Step 1 using the same set of cases.

3. ***Step 3:*** **Calculate the budget neutral adjustment factor.**

   Using the same methodology outlined in the CY 2026 HH PPS Proposed Rule, we calculated what the CY 2026 HH PPS permanent adjustment should have been after accounting for permanent adjustments that have been applied thus far.

Results from this analysis are described below.

We used 3,794,744 60-day episodes from CMS' regrouping of CY 2024 claims for our analysis. Results showed that the CY 2024 counterfactual aggregate budget neutral target should have been

$12,702,150,266 instead of $12,233,384,718. This translates into 4.31 percentage point reduction to the CY 2026 proposed calculated permanent adjustment shifting from -4.06 percent to -0.65 percent.

C. Temporary Adjustment Concerns

CMS' Proposed Methodology: CMS proposes a 5.0 percent reduction in CY 2026 (or a 0.9500 temporary adjustment factor) to be applied to the CY 2026 national standardized payment rate. Based on CMS' estimated volume of 7,723,632 30-day periods in CY 2026, this reduction would collect approximately $786 million, or 14.8 percent of the total $5.3 billion CMS has identified in temporary adjustments needed.

Methodological Issues: The proposed static percentage temporary adjustment reduction is inappropriate and inaccurate for the following reasons:

- Declining Number of Medicare FFS Home Health Users: Between 2019 and 2024, the total number of Medicare FFS 30-day periods declined by 5.3 percent and the number of FFS beneficiaries with at least one home health episode decreased by 18.8 percent, reflecting both reduced FFS enrollment and lower post-acute discharges. Overall, the number of Medicare FFS beneficiaries declined by 12.1 percent between 2019 and 2024 as shown in the **Exhibit 13** below.

Exhibit 13: Trends in Medicare FFS HH Utilization, 2019-2024

Year	2019	2020	2021	2022	2023	2024	Percent Difference 2019-2024
Unique FFS Benes with at least one HH Claim	3,310,007	3,014,721	3,063,386	2,863,700	2,756,481	2,688,962	-18.8%
FFS Benes	38,577,012	37,776,345	36,356,380	35,270,914	34,367,703	33,901,001	-12.1%
Unique Rural FFS Benes with at least one HH Claim	443,891	422,827	420,596	378,387	373,477	354,651	-20.1%
Total Number of MA Benes	22,937,498	25,063,922	27,536,246	29,829,632	32,142,166	34,083,063	48.6%
30-Day HH Episodes	8,744,171	9,139,449	9,318,681	8,559,023	8,337,953	8,278,250	-5.3%

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646, Medicare Monthly Enrollment Files and CY 2026 HH PPS Proposed Rule Table 2

- **Growth in Medicare Advantage (MA):** MA enrollment has increased nearly 50 percent between CY 2019 and CY 2024, further reducing the number of FFS beneficiaries. A static FFS recoupment target fails to account for this shift in coverage.
- **Changes in Participating Agencies:** The number of HHAs billing Medicare FFS declined by 13.6 percent nationally between 2019 and 2024 (excluding California). In California, however, HHA counts increased by 74 percent (approximately 1,074 agencies). A uniform percentage cut fails to reflect these regional variations, resulting in disproportionate burdens on remaining providers, especially small or rural agencies that may be vulnerable to these cuts. These trends are shown in **Exhibit 14** below.

Exhibit 14: Number of HHAs with at least one Medicare FFS Claims, 2019-2024

State	2019	2020	2021	2022	2023	2024*	Percent Difference in Number of Agencies (2019-2024)	Difference in Number of Agencies (2019-2024)
Total	9,971	9,678	9,615	9,653	9,717	9,889	-0.8%	(82)
Total Excluding CA	8,518	8,127	7,914	7,686	7,516	7,361	-13.6%	(1,157)
California	1,453	1,551	1,701	1,967	2,201	2,528	74.0%	1,075

Source: Dobson | DaVanzo Analysis OASIS LDS File Under DUA 71646