National Alliance for Care at Home

August 31, 2026

VIA ELECTRONIC SUBMISSION

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1844-P
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: CMS-1844-P, Medicare Program; CY 2027 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 (the Alliance) appreciates the opportunity to submit comments on the **Calendar Year (CY) 2027 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 2 million employees, staff, and volunteers. 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, those with chronic and serious illnesses, and Americans at the end of life who depend on those supports.

Executive Summary

CY 2027 Payment Rates and Permanent and Temporary Payment Adjustments
The Alliance appreciates that, for the first time since CY 2022, CMS proposes a full annual payment update, does not propose to apply a new permanent adjustment, and acknowledges that behavior changes reflected in CY 2023 and later claims are attributable to confounding factors rather than to the Patient-Driven Groupings Model (PDGM).

These decisions do not undo the harm already built into the payment rate. Four consecutive years of permanent adjustments have reduced the 30-day rate by 9.37 percent or over $1.5 billion annually. CMS also proposes to continue the -3 percent temporary adjustment, collecting approximately $500 million against a calculated balance of $4.9 billion. The Alliance estimates the permanent adjustments will produce aggregate reductions of $18.9 billion from CY 2020 through CY 2030. A single positive update does not restore a base rate reduced by 9.37 percent that will continue to be cut by roughly 3 percent annually for the next decade. The confounding factors CMS correctly identifies for CY 2023 and later were present earlier, and the methodology that produced the adjustments still embedded in the rate remains flawed.

<u>Key concerns with CMS's approach:</u>

- The statute directs CMS to determine expenditures "if [PDGM] had not been enacted," which CMS does by simulating pre-PDGM payments using PDGM claims for a year then comparing those to actual PDGM payment on those same claims. However, simulating the pre-PDGM therapy-threshold group against current claims in this way guarantees an erroneous finding such that aggregate payments were not budget neutral and that agencies owe excess dollars to Medicare.
- COVID-era anomalies inappropriately drive half of the measured cuts. The -6.52 percent assessment rests on the transition year and first year of the COVID-19 Public Health Emergency (PHE). The Low Utilization Payment Adjustment (LUPA)-share spike is concurrent with the PHE and fully reverts. CMS itself declined to use CY 2020 to recalibrate LUPA thresholds for that reason and should apply that logic to the payment rate as well.
- Annual case-mix recalibration began in CY 2022, not CY 2023, using highly disrupted CY 2020 data. CMS's rationale for excluding CY 2023 and later applies with equal force to CY 2022.
- Los Angeles County holds roughly 2.5 percent of Medicare fee-for-service (FFS) enrollees but approximately 6 percent of home health users and 10 percent of outlays, distorting case-mix weights, the FDL ratio, and the adjustments.
- Exclusion of roughly 20 percent of claims; structural LUPA misassignments; a static 0.51 fixed dollar loss (FDL) ratio driving simulated outliers below the 2.5 percent statutory target; no case-mix recalibration of the counterfactual 60-day rate; and simulated episodes that do not reflect the system they represent. Each is quantified for CY 2021 and CY 2022 in this letter and the attached technical report.

- Market basket forecasts underestimated actual price growth by a cumulative 7.6 percent over CYs 2021–2025, permanently embedded in the rates, which is compounded by the statutory productivity adjustment.
- Negative adjustments continue to be applied at a time when access to home health is increasingly constrained. Through the third quarter of 2025, 38 percent of Medicare beneficiaries who were referred for home health at hospital discharge did not receive it, up 6.4 percent since 2023. Those who did not receive home health had a 36 percent higher 90-day mortality rate, 33 percent higher readmission rates, and approximately 8 percent higher 90-day Medicare spending. Rural beneficiaries fare worse on these measures.[1]

Alliance recommendations:

- Based on the methodological flaws and data concerns described below, including the inability to discern behavior related and unrelated to PDGM for all data years (2020 through 2026), we strongly recommend that CMS eliminate all permanent and temporary adjustments.
- If CMS determines not to adopt the above recommendation, the Agency should, at a minimum, not finalize the proposed -3.0 percent temporary adjustment for CY 2027, exclude the data for CY 2022 and recalculate the total permanent adjustments determined based on CYs 2020 – 2021 data correcting for the flaws identified above, and finalize a positive permanent increase to the 30-day payment rate in CY 2027.
- Exclude Los Angeles County and other areas with suspect billing patterns from the adjustment, case mix weight, and outlier calculations.
- Finalize a one-time forecast error adjustment of 7.6 percentage points and make CMS's forecast models public.

Medicare Provider Enrollment Proposals

The Alliance resolutely supports CMS's efforts to strengthen program integrity and remove bad actors from the Medicare program. However, several proposed enrollment provisions could subject legitimate providers to denial or revocation based on factors unrelated to fraud or abuse, including shared locations, vendor relationships, or administrative errors. The Alliance is particularly concerned that these proposals fail to distinguish between bad actors and providers operating in good faith and could disrupt access to care for beneficiaries, especially in rural and underserved communities.

Congress explicitly identified four grounds for terminating a Medicare provider agreement, which constrains CMS's authority from expanding those statutory bases through rulemaking alone. Specifically, section 1866(b)(2) of the Social Security Act (the Act) enumerates four bases for terminating a provider agreement: substantial noncompliance, failure to meet the requirements of 42 U.S.C. § 1395x, exclusion under section 1128, and a

[1] CareJourney by Arcadia, Home Health Access and Patient Outcomes: 2025 Q3 Results and Insights, Analysis of Medicare fee-for-service inpatient claims

felony conviction the Secretary determines is detrimental to the program. General rulemaking authority does not permit CMS to enlarge the list.

The Alliance is also concerned that CMS has embedded a far-reaching Medicare-wide enrollment and enforcement initiative within an annual home health rulemaking principally focused on payment updates, quality reporting, and home health policy. The enrollment proposals extend well beyond home health and would affect virtually every Medicare provider and supplier, raising significant legal, operational, and beneficiary access considerations. Given their breadth and potential consequences, these provisions warrant separate and dedicated consideration. **Accordingly, the Alliance urges CMS to remove the enrollment proposals from the CY 2027 Home Health Proposed Rule and reissue them through a standalone notice of proposed rulemaking following meaningful engagement with stakeholders.**

The Alliance supports CMS's efforts to stop bad actors and protect the Medicare program. **Yet, given the immense operational, legal, and financial complexities of these proposals, we respectfully request a formal meeting with you, your team, and appropriate leadership of the Provider Enrollment and Oversight Group.** We also urge CMS to conduct provider-specific listening sessions, including separate sessions for home health and hospice, before pursuing additional provider enrollment changes.

<u>Key concerns with CMS's approach:</u>

- Revocations effective as of the underlying event would take effect before adequate notice is provided, contrary to sections 1866(b)(3) and 1128(c) of the Act.
- Treating every late enrollment filing as grounds for retroactive revocation removes the distinction between intentional concealed ownership change and a correspondence address updated late.
- Shortening the post-revocation claim window from 60 days to 15 days, measured from the letter date, forfeits payment for care already delivered.
- Revocation based on proximity to other providers, denial based on co-location, and extension of denial and revocation authority to misdemeanor convictions rest on bases that appear nowhere in section 1866(b)(2) of the Act.
- Extending denial and revocation to misdemeanor convictions departs from the felony standard.
- Removing the required factors for the ten-year reapplication bar and extending it to every denial will result in inconsistent application and is disproportionate in scope.
- Removing the "pattern or practice" factors at § 424.535(a)(8)(ii) leaves no way to separate abusive billing from ordinary claim errors that are not fraudulent in nature.
- Extending the debt and suspension grounds to "any other form of business or financial relationship" and expanding the false or misleading information grounds attach severe consequences to third-party conduct and to submissions never certified as true or material to enrollment.

- Proposed expansion of "affiliation" would reach any marketing, business, fulfillment, financial, managerial, or beneficiary relationship with the removal of the five-year lookback.
- Proposed expansion of "managing employee" to include clinical directors, department heads, nursing directors, and other clinical staff, which, in tandem with reporting requirements, will impose considerable burden and risk.
- Denial of a hospice's enrollment where its medical director or administrator serves multiple other hospices or is located too far away to perform the role ignores legitimate scenarios in which this practice is observed.
- CMS underestimates information collection burden and compliance requirements, projecting 337 retroactive revocations a year out of two million providers, while failing to quantify private-sector compliance costs.

Alliance recommendations:

- Do not finalize the proposals to make revocation grounds retroactive at § 424.535(g)(1) and § 424.535(g)(1)(ix).
- Do not finalize the reduction of the post-revocation claim submission period from 60 days to 15 days.
- Do not finalize location-based revocation grounds, co-location denial grounds, and the extension of denial and revocation authority to misdemeanor convictions.
- Retain factors at § 424.530(f)(2) and § 424.535(a)(8)(ii), retain the existing reapplication bar grounds, retain the five-year lookback for affiliation disclosures and the current definition of managing employee, and not extend the debt and payment suspension grounds beyond the applicant and its owners and managing employees.
- CMS should remove the existing rulemaking and address the Medicare enrollment proposals in a new notice of proposed rulemaking after CMS has had an opportunity to engage with providers.

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I. Home Health Prospective Payment System

The Alliance writes with continued concern regarding the data and methodology behind rate reductions to the Home Health Prospective Payment System (HH PPS) base rate. The Alliance appreciates the Agency's acknowledgement in the CY 2026 final and CY 2027 proposed HH PPS rulemaking that the plausible effects of PDGM-related behavioral impacts are time-limited and discontinuing further application of permanent adjustments stemming from data taken from CY 2023 – CY 2026. However, we implore the Agency to look more closely at CY 2020 and CY 2022 especially and to apply its rulings consistently, as well as note general methods concerns.

In this section, we note that recent annual payment rules have undermined patient access to this necessary service, raise new concerns about specific historical data problems, and reiterate concerns with CMS's methodology that were previously raised with CMS, but were not addressed by the Agency in prior rulemaking.

A. Monitoring Effects of PDGM

CMS's ongoing implementation of PDGM continues to degrade beneficiary access via significant rate reductions and annual rate updates that do not fully account for actual increases in labor and other cost inputs. Labor is the primary cost driver for HHAs and reductions in payments (combined with increases below actual price inflation) create significant workforce challenges for HHAs in staffing within a competitive health care labor market. This harms patient access by forcing agencies to serve only a limited number of referrals and restrict the number of service areas where they can provide care.

The adverse consequences of delays in home health care are well documented.[2] The benefits of receiving timely home health care are also very clear, and studies have consistently demonstrated positive outcomes associated with home health care. Illustratively, as CMS observed in the FY 2027 Inpatient Prospective Payment System final rule, a "study of patients with severe sepsis showed that post-discharge strategies, including timely home health visits and outpatient physician follow-up within the first week, reduced all-cause 30-day readmissions."[3] However, reductions in home health payments have stymied efforts to better address unmet community home health needs as increasing labor costs and supply pressures have continued to create challenges.

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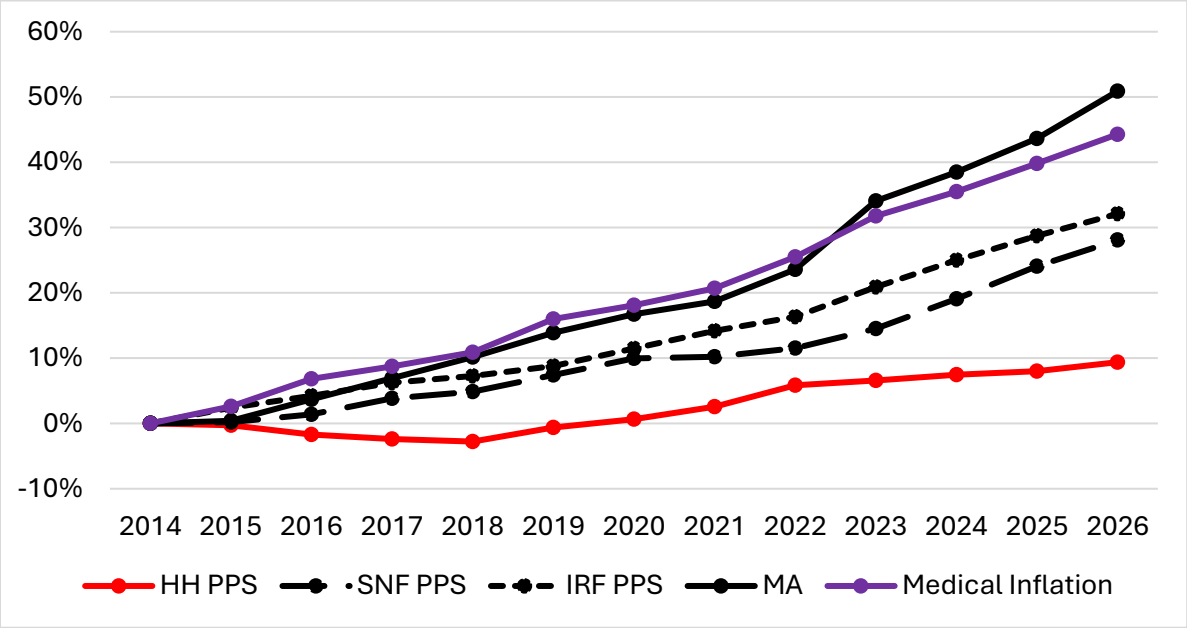
[2] M. Topaz, Y. Barrón, J. Song, et al. "Risk of Rehospitalization or Emergency Department Visit is Significantly Higher for Patients who Receive Their First Home Health Care Nursing Visit Later than 2 Days After Hospital Discharge," Journal of the American Medical Directors Association, Volume 23, Issue 10, 2022, https://doi.org/10.1016/j.jamda.2022.07.001.

[3] 91 Fed. Reg. 49570, 49886 (Aug. 4, 2026) (citing Deb P, Murtaugh CM, Bowles KH, et al. Does Early Follow-Up Improve the Outcomes of Sepsis Survivors Discharged to Home Health Care? Medical Care. 2019;57(8):633-640).

Chart 1 demonstrates that unlike most other post-acute payment systems and Medicare Advantage (MA), HH PPS spending has not kept pace with medical inflation. This very modest nominal growth — an inflation-adjusted payment decrease — represents a policy of underinvestment in home health care by Medicare and can undermine providers' best efforts to deliver effective and efficient care.

Chart 1: Nominal changes in medical inflation, MA payments, HH PPS, SNF PPS, and IRF PPS, 2014-2026



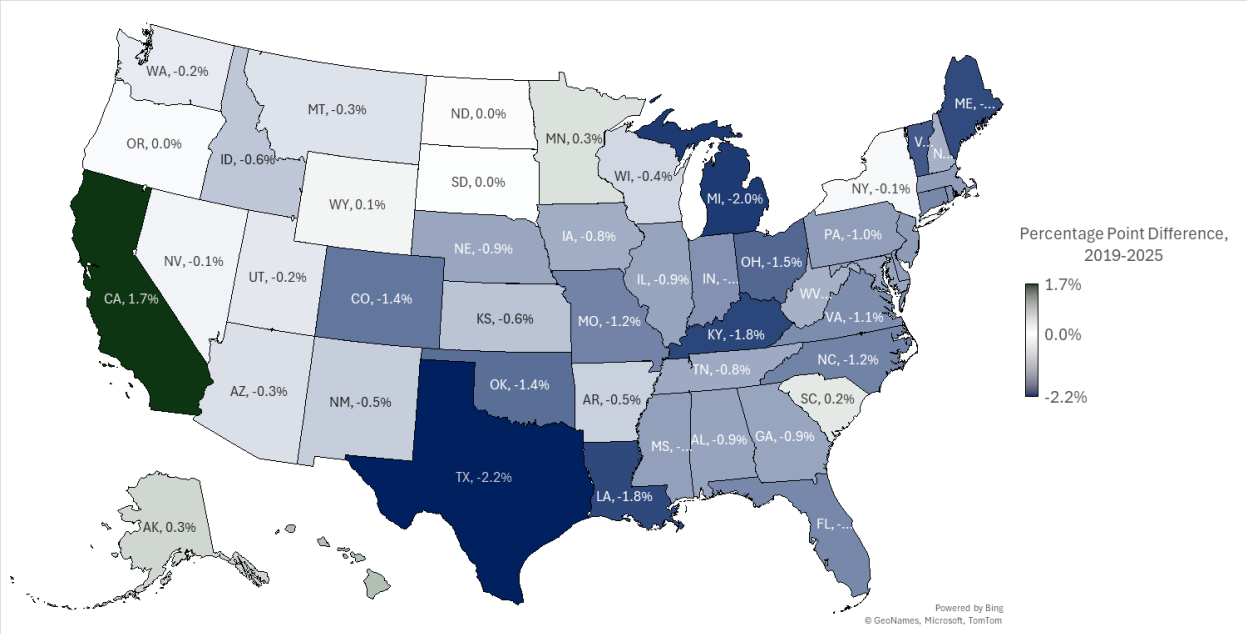
Source: Alliance analysis of CMS rulemaking and Bureau of Labor Statistics data

While CMS and MedPAC assert agencies have high Medicare margins and this indicates payment rate sufficiency, the CMS Office of the Actuary shows that more than a third of agencies operate with a negative total margin.[4] Margins as calculated by the Agency in rulemaking and by MedPAC fail to measure many of the true costs of providing care to Medicare beneficiaries. Put simply, if margins were as strong as alleged, there would not be labor shortages and closures would not be common in the home health sector. Instead, home health providers are unable to see many of the patients who are referred to them.

Chart 2 shows on net agencies have been closing since the implementation of PDGM by demonstrating percent change in agencies providing at least one HH PPS claim from 2019-2025 with net declines in 41 states.

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

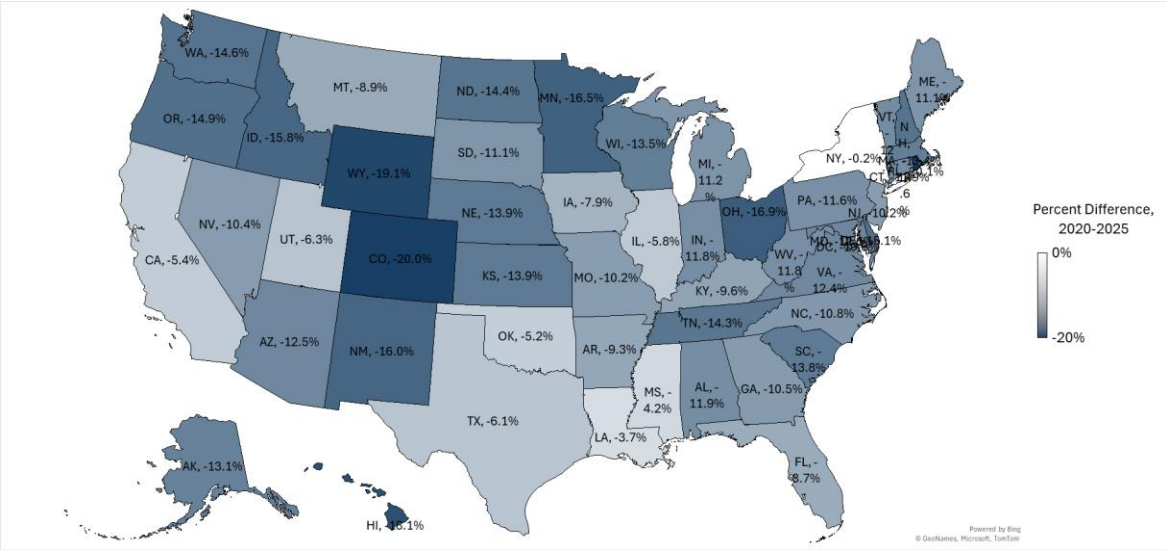
Chart 2: Change in number of providers with at least one Medicare HH claim from 2019 to 2025



Source: Dobson DaVanzo & Associates analysis of Medicare claims, 2019-2025

Chart 3 shows a decline in visits per episode from 2020-2025. This is coupled with the loss of units demonstrating the widespread but geographically varied impact of payment reductions and inadequate rate increases – over 9 percent decline nationally corresponding neatly to over 12 percent in total rate cuts along with market changes. We show the change from 2020 to have a comparable episode basis (30-day system) and isolate the impacts of post-implementation payment policy.

Chart 3: Percent difference in Home Health visits per episode from 2020-2025

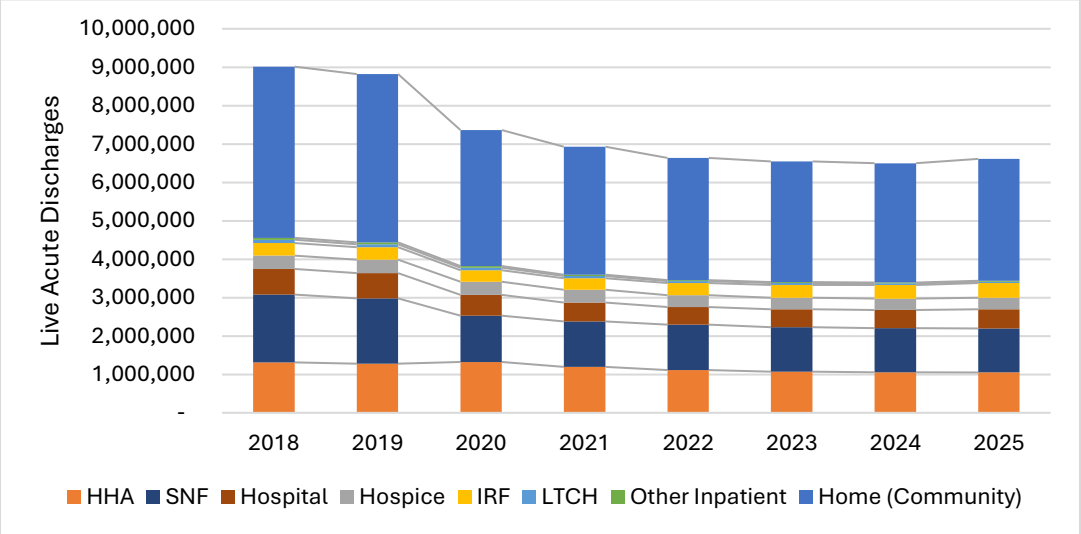


Source: Dobson DaVanzo & Associates analysis of Medicare claims, 2019-2025

The Medicare home health benefit serves homebound beneficiaries with skilled care following acute hospitalization, as a step-down from institutional post-acute care, or other reasons in the community. We focus on post-acute care as there is better data to measure access, and we welcome CMS's partnership to develop more meaningful community care access measures for the 61 percent of stays that begin in the community.

Chart 4 gives broader context showing changes in acute discharges. Medicare FFS radically changed starting in 2020, affecting over a third of home health cases. This massive market restructuring — huge declines in acute hospitalizations in FFS and downstream shifts in PAC care — was due to a combination of the PHE, MA enrollment growth, and technological shifts in surgeries from inpatient to outpatient. Overall, PDGM was only a small factor amongst the backdrop of radical macroeconomic change for HH PPS from 2020.

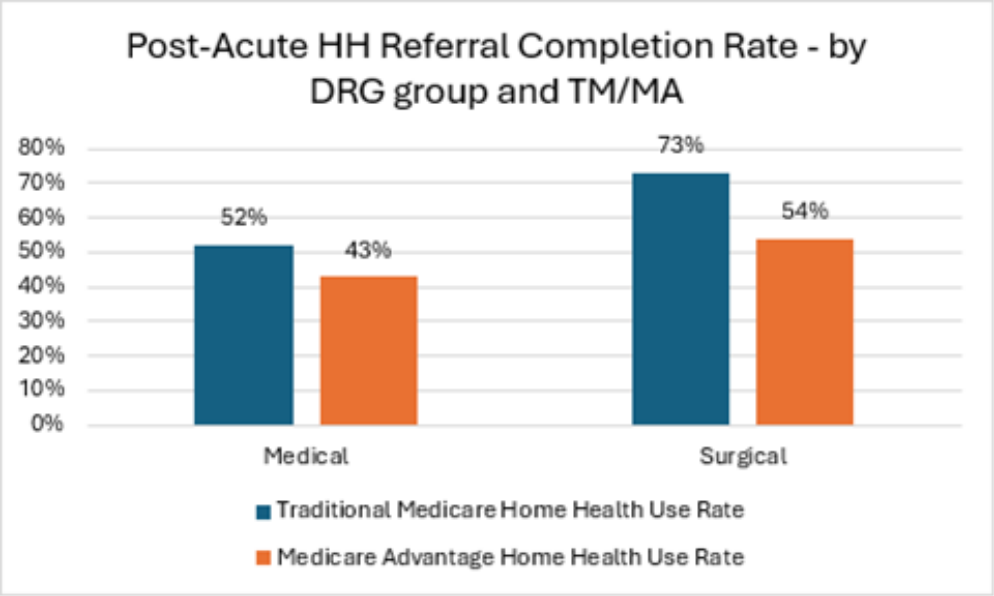
Chart 4: Medicare FFS Post-Acute Live Discharges by Setting and Year



Source: Dobson DaVanzo & Associates analysis of Medicare claims, 2018-2025

For post-acute care access, we rely on the discharge disposition record indicating the patient was sent home with home care (code = 6) and test to see whether they receive that care. With this lens, we observed nationally that post-acute home health referrals were completed within a week only 58 percent of the time, with differentiation between surgical and medical discharges (Chart 5). At the same time (and from the same hospitals), access in MA was substantially worse at 45 percent, reflecting the situation of low rates and denials, among other things.

Chart 5: Post-Acute Home Health Referral Completion Rate by DRG Group and Payer



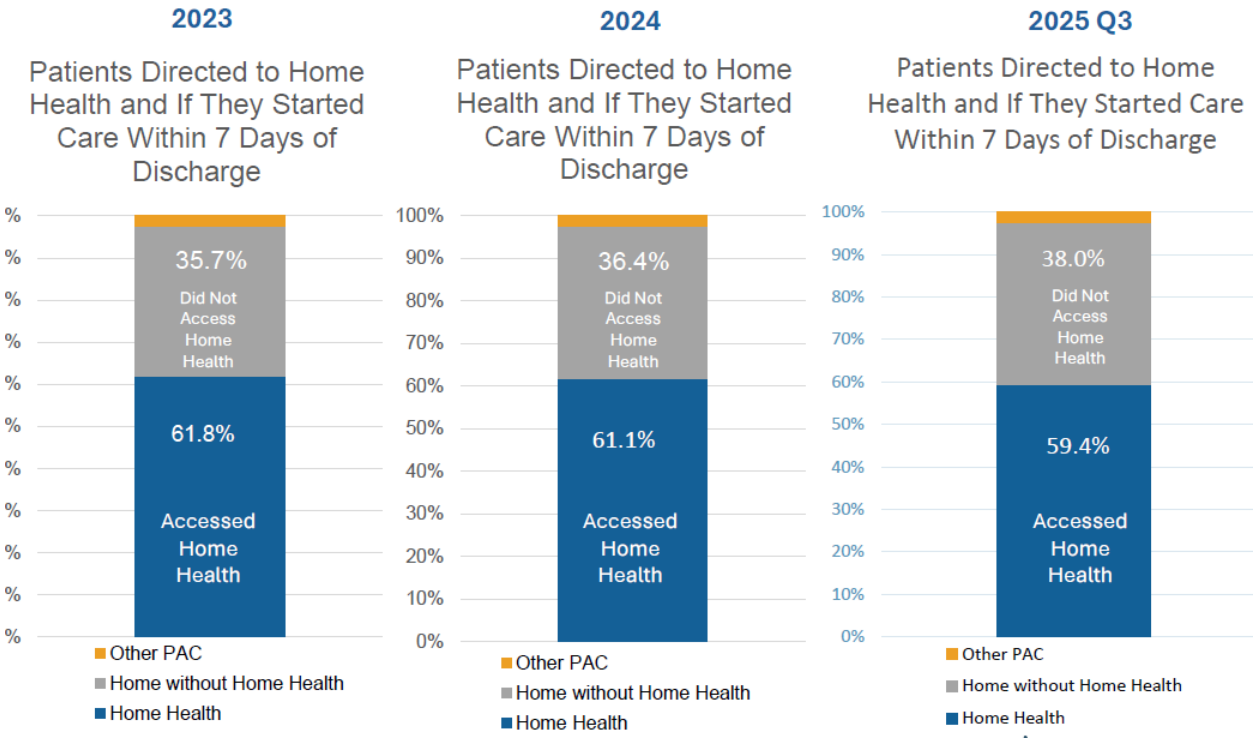
Source: KNG analysis of Medicare claims and MA Encounters, 2022

As access to home health care becomes increasingly constrained for beneficiaries nationwide, mounting cost pressures are further undermining providers' ability to sustain services in communities that rely on care at home. Among Medicare beneficiaries directed to home health at hospital discharge, the share who did not receive home health care rose from 35.7 percent in 2023 to 36.4 percent in 2024, and up to 38 percent through the third quarter of 2025.[5] Chart 6 illustrates this further. More than one in three beneficiaries who were referred for home health care did not receive it — a trend that is unfortunately getting worse.

(continued on the next page)

[5] CareJourney by Arcadia, Home Health Access and Patient Outcomes: 2025 Q3 Results and Insights, Analysis of Medicare fee-for-service inpatient claims.

Chart 6: The Percentage of Medicare Fee-for-Service Patients not Accessing Home Health Care



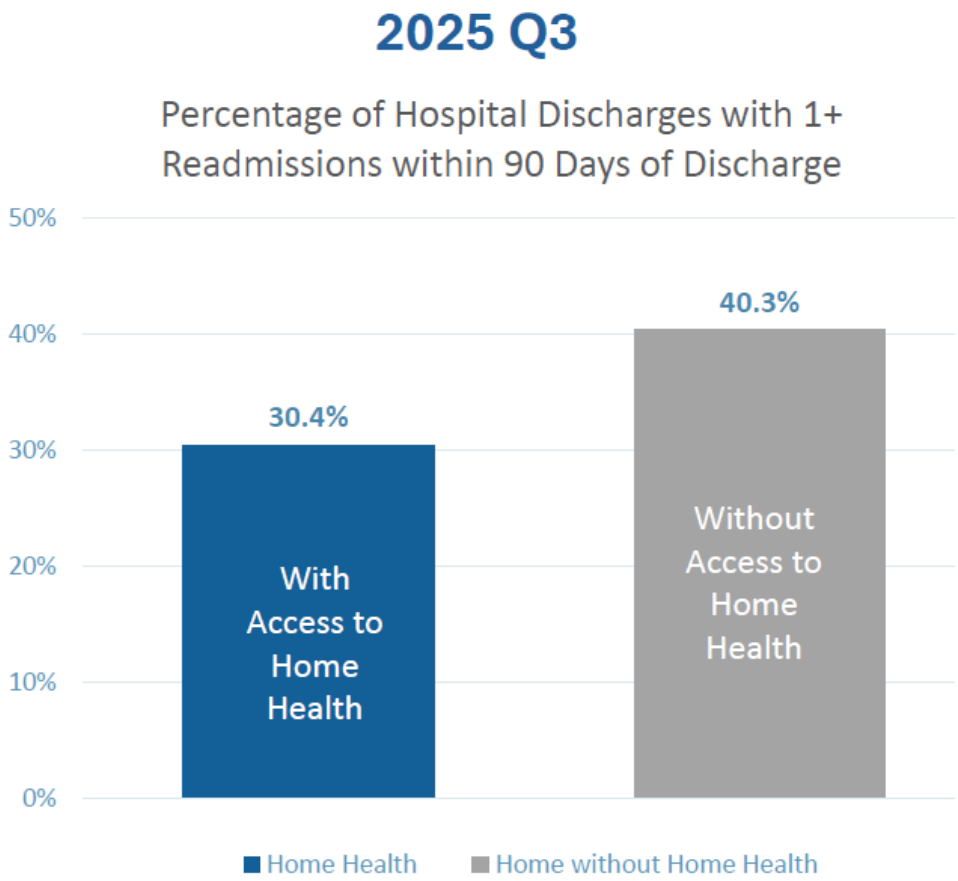
Source: CareJourney by Arcadia, Home Health Access and Patient Outcomes: 2025 Q3 Results and Insights, Analysis of Medicare fee-for-service inpatient claims

The consequences for beneficiaries cannot be overstated. Among beneficiaries referred for home health care following an acute care stay, those who did not receive it experienced a 90-day mortality rate of 10.5 percent, compared to 7.7 percent among those who did receive home health within seven days of discharge — a 36 percent higher mortality rate.[6]

Readmissions followed a similar pattern. 40.3 percent of beneficiaries who did not receive home health experienced at least one readmission within 90 days, compared to 30.4 percent of those who did.[7] In fact, beneficiaries who received home health were also less likely to visit the emergency department within 90 days (25.4%, compared to 29.2%).[8]

[6] *Id.*
[7] *Id.*
[8] *Id.*

Chart 7: The Percentage of Hospital Discharges with 1+ Readmissions within 90 Days of Discharge



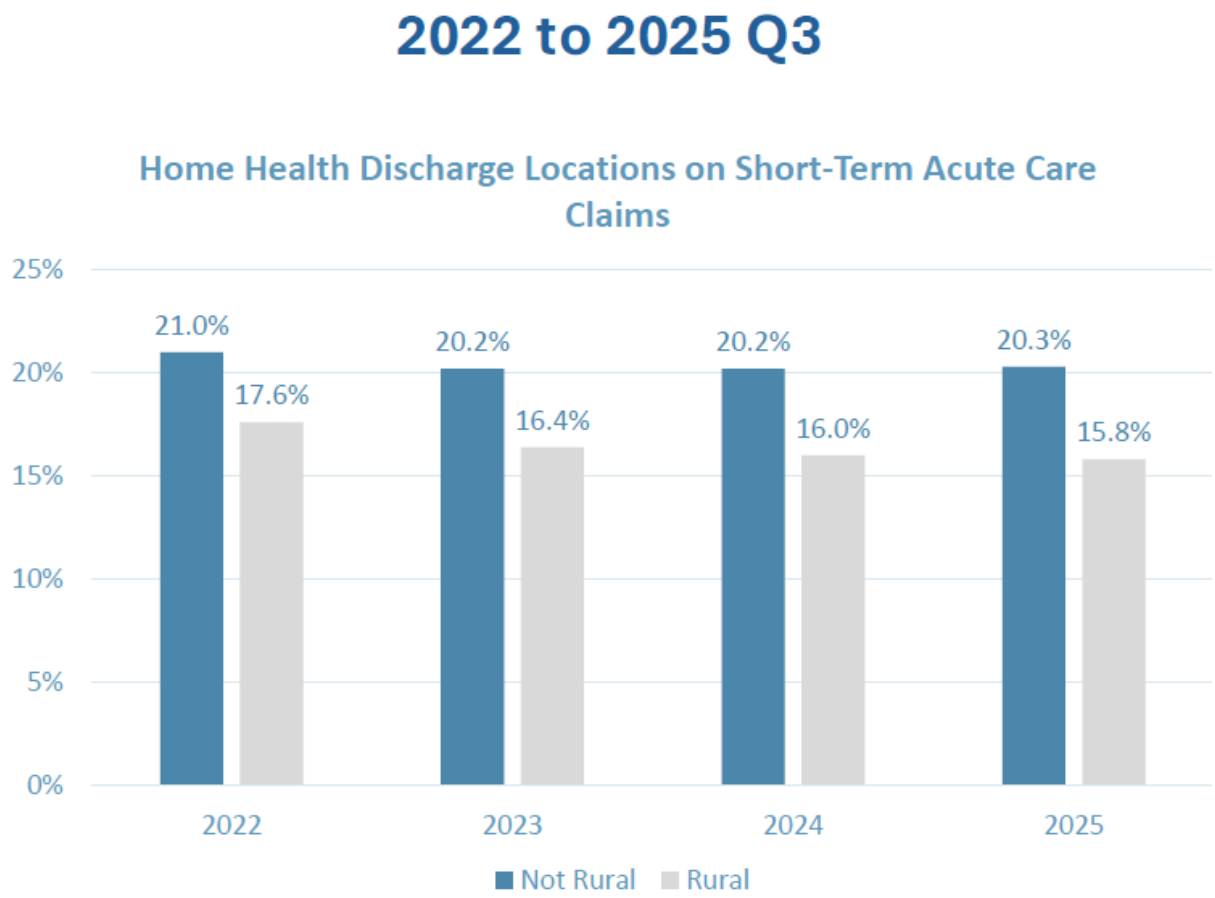
Source: CareJourney by Arcadia, Home Health Access and Patient Outcomes: 2025 Q3 Results and Insights, Analysis of Medicare fee-for-service inpatient claims

It is important to note that each death, each emergency department visit, and each hospital stay might have been avoidable had the individual been able to access home health care.

Nowhere are the consequences of negative home health payment reductions more apparent than in rural America. Rural beneficiaries who did not receive necessary home health died within 90 days at a rate 17percent higher than similarly situated non-rural beneficiaries, and visited the emergency department at a rate 18 percent higher.[9] Meanwhile, the share of rural patients directed to home health at discharge has fallen 9.7 percent since 2022, compared to roughly 3 percent for non-rural beneficiaries.[10] Rural beneficiaries are being referred to home health less often, receiving it less often when referred, and dying more often when they do not.

[9] *Id.*
[10] *Id.*

Chart 8: Home Health Discharge Locations on Short-Term Acute Care Claims



Source: CareJourney by Arcadia, Home Health Access and Patient Outcomes: 2025 Q3 Results and Insights, Analysis of Medicare fee-for-service inpatient claims

Among beneficiaries discharged to home health, later initiation of care is associated with higher total Medicare spending. Total average spending rose by 6.7 percent between receiving home health care from 1 and 7 days after discharge.[11]

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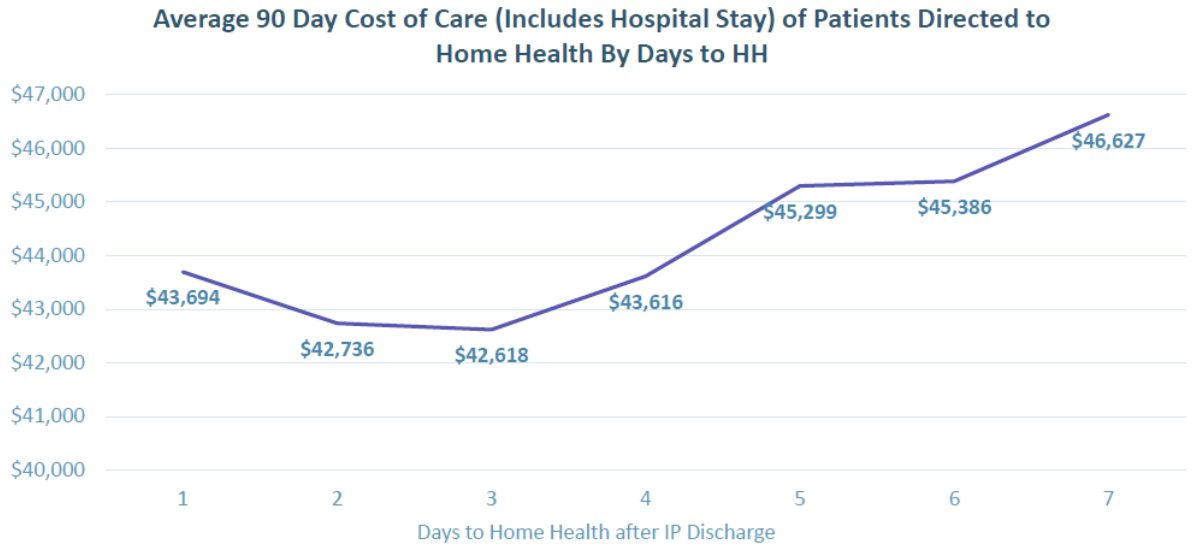
[11] *Id.*

Chart 9: Average 90 Day Cost of Care (Includes Hospital Stay) of Patients Directed to Home Health by Days to Home Health



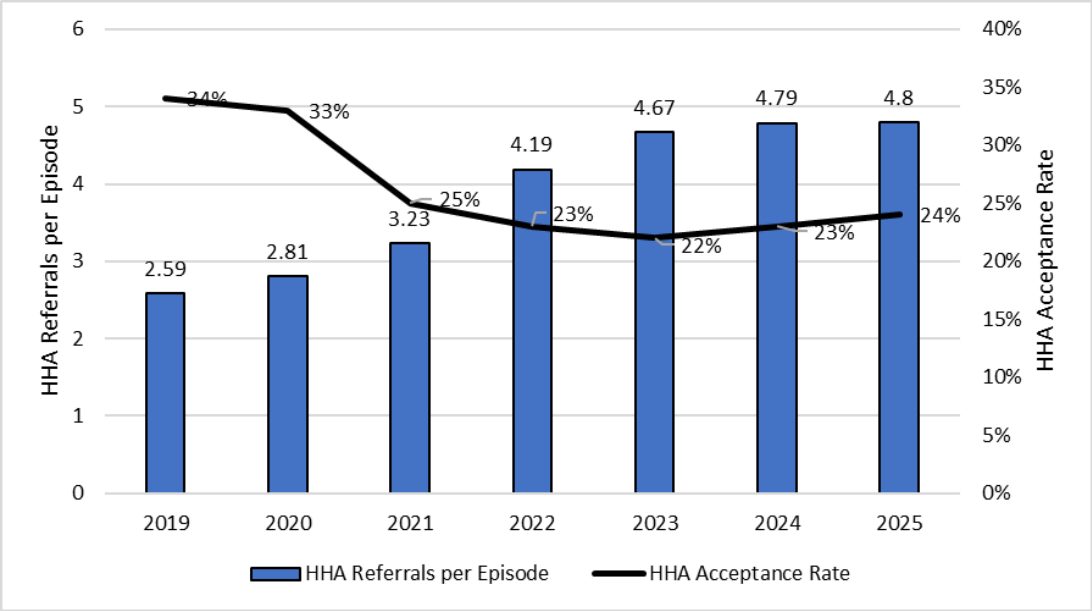
Source: CareJourney by Arcadia, Home Health Access and Patient Outcomes: 2025 Q3 Results and Insights, Analysis of Medicare fee-for-service inpatient claims

At the same time, data from partners at WellSky[12] shows home health agencies became less able to take on cases from acute referrers and this has steadily driven up the difficulty of assuring patient access. WellSky supports acute care providers and home health agencies to make referral connections, so trends observed in their systems are especially alarming and give insight beyond the claims systems.

In 2025, WellSky found that hospitals had to make 4.8 referrals on average for a patient to get home health care, nearly double from 2019 (2.6). At the same time, HHAs were only able to accept 24 percent of requested referrals from acute hospitals, a decline of nearly ten percentage points from 2019 (34%). Chart 10 shows the time trend.

[12] https://wellsky.com/about-us/.

Chart 10: HHA Referrals per Acute Episode and HHA Referral Acceptance Rate, 2019-2025



Source: Data and analysis by WellSky

In areas with low population density, such as rural communities, it is common for small agencies to serve people across a large geographic service area, creating challenges in the delivery of care which are exacerbated by recent payment reductions. We have heard from our members of particular difficulty in operating home health agencies in rural areas, and these were the agencies under threat of closure during last year's threatened 6-point decrease. One alarming trend is that the number of rural home health users in FFS dropped by 3.2 percent from 2024-2025 while the total number of US home health users stayed about the same. This is worrisome and signals the need for innovative rural access solutions and a stable Medicare payment environment. We stand ready to partner with CMS and MedPAC on potential measures to improve rural care access for vulnerable populations.

In summary, the data presented above clearly demonstrate that Medicare HH PPS payments are insufficient to enable all Medicare beneficiaries who would benefit from skilled home health to receive it in a timely manner. We urge CMS to take action to ensure that access to care is improved under this critical Medicare benefit.

In addition, and while not the subject of this proposed rule, the data above show that many MA plans clearly must do more to assure their beneficiaries receive appropriate access to skilled home health services. We also understand that MA plans commonly anchor home health MA rates as a percentage of Medicare FFS home health payments, which means that any reduction in Medicare payments has downstream consequences for MA enrollee

access. The Alliance urges CMS to take regulatory action to assure that all Medicare beneficiaries can access care, regardless of whether a patient is FFS or enrolled in an MA plan. For example, CMS could address the current exclusion of home health from MA network adequacy standards at 42 C.F.R. § 422.116, which acts to heighten current access challenges at a time when demand is rising and MA enrollment is increasing.

B. Proposed CY 2027 Payment Rates, Temporary Adjustments, and Other Changes to Payments

The Alliance appreciates that, for the first time since CY 2022, CMS has proposed to apply a positive annual payment update to the HHA payment rates for CY 2027. We are hopeful that this proposal signals a new emphasis by CMS on ensuring that payments under the home health PPS and benefit support a more stable and predictable reimbursement environment. However, past decisions by the Agency have resulted in successive years of cuts and payment rates that have failed to keep pace with the dramatic increases in labor costs and other necessary resources for care delivery. This continues to have a destabilizing effect on the economics of the home health sector and results in challenges for providers in delivering critical services to beneficiaries.

As the evidence presented in the previous section demonstrates, beneficiaries continue to experience reduced access to care as HHA payments continue to be depressed due to past actions by the Agency in annual rulemaking and flaws that continue to impact CMS's payment methodology moving forward. While the Alliance appreciates CMS's acknowledgement of various confounding factors that influence the data, making it impossible to accurately determine permanent adjustments moving forward, flaws in the methodology used with earlier data years remain. These alone have resulted in a 9.37 percent reduction in the current rates or over $1.5 billion in HHA payments annually for care provided to Medicare beneficiaries.

These 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 account for the proliferation of significant fraud in areas of the country that has corrupted CMS's data and rate setting; and most importantly, aggressive actions in recent years aimed at cutting payments and reducing benefits that give little consideration to the economics of the home health sector and patient care delivery.

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's policies are continuing to significantly erode the home health benefit in a way that fails patients, providers, and the Medicare program. 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 of ensuring budget neutrality in the implementation of PDGM.

The Alliance submitted formal comments[13] to the CY 2026 proposed rule that provided 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 reiterate a number of these flaws and discuss various aspects of the payment system and PDGM that the Alliance believes must still 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 correct the 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 who rely on this critical Medicare benefit.

C. Permanent and Temporary Adjustments

The CY 2027 Proposed Rule would continue to apply a -3.0 percent temporary adjustment to the 30-day payment rate, consistent with the CY 2026 final rule. However, similar to what was finalized in the CY 2026 final rule,[14] CMS believes any behavior changes reflected in preliminary CY 2025 claims used for development of the CY 2027 proposed rule are not directly attributable to the PDGM but rather, "other confounding factors that began in CY 2023 (that is, continued recalibration of case-mix weights, a change to the OASIS–E, and previous reductions to the home health payment rate)."

CMS calculates an illustrative permanent adjustment as part of its annual analysis but does not propose to apply one to the CY 2027 payment rate. As a result of maintaining the temporary adjustment at the same level as 2026 and applying the annual payment update (market basket minus productivity), the 30-day home health payment rate will increase by 2.1 percent in 2027. This is notable as it is the first year that HHAs will receive a meaningful update since 2022 despite years with high inflation and spiraling labor and other input costs (e.g., fuel, medical supplies).

The Alliance appreciates CMS's proposal providing for a positive update to the payment rates in CY 2027. However, the damage resulting from the prior four years of consecutive payment cuts has acted to erode the economic viability of this important Medicare benefit and degraded access to care for the many beneficiaries who depend on it. Tables 1 and 2

[13] Comments of the National Alliance for Care at Home to 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 (Aug. 28, 2025), https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf [*hereinafter* CY 2026 Home Health Alliance Comment Letter].
[14] 90 Fed. Reg. 55364 through 55365.

below detail the level of permanent adjustments (reductions) both determined and applied by CMS to date (a 9.37 percent reduction). Table 3 shows this year's proposed CY 2027 temporary adjustment that is aimed at collecting approximately $500 million of the remaining $4.9 billion determined by CMS.

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
Total to Date	**-9.48 Percent ****

**Illustrative Adjustment* Only – As *Proposed for CY 2027*

*** Cumulative multiplicative total*

Table 2: Permanent Adjustments Applied

CY Rate Year	Percent Reduction in Rate
CY 2023	-3.925 Percent
CY 2024	-2.89 Percent
CY 2025	-1.975 Percent
CY 2026	-0.9 Percent
CY 2027	-0.0 Percent*
Total to Date	**-9.37 Percent ****

**Proposed for CY 2027*

*** Cumulative multiplicative total*

Table 3: Temporary Adjustments – Total and Applied

Total / Applied	Percent Reduction	Dollar Value
Total Outstanding*		-$4,908,531,936***
CY 2026	-3 Percent	- $460,000,000
CY 2027**	-3 Percent**	-$500,000,000**
Total to Date	**-3 Percent**	**-$960,000,000**

**Based on Data Years 2020 thru 2022*

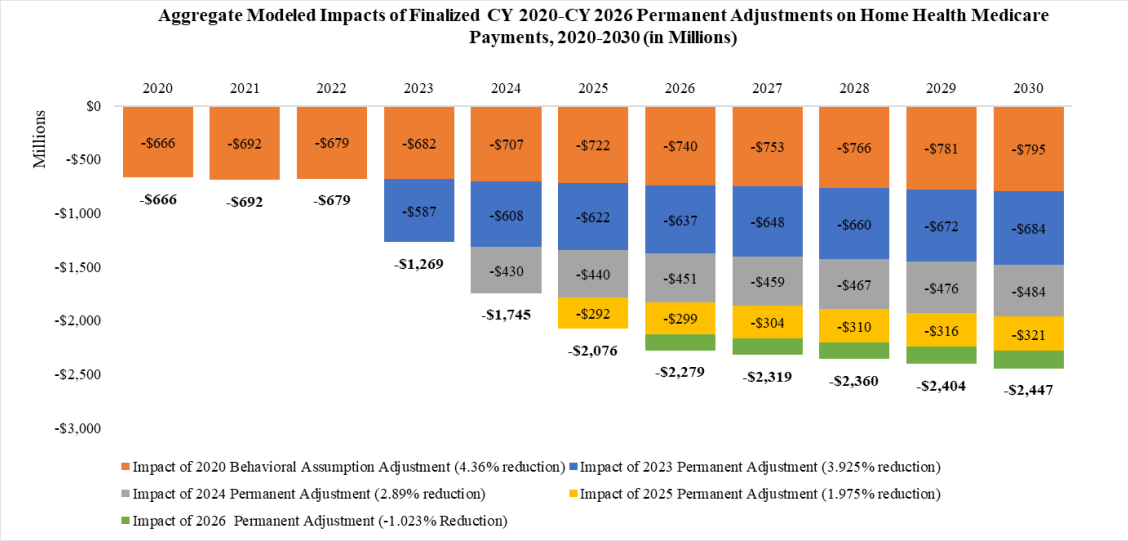
*** Proposed for CY 2027*

**** Estimated Remaining Dollar Value from CY 2027 Proposed Rule*

The Alliance estimates the currently applied and proposed permanent and temporary adjustments will result in aggregate cuts to home health reimbursement of $18.9 billion

(9.4%) 2020-2030 in permanent cuts. Chart 11 below details the year-by-year and cumulative impact of these harmful permanent cuts through the end of the most recent CBO HH baseline projection window. Not included in this chart are the temporary cuts which are set to remove an additional $4.9 billion from the payment system, scheduled as approximately 3 percent cuts each year for a decade. As noted above, the Alliance continues to have significant concerns with the legal basis, development, application, and most importantly the impact of these cuts on beneficiaries and the providers that serve them.

Chart 11: Projected Impact of Permanent and Temporary Adjustments, CY 2020 through CY 2030[15]



Source: Dobson DaVanzo & Associates analysis of rule cuts and outlay statements; for greater detail, see attached technical appendix

1. Legal Background

The Alliance continues to assert that the methodology underlying the Agency's determination and application of permanent and temporary adjustments since 2020 and the implementation of PDGM conflicts with the requirements of the law. While we have commented on these legal issues in prior formal comment letters to annual Home Health PPS rules, we reiterate these concerns in this section.

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,[16] and to eliminate the use of therapy thresholds in the case-mix system for CY 2020 and beyond.[17]

[15] CMS proposed to collect $786 million of the $5.3 billion in temporary adjustments for CY 2026.
[16] 42 U.S.C. § 1395fff.
[17] 42 U.S.C. § 1395fff(b)(4)(B)(ii).

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 *had the payment system overhaul not been enacted*. 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 change to a 30-day unit of service.

The Act 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.[18]

2. ***Legal and Policy Concerns***

The approach adopted by CMS does not comport 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 2025 under the pre-PDGM payment system to what is essentially a rigged test — the old system functioned on therapy thresholds and a stated purpose of PDGM is to move HH PPS away from a focus on therapy provision. Comparing the PDGM back to the bygone system is Kafkaesque in its logic and contradicts the statute. Section 1895(b)(3)(A)(iv) of the Act provides the following in pertinent part:

> . . . the estimated aggregate amount of expenditures under the system during such period with application of [the 30-day unit of service] is equal to the estimated aggregate amount of expenditures that otherwise would have been made under the system during such period if [the 30-day unit of service] had not been enacted.[19]

In other words, Section 1895 of the Act requires CMS to establish a budget neutral payment amount for the transition to 30-day units of payment and to make assumptions regarding behavioral changes that could result from that transition. CMS must then annually determine the impact on estimated aggregate expenditures of the difference between those assumed behavioral changes and the behavioral changes that actually occurred. CMS's methodology does not reliably make that determination. By failing to account for how providers would not have changed had therapy thresholds remained in

[18] 42 U.S.C. § 1395fff(b)(4)(B)(ii).

[19] 42 U.S.C. § 1395fff(b)(3)(A)(iv).

place, CMS does not uphold the clear directive in the Social Security Act.[20] Rather, the methodology CMS established results in a one-sided test such that it will always find agencies moved away from the 153-group system and thus owe payments back to CMS.

CMS's methodology ties the current payment system inextricably to the pre-PDGM payment system, last in effect in 2019, and makes no attempt to apply the requisite adjustments to comply with authorizing legislation or the normal updates CMS would have made in the 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 distorted data from inappropriately laying the old threshold system (LUPAs and all) on top of the new one.

CMS's overall approach conflicts with basic requirements of the statute by: (1) not measuring either assumed or actual behavior changes at all, nor calculating the 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) 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 reveals 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.[21]

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 their statutory authority. This independent judgment inherently involves scrutinizing

[20] 42 U.S.C. § 1395fff(b)(4)(D).

[21] 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 can demonstrate a connection between the facts found and the choices made.

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 gaps in them, 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 legal perspectives we set forth herein, even as they contradict the Agency's proposals and the logic supporting them. Accordingly, the Alliance's 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.

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

The Alliance continues to demonstrate that technical flaws significantly impact CMS's determination of both permanent and temporary adjustments beginning with the 2020 data year and first application of a permanent adjustment in CY 2023 and forward to this Proposed Rule. As noted above, we appreciate the Agency's recognition that any perceived behavior changes reflected in claims from CY 2023 and beyond are not directly attributable to the PDGM implementation but rather to other confounding factors. These flaws are distinct from the above policy concerns which have to do with the data and philosophy of the approach. Rather, these methodological concerns have to do with the fidelity of the implementation of the rule to the stated actions in those rules.

Consistent with our detailed comments to CY 2026 proposed rule[22] on the methodology and attached technical appendix, we continue to have significant concerns with an approach that relies on a biased test simulating payments under the obsolete 60-day threshold payment system which is not appropriately adjusted to reflect the intent of the statute or the Agency's assertions of technical adequacy in this and past rules. We believe that CMS should take action in this final rule to address other technical concerns identified by the Alliance, as indicated below.

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

In explaining its rationale in the Proposed Rule for not using 2025 claims data to identify and account for behavior changes, CMS explains that it believes any behavior changes reflected in preliminary CY 2025 claims for this CY 2027 proposed rule are not directly attributable to the PDGM but other confounding factors that began *in CY 2023*. CMS goes

[22] Comment Letter of the National Alliance for Care at Home, CMS-1828-P: Medicare Program; Calendar Year (CY) 2026 Home Health Prospective Payment System Rate Update (Aug. 28, 2025).

on to identify these factors as "continued recalibration of case-mix weights, a change to the OASIS–E, and previous reductions to the home health payment rate."[23]

The Alliance supports the Agency's view but believes this rationale must also apply to the 2022 data year and claims. We note that CMS began annually recalibrating the PDGM case-mix weights using the most current, complete data available at the time of rulemaking beginning in CY 2022 and *not* CY 2023. 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, starting in 2023, the base rate payment cuts – 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.

In addition, other factors unrelated to PDGM influenced behavior as reflected in 2022 claims. CY 2022 rates relied on the highly disrupted CY 2020 data, which was used to recalibrate the PDGM case-mix weights. 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.[24] 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[.]*"[25]

The CY 2022 recalibration produced significant shifts in case-mix weights and payments. It heavily influenced visit patterns that deviated greatly from past practice due to the COVID-19 pandemic, MA growth (affecting FFS case-mix), and technological change. Changes in these weights ranged from +16 percent to –26 percent 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 (among much other tumult in 2020) 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, MA growth, and technological

[23] Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies, 91 Fed. Reg. 41216, 41236.

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

[25] 86 Fed. Reg. 62249 (emphasis added).

changes. CMS then continued to recalibrate the case-mix weights annually in CY 2023 and beyond.

Again, the Alliance supports CMS's determinations that data from 2023 and subsequent years reflect nominal changes that are unrelated to the implementation of PDGM and thus cannot be used for calculating permanent and temporary adjustments. For the same reason that CMS determined that data for 2023 and beyond reflects the influence of unrelated policy (i.e., recalibration, payment reductions, changes in other sectors, etc.) and macroeconomic conditions, we believe CMS should similarly find that 2022 data reflects the influence of the same type of "confounding factors."

The Alliance strongly recommends that CMS not make permanent or temporary adjustments based on data from CY 2022 and that CMS restore the permanent adjustment determined with this data year to the 30-day rate in CY 2027. We estimate that the exclusion of data from CY 2022 would result in the need for a small increase to the 30-day payment rate in CY 2027 and necessitate recalculating the temporary adjustment dollar amounts for CY 2020 and CY 2021 to offset the amount already collected in CY 2025 and CY 2026 by virtue of the base rate for 2025 and 2026 being set too low.

B. CY 2020 and CY 2021 do not provide a reliable basis to isolate PDGM-related behavioral change

The same attribution problem is also present in CY 2020 and CY 2021 data underlying the Agency's permanent adjustment determination. The methodology underlying permanent adjustments descends from a single determination made in the CY 2023 final rule using only CY 2020 and CY 2021 claims. Table 1 of this comment letter shows that CMS assessed a -6.52 percent permanent adjustment for CY 2020 — by far the greatest impact of any year, the transition year, and the first year of the COVID-19 public health emergency (PHE) which upended acute hospital and post-acute care. In other words, CY 2020 was both the first year of PDGM implementation and the first year of the COVID-19 PHE, which substantially disrupted hospital, post-acute care, and home health utilization.

The analysis below highlights the broader structural problem. It demonstrates that CMS's methodology cannot assume that a PHE-driven change in visit patterns affects PDGM and simulated pre-PDGM systems proportionally. The single most disrupted year in the dataset supplied nearly half of the percentage-point finding underlying the CMS justification for every dollar recouped or proposed to be recouped.

This finding largely rests on a single year's measurement of a behavior the Agency's own data shows behaved anomalously in that exact year. CMS has already noted in this proposed rule (quoted below) that this specific measure is the one COVID-era data cannot be trusted to represent.

CMS explains why it declined to use CY 2020 data to recalibrate LUPA thresholds:

> . . . the LUPA thresholds are based on the number of overall visits in a particular case-mix group… instead of a relative value… that will control for the impacts of the COVID-19 PHE. We noted that visit patterns and some of the decrease in overall visits in CY 2020 may not be representative of visit patterns in CY 2022.[26]

Ratio-based measures can cancel out a common shock; count-based, threshold-sensitive measures cannot. LUPA-threshold avoidance is one of the three behaviors finalized as an "assumed behavior" underlying the entire permanent-adjustment methodology (clinical group coding, comorbidity coding, and "LUPA Threshold… assumes that for one-third of LUPAs that are 1 to 2 visits away from the LUPA threshold HHAs will provide 1 to 2 extra visits to receive a full 30-day payment"). This LUPA assumption is a count-based, threshold-sensitive behavior. By CMS's own stated logic, it is exactly the kind of behavior CY 2020 data cannot reliably measure.

The Proposed Rule's Table 4 confirms this, showing total LUPA share of all 30-day periods at 6.70 percent (CY 2018, simulated) and 6.80 percent(CY 2019, simulated), spiking to a peak of 8.7 percent in CY 2020 before declining through CY 2021 (7.9%) and settling back to 6.6–6.9 percent by CY 2023–2025,[27] essentially returning to the pre-pandemic baseline. This is not noise; it is a clear spike in exactly the metric the LUPA-avoidance assumption is meant to capture, occurring in exactly the year CMS's own LUPA-recalibration reasoning says is unrepresentative for count-based measures.

The Agency's two historic rebuttals do not address this. First, CMS adopted MedPAC's view that using the same claims dataset under both payment systems "controls for changes in utilization as a result of exogenous factors such as the COVID-19 PHE," since any PHE effect "is included in both estimated aggregate expenditures" and so "would not be attributable to the COVID-19 PHE."[28] That assumes the shock is common-mode and proportional across both systems, the same assumption CMS itself rejected for LUPA thresholds. For the reason quoted above: the two systems are not symmetrically sensitive to visit-count suppression, so a COVID-driven change in threshold-clearing visits will not cancel in the subtraction.

Second, the Agency rebutted a COVID argument specific to therapy visits, noting the decline "began before COVID-19 PHE started in March 2020" and calling it "a concerted provider behavior change in response to a financial incentive rather than the COVID-19 PHE."[29] That addresses a different behavior with a different timing signature. While the

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[26] 87 Fed. Reg. at 66816.
[27] 91 Fed. Reg. at 41125.
[28] Medicare Program; Calendar Year (CY) 2023 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; Home Health Value-Based Purchasing Expanded Model Requirements; and Home Infusion Therapy Services Requirements, 87 Fed. Reg. 66790, 66800 (Nov. 4, 2022).
[29] *Id.* at 66798.

therapy decline may predate the PHE, the LUPA-share spike is concurrent with it and fully reverts afterward.

Neither previous Agency rebuttal engages with the specific claim here: the LUPA-avoidance component of the foundational behavior-change finding. This is a component CMS itself has separately and explicitly identified as not controlled for by its differencing methodology and is responsible for most of the assessed penalties on agencies.

The Alliance strongly recommends that CMS remove CY 2020 from rate impact assessments entirely or at minimum adjust for the change in LUPAs and overall case-mix. Doing so is necessary to remain consistent with other finalized use of this data in the rule. While we have demonstrated here that the LUPA cases should specifically be excluded from the measure, the very nature of its threshold effects means that the Agency cannot also simply remove only the LUPA portion of the rate assessment without also potentially biasing it further.

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

The Alliance supports CMS's efforts to address fraud in the home health sector and its efforts in Los Angeles County and other areas of the country where the Agency has identified fraudulent actors and taken action. In our comment letter to the CY 2026 Proposed rule, we raised concerns about suspicious billing patterns by potentially fraudulent actors under the home health PPS and provided detailed data pointing to these billing patterns and the aberrant growth trends in the number of suspicious agencies and associated claims which seems to have escalated dramatically since 2019.

Based on our observation and analysis of both the CY 2026 and current (CY 2027) rate setting process, we believe that the extensive nature of these highly-suspect billing patterns continues to affect 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 reflected in provider payments. While we are hopeful CMS's anti-fraud efforts may ultimately address some of these concerns in the future, 2025 data most certainly reflects the widespread fraud in LA County and other hot spots around the country.

In our comments to the CY 2026 rule, the Alliance recommended that CMS examine and exclude claims data from potentially fraudulent agencies and areas with suspect billing patterns in development of payment rates and various adjustments, including, calculating the permanent and temporary adjustments. We were disappointed with CMS's response that the Agency does not consider anomalous patterns to determine whether it should review cost reports and claims and might initiate investigation for evidence of fraud, waste, and abuse. CMS explained that it generally "has not excluded providers accused of fraud, waste, and abuse from [rate setting] samples before completing the adjudicatory process,

and decline[d] to do so for LA [C]ounty claims."[30] Given the imposition of a nationwide moratorium for home health,[31] this raises the question of why CMS has not done so with 2025 data, and we reiterate our prior recommendation here.

LA County specifically demonstrates very strange billing patterns that bear further investigation. In recent years, LA County has been home to roughly 2.5 percent of the Medicare FFS-enrolled population while accounting for some 6 percent of home health users and 10 percent of home health PPS outlays in 2024. The Agency has not yet published full lists of HHAs or hospices that had payment holds issued as a part of Operation Never Say Die.

The Alliance strongly believes that this aberrant data continues to impact CMS's rate setting. We recommend that CMS reconsider its position in CY 2026 rulemaking and use any new available data from its anti-fraud efforts and exclude data from LA County from its calculations that use data years 2020-2022 related to permanent and temporary adjustments and in CY 2027 and future years for case mix weights and the outlier adjustment until the fraud concerns are resolved.

D. Technical problems that undermine the accuracy of CMS's calculations.

The Alliance, working with Dobson DaVanzo, identified numerous concerns with CMS's approach and has conducted analyses of CY 2021 and CY 2022 claims data (made available in the CY 2023 and CY 2024 OASIS LDS files) to quantify the impact of CMS's exclusions and assumptions on the calculated permanent adjustments relevant to those claim years. Their technical report is attached as an appendix.

Results show that changes to the calculations to address each of these concerns lead to substantial reductions in the proposed permanent adjustment. In our CY 2026 proposed rule comment, data shared there focused on the CY 2026 rulemaking; we stand by that data and consider it additive to what we show here. In this CY 2027 proposed rule comment letter, we focus on data relevant to earlier updates to show that methodological problems persist throughout the historical use of this biased budget neutrality test, using available CY 2021 and CY 2022 data.

These results demonstrate that the detailed technical approach taken by the Agency does not meet the statutory requirement to test what payments would have been had PDGM not been enacted. The statute did not direct CMS to solely examine what the historic pre-PDGM grouper would have paid new cases; it directed the Agency to examine what it would have paid had the entire system not been enacted. CMS did not meet this directive for the philosophical and broad data quality concerns described above, but also for the flaws in the technical implementation of the biased test.

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[30] 90 Fed. Reg. at 55361.

[31] Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Home Health Agencies (HHAs), 91 Fed. Reg. 27954, 27956 (May 15, 2026).

Below follows a brief explanation of the technical findings and the impact an appropriate adjustment would have on the measured permanent adjustments. In our prior year's comment letter and accompanying technical report we outline specific methods.[32] These topics include excluded claims, structural LUPA assignments, outlier assumptions, case-mix update factors, 60-day episode structure, and the impact of COVID-19 cases. Clinical group assignments and OASIS assumptions were explored and found to have significant issues that were difficult to quantify.

Excluded claims. Excluded claims may have complex billing patterns therefore excluding ~20 percent of claims disproportionately removes higher-acuity or atypical cases. Accounting for the impact of reduced therapy utilization reflected in the excluded claims results in a lower permanent adjustment. For example, the CY 2021 rulemaking includes approximately 19.6 percent of HH PPS cases due to OASIS data handling problems. Excluded cases were more often LUPAs and had more therapy visits on average. The CY 2021 final claims used for repricing had on average an extra visit per episode compared to the full HH PPS universe. Addressing these exclusions to represent the full HH PPS universe would materially impact the budget neutrality calculation each year it was run. For CY 2021 and CY 2022 claims, this is estimated 1.95 and 1.31 percentage point (respective) impact on the permanent adjustment finding.

Structural LUPA misassignments. Given the static LUPA threshold of <4 visits under the 60-day system, there are instances where cases are flagged as LUPAs under the old system when they otherwise would have been non-LUPAs under the PDGM.

- Analysis of the CY 2021 claims indicates that this occurs in 5.5 percent of simulated 60-day episodes. The LUPA rate for the corresponding CY 2021 simulated 60-day periods is 11.6 percent as compared to 8.5 percent 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's enactment clause "had not been enacted" as providers' behavior changed to respond to the enacted statute without mathematical adjustment.
- Correcting this arbitrary application of LUPA thresholds would materially impact the budget neutrality calculation each year it was run. For CY 2021 and CY 2022 claims, this is estimated 2.57 percentage points and 1.53 percentage points (respective) impact on the permanent adjustment finding.

Outlier assumptions. When simulating 60-day episodes from 30-day periods, CMS applies a static FDL ratio of 0.51 to calculate the outlier threshold. This is substantially

[32] CY 2026 Home Health Alliance Comment Letter, https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf.

higher than the FDL ratios identified in the CY 2021 and CY 2022 Final Rules. The inflated FDL ratio results in total outlier payments falling well below the 2.5 percent statutory target, thereby understating the simulated counterfactual aggregate payments. Correcting this clear analytic oversight to estimate payments such that they achieve the outlier threshold policy would materially impact the budget neutrality calculation each year it was run. For CY 2021 and CY 2022 claims, this is estimated 0.99 percentage point and 0.66 percentage point (respective) impact on the permanent adjustment finding.

Case-Mix Update Factors. CMS omits case mix recalibration when determining the pre-PDGM simulated payment rates (which historically 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 annually performs a case-mix recalibration to set the PDGM case-mix weights using the most current and complete data. This is also in direct contrast to CMS's stated approach to calculate what payments would have been under the pre-PDGM system.
- Historic 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 percent to maintain budget neutrality.
- Applying the CY 2022 PDGM case mix updates increases counterfactual payments and lowers the permanent adjustment by 2.01 percentage points for CY 2022. CY 2021 did not include a relevant recalibration.

60-Day episode structure. Overall number of episodes, proportion of LUPAs, PEPs, outliers and visit patterns do not reflect the counterfactual 60-day payment system.

- The pre-PDGM 153-group, 60-day system was regularly updated for its proportion of LUPAs, PEPs, and outliers. After 2019, these aspects were held constant in a way that does not meet the statutory requirement – this system would not have ossified in 2019 had PDGM not been enacted.
- Applying the 60-day case mix from pre-PDGM 2019 claims lowers the permanent adjustment. For CY 2021 and CY 2022 claims, this is estimated 0.08 percentage points and 0.39 percentage points (respective) impact on the permanent adjustment finding.

Impact of COVID-19. Excluding episodes containing a COVID-19 diagnosis to test whether COVID-19 cases had lower therapy utilization, thereby reducing counterfactual payments under the former system and potentially increasing the estimated permanent adjustment.

- Where the Agency has made mixed assertions about the impact of COVID-19 on claims, we explored the direct effect on home health claims. Analyses found that in CY 2021 claims with a U07.1 (COVID-19) diagnosis would have been grouped to higher levels than simulated, and in CY 2022 lower.
- If CMS directly adjusted for the PHE by removing cases with a diagnosis code of U07.1 it would have a small impact on payments. For CY 2022 claims, this is

estimated 0.14 percentage point and 0.08 percentage point (respective) impact on the permanent adjustment finding.

Clinical group assignments. There are consecutive 30-day claims where the clinical domain is different, resulting in CMS making assumptions about the clinical domain designation for the 60-day system. When a simulated 60-day episode contains two consecutive 30-day periods with different clinical groups, CMS assigns the first period's diagnosis and clinical group to the entire episode. This may understate counterfactual case mix when the second period reflects greater acuity and does not capture mid-episode case-mix changes permitted under the former system.

OASIS assumptions. Under PDGM, data collection at certain time points for 23 existing OASIS items is optional. CMS assumptions and crosswalk of OASIS items could impact the counterfactual payments. OASIS-E, implemented January 1, 2023, changed the availability and coding of several items used by the former 153-group system. Mapping OASIS-E responses back to earlier OASIS specifications could understate severity or misclassify counterfactual case-mix groups.

Summary and Recommendations of the Alliance

The significant nature of these flaws and their compounding effects result in an inaccurate modeling of the difference in payments under the pre-PDGM and PDGM systems, which itself is an incomplete and biased test. While CMS acknowledges the confounding factors limiting its use of 2023 data and beyond, CMS continues to view its methodology as an absolute and precise calculation of this difference without any acknowledgement of estimation error and the limits of its approach which make it difficult if not impossible to determine a relationship to provider behavior. The Alliance has demonstrated this is not a reasonable policy and that CMS's choice to assert budget neutrality in this way fails to achieve the letter of the statute and 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 serves to erode the viability of the home health benefit to the detriment of Medicare beneficiaries and providers.

In summary, CMS's approach contains critical flaws that misstate 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 in the Agency's methodology.

Recommendations:

- Based on the methodological flaws and data concerns described above, including the inability to discern behavior related and unrelated to PDGM for all data years

(2020 through 2026), we strongly recommend that CMS eliminate all permanent and temporary adjustments.

- If CMS determines not to adopt the above recommendation, the Agency should, at a minimum, not finalize the proposed -3.0 percent temporary adjustment for CY 2027, exclude the data for CY 2022 and recalculate the total permanent adjustments determined based on CYs 2020 – 2021 data correcting for the flaws identified above, and finalize a positive permanent increase to the 30-day payment rate in CY 2027.

D. Proposed CY 2027 Home Health Low Utilization Payment Adjustment (LUPA) Thresholds, Functional Impairment Levels, Comorbidity Sub-Groups, and Case Mix Weights

For CY 2027, CMS proposes to recalibrate the PDGM case-mix weights, LUPA thresholds, and functional impairment levels using data from 2025 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 2025 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, as discussed above, we continue to be 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. In addition, we continue to have concerns about the impact of the phase-out of the Inpatient-Only (IPO) list and the expansion of procedures permitted in the ambulatory surgical center (ASC) setting on the admission source variable used in the HH PPS case-mix adjustment methodology to adjust for patient acuity. This three-year phase out was finalized in the CY 2026 Hospital Outpatient Prospective Payment System (OPPS) Final Rule.[33]

CMS finalized the phase-out the IPO list (1500+ services) beginning on January 1, 2026, over a 3-year period starting with the removal of 285 procedures (mostly musculoskeletal). CMS also finalized expansion of 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). As care continues to shift from inpatient to outpatient settings, the admission source distribution will change in ways not fully captured by historical home health claims. We appreciate CMS's acknowledgement of the Alliance's comment on this issue in the CY 2026 Final Rule and commitment to continue to monitor these trends and assess whether refinements to the admission source variable are warranted in future rulemaking.

[33] 90 Fed. Reg. 53448.

Recommendations:

- The Alliance supports recalibration of the case-mix weights using updated data from 2025 claims; however, we recommend CMS remove data from potentially fraudulent actors, such as those identified in recent program integrity interventions.
- The Alliance also strongly recommends that CMS continue to 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.

E. Proposed CY 2027 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 home health providers' costs. The Alliance appreciates that, for the first time since CY 2022, the Proposed Rule provides for a full annual payment rate update for HHAs. However, 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 2027 that does not reflect the reality of care delivery in the home. Combined with the payment cuts in recent years, this creates significant financial challenges for HHAs, including hiring and retention of clinical staff in a competitive labor market and meeting other rising costs critical to care delivery for our patients.

*1. **Update Factor***

The Proposed Rule provides for an annual payment rate update of +2.1 percent. This update is based on a market basket increase of 3.1 percent minus a 1.0 percent productivity adjustment. As a result, the 30-day period payment rate for CY 2026 of $2,038.22 increases to $2,092.27 for CY 2027. As it did for CY 2026, the 2027 30-day period payment rate reflects the -3 percent temporary adjustment for CY 2027.

The proposed payment update for CY 2027 is a positive step that the Alliance hopes signals CMS's intent to bring greater stability and predictability to home health payments. It is critically important that the annual payment update be applied and 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 forecast models used to prospectively set payment rates for each calendar year. In addition, we encourage CMS to make these forecast models public so that stakeholders can provide input on the approach used by CMS and its contractors.

*2. **Significant Forecast Error in the Market Basket***

The Alliance continues to have deep concerns with CMS's significant under-forecasts of the market basket that are applied in rate setting each year. 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 five years (CYs 2021 through 2025), CMS's forecasts for the market basket have significantly underestimated actual price growth. In effect, this has served as a second significant cut to payments on top of the already devastating permanent adjustments that CMS has applied.

Based on our analysis of the most recent data from the CMS Office of the Actuary,[34] the cumulative forecast error reflected in the home health payment rates totals -7.6 percent over the period 2021 through the 2025 rulemaking. Table 4 below shows the significant forecast errors in each year over this five-year period resulting in this cumulative compounded error of -7.6 percent. Unless corrected, this forecast error remains in the payments rates contributing to the chronic underfunding of the home health benefit resulting from combined policies to cut payments.

Table 4: Market Basket Forecast Error, CY 2021 through CY 2025

MB Forecast Error Impact	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	Cumulative
Actual Market Basket	3.9%	6.2%	4.7%	3.9%	3.8%	24.6%
Projected Market Basket (Final Rules)	2.3%	3.1%	4.1%	3.3%	3.2%	17.0%
Difference	**-1.6%**	**-3.1%**	**-0.6%**	**-0.7%**	**-0.6%**	**-7.6%***

*Actual cumulative compounded forecast error over the five-year period where final data is available, Data Source: CMS Office of the Actuary, July 15, 2026, 1st quarter 2026 data.

The cost of providing care has grown dramatically over this five-year period, even in excess of market basket final actual numbers according to the experience of Alliance members. This is especially true in the case of labor costs but also other critical resources necessary to provide skilled care to patients in the home, including gasoline and medical supplies. When CMS's projections consistently under-forecast the final actual price growth, this exacerbates the problem causing additional financial challenges.

CMS acknowledged the comments of the Alliance and other stakeholders regarding this concern in the CY 2026 Home Health Final Rule saying, "the issue would require careful consideration of the statutory and regulatory frameworks specific to the HH PPS, and any changes deemed necessary would be proposed through notice and comment

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

rulemaking."[35] However, we see no consideration of this issue by CMS that is apparent in the Proposed Rule and no action has been taken by CMS to address this ongoing and significant problem impacting the accuracy of home health payments and viability of the benefit.

The combined effects 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 are troubling and continues to cause financial challenges for providers and impact patient access and care delivery.

Given the substantial successive forecast errors in the home health market basket, the Alliance recommends that CMS finalize a one-time forecast error correction to avoid significant long-term underfunding of the home health benefit. This correction would increase the 30-day market basket amount by 7.6 percentage points to account for the underestimates of the market basket for CY 2021 through CY 2025.

This correction would be applied prospectively to CY 2027 payments. This one-time adjustment would account for the significant forecast error reflected in the payment rates going forward, which, given the level of error, 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 or other concerns CMS has noted in past responses to comments. 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 the proposed temporary adjustment in CY 2027.

In addition, the Alliance urges CMS to explore options to improve the accuracy of its forecast model and make it transparent to the public. While CMS provides significant detail in regulation preamble regarding the construction of the market basket, there is no information at all provided on the forecast model actually used for annual rate setting which, while highly material and critical to Medicare payments each year, has never gone through notice and comment rulemaking allowing stakeholders an opportunity to provide meaningful input.

Recommendation:

- Finalize a one-time forecast error correction to avoid significant long-term underfunding of the home health benefit.

[35] 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, 90 Fed. Reg. 55342, 55401 (Dec. 2, 2025).

3. ***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 yet another rate cut. We encourage CMS to weigh this consideration in the context of other changes it is proposing and deficiencies in the market basket 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,[36] 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. It is being increasingly impacted by AI. 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 for hands on care.

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 has noted in the past that these technology-centered aspects of care delivery are not utilized significantly in home health.

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

Finally, we wish to highlight language in the 2025 study[37] 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 percent per year under the achievable productivity scenario."[38] This is far lower than the 1.0 percent reduction proposed for CY 2027.

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 four 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.

*4. **Home Health Wage Index***

The wage index is an important mechanism used to help ensure payments under the HH PPS reflect geographic differences in prevailing wages. Below we address both the proposed wage index policy for CY 2027 and the Proposed Rule's request for information (RFI) on a potential new wage index based on alternative data sources.

a. CY 2027 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 2027, CMS proposes to base the Home Health Wage Index on the FY 2027 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2022, and before October 1, 2023 (FY 2023 cost report data). Based on existing regulations and policy, the proposed CY 2027 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 pool of clinical and administrative staff. While we support the -5 percent cap on wage index decreases, any decrease in the wage index when combined with proposed temporary adjustments, previously applied permanent adjustments, and a cumulative forecast error greatly impacts the stability of the home health delivery system in affected geographic areas.

[37] https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-updateprovisions-part-provider-financial-margins.pdf-0.
[38] *Id*.

b. RFI on wage index based on alternative data sources

The Proposed Rule also solicits comments on whether the Agency should consider using alternative data sources to construct an HHA specific wage index for potential use in future years. This would replace the current wage index based on hospitals' wages reported on the hospital cost report. CMS indicates that it is seeking feedback to understand the potential advantages and limitations of using alternative data sources, such as BLS data and home health Medicare cost reports, as well as other methodologies or factors specific to home health that stakeholders believe could appropriately reflect the geographic variation in labor costs for HHAs.

Both the BLS data and the HHA cost reports offer significant challenges and likely could not be used to construct an accurate ESRD PPS-style sector-specific wage index at present. First, BLS data on home care includes many providers who do not necessarily serve Medicare beneficiaries. The BLS data shows 1.6 million home care clinicians and support personnel earning $100B annually – dwarfing the size of the Medicare HH PPS. This differs from ESRD where the Medicare PPS is the primary payer for the industry. Without a way to distinguish Medicare providers within the BLS data, that data includes personnel labor mixes that are likely not reflective of Medicare case cost structures and thus potentially inappropriate for use in wage index construction.

Second, the Medicare HHA cost report data is a faulty data source here due to 1) specific problems in HHA worksheet S3, 2) foundationally different uses of contract labor in HH and ESRD sectors and 3) a lack of systematic reviews for data quality. Worksheet S3 in the home health cost reports includes reporting of hours and per hour wages and does not include separate entries for employed and contract labor. This ignores the fact that most contract labor is provided on a per-visit basis (not per hour) and there is no clear difference or conversion factor. The data may seem fine at a glance but in reality, aggregating and treating the field as hours quickly results in outlier results for agencies using contract labor and distorts the actual labor mix. This problem compounds because of both the structure of the S3 – "hours" and "per hour" wages that are multiplied against each other - and that contract labor is more commonly used in home health. Making all of this worse is the lack of regular reviews of home health cost reports; in our experience (similar to MedPAC) less than half of cost reports submitted by agencies pass basic data cleaning checks.

If the underlying data were sensible, the Alliance believes such an approach could possibly offer improvements for home health providers. A more ideal system would adjust for geographic variation in wages over the wage index based on hospitals' wages and account for key differences such as occupational mix. However, the data that CMS presently has available to make such reforms is very poor and it is difficult for stakeholders to evaluate this potential policy change without understanding the construction and impact of such a wage index. If CMS intends to pursue such an approach in the future, we encourage the Agency to engage with home health industry stakeholders through a Technical Expert Panel like CMS convened for hospice, and also publish a comprehensive

RFI detailing CMS's approach, including its data sources (e.g., BLS occupation-level wage data, cost report, etc.), simulated impacts, and effect on the 30-day base rate.

The change to a new wage index has the potential to have a significant redistributive effect on payments and should be considered carefully. Not only would we be concerned about the impact on specific providers and areas of the country, but also the potential (downward) impact on the wage index budget neutrality factor applied to the base 30-day payment rate, particularly given the application of the -5 percent cap policy to mitigate downward changes in wage index values. Any policy that provides yet another downward adjustment to the base 30-day rate is a concern in light of the multiple policies discussed elsewhere in this comment letter that already act to force payments lower. More broadly, we would want to ensure that the change improves home health providers' ability to be competitive with other provider types in the labor markets in which they operate and not exacerbate current disadvantages. We also note that any future index should adequately recognize cross-border labor competition and should not inadvertently disadvantage small states or regional markets.

This is a significant policy change that will potentially impact every HHA in the country at a time when payment stability and predictability have been a deep concern. If CMS wishes to pursue this potential change, we again urge the Agency to publish a new more comprehensive RFI detailing the specific BLS and other data sources, its construction, and impact so that stakeholders can provide meaningful comments and input.

Recommendations:

- Given the significant problems with data that underlie a potential wage index reform effort, the Alliance recommends that CMS take action to improve data for future use and, once data is available, to establish a Technical Expert Panel to give specific advice to the Agency. To do so, CMS should at minimum enact specific changes to the HH cost report S3 worksheet to enable respondents to identify labor units for reporting lines, for there to be time to accrue data, and for the frequency of cost report reviews to increase to improve the accuracy of all reported fields. Finally, CMS should publish a more detailed RFI showing its methodology, data sources, and the impact of a potential change.

5. ***Outlier Policy FDL and Fraud Effects on Outlier Payments***

The proposed rule includes an updated FDL ratio of 0.29 (down from 0.37 in CY 2026). This FDL adjustment contributes an estimated 0.3 percent increase ($50 million) to overall aggregate home health payments for CY 2027. The Alliance supports the annual update of the FDL and outlier policy to ensure additional payments are directed to high-cost patients requiring additional skilled services. However, we continue to have concerns that the data underlying this critical payment adjustment is corrupted by inclusion of claims from high-fraud areas, like Los Angeles County, that distort CMS's mathematical calculations to ensure budget neutrality, potentially disadvantaging legitimate HHAs who rely on these additional payments to care for more severely ill and high cost cases.

The Alliance recommends that CMS finalize an update for CY 2027, however, CMS should evaluate removing highly suspect claims data from its calculation for the final rule. The data used for this important payment mechanism should reflect claims experience from actual care provided by legitimate HHAs.

II. Palliative Care Services as Home Health Services

The Alliance strongly supports CMS's clarification that skilled services furnished for palliative purposes are covered home health services when the beneficiary meets the eligibility requirements at 42 C.F.R. § 409.42 and the services are ordered by an allowed practitioner. We are especially grateful that CMS restated the governing standard in plain terms:

> [T]he restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.[39]

This is a restatement of longstanding law, including the maintenance-coverage standard confirmed by the *Jimmo v. Sebelius* settlement, and it will materially improve access for seriously ill beneficiaries who have historically been turned away, discharged prematurely, or denied on the erroneous theory that care without rehabilitative potential is unskilled. Our members report that this misconception remains widespread among clinicians, referral sources, and reviewers, so an authoritative statement in the preamble followed by future examples in the Medicare Benefit Policy Manual (Manual) is genuinely valuable.

To make the clarification durable and operational, we offer the following recommendations:

- Confirm in the final rule that the clarification applies across all home health disciplines and all PDGM clinical groups—not only to the Medication Management, Teaching, and Assessment (MMTA) grouping.
- Adopt Benefit Policy Manual examples drawn from real palliative home health patients, including the patients described below.
- Realign the HH Quality Reporting Program (QRP) so that agencies serving maintenance and comfort-focused populations are measured on goals their patients actually have, rather than on functional improvement alone.
- Study the resource use of palliative and maintenance periods and pay commensurately..
- State expressly what the clarification does not do - it does not create a Medicare community-based palliative care program, and it does not make home health certification a prerequisite to furnishing palliative care.

[39] 91 Fed. Reg. at 41275.

CMS observes that the PDGM structure allows, "in general," for palliative care services to be "most appropriately grouped" into the MMTA clinical group. We read this as a payment-classification observation rather than a coverage boundary. CMS's reasoning in the clarification confirms this as CMS further states that the palliative care definition it adopts "encompasses all the services provided under the Medicare home health benefit." CMS then illustrates the point across disciplines and clinical services - skilled nursing symptom and medication management; medical social services for advance care planning and caregiver support; and physical therapy, occupational therapy, and speech-language pathology for comfort, safe mobility and transfers, adapted activities of daily living, safe swallowing, and communication.

Because the preamble discussion of MMTA precedes the broader statement, however, we are concerned that reviewers, Medicare Administrative Contractors (MACs), Unified Program Integrity Contractors (UPICs), and Recovery Audit Contractors (RACs) will read the clarification as an MMTA-only policy and deny palliative skilled care that is properly grouped elsewhere, which would be inconsistent with the regulations. Skilled maintenance therapy is expressly covered where a qualified therapist must establish a safe and effective maintenance program or must furnish or supervise the program because of the complexity of the services or the patient's condition. The illustrative skilled services at 42 C.F.R. § 409.33 - management and evaluation of a patient care plan, observation and assessment of a changing condition, and patient and caregiver teaching - are discipline-neutral and are incorporated by the home health provisions. Chapter 7 of the Manual already states that coverage of a maintenance program "does not turn on the presence or absence of a patient's potential for improvement," but rather on the patient's need for skilled care.

Recommendation:

- In the final rule, CMS should clarify that skilled palliative care under the home health benefit is not limited to any single clinical group or discipline, and that a period may be grouped into MMTA–Other, Neurological Rehabilitation, Behavioral Health, Complex Nursing Interventions, Wound, or another clinical group depending on the primary reason for the period, without affecting whether palliative skilled services are covered. CMS should direct its contractors accordingly in the Medicare Benefit Policy Manual so that the clarification is applied consistently in medical review.

A. Manual Examples Should Reflect Actual Palliative Home Health Patients

We greatly appreciate CMS's commitment to "add[] additional palliative care examples of skilled care to the [Manual] following the publication of the CY 2027 HH PPS final rule."[40] The existing Chapter 7 example of a patient with malignant melanoma who has not elected hospice is useful but narrow. The following de-identified composites, drawn from member

[40] 91 Fed. Reg. at 41276.

experience, illustrate the populations most affected by the clarification. We would welcome the opportunity to work with CMS on final example language.

Advanced Cardiopulmonary Disease

- End-stage heart failure without hospice election. An 81-year-old with NYHA Class IV heart failure, an ejection fraction of 20 percent, chronic kidney disease stage 4, and three hospitalizations in six months declines hospice because she wishes to continue an oral diuretic regimen and periodic infusions. Her goals are to breathe comfortably, sleep flat enough to rest, and remain at home. Skilled nursing is needed to assess daily weight, edema, orthostatic changes, and dyspnea at rest; to titrate diuretics and evaluate response within practitioner-approved parameters; to monitor for hypotension, hyperkalemia, and worsening renal function; to teach the patient and her daughter to recognize decompensation and to use a symptom action plan; and to manage and evaluate an unstable plan of care in coordination with cardiology and the certifying practitioner. Occupational therapy establishes energy-conservation and seated-ADL strategies; physical therapy addresses safe transfers with dyspnea on exertion. No improvement in function is expected. Every visit is nonetheless skilled under § 409.33(a) and (b), and each averted emergency department visit is a direct Medicare saving.
- Severe COPD with chronic respiratory failure. A 74-year-old veteran with GOLD Stage IV COPD on continuous oxygen, on his third exacerbation this year, is anxious and increasingly housebound. Skilled nursing assesses work of breathing, oxygen saturation on exertion, and sputum change; evaluates response to bronchodilators, corticosteroids, and low-dose opioids for refractory dyspnea; screens for opioid-related sedation and constipation; and teaches inhaler technique, pursed-lip breathing, oxygen safety, and an exacerbation action plan. Medical social services address panic-dyspnea cycling, isolation, and advance care planning, including a discussion of hospice for the future. The clinical objective is stabilization and crisis avoidance, not restoration of pulmonary function.

Parkinson's Disease

- 78 yr old male admitted to home health following a hospitalization and rehab for a hip fracture from a fall at home. Primary caregiver is patient's 75 yr old wife. Symptoms of increasing functional limitations with disease progression resulting in increased use of a wheelchair for mobility. The patient has been experiencing increased anxiety and depression related to decreased mobility and balance issues. He has difficulty eating independently due to tremors and has increased concern about the burden he places on his wife. The patient and his wife want the patient to remain at home for as long as possible. His wife is concerned, given her own health issues, she won't be able to provide the level of care the patient needs to remain safe and comfortable at home. Home Health services ordered will focus therapy services on assessing needs for adaptive equipment in the home, transfers, balance and gait training. Caregiver education and training on safely assisting the patient

and implementation of a home exercise program based on the patient's specific needs. Nurses will focus on medication management and reconciliation, post-surgical care and symptom management as well as education on the disease process, dietary considerations, pain management and fatigue. Referrals were made for palliative services as additional support to focus on anticipating and managing symptom distress such as hypotension and balance issues, potential ongoing adverse effects related to changes/increases in medications to manage symptoms, eating or swallowing issues. Initiation of goals of care discussion with an emphasis on caregiver burden concerns through referrals to community resources to obtain more help at home, address caregiver stress and provide education and training for the caregiver on patient care needs currently and as the disease progresses. Palliative care services as described can reduce hospitalizations, address symptoms and caregiver burden and prepare the patient and caregiver by planning for needs based on disease trajectory.

Congestive Heart Failure

- Current Home Health patient is nearing the end of a restorative episode of care and the team has determined initiation of maintenance therapy is needed to maintain or prevent deterioration of function related to an acute episode of Congestive Heart Failure (CHF). Maintenance program targeted at maintaining the patient's current functional level to remain as independent as possible. Referral made to palliative care services. The services can enhance the pt/caregivers' understanding of the disease trajectory of CHF through education and care coordination between the family and providers. Nurses will focus on symptom burden and management to reduce the frequency of re-hospitalizations and improve the patient's overall quality of life by development of fluid plans to monitor weight gain and edema and education on fluid adjustment techniques. Manage multiple medications with education to improve compliance with diuretic use for fluid overload and dyspnea.
- Opioid use, if needed for pain and reduction of dyspnea. Assessing for any signs of depression or anxiety which may require medication intervention. Social work will focus on psychosocial needs including any social determinants of health concerns identified. Initiation of advance care planning discussions to better understand the goals of care to provide support and assist the patient/family in exploring expectations of care, re-hospitalization, among other things. Initiating palliative care services early in the process for this patient and caregiver can enhance standard treatments, reduce unnecessary hospitalization and improve communication and exploration of what the patient and caregiver want related to care and services while living with CHF.

Serious Illness With Complex Treatment Regimens

- Advanced cancer, not yet hospice-eligible. A 66-year-old with metastatic pancreatic adenocarcinoma remains on palliative chemotherapy and is therefore not electing hospice. She has poorly controlled visceral pain, nausea, malignant ascites, and a 14-medication regimen including a long-acting opioid, breakthrough opioid, antiemetics, a stimulant laxative regimen, and an anticoagulant. Skilled nursing performs structured pain and symptom assessment, evaluates and reports opioid effectiveness and adverse effects, manages opioid-induced constipation before it becomes an obstruction, assesses for bleeding risk and drug interactions, monitors the abdominal girth and reports the need for paracentesis, and teaches the patient and spouse safe opioid storage, dosing, and disposal. Speech-language pathology evaluates safe oral intake as cachexia progresses. This is textbook management and evaluation of the plan of care, observation and assessment, and teaching and training.
- Multimorbidity, polypharmacy, and a complex wound. A 79-year-old with type 2 diabetes, peripheral arterial disease, heart failure, and a nonhealing ischemic heel ulcer is not a revascularization candidate. The documented goal is comfort, infection avoidance, and limb preservation rather than healing. Skilled nursing performs palliative wound management and pain premedication, assesses for local and systemic infection, reconciles 17 medications across three prescribers after each transition, and teaches the caregiver a dressing and offloading routine. The period may group to a Wound clinical group, not MMTA—precisely why the clarification must not be read as MMTA-limited.

Each of these patients requires frequent, long-duration visits by experienced skilled care clinicians; more than one discipline; extensive caregiver teaching; documentation-heavy coordination with specialists; and after-hours availability. None of them will show functional improvement. Both facts matter for the two recommendations that follow.

B. The HH QRP Should Measure What These Patients and Families Actually Value

CMS states that the CY 2027 HH QRP measure set comprises 18 measures, 13 assessment-based, four claims-based, and the HHCAHPS survey-based measure, and CMS does not propose to add or remove a measure in this rule. The assessment-based set is dominated by improvement constructs, including improvement in ambulation and locomotion, bathing, bed transferring, dyspnea, and management of oral medications, and the Discharge Function Score compares an observed discharge function score to a risk-adjusted expected score built from Section GG self-care and mobility items.

For the patients described above, improvement is not the clinical goal and is frequently not clinically possible. An Agency that succeeds by controlling dyspnea, preventing an obstruction, keeping a patient out of the hospital, and preparing a family for a peaceful death at home will nonetheless post weaker publicly reported outcomes than an Agency

serving an elective joint replacement population. Risk adjustment mitigates but does not resolve this. CMS's risk-adjustment models are built primarily from OASIS items and condition mappings and are not designed to distinguish a patient whose plan of care is comfort-focused from one whose plan of care is rehabilitative. The practical consequence is a quiet disincentive to accept exactly the patients CMS is now encouraging agencies to serve. That is an access problem, not merely a measurement problem.

Recommendations:

- Identify the palliative and maintenance cohort. Use OASIS items, plan-of-care and goal documentation, diagnosis and comorbidity patterns, and claims history to define an analytically usable cohort of periods in which the documented goal is symptom control, stabilization, or prevention of decline. Publish the specification for comment.
- Stratify or exclude, rather than penalize. For improvement-based outcome measures and the Discharge Function Score, stratify results for this cohort or exclude clinically inappropriate cases, in the same manner CMS has long recognized clinically inappropriate denominators elsewhere.
- Restore and modernize stabilization measurement. CMS's own outcome tables already specify functional stabilization measures including grooming, bathing, toilet transferring, toileting hygiene, bed transferring, and management of oral medications that credit "improved or stayed the same," but they are neither risk adjusted nor publicly reported. CMS should risk-adjust, test, and advance a modernized stabilization measure through the pre-rulemaking process. The construct already exists; it needs investment.
- Develop goal-concordance and symptom measures. We support CMS's request for information on advance care planning measure concepts and encourage CMS to pair it with symptom-management and caregiver-preparedness concepts. The hospice program's experience with symptom follow-up and the HOPE assessment offers transferable design lessons, and measures of avoidable acute care use are more aligned with these patients' goals than functional improvement is.
- Apply the same logic to the expanded Home Health Value-Based Purchasing Program (HHVBP). Because the expanded HHVBP applies a measure set that draws on the same improvement-oriented measures, any HH QRP stratification or exclusion should carry through to the Model so that payment is not adjusted against agencies for serving palliative-focused patients.

C. Payment Should Be Commensurate with the Resources These Patients Require

CMS proposes to recalibrate the CY 2027 case-mix weights, functional levels, comorbidity subgroups, and LUPA thresholds using CY 2025 claims in order "to more accurately pay for the types of patients HHAs are serving." We support that objective and ask CMS to apply it to the population this section of the rule is designed to reach. However, we caution that recalibration on historical claims will reproduce historical patterns; meaning it cannot

necessarily anticipate the resource profile of a cohort whose access CMS is deliberately expanding. Neither the aggregate cost comparison in the proposed rule nor MedPAC's aggregate margin estimate for freestanding agencies speaks to the adequacy of payment for a resource-intensive palliative subgroup. Aggregate margins do not establish subgroup adequacy, and CMS should not assume adequacy it has not measured, particularly while a -3.0 percent temporary behavior-adjustment factor continues to reduce the 30-day base payment amount.

D. CMS Should State Expressly What this Clarification Does Not Do

CMS describes its goal as "encouraging community-based palliative care services, particularly under the Medicare home health benefit." The Alliance shares this goal. However, based on the number of questions we have received, we are concerned that the phrase "community-based palliative care," a term being used in healthcare as a distinct service model, and the subject of years of legislative and demonstration proposals, is being misread. . . The Alliance has received numerous questions, and there appears to be significant confusion across various healthcare sectors about this. We respectfully suggest that CMS include clarifying language in the final rule to address this.

CMS' discussion in the proposed rule clarifies how existing home health coverage requirements apply to skilled services furnished for a palliative purpose. It does not establish a separate community-based palliative care benefit or program, does not modify the eligibility requirements for the home health benefit, and does not require any provider or supplier to enroll or be certified as a home health agency in order to furnish palliative care. Palliative care furnished under other Medicare benefits and authorities is unaffected by this rule's home health coverage clarification. The homebound requirement, the need for a qualifying skilled service, the allowed-practitioner order and certification, the face-to-face encounter, and the plan-of-care requirements all continue to apply.

Palliative care is, as CMS recognizes, a method of care delivery that may be furnished under various Medicare benefits and by many kinds of providers and suppliers. Physicians, nurse practitioners, and physician assistants furnish palliative care under Part B; hospices furnish it under the hospice benefit; hospital-based and independent palliative practices, Medicare Advantage supplemental benefit programs, accountable care organizations, and CMMI model participants furnish it under other authorities.

Finally, we ask CMS to keep the boundary with the hospice benefit clear in both directions. The home health benefit is an important access point for beneficiaries who are seriously ill but not yet hospice-eligible or not yet ready to elect hospice, and we agree with CMS that it can serve as a bridge. It is not a substitute for hospice, and it does not support the same intensity of interdisciplinary care.

We appreciate CMS's leadership on this issue and the care evident in Section II.F. We would welcome the opportunity to work with the Agency on the manual examples, the measurement questions, and the payment analysis described above.

III. Home Health Quality Reporting Program (HH QRP)

A. Opportunities for Potential Alignment Between the HH QRP and the Expanded HHVBP Model

The Alliance supports alignment of HH QRP and expanded HHVBP Model measure reporting periods, of the HH QRP annual payment update and HHVBP annual payment reporting periods, the HHVBP Interim Performance Report and HH QRP Quality of Patient Care Star Rating Report release schedules and appeals and suppression review timeframes. These four items are administratively straightforward and would materially reduce the reconciliation work agencies currently perform to understand why two CMS reports describing the same care show different results for different periods. We ask that CMS propose them as a package rather than sequentially, so that agencies absorb one transition rather than four.

B. Form, Manner, and Timing of Data Submission Under the HH QRP

CMS proposes that, beginning with the CY 2027 HH QRP, HHAs complete OASIS data submissions and any necessary corrections no later than the 15th day of the second month after the end of the calendar quarter, replacing the current 4.5-month timeframe. The Alliance shares CMS's goal of more timely public reporting and more actionable feedback reports. We do note, however, that in CMS's calculation of the 99.27 percent of all OASIS assessments being submitted to CMS within a 45-day timeframe, the CY 2024 baseline was used, and it is not representative of the population to which the proposed deadline would apply.

Mandatory all-payer OASIS submission did not begin until July 1, 2025, following a voluntary phase-in period that began January 1, 2025. In addition, the OASIS-E2 item set took effect April 1, 2026, so CY 2027 would be the first full program year under a new instrument. CMS's 2024 data therefore reflect only Medicare and Medicaid assessments and some voluntary all-payer assessments and cannot measure timeliness for the expanded all-payer volume that agencies now submit. CMS should re-run its timeliness analysis using data from the mandatory all-payer period and, if possible, from the first quarters of OASIS-E2 submission, and publish the updated results in the final rule. The presumption is that there will still be a high percentage of submissions within the 45-day timeframe; however, finalizing the change to this time period should rest on the most accurate data.

We support CMS's proposals to revise the OASIS and HHCAHPS annual payment update reporting timeframes to a January 1 through December 31 basis, which would align pay-

for-reporting with the HH PPS payment year and with the expanded HHVBP Model. This is a welcome alignment. We do have a concern with the transition years as expressed to us by members. The 2028 annual payment update determination would rest on six months of OASIS data (July 1 through December 31, 2026) and nine months of HHCAHPS data (April 1 through December 31, 2026). We ask that CMS confirm that the nine-month HHCAHPS transition period, which begins with the April 2026 sample month, accounts for the revised HHCAHPS Survey that CMS finalized effective with that same sample month, and explain how survey transition effects will be handled in the compliance determination.

CMS proposes to replace the "letter of noncompliance" with an electronic "notification of noncompliance" delivered through the CMS-designated data submission system, and to eliminate United States Postal Service delivery and Medicare Administrative Contractor email as channels for final reconsideration decisions. We do not object to electronic delivery, which is faster and creates a better record. We recommend that CMS adopt three safeguards, given that the consequence of a missed notification is a two-percentage-point payment reduction.

Recommendations:

- Require that notifications also be sent by email to the agency contacts of record and confirm which contact fields CMS will use and how agencies update them.
- Confirm that the 30-day reconsideration request period runs from the date the notification is available in the CMS-designated system, and that the system generates a durable, Agency-retrievable record of the posting date.
- Confirm that a system outage, access failure, or credentialing problem that prevents timely retrieval of a notification qualifies for the extraordinary circumstances extension.

IV. Provider Enrollment Provisions

A. Background and Overview

The Alliance resolutely supports CMS's efforts to protect Medicare beneficiaries and strengthen program integrity by identifying and removing bad actors from the Medicare program. Fraud harms beneficiaries, erodes confidence in the healthcare system, depletes Medicare Trust Fund resources, and undermines the reputation of mission-driven providers that deliver high-quality care to homebound and terminally ill patients. Consistent with this commitment, the Alliance, together with LeadingAge, submitted comprehensive program integrity recommendations in December 2025 that emphasized targeted, data-driven enforcement strategies.[41] Indeed, the Alliance supports program integrity measures that hold bad actors accountable through targeted, data-driven enforcement, without restricting patient access or harming the legitimate providers that

[41] https://allianceforcareathome.org/wp-content/uploads/Final-Alliance-and-LeadingAge-Home-Health-and-Hospice-Program-Integrity-Recommendations.pdf.

patients rely on. We remain committed to working collaboratively with CMS to advance that work and stand ready to continue it.

We are concerned, however, that many of these proposals do not distinguish bad actors from legitimate providers operating in good faith, and will ultimately impair access to care for beneficiaries. While intended to combat fraud and abuse, certain provisions may expose compliant providers to enrollment denials, revocations, or significant operational and compliance burdens based on factors unrelated to fraudulent conduct.

If finalized, CMS could effectively deny or revoke a legitimate provider's enrollment based on a neighbor's conduct, a shared address, a vendor relationship, proximity to other providers, or inadvertent administrative errors, none of which is fraudulent activity. Other proposals rely on standards that CMS does not define, raising questions and doubt among the provider community and ultimately threatening decreased investment in and access to care at home. These proposed provisions would significantly increase compliance burdens for providers, particularly where undefined or overly broad standards could be applied without adequate consideration of the facts, context, and mitigating factors CMS should assess before imposing adverse action.

The consequences in our sector are severe. In the absence of clear standards, objective criteria, and defined safeguards, these policies risk creating uncertainty throughout the provider community, discouraging investment in care-at-home services, and reducing access to care for Medicare beneficiaries, particularly in rural and underserved communities. In communities served by a single hospice or home health agency, for example, the loss of a provider may eliminate essential services altogether.

An enforcement tool that does not distinguish between bad actors and legitimate providers operating in good faith ultimately reaches the very beneficiaries who depend on them. This is not in the best interest of the Medicare program.

The legal defects in these proposals are fundamental and cumulative. Congress established an express statutory framework governing who may participate in the Medicare program, the circumstances in which participation may be terminated or not renewed, the process for provider and supplier enrollment, and the notice and procedural protections applicable to adverse action. CMS may administer and enforce that framework, but it may not use enrollment regulations or general rulemaking authority to create new, open-ended grounds for removing otherwise legitimate providers participating in Medicare, to impose consequences Congress did not authorize, or to give retroactive effect to adverse action in a manner inconsistent with the law.

Many proposed provisions exceed those limits. They would permit adverse enrollment action based on broad and undefined concepts, such as proximity, shared office space, an "excessive" number of providers, or an expansive network of business relationships — instead of a provider's own conduct. They would also extend severe consequences,

including revocation, termination, a reapplication bar, and payment loss, without clear statutory authorization, objective standards, or meaningful notice. CMS should therefore remove the existing rulemaking and address the Medicare enrollment proposals in a separate notice of proposed rulemaking after engaging meaningfully with the stakeholder community.

1. Congress explicitly defined the grounds on which a provider may be removed from Medicare

In the Proposed Rule, CMS relies on section 1866(j) of the Act, together with general rulemaking authority in sections 1102 and 1871, as the legal basis for these proposals.[42] Section 1866(j) of the Act directs the Secretary to establish a process for the enrollment of providers and suppliers, and to address specific mechanics of that process, such as provider screening, a provisional period of enhanced oversight, disclosure of affiliations, temporary enrollment moratoria, and the establishment of compliance programs. It does not establish the grounds on which a provider may be removed from the program. Congress addressed that question separately and specifically.

Section 1866(a)(1) of the Act provides that a provider of services with a provider agreement satisfying the statutory criteria "shall be qualified to participate [in Medicare] and **shall be eligible for payments**" if it has entered into a provider agreement satisfying certain criteria.[43] Section 1866(b)(2) then enumerates four bases on which the Secretary may terminate or refuse to renew a provider agreement: (1) noncompliance with the provider agreement or applicable law,[44] (2) failure to "substantially meet the applicable provisions of [42 U.S.C. § 1395x]",[45] (3) exclusion from participation under section 1128 of the Act;[46] and (4) a conviction "of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries."[47]

This enumerated list is specific, and Congress gave no indication that it is illustrative. Under the canon of *expressio unius*, where a legislature enumerates a list of related items, it is understood to have intended to purposefully exclude similar items not included in the list.[48] In other words, there are only limited bases that enable CMS to terminate or revoke a provider agreement.

2. Any revocation must be measured against statutory limits on termination

CMS's enrollment regulations operate through revocation of billing privileges, a mechanism that does not appear in section 1866 of the Act. Revocation nonetheless has

[42] *See* 91 Fed. Reg. at 41283.
[43] 42 U.S.C. § 1395cc(a)(1).
[44] 42 U.S.C. § 1395cc(b)(2)(A).
[45] 42 U.S.C. § 1395cc(b)(2)(B).
[46] 42 U.S.C. § 1395cc(b)(2)(C).
[47] 42 U.S.C. § 1395cc(b)(2)(D).
[48] *See, e.g.*, *Christian Coal. of Fla., Inc. v. United States*, 662 F.3d 1182, 1193 (11th Cir. 2011).

the same practical effect as termination, in that a revoked provider can no longer receive Medicare payment for services. Revocation also triggers termination of the provider agreement under CMS's own regulations.[49]

The law is clear. There is no category of provider that holds a valid provider agreement and is at the same time ineligible for Medicare payment. The statute provides the opposite.[50] It follows that any revocation ground must therefore be assessed against the statutory limits Congress placed on termination. Conversely, any grant of generalized authority would render superfluous the specific enumerated bases Congress enacted to specify on what grounds the Secretary may terminate a provider agreement.

And yet, several proposals would authorize revocation, and therefore termination of a provider's Medicare eligibility, on grounds that appear nowhere in section 1866(b)(2) of the Act. Proximity to another provider, sharing a suite, and a misdemeanor conviction of a managing employee may be well intended proposals, yet none of these are among the reasons for termination Congress enumerated in statute.

3. ***General rulemaking authority does not permit CMS to expand the statute***

An agency may not enlarge its authority merely by giving a statutory action a different name.[51] A general grant of authority cannot displace the clear, specific text of a statute, and it does not confer "[c]arte blanche authority" to promulgate any rule on any matter relating to that statute.[52] Where a question is one of deep economic and political significance, Congress must delegate authority expressly rather than through "vague terms" or "subtle devices," and enabling statutes do not permit an agency to make fundamental changes to a statutory scheme.[53] We also remind CMS that the Supreme Court has made clear that statutes are to be interpreted "based on the traditional tools of statutory construction, not individual policy preferences."[54]

4. ***Several proposals rely on undefined standards***

A number of these proposals turn on terms CMS expressly declines to define, such as "limited geographic area," "excessive number," "high risk," "same suite or office," and a category of "affiliation" reaching any "marketing, business, fulfillment, financial, managerial, or beneficiary relationship." In *FCC v. Fox Television Stations*, 567 U.S. 239 (2012), the Supreme Court held that due process requires agencies to give regulated entities fair notice of the conduct that is prohibited or required. A rule is constitutionally deficient when an ordinary person cannot tell what facts must be established, or when it

[49] *See* 42 C.F.R. § 424.535(a).
[50] *See* 42 U.S.C. § 1395cc(a)(1).
[51] *Cf. Utility Air Regulatory Group v. EPA*, 573 U.S. 302, 328 (2014) (holding that an agency cannot alter clear statutory requirements to make its asserted authority workable).
[52] *Murray Energy Corp. v. Env't Prot. Agency*, 936 F.3d 597, 627 (D.C. Cir. 2019).
[53] *W. Virginia v. Env't Prot. Agency*, 597 U.S. 697, 723 (2022).
[54] *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 403 (2024).

leaves enforcement without adequate standards.[55] A provider cannot conform its conduct to a standard the Agency declines to articulate.

Due process requires more than an instruction that providers should act in good faith. A provider that undertakes reasonable, documented diligence to confirm that its owners, managing employees, and other relevant parties are properly licensed, enrolled where required, and not subject to publicly available exclusions or other disqualifying action must be able to determine what further conduct CMS requires to remain compliant. CMS cannot predicate revocation or another consequence on adverse information held exclusively by the government or another third party, when the provider had no reasonable means to obtain, verify, or contest that information before the adverse action. The relevant question is whether the provider had fair notice of the information it was required to obtain, a reasonable means to obtain it, and clear standards by which to assess its significance. Stated plainly, regulated entities must be able to understand what conduct is required or prohibited, and the agency must supply standards sufficient to constrain arbitrary enforcement.[56]

The consequences proposed here make those protections especially important. A revocation can end an organization's ability to bill Medicare, disrupt care for current patients, and create other collateral consequences for related enrollments, personnel, and future program participation. A provider should not face those consequences merely because CMS determines, based on nonpublic, inaccessible, delayed, or undefined information, that a relationship created an unarticulated risk.

In summary, many of these proposals go too far in tilting the scales that threaten access in favor of expanded program integrity powers. We reiterate our appreciation of CMS's efforts to combat fraud and root out bad actors. Yet even the most well-intentioned of proposals must conform to applicable law. As the Supreme Court has observed, "[r]egardless of how serious the problem an administrative agency seeks to address, however, it may not exercise its authority 'in a manner that is inconsistent with the administrative structure that Congress enacted into law.'"[57]

5. CMS must provide a meaningful, statutorily compliant opportunity to comment on Medicare-wide enrollment proposals

The Alliance supports effective, targeted program-integrity enforcement and recognizes CMS's obligation to protect beneficiaries and the Medicare Trust Funds. But the breadth and Medicare-wide effect of the provider and supplier enrollment proposals require a full and accessible opportunity for affected providers, suppliers, clinicians, beneficiaries, and other stakeholders to comment.

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[55] *Fed. Commc'ns Comm'n v. Fox Television Stations, Inc.*, 567 U.S. 239 (2012).
[56] *Id.*
[57] *F.D.A. v. Brown & Williamson Tobacco*, 529 U.S. 120 (2000) (citing *ETSI Pipeline Project v. Missouri*, 484 U.S. 495, 517 (1988)).

First, CMS "encourage[s]" electronic comments, but the stated address ends in the placeholder docket identifier CMS-2026-XXXX, rather than a valid docket destination. The Administrative Procedure Act (APA) requires a Federal Register notice that identifies the rulemaking proceeding and then requires the agency to give interested persons an opportunity to participate through written submissions.[58] A notice that affirmatively directs stakeholders to an unusable electronic destination, while also encouraging that route, does not facilitate meaningful participation.

Here, the flaw is especially consequential. CMS proposes sweeping enrollment provisions that will impact the entire Medicare provider and supplier community, not just HHAs in the home health Proposed Rule. They include, among other things, denial and revocation grounds, retroactive terminations, claim submission timing, reapplication bars, moratoria, enrollment disclosures, and reporting requirements. CMS also estimates approximately $82 million in annual savings from retroactive revocation changes alone, while acknowledging that it cannot estimate savings from several new or expanded authorities because it cannot predict how often they will be used.[59]

The Agency has packaged an exceptionally broad, Medicare-wide enforcement initiative in an annual home-health payment rule whose primary focus is payment updates, quality reporting, and home health policy — not provider enrollment. Accordingly, we urge CMS to remove the existing rulemaking and address the Medicare enrollment proposals in a separate notice of proposed rulemaking after engaging with the provider community. Not only will CMS have a better understanding of the operational realities of the proposals under consideration, but all stakeholders would be made aware of the proposals through a separate rule with a meaningful opportunity to comment.

6. ***The regulatory impact analysis does not support the breadth of the new authorities***

CMS concludes that the proposed denial and revocation grounds will not significantly affect providers, suppliers, or beneficiaries because revocations are infrequent, only a small share of providers are revoked, and CMS expects to use the authorities only when appropriate. That analysis does not evaluate the distinct effects of the newly proposed grounds, including the location-based revocation authority, same-suite denial authority, expanded affiliation disclosures, broader managing-employee definition, and extension of reapplication bars. Nor does it quantify the likelihood that a denial at one location could lead to revocation of an organization's other enrollments under proposed § 424.535(i).

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[58] *See* 5 U.S.C. § 553(b)–(c).

[59] The Alliance also notes that the Proposed Rule includes an extended passage wholly unrelated to Medicare, home health, or any proposal under consideration. The passage concerns proposed "Observer provisions" in the amended bylaws of an exchange and appears in the discussion of CMS's CY 2025 data exclusions and assumptions used for its permanent and temporary adjustment analysis. 91 Fed. Reg. at 41236 ("The Company believes the proposed Observer provisions in the amended By-Laws are consistent with the Act . . .").

Conversely, the Alliance has heard from its members that these proposals will have significant and far-reaching impacts.

We also note that in the Proposed Rule, CMS indicates the Agency reviewed it under Executive Order 14192, *Unleashing Prosperity Through Deregulation*.[60] CMS further acknowledges that the Order requires, to the extent permitted by law, that new incremental costs associated with a new regulation be offset through elimination of costs associated with at least ten prior regulations.

The enrollment proposals, taken collectively, are difficult to reconcile with that commitment to reduce regulatory burdens. The proposals would create or expand compliance obligations across the Medicare provider and supplier community, including indefinite affiliation review, expanded personnel identification and monitoring, assessment of business and financial relationships, enhanced reporting controls, location-based diligence, and response procedures for materially broader denial and revocation exposure. These are not merely internal CMS enforcement tools. They impose significant compliance, governance, legal-review, systems, and vendor-management costs on providers and suppliers.

Yet CMS states that it does not believe these proposals would impose an information collection burden, while separately acknowledging that the proposed hospice reactivation change would impose an additional $1.4 million in annual survey or accreditation costs.

CMS also states that it cannot estimate savings from several new and expanded revocation authorities because it cannot predict how frequently they will be used. In fact, CMS's own Regulatory Impact Analysis calls for assessment of costs and benefits of alternatives and selection of approaches that maximize net benefits, but the analysis does not identify the enrollment provisions' private sector compliance costs, quantify them, or identify the regulatory cost offsets and ten prior regulations contemplated by EO 14192.

The absence of this analysis matters most precisely in instances where proposed authorities are broad and discretionary. For example, the rule would require providers to evaluate relationships CMS proposes to characterize as affiliations, including marketing, business, fulfillment, financial, managerial, and beneficiary relationships, without a defined lookback limit. It would also expand the managing employee definition and make all late enrollment data reports subject to revocation and denials retroactively. CMS cannot characterize these changes as costless without evaluating the diligence, data collection, record reconstruction, counsel and consultant review, staff training, and systems modifications needed to comply with such provisions.

Accordingly, CMS should conduct an analysis and separately identify and quantify the incremental compliance costs imposed on each affected provider and supplier category,

[60] *See* 91 Fed. Reg. at 41309.

including costs associated with affiliation review, expanded personnel reporting, vendor and location diligence, new recordkeeping, legal review, training, and other system changes. CMS should also separately identify the program integrity benefit attributable to each proposal, rather than relying on aggregate savings from retroactive revocations or general assurances that CMS will exercise discretion appropriately.

In summary, CMS should not finalize proposals of this scale without a proposal-specific assessment of the affected universe, estimated frequency of action, compliance and monitoring costs, implementation burden, and beneficiary access implications. The Agency should separately analyze the impact on rural and underserved communities, where one provider's removal or a multi-site organization's loss of enrollment can have significant consequences disproportionate to the alleged infraction. CMS should also solicit data on the number of existing shared location arrangements, the prevalence of shared vendors and management relationships, and the operational cost of identifying historic affiliations and newly reportable personnel.

7. ***Cross-cutting safeguards should be adopted before finalization***

Even if CMS proceeds with the provider and supplier enrollment proposals, the final rule should not rely on unbounded discretion, nonbinding preamble assurances, or case-by-case determinations made after the fact. The proposed rule repeatedly states that CMS seeks "maximum flexibility," declines to adopt thresholds or mandatory factors, and states that some proposals would be applied only when CMS considers them justified. Those statements do not supply providers with administrable standards or a reliable basis for prospective compliance.

Accordingly, in the final rule, CMS should more clearly spell out the connection between the provider's own conduct or a person with meaningful control over the provider and a concrete, articulable risk to beneficiaries or the Medicare Trust Fund. A vendor relationship, a shared address, a remote historical association, or a clerical reporting lapse should not alone establish this nexus. CMS should also specify relevant factors, such as the evidence considered, the individual's actual authority over and relationship to the provider, the provider's knowledge, the seriousness and persistence of any concern, any remedial measures, and expected impacts on beneficiary access.

Finally, CMS should provide reasonable and timely notice to providers and suppliers prior to any adverse action. Any notice should state the specific factual basis, evidence relied upon, effective date, available corrective action, and applicable administrative review rights.

We provide more detailed comments below on these provisions.

B. Revocations, Enrollment Denials, and Other Enforcement Remedies

1. Making revocation grounds retroactive contradicts the statutory requirement that termination is effective only upon the provision of reasonable notice (§ 424.535(g))

CMS proposes to make all revocation grounds retroactive, generally effective as of the date of the underlying noncompliance, conviction, licensure action, or other triggering event. CMS projects approximately $82 million in annual savings from this change.[61]

The Alliance opposes this proposal. This proposal violates the statutory scheme that Congress enacted. Section 1866(b)(3) of the Act provides that the effective date of a termination or a refusal to renew an agreement "shall become effective on the same date and in the same manner as an exclusion from participation . . . under section 1128(c)."[62] Section 1128(c)(1) further conditions such an exclusion on "reasonable notice"[63] and section 1128(c)(2)(A) limits this exclusion to "services furnished to an individual on or after the effective date."[64] Finally, section 1128(c)(2)(B)(ii) provides that, absent a health and safety determination, an exclusion does not apply to payment for "home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion."[65]

It follows that under the law Congress enacted, a provider must first receive adequate notice prior to the effective date of any such termination action, including revocation. Proposed § 424.535(g) would violate this statutory requirement, as the termination effective date would precede notice and apply retroactively to services already provided. We appreciate and acknowledge the challenges with removing bad actors from the Medicare program and preventing further harm. Indeed, the Alliance agrees that Medicare should not pay for periods that do not meet Medicare coverage requirements, such as the case where a practitioner has their state license revoked and continues to bill while unlicensed.

Yet revocation is not the only remedy CMS has available to stop these actors, and already the Agency has deployed many tools through increased audits and oversight to great effect. We encourage the Agency to leverage these tools to hold bad actors accountable through targeted, data-driven enforcement, but not at the expense of legitimate providers. Even the most well intended proposals can run afoul of the law that Congress enacted.

For the sake of argument, if revocations are not bound by fair notice, section 1871(e) of the Act further provides that a substantive Medicare change generally may not be applied retroactively to items and services furnished before the change's effective date unless the

[61] 91 Fed. Reg. at 41303.
[62] 42 U.S.C. § 1395cc(b)(3).
[63] 42 U.S.C. § 1320a-7(c)(1).
[64] 42 U.S.C. § 1320a-7(c)(2)(A).
[65] 42 U.S.C. § 1320a-7(c)(2)(B)(ii).

Secretary determines that retroactivity is necessary to comply with statutory requirements or that nonretroactive application would be contrary to the public interest.[66] It follows that CMS should make any such determination expressly, identify the specific statutory requirement or public interest basis, and explain why a prospective remedy, targeted payment suspension, prepayment review, or other existing authority would be inadequate.

Recommendations:

- Do not finalize the proposal to make all revocation grounds retroactive, generally effective as of the date the underlying noncompliance, conviction, licensure action, or other triggering event.
- Maintain current 42 C.F.R. § 424.535(g)(1).

2. ***Administrative Reporting Lapses are Not the Same as Fraudulent Omissions (§ 424.535(g)(1)(ix))***

CMS proposes at new § 424.535(g)(1)(ix) to make every revocation under § 424.535(a)(9) retroactive to the day following the date the change was due to be reported. Under current § 424.535(g)(2)(x), that treatment applies only to failures to report a change of ownership, an adverse legal action, or a change, addition, or deletion of a practice location.

The Alliance opposes making all reporting lapses retroactive and urges CMS to distinguish material, intentional concealment from good faith administrative error. The rule indicates that the failure to timely report any change can threaten the Medicare Trust Fund and that every such failure constitutes noncompliance, but it offers no evidence that routine late reporting of an administrative change produces the same risk as an undisclosed ownership change, adverse legal action, or fraudulent effort to redirect payment.

The final rule should preserve the current distinction among reporting categories. For less serious or remediable reporting defects, CMS should first notify the provider of the deficiency and permit correction. CMS should reserve revocation and retroactive treatment for material omissions involving intentional or reckless conduct, a material effect on payment or beneficiary safety, or a documented effort to conceal disqualifying information.

Further, the proposed effective date is earlier than the date of notice, which is a statutory requirement (as noted above). As proposed, a revocation effective the day after a reporting deadline could precede any date that notice was delivered to the provider. For the reasons set out above, such a result cannot be reconciled with sections 1866(b)(3) and 1128(c) of the Act.[67,68]

[66] 42 U.S.C. § 1395hh(e)(1).
[67] 42 U.S.C. § 1395cc(b)(3).
[68] 42 U.S.C. § 1320a-7(c)(1).

Section 1866(b)(2)(A) of the Act authorizes termination where a provider fails to comply *substantially* with title XVIII or the regulations thereunder. CMS proposes to permit revocation for every failure under § 424.516(d), from a willful unreported change in majority ownership to a correspondence address that was updated late. These are not one and the same. In its reasoning, CMS pairs a new managing employee who poses a program integrity risk with an updated correspondence address as if the two are interchangeable:

> The point is that outdated or erroneous **enrollment information of any type**—not simply ownership, adverse action, or location data—can threaten the Trust Funds, and any failure to timely report such changes mean the provider is non-compliant with enrollment requirements.[69]

Treating both as grounds for a revocation dated back to a purported missed deadline gives no effect to the word "substantially." A single pre-notice revocation date is not a proportionate response to both, as section 1866(b)(2)(A) of the Act does not treat every regulatory omission as equivalent.[70] Mere noncompliance is *not* the statutory standard. It is also important to note that the Alliance has heard from many of its members of attempts to report tax status (among other information); yet this information often *is reported incorrectly by CMS* on the Care Compare website and takes months to correct.[71]

These errors on Care Compare certainly are not intentional. Rather, this is illustrative that there is in fact a difference between willful reporting omissions and omissions due to administrative error. We note further that compliance will be more challenging if CMS finalizes these proposals, particularly the expanded definition of “managing employee” and “associated party.” As discussed further below, the potential scale of who all must be reported is staggering.

Second, CMS proposes to expand “managing employee” to include medical directors, clinical directors, department heads, supervising physicians, nursing directors, alternate administrators, and other clinical personnel meeting the definition, while stating that these individuals already qualify and should have always been reported.[72] Read with proposed § 424.535(g)(1)(ix), the two proposals would treat a provider that never reported a department head, such as, in the case of hospice, the bereavement manager, as noncompliant, which could prompt a resulting revocation retroactive to a deadline that passed before the final rule existed. 42 C.F.R. § 418.64(d)(1) requires every hospice to have an organized program for bereavement services under the supervision of a qualified professional with experience or education in grief or loss counseling, and to make those services available to the family for up to one year *following the death of the patient*. Importantly, the entire function occurs after the patient has died, for which no claims are

[69] 91 Fed. Reg. at 41287 (emphasis added).
[70] 42 U.S.C. § 1395cc(b)(2)(A)–(D).
[71] https://www.medicare.gov/care-compare/
[72] 91 Fed. Reg. at 41300 (stating that the listed individuals already qualify as managing employees and should have always been reported, and that their inclusion is “in large part, a reminder”).

submitted. In other words, any nexus here between the risk to the Medicare Trust Fund and reporting such an individual is absent.

Third, there have already been reported instances where a provider had their enrollment revoked despite the absence of any participation in or knowledge of purported fraudulent conduct. One example concerns a physician who had served for a period at a hospice that was later suspended well after the physician's service, knowledge, or involvement. That physician, and the agency they later joined, were both revoked on the basis of that prior affiliation. Here, neither party was aware of the issues of the revoked provider, and the physician had not been affiliated with such provider for years. How was the physician, or even provider agency, supposed to identify and report this? The consequence of a revocation here not only extends to the provider and physician, but the patients they serve as well. There have been other similar examples, including those involving suspension of payments for legitimate providers.

Finally, CMS misunderstands the degree to which many of these individuals exercise oversight and control over a provider organization such that reporting is required. We also remind CMS that providers are different with different reporting structures, resources, functions, and leadership. Treating these categories of individuals as the same within the construct of a "managing employee" is a misunderstanding of the role these individuals play in their organizations.

A provider cannot be found to have failed to report an individual under a definition that did not identify that individual as reportable. As noted above, adequate notice requires that regulated parties be able to know what is required of them so they may act accordingly.[73]

Recommendations:

- Do not finalize proposed § 424.535(g)(1)(ix).
- Retain existing § 424.535(g)(2)(x), which addresses revocations due to failures to timely report a change of ownership, an adverse legal action, or a practice location.

3. ***Reducing the Post-Revocation Claim Submission Period to 15 Days Would Require Providers to Forfeit Payment for Care Already Delivered (§ 424.535(h))***

CMS proposes to reduce the post-revocation claim submission period from 60 calendar days to 15 calendar days. CMS also proposes to measure that period from the date of the revocation letter. **The Alliance opposes the proposed shortened claim submission period of 15 calendar days. To the extent CMS moves forward with this proposal, we urge the Agency to ensure notice of revocation is sent and received in a timely manner.**

Measuring from the date of the letter already takes much of the period before the provider knows it has even received a letter. Correspondence is often delayed, and many legitimate

[73] *Fox Television Stations, Inc.*, 567 U.S. 239

providers report receiving various communications well after the date of the letter. A 15-day period measured from the letter date may in practice afford a week or less, and less still where the letter arrives before a weekend or holiday. In its rationale, CMS observes that "a revoked provider could submit hundreds of improper claims for hundreds of thousands of dollars during this period."[74] Yet, as noted above, CMS has other tools to combat these actors. For a legitimate provider, the consequence is forfeiture of payment for services that were furnished and covered. It is important to note that unlike many fraudulent entities, these providers are responsible for and continuing to provide care. A provider that misses the window does not lose the opportunity to submit improper claims. Rather, the provider loses the ability to be paid for covered services delivered to eligible beneficiaries who depend on such services.

Recommendations:

- Do not finalize the reduction from 60 days to 15 days.
- To the extent CMS moves forward with this proposal, the Agency should ensure notice of revocation is sent and received in a timely manner.

4. ***Revoking enrollment based on the number of other providers nearby is not enumerated in the statutory bases that Congress enacted (§ 424.535(a)(24))***

CMS proposes new § 424.535(a)(24), permitting revocation where the Agency deems a provider's enrollment to present a high risk of fraud, waste, or abuse due to the provider's location within a limited geographic area that has an excessive number of providers and suppliers. CMS states that "limited geographic area" and "excessive number" will carry their ordinary, plain-language meanings and that the Agency will not adopt distance or numerical thresholds out of concern that it will tip off fraudulent actors. Notably, this proposal would require no finding of actual fraud, waste, or abuse by the provider or by any nearby provider; nor will any mandatory factors constrain the determination.[75]

The Alliance strongly opposes this proposal and urges CMS to withdraw it. The Alliance shares CMS's concern about the proliferation of bad actors in the Medicare program. The concentration data CMS cites is alarming, including several dozen hospices within a four-block area of Los Angeles County, 18 home health agencies within a single building in Columbus, Ohio, and an increase of more than 45 percent in the number of home health agencies in Los Angeles County between 2019 and 2023.[76] We identified similar concerns in our December 2025 recommendations.[77] These concerns however don't circumvent the statutory bases for terminating a provider's agreement under the Medicare program. Rather, this proposal acts solely based on the provider's address.

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[74] 91 Fed. Reg. at 41290

[75] *See* 91 Fed. Reg. at 41291 (stating that "limited geographic area" and "excessive number" will carry their ordinary, plain-language meanings, and declining to adopt distance or numerical thresholds).

[76] 91 Fed. Reg. at 41290–41291.

[77] https://allianceforcareathome.org/wp-content/uploads/Final-Alliance-and-LeadingAge-Home-Health-and-Hospice-Program-Integrity-Recommendations.pdf.

Geographic location is not among the statutory grounds Congress enacted. Being located near other providers is not substantial noncompliance with the provider agreement, title XVIII, or the regulations thereunder; not a failure to meet Medicare provider requirements; not an exclusion; or a felony conviction.[78] Because revocation is termination in practice, proposed § 424.535(a)(24) would remove a provider from Medicare on a basis Congress did not enumerate.

The analogy to section 1866(j)(5) of the Act defeats rather than supports the proposal. CMS reasons that no finding of actual fraud is required under § 424.535(a)(24) because none is required under section 1866(j)(5), which permits action where an affiliation poses an undue risk of fraud, waste, or abuse.[79] Section 1866(j)(5)(B) authorizes the Secretary to *deny an enrollment application* on that basis. It does not authorize revocation of an existing enrollment, and it is tied to a defined category of *affiliations*, meaning actual relationships between identified parties involving specified disclosable events.[80] In the present case, CMS substitutes physical proximity for a defined relationship.

Congress already provided a different remedy to address geographic concentrations of fraudulent activity. Section 1866(j)(7) of the Act authorizes a temporary moratorium on the enrollment of new providers and suppliers where necessary to prevent or combat fraud, waste, or abuse.[81] Indeed, on May 13, 2026, CMS leveraged this authority to impose nationwide moratoria for both home health and hospice.[82,83] Where Congress has provided a targeted tool for a problem, an Agency does not have license to construct a broader one by regulation. CMS has not explained why the moratorium authority, enhanced provider screening, the provisional period of enhanced oversight, payment suspension on a credible allegation of fraud, and prepayment review are inadequate, or why the response is to revoke providers already caring for beneficiaries.

In addition, the nationwide scope of those moratoria is difficult to reconcile with the premise of proposed § 424.535(a)(24). A nationwide moratorium rests on a determination that widespread fraud is not confined to particular localities. The proposed revocation ground rests on the opposite premise, that risk can be identified by a provider's presence within a certain geographic area containing too many providers. CMS does not explain how both propositions hold at once. If the Agency's position is that the concern is nationwide, no provider can identify a "limited geographic area" distinguishable from any other. If the concern is instead localized, CMS should identify those areas and end the nationwide moratoria.

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[78] 42 U.S.C. § 1395cc(b)(2)(A)–(D).
[79] 91 Fed. Reg. at 41290–41291.
[80] *See* 42 U.S.C. § 1395cc(j)(5)(B).
[81] 42 U.S.C. § 1395cc(j)(7) (section 1866(j)(7) of the Act); 42 C.F.R. § 424.570.
[82] Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Home Health Agencies (HHAs), 91 Fed. Reg. 27954 (May 15, 2026).
[83] Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratorium on Enrollment of Hospices, 91 Fed. Reg. 27946 (May 13, 2026).

This proposal would also place CMS in the position of determining how many providers a given area should have, and of removing providers it concludes exceed that number. That is a judgment about provider supply and community need, and CMS proposes to make it without any published criteria.

We note that CMS has recently addressed need-based limits on provider supply in a different manner. Under the Rural Health Transformation Program, CMS awarded states points toward their funding allocation for eliminating or loosening certificate of need (CON) laws.[84] We respectfully ask the Agency to explain why a limit on provider supply that it discourages States from imposing through published criteria and adjudicative process is an appropriate basis for removing existing providers from Medicare without either.

The absence of an articulable standard is susceptible to inconsistent application. As noted above, CMS declines to define "limited geographic area" or "excessive number" and explains that thresholds would alert potentially problematic providers as to how to circumvent a revocation. A standard that cannot be defined without defeating its purpose is also a standard no legitimate provider can plan around. As noted above, a provider signing a ten-year lease, financing a branch office, or hiring clinical staff for a new service area cannot determine whether its location falls within a limited geographic area or whether the number of providers there is excessive, and it cannot control whether other providers later enroll nearby and render its own address revocable. Fair notice requires both that regulated parties know what is required of them and that those enforcing the law have sufficient guidance to avoid arbitrary application.[85] Neither condition is satisfied.

Mere assurances do not provide substantive notice of what is required. CMS indicates that § 424.535(a)(24) is not designed to revoke good-faith providers, that providers should not assume they would be revoked merely because they operate near other providers, and that the ground would be applied only when the risk truly justifies it. Those statements only appear in the preamble of the Proposed Rule, do not bind the Agency, and cannot be invoked by a provider facing revocation. Because CMS declines to define "limited geographic area" or "excessive number," a provider is left to rely on the Agency's assurance that it will act only where warranted. A provider, such as a home health agency or hospice, deciding whether to renew a lease, open a branch, or hire clinical staff cannot determine from the proposal whether it operates in an area CMS regards as saturated, and it cannot control whether other providers later enroll nearby and place it there.

Because CMS proposes no mandatory factors, no thresholds, or any other evidentiary factors, the specter of potential revocation due merely to the entry of new providers in a market is a legitimate fear.

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[84] https://grants.gov/search-results-detail/360442.

[85] *Fox Television Stations*, 567 U.S. 239.

The access consequences run counter to the Medicare program's goals. Revoking legitimate providers from densely populated areas removes capacity from the communities with the greatest volume of need. The effect on expansion is equally significant, because a rule under which later entrants can render an existing location revocable will discourage investment in underserved and rural markets. The Proposed Rule analyzes neither effect.

Recommendations:

- Do not finalize proposed § 424.535(a)(24).
- Act on the recommendations previously submitted by the Alliance.

5. ***Co-location with another provider is not one of the four enumerated statutory bases for termination or denial (§ 424.530(a)(19))***

CMS proposes new § 424.530(a)(19), permitting denial of an enrollment application where the applicant's practice location is in the same suite or office as another provider whose Medicare enrollment has been revoked or denied. The provision requires no relationship between the applicant and that provider, no knowledge by the applicant of that provider's status, and no finding of wrongdoing by the applicant.

The Alliance supports the intent behind this proposal, given documented cases of bad actors operating in the same space. That said, we nonetheless must raise concerns about the Agency's authority to proceed, as well as the lack of definition and specificity of this proposal.

Co-location is not among the statutory grounds for denial. Sharing an address with another provider does not trigger any of the four enumerated bases for denial or termination.[86] Specifically, mere co-location with another provider does not constitute substantial noncompliance, a failure to meet the section 1861 definition of the provider type, an OIG exclusion, or a felony conviction. A landlord's tenant roster is not a relationship between providers. Moreover, a provider, absent such a relationship, exercises no control, oversight, or even has knowledge of a provider co-tenant's activities in the suite. How are they to know whether another provider in their "suite" or "office" had their enrollment revoked or denied? Would this query extend to any and all providers in the same suite or office? The burden for such due diligence and monitoring could be significant.

The Alliance certainly agrees that there are certain instances where co-location would be concerning and indicate a potential threat to the Medicare program and the beneficiaries it serves. But this is an indicator, and without more, is not enough to satisfy statutory requirements.

[86] 42 U.S.C. § 1395cc(b)(2)(A)–(D).

"Same suite or office" is undefined and open to interpretation. Providers frequently occupy medical office buildings, hospital campuses, shared-service arrangements, executive suites, and co-working space. Whether two providers occupy the same suite when they share a reception area, a floor, a street address with different suite numbers, or a single suite number subdivided by internal lease is not addressed in the Proposed Rule. The question is therefore consequential as to how these terms are defined, given providers often share administrative space to control overhead. Similarly, hospital-based agencies frequently operate on campuses shared with many other enrolled providers.

To the extent CMS moves forward with this proposal, we urge the need for more clarity as to how these terms are defined. Moreover, it will be important to consider the realities of care delivery and real estate markets and how provider operations are structured and housed. We note, for example, that co-location in an office building is very different than a single working space. Moreover, co-lease considerations such as duration are also relevant. For example, are providers co-located on a temporary basis following a move, reorganization, or disaster? Are these providers of different types with same ownership that are co-located for efficiency and centralized administrative operations, where reasonable and in observance of requirements to independently meet the applicable conditions of participation? We would also emphasize the need to consider additional evidence of activity satisfying one of the four enumerated bases for denial.

The proposal contains no temporal limitation. On its face, proposed § 424.530(a)(19) does not appear to be limited to contemporaneous co-location. A provider that leases space previously occupied by a revoked provider, space that may be attractive precisely because it is already built out for clinical use, may fall within the ground. We ask CMS to provide more clarity around these situations, as there may certainly be instances where a legitimate provider may enter a space previously vacated by a terminated provider to serve the community.

A denial under this ground could cost the organization enrollments currently being used to serve Medicare beneficiaries. CMS separately proposes to expand § 424.535(i) so that a *denial* of one enrollment may trigger revocation of the provider's other enrollments. Combined with § 424.530(a)(19), a multi-site organization applying to enroll a new branch in space that shares a suite with a previously denied provider could face revocation of the enrollments under which it is currently serving patients. The consequences could be irreparable to the patients served by the organization, the organization and the staff it employs. To the extent CMS moves forward with this proposal, the Agency should exclude such an outcome.

Recommendations:

- Do not finalize proposed § 424.530(a)(19).
- If CMS proceeds, define "same suite or office" in a manner that is in alignment with care delivery operations and practice, adopt a temporal limitation to only currently co-located tenants, and formally consider additional factors evidentiary of fraud.

6. ***Extending denial and revocation authority to misdemeanor convictions departs from the statutory framework Congress established (§§ 424.535(a)(16) and 424.530(a)(16))***

CMS proposes to deny or revoke enrollment where the provider, or any owner, managing employee or organization, officer, or director, was convicted within the past 10 years of a federal or state misdemeanor related to sexual assault or financial misconduct that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries, and to add such misdemeanors as a new category in the "final adverse action" definition at § 424.502.

The Alliance supports the Agency's objective of protecting beneficiaries and the Trust Funds from individuals convicted of sexual and financial misconduct. We also appreciate that CMS has meaningfully narrowed this proposal relative to the version it advanced in the CY 2024 PFS proposed rule, limiting it to two defined categories rather than an open-ended list of misdemeanors. We nonetheless must raise a concern about the Agency's authority to proceed with this proposal, as well as the breadth and subjectivity of the terms as drafted. To the extent CMS moves forward, we ask the Agency to clarify several points so that the provision reaches the conduct CMS has described without sweeping in compliant providers.

First, section 1866(b)(2)(D) of the Act authorizes the Secretary to terminate or refuse to renew a provider agreement where the provider has been convicted of a *felony* that the Secretary determines is detrimental to the best interests of the program or program beneficiaries.[87]

Proposed §§ 424.535(a)(16) and 424.530(a)(16), while well intended, go beyond what the statute allows. Had Congress intended a misdemeanor conviction to render a provider ineligible for Medicare payment, it could have done so. This, Congress did not do. We certainly agree that misdemeanors involving financial misconduct or the abuse of patients are serious and warrant a response. And indeed, there are some methods to address this, for example, through existing OIG exclusion authorities.[88] That said, we encourage CMS to engage with the Alliance and the care-at-home community on collaborative ways to protect patients from actors who may do them harm.

In addition, our concern is definitional. CMS states that terms such as "financial misconduct" would be applied according to their "plain meaning." Because misdemeanor "financial misconduct" is not a defined offense and varies widely across jurisdictions, a plain-meaning reading could reach comparatively minor or remote conduct, for example, an offense pled down from a more serious charge years earlier or conduct wholly unrelated to health care or the handling of program funds. Conduct classified as "sexual assault" likewise differs from state to state. To the extent CMS moves forward with this proposal,

[87] 42 U.S.C. § 1395cc(b)(2)(D).
[88] 42 U.S.C. § 1320a-7

the Alliance urges the Agency to define both categories by reference to specific offense elements or, at a minimum, to require a demonstrated nexus between the offense and either the delivery of care to beneficiaries or the handling of federal health care program funds.

We are also concerned about the breadth of covered individuals. The provision reaches "any owner, managing employee or organization, officer, or director," for a large multi-site organization or a health system–affiliated provider, which contemplates a substantial population of individuals. As drafted, a single covered individual's unrelated misdemeanor could jeopardize the enrollment of an entire compliant organization and, through the companion revocation ground and § 424.535(i), its other enrollments as well. To the extent CMS moves forward, the Alliance asks the Agency to tie the covered offense to the individual's role at, or relationship to, the enrolled entity, and to confirm that an organization may remedy the concern by removing or replacing the individual before an adverse action is imposed.

Finally, the standard "CMS deems detrimental to the best interests of the Medicare program and its beneficiaries" is inherently subjective. The Alliance asks the Agency to identify the factors it will weigh in making this determination, to require a written explanation of the basis for any adverse action, and to confirm that the reconsideration and appeal rights under 42 C.F.R. part 498 apply. We further ask CMS to confirm that convictions that have been expunged, vacated, sealed, or pardoned are excluded, and that the 10-year lookback runs from the date of conviction.

Recommendations:

- Do not finalize proposed §§ 424.535(a)(16) and 424.530(a)(16).
- To the extent CMS finalizes this proposal, clarify several points so that the provision reaches the conduct CMS has described without sweeping in compliant providers.

7. ***Denials based on misuse of identity (§ 424.530(a)(21))***

CMS proposes to deny enrollment if the prospective provider or supplier is attempting to enroll under another party's identity. **The Alliance supports this proposal, provided that victims whose identities are stolen are not adversely impacted.** Enrollment identity theft, in which an individual enrolls under a practitioner's credentials without that person's knowledge and bills Medicare in their name, causes serious injury to the victim, who may face collection activity, tax consequences, licensure inquiries, and enrollment complications arising from claims they never submitted.

We ask for two clarifications. First, we read "attempting to enroll under another party's identity" to require knowing and intentional conduct,[89] and ask CMS to clarify this would

[89] For the sake of argument, we assume that such intentional conduct contemplated here would violate one of the four enumerated bases for enrollment denial or termination that Congress established.

not apply to clerical error, such as an application submitted with a transposed identifier or a legitimate reassignment or change of ownership recorded imperfectly.

Second, we ask CMS to address the position of the victim impacted by such identity theft. A practitioner whose identity has been misappropriated has done nothing wrong, yet the fraudulent enrollment and the claims submitted under it are associated with their name and identifiers. CMS should confirm that such a party will not be denied, revoked, or subjected to a reapplication or reenrollment bar as a result. We also ask that CMS clarify that the fraudulent enrollment will not be treated as an affiliation or other adverse action that could penalize the victim and any Agency by which they are employed or contracted with.

Recommendations:

- Finalize proposed § 424.530(a)(21), provided that victims whose identities are stolen are not adversely impacted.
- Clarify that the proposal contemplates intentional conduct and will not be applied to clerical or administrative error.

8. ***Removing the required factors for the ten-year reapplication bar and extending it to every denial will result in inconsistent application and is disproportionate in scope (§ 424.530(f))***

Section 424.530(f) currently permits CMS to bar a prospective provider from enrolling for up to ten years where its application is denied under § 424.530(a)(4), that is, because it submitted false or misleading information on or with, or omitted information from, its application. Section 424.530(f)(2) sets out factors CMS must weigh in deciding whether to impose a bar and for how long. CMS proposes to extend the bar to denials on *any* § 424.530(a) ground and simultaneously to delete the § 424.530(f)(2) factors.

The Alliance opposes the deletion of the factors and opposes extending the bar to denial grounds that have nothing to do with reducing fraud, waste, and abuse. In support of this proposal, CMS cites several examples, including a false storefront and an attempt to enroll under a different identity following revocation, as indicative of conduct for which a bar is proportionate.[90] The proposal, however, does not distinguish those cases from the remainder of § 424.530(a), and it removes the only mechanism in the regulation that requires the distinction to be drawn.

Section 424.530(a) is not a list of misconduct. It spans grounds ranging from the deliberate to the purely administrative, including noncompliance with an enrollment requirement under § 424.530(a)(1), an unpaid application fee, and an existing Medicare debt, which CMS separately proposes to extend to debts held by managing employees, managing organizations, and any individual or entity with any other form of business or financial relationship with the applicant. If proposed § 424.530(a)(19) is finalized, the list

[90] *See* 91 Fed. Reg. at 41295.

would also include co-location with a previously denied provider. Under the proposal, a ten-year bar could be applied for any of these reasons. Such an outcome leads to considerable risk, unpredictability, and could have a lasting chilling effect on further investment in and growth of home health and hospice providers caring for patients in their homes.

The Proposed Rule presents a false choice between retaining the current factors unchanged and eliminating them altogether. It does not meaningfully consider the obvious intermediate alternative of adopting generally applicable factors tailored to the particular denial ground. Before rescinding an existing regulatory safeguard, CMS must provide a reasoned explanation for its choice and address a workable alternative that would preserve the rule's underlying objectives.[91] CMS should therefore explain in the final rule why generally applicable factors are inadequate, rather than dismissing that alternative in a conclusory sentence.

A ten-year bar effectively operates as a permanent exclusion. An organization cannot suspend operations for a decade and resume. Clinical staff disperse, referral relationships end, leases terminate, and patients are transferred or, in communities without another provider, go without care. We note that Congress set five years as the *minimum* period for a mandatory exclusion predicated on a program-related criminal conviction.[92] A ten-year bar imposed for an unpaid application fee, without factors and without a hearing on duration, would exceed that period for conduct Congress did not treat as warranting exclusion at all.

Pairing a no-fault denial ground with a ten-year bar produces a result we do not believe the Agency intends. A provider denied under § 424.530(a)(19) because of a neighbor's revocation, or under § 424.530(a)(6) because a vendor holds a Medicare debt, has engaged in no misconduct, yet could be barred from Medicare for a decade with no governing factors and no corrective action plan available. Such an outcome is irreconcilable with the Medicare program and its beneficiaries.

Recommendations:

- Do not finalize the deletion of the factors at § 424.530(f)(2).
- Retain existing reapplication bar denial grounds at § 424.530(f), i.e., the submission of false or misleading information for the purpose of gaining enrollment in the Medicare program.

9. ***Removing specified factors leaves no standard for distinguishing abusive billing behavior (§ 424.535(a)(8)(ii))***

CMS proposes to remove all the existing factors that guide a determination whether a provider has engaged in a "pattern or practice" of submitting claims that fail to meet

[91] *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 42–43, 46–48 (1983).
[92] 42 U.S.C. § 1320a-7(c)(3)(B)

Medicare requirements. CMS states that, after the factors are removed, a pattern or practice might be established by a finding that several claims do not meet Medicare requirements, while declining to establish a minimum threshold or identify the circumstances that distinguish an actionable pattern from ordinary claim-error variation. A "pattern or practice" within the meaning of proposed revised § 424.535(a)(8)(ii) might be established, for example, by a simple finding that several of the provider's claims do not meet Medicare requirements.

The Alliance opposes this proposal. The current factors are not an impediment to addressing truly abusive billing. Rather, they require CMS to distinguish a persistent, provider-specific pattern from isolated errors, claim-processing issues, good-faith clinical or coding disputes, and the normal variation that occurs in a complex payment system. When commenters urged CMS in 2019 to adopt a materiality threshold, CMS declined on the express ground that "many of our existing and proposed denial and revocation reasons contained regulatory-prescribed criteria that CMS must carefully take into account before taking action." CMS should not now delete this criteria. Eliminating the factors while offering "several" deficient claims as the only illustration creates an enforcement standard with no discernible floor and no guardrail against inconsistent application. CMS should retain the existing factors. If CMS concludes that refinement is necessary, CMS should make additional changes through further rulemaking.

Recommendation:

- Do not finalize the removal of the factors in § 424.535(a)(8)(ii).

10. ***The proposed expansion would attach denial and revocation to submissions never certified as true and never material to enrollment (§§ 424.530(a)(4) and 424.535(a)(4))***

CMS proposes to expand the false or misleading information grounds from certified enrollment applications to any CMS or Medicare enrollment-related form, any documentation associated with such a form, and any other required or requested enrollment-related documentation. This proposal would apply even where the submission was not intended to gain or maintain enrollment and was not certified as true.

The Alliance agrees that CMS must be able to act on deliberately false enrollment submissions and material omissions. But the proposed language sweeps far beyond that objective. It would expose providers to denial or revocation based on an undefined universe of contractor communications and requested documentation, without a certification, materiality, knowledge, intent, or reliance limitation. It would also make the effective date retroactive to the date of submission for certain communications. A consequence of that severity should not turn on an immaterial inconsistency, an inadvertent administrative error, a reasonable interpretive disagreement, or a document submitted in good faith and promptly corrected.

If CMS proceeds, the regulation should require that the statement or omission be knowing or reckless, material to an enrollment determination, and made by or directly attributable to the provider. CMS should define the closed set of forms and documents covered by the rule or, at minimum, require that the document be identified in published CMS guidance before it can support an adverse action. CMS should also:

- Provide a cure opportunity for nonmaterial, inadvertent, or promptly corrected errors;
- Preclude vicarious liability for a contractor's error absent the provider's knowledge or reckless disregard; and
- Maintain prospective effective dates.

Recommendations:

- Do not finalize the proposed expansion as written.
- If finalized, limit such expansion to knowing or reckless, material misrepresentations in specified enrollment documents, with a meaningful corrective process.

11. ***Extending the debt and suspension grounds to "any other form of business or financial relationship" reaches parties the applicant does not control (§§ 424.530(a)(6) and (a)(7))***

CMS proposes to extend denial authority based on Medicare debt and payment suspension beyond the applicant and its owners or managing employees to persons and entities with "any other form of business or financial relationship" with the applicant. CMS explains that it seeks to reach parties such as service providers, financiers, and closely associated health care providers, and that the relationship itself rather than its label is the relevant concern.

The Alliance strongly opposes the expansion to any business or financial relationship and urges the Agency to withdraw this proposal. Modern providers necessarily rely on landlords, lenders, billing vendors, technology providers, staffing agencies, accountants, pharmacies, clinical contractors, suppliers, and other service relationships. Those relationships do not establish operational control, knowledge of another party's debt or suspension, or responsibility for its conduct. The proposed language would create unmanageable diligence obligations and deter ordinary business arrangements essential to patient care. Contrary to the Agency's assertion that proposed denial and revocation grounds will *not* have "a significant impact on providers, suppliers, or beneficiaries[,]"[93] if finalized, the adverse impact of this proposal on provider finances and operations will be no less than extraordinary.

Any final rule should be limited to a person or entity that exercises actual operational or managerial control over the applicant, materially participates in the conduct giving rise to the debt or suspension, or is used as part of a documented effort to evade a debt or

[93] 91 Fed. Reg. at 41303.

suspension. CMS should require a written finding of that nexus and confirm that a routine vendor, landlord, lender, or staffing arrangement is insufficient by itself.

Recommendation:

- Do not finalize debt and suspension ground expansion beyond the applicant and its owners or managing employees.

12. ***Hospice Medical Directors and Administrators***

CMS is proposing to deny a hospice's enrollment application where the hospice's medical director or administrator serves multiple other hospices or is located at such a distance that the individual cannot realistically perform the functions required under 42 C.F.R. part 418, or where the hospice's medical director lacks an active physician license in the state of practice. The Agency grounds the proposal in OIG findings and in concerns about absentee oversight, cross-country arrangements, and inactive licenses.

The Alliance takes hospice program integrity seriously and shares the Agency's concern about the issues OIG has identified, including false certifications and inadequate oversight, and we support CMS's interest in ensuring that hospice medical directors and administrators can meaningfully perform their duties. We are concerned, however, that the standards as drafted lack objective guardrails and could adversely affect not only rural providers, but also small markets with only a handful of available providers, absent a demonstrated tie to program-integrity risk.

The proposal does not define "multiple other hospices," which, read literally, could mean two or more. Many qualified physicians legitimately serve as medical directors for more than one hospice service, particularly in rural areas, where the pool of physicians willing and able to serve in this role is very small, and within commonly owned or affiliated hospice networks that share clinical leadership by design. Serving more than one hospice is not, by itself, evidence of inadequate oversight, and a strict bar would reduce beneficiary access to end-of-life care in exactly the communities where the physician supply is thinnest. The Alliance asks CMS to define "multiple," to base any threshold on evidence about oversight capacity rather than a bare count, and to exclude arrangements within a commonly owned or affiliated organization.

Whether an individual can "realistically perform" required functions is likewise a subjective standard, and physical distance is an increasingly poor proxy for effective oversight. For example, in New England, geographic distance and state boundaries do not necessarily correspond to meaningful differences in a physician's ability to provide effective clinical leadership. The medical director role is substantially administrative and supervisory, part 418 already governs its performance, and telehealth and coordination with on-site clinical staff now allow effective oversight across distances that once would have precluded it. Rural and regional hospices frequently and appropriately rely on physicians who cover wide geographic areas. The Alliance urges CMS to focus on whether required functions are

in fact being performed, rather than on geography, and to recognize telehealth and team-based coverage models.

We agree that a medical director must hold an active physician license, and this ground has a clear objective basis. A lapse in license can be transient or administrative, such as a renewal in process. Therefore, the Alliance asks CMS to provide an opportunity to cure before denial, and to clarify how this ground interacts with the existing Conditions of Participation, which already address physician licensure. We ask CMS to weigh the cumulative effect on legitimate hospices, to phase in implementation, and to consider grandfathering existing, disclosed arrangements that comply with part 418.

13. ***Changes in Majority Ownership***

CMS proposes new denial and revocation grounds in instances where CMS determines that a provider or supplier has failed to comply with applicable change in majority ownership requirements at §§ 424.550(b) for HHAs and hospices, or 424.551 for DMEPOS suppliers. The Agency aims to deter two circumvention tactics it has observed: failing to notify CMS of an ownership change so that the buyer assumes the existing enrollment without re-enrolling and undergoing a new survey or accreditation; and using a management agreement to effect a de facto sale within the 36-month window under the guise of a management arrangement.

The Alliance appreciates the Agency's interest in preventing "flipping" and ensuring that new owners are fully screened and surveyed. Indeed, we have recommended greater scrutiny of ownership changes, including additional documentation such as tax returns, audited financials, and cost-report review at change of ownership, in our December 2025 recommendations. We do not object to CMS having an enforcement tool aimed at genuine, knowing circumvention of the rule.

The Alliance's concerns are directed at the breadth of the standard and the absence of process safeguards. As drafted, denial or revocation would follow from a determination that the provider "failed to comply with the provisions and requirements of[,]"[94] language that does not distinguish deliberate evasion, the conduct CMS describes, technical non-compliance, or from a good-faith and genuinely disputed question of whether a particular transaction even constitutes a change in majority ownership. For example, there is a restructuring to go from a corporation to another entity, which is a valid 36-month rule exception. However, there is a typo in the paperwork, the original corporation lists the owner percentages as 50 percent and 50 percent. On the CIMO paperwork, the ownership percentages are listed as 50.2 percent and 49.8 percent. Or the name of the owner on the original application is Jane Smith Doe and on the CIMO paperwork the name is listed as Jane Smith-Doe. An exact match is required and so the MAC denies the application for a CIMO. Providers have reported denials resulting from these types of scenarios. However, these are precisely the types of errors for which a contractor should use a development

[94] §§ 424.550(b) or 424.551

request not a denial. The Alliance believes that a sanction of this severity should be reserved for the evasive conduct the rule is designed to deter. Relatedly, allowing opportunities to cure any nonmaterial or inadvertent errors would better distinguish between the conduct this proposal aims to address and administrative mistakes.

We also note that like many other proposals, CMS proposes to make the effective date of revocation arising from these instances the determination date — in other words, before the provider receives adequate notice. We reiterate the statutory limitations and concerns here as above.

14. ***Affiliation Disclosures and Managing Employee***

CMS is proposing to add a new prong to the "affiliation" definition that would capture "any marketing, business, fulfillment, financial, managerial, or beneficiary relationship," with the current five-year lookback period eliminated. CMS is also proposing to revise the definition of "managing employee". The "affiliation" definition uses the same "operational or managerial control" test as the "managing employee". The two definitions are interrelated and we address both here.

CMS proposes to add seven clinical party categories to the definition of "managing employee"

- Medical directors (not merely those at SNFs and hospices)
- Clinical directors
- Departmental heads (for example, a hospital's chief of cardiology)
- Supervising physicians (not simply those at IDTFs)
- Nursing directors
- Alternate administrators
- All other clinical personnel that meet the "managing employee'' definition.

CMS states ". . . we believe the persons in these categories already qualify as ''managing employees'' and should have always been reported" and characterizes this as "in large part, as a reminder to stakeholders." The phrasing "in large part, as a reminder" indicates that some portion of the change is not a reminder, but which portion is not identified. The impact here is that at least some individuals that CMS believes should be reported have not been reported. Finalizing this proposal will result in a substantial volume of new disclosures upon finalization and a permanent increase in the number of individuals to be reported and change of information filings for these individuals.

The Alliance is deeply concerned that 'managing employee' disclosures are and will continue to be required based on title and not on function. The regulation at § 424.502 defines a managing employee as "A general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2

employee of the provider or supplier." For more than a decade, providers have reported managing employees using the administrative roles the regulation actually names as well as individuals in the organization that meet the functional test contained in the definition – exercises operational or managerial control over or directly or indirectly conducts day-to-day operations. In practice, the distinction between title and function is not being applied. The Alliance was made aware of more than one instance where a provider was directed by its Medicare Administrative Contractor (MAC) to include the "office manager" in the enrollment record and was advised that the failure to do so would support revocation.

The "office manager" held no budget authority, no authority over staffing or admissions, no clinical or operational decision-making authority and no delegated managerial control, and performed administrative support functions under supervision. The MAC's demand rested solely on the title. This example highlights that where a standard is functional but undefined, contractors will administer it by title, because a title is the only observable fact available to a reviewer working from a paper record. There is no mechanism for obtaining an advance determination of a managing employee status, and no forum for resolving the question other than after an adverse action is issued.

CMS states that the seven new categories "do not establish any minimum threshold for disclosure", such that "even if an individual has less influence than a departmental head, the person must still be reported." In the same paragraph, CMS states "this does not mean that every clinical employee regardless of influence must be reported." This is not implementable guidance. A compliance officer asked to identify every clinical individual who exercises indirect day-to-day operational influence, with no floor and a general catch-all category as described, has no principled stopping point. For the average provider, a mid-sized organization, the population that would need to be reported under the proposed expansion of "managing employee" would be expanded to include, but not be limited to every level of clinical supervisor including a 'charge nurse"/"shift supervisor"/"team leader" and their back up even if they are performing this function for one shift. These are high-turnover roles, and each addition and departure becomes a reportable change of information subject to the § 424.516(e) timeframes. A multi-site provider would move from a handful of enrollment updates per year to a continuous filing obligation. This is potentially hundreds of transactions annually. This significantly increases the risk of a clerical omission leading to a retroactive revocation.

Most concerning is that if these individuals have always been reportable, then every organization that has not been reporting them is, technically, currently out of compliance and has been for as long as the individuals have held their roles. This, coupled with the proposal to make every revocation ground retroactive to the date the noncompliance began, bears detrimental consequences. The Alliance does not believe this is CMS's intent, and if the proposal to expand the definition of 'managing employee' is finalized, CMS should not hold providers accountable for a non-compliant disclosure prior to the implementation date.

The existing five prongs of the "affiliation" definition can generally objectively be determined by a provider:

- 5% or greater ownership interest
- Partnership interest
- An officer or director
- Operational or managerial control
- Having a reassignment relationship (as defined in § 424.80)

The proposed sixth prong is not at all objectively determined. It encompasses every vendor, every consultant, every lender, every billing company, every coding company, every landlord, every building or maintenance contractor (cleaning service, lawn service, window washing, painting, bottled water, etc.), every care partner such as a pharmacy, DME/supply company, transportation company, mobile imaging company, EMR vendor, etc. It even extends to beneficiaries, which, without a look-back period, encompasses every patient the organization has ever served. A new reportable clinical director carries with them a career lifetime of prior affiliations that a new employing provider must somehow discover, verify and monitor.

For home health and hospice providers, many of the managing employee positions are filled by RNs. The RN turnover rate was 27 percent in 2025 according to the Home Care Salary & Benefits Report,[95] necessitating frequent enrollment record updates. No commercially available screening products perform the necessary diligence function for this expanded proposal. Records often do not exist for relationships that ended fifteen or twenty years ago, or more. Nor can most individuals reliably recall them. The universe of relationships that CMS is proposing be disclosed upon enrollment and revalidation is hundreds to thousands. Multiply this by the number of providers that the regulation would apply to, approximately 2 million[96], and it is clear that there must be defined parameters around these provider enrollment proposals.

Providers would need to obtain information from each of these parties and then maintain and update it. Essentially, there are no limits to the affiliation information a provider would need to disclose. Providers have no lawful means to investigate or right to compel information from the majority of these parties. With this provision CMS would be holding providers accountable for relationships and information over which they have no control.

15. ***Additional Details on Burden***

CMS assigns no burden to the managing employee expansion and performs no analysis for affiliations. CMS states in the Information Collection Request (ICR) for the provider enrollment provisions that "[w]e do not believe that any of our proposed provider enrollment regulatory revisions would impose an information collection burden on

[95] https://hhcsinc.com/hcs-reports/home-care-salary-benefits-report/

[96] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/CMS_PE_Conference-General_Session.pdf

interested parties." For the managing employee expansion, CMS states that the requirement for reporting these individuals ". . . falls within the overall OMB-approved ICR burden..." for the Form CMS-855 family, and that the proposed changes "would not impose an additional ICR burden, though, because these persons have always qualified as managing employees and thus must be reported." The active 0938-0685 burden hours are modeled on historical reporting thresholds. This CY 2027 proposed rule fundamentally alters the baseline data elements that a provider must research and disclose, as stated elsewhere in these comments.

Under historical rules, providers were only required to disclose affiliations within a five-year lookback period. The CY 2027 proposed rule completely eliminates the 5-year lookback constraint for affiliation disclosures. Removing this lookback forces providers to research historical entity relationships indefinitely, a massive tracking burden missing from current OMB time-per-response calculations. Furthermore, the provider enrollment provisions explicitly impact all Medicare provider and supplier types utilizing the CMS-855 forms. Current OMB approved burden models estimate respondent volume based on standard transaction baselines (e.g., normal new enrollments or standard revalidations). Because the new proposed rule forces a widespread compliance re-evaluation across *all* sectors (not just home health agencies), the existing OMB macro-estimate fails to reflect the sheer volume of universal provider recalculations that the expanded definitions dictate.

For the affiliation provisions, CMS performs no analysis and solicits comment from interested parties as to whether any additional ICR burden would ensue from the changes. The Paperwork Reduction Act requires CMS to evaluate the burden of a proposed collection from 10 or more people, obtain approval from the Office of Management and Budget (OMB) before conducting the collection, and publish its estimates for public comment in connection with the proposed rule that creates the burden. A provider cannot report an affiliation unless there is a field for reporting. Within this proposed rule, CMS does not propose revisions to the family of CMS-855 forms or to the PECOS, nor does CMS propose another form for reporting affiliations. While commenters to this proposed rule can state that, in fact, a burden is created from the proposal and describe that burden, commenters cannot develop the estimates for the analysis the PRA requires to be performed and published before a proposal is finalized.

Conversely, in addressing private equity (PE) and real estate investment trust (REIT) identification in this proposed rule, CMS states that revising the Forms CMS-855B and CMS-855S to collect this data would impose an information collection burden, and that burden "will be addressed in the information collection requests that CMS will submit to the Office of Management and Budget to request revisions to these two forms." Here, CMS acknowledges burden where it intends to add fields to a form.

The distinction between the affiliations and the PE/REIT reporting cannot be that the affiliation changes require no new fields or that burden estimates associated with previous

Form CMS-855 affiliation changes or previous rulemaking include the burden of the current proposal. In fact, these proposed changes require fields for prior finalized affiliation disclosures that CMS has never built. When CMS finalized the affiliation framework in 2019, it adopted a phased-in approach and stated that it would not request affiliation disclosures until it had revised the Form CMS-855 applications to include such disclosure sections, together with the corresponding PECOS functionality[97]. In March 2021, CMS stated that it would not begin updating the applications with an affiliation disclosure section "for at least another 12 months."[98] To date, the forms have not been updated with questions specific to the disclosable events in § 424.519(b). Moreover, the form revision schedule CMS presented to the March 2025 Medicare Provider Enrollment Compliance Conference does not mention revisions to add affiliation reporting[99].

CMS also acknowledged the burden of adding fields to Form CMS-855A when it proposed a revision to the form to add PE and REIT questions for SNFs. Specifically, CMS proposed the form revision in a PRA submission before the rulemaking and then published an estimate that identified the PE/REIT transaction types, number and length of responses and price for completion in a proposed[100] and final rule[101]. In that final rule estimate, CMS acknowledged the complexity of the supplemental data to be reported by explicitly stating "given the potential complexity of the supplemental data to be reported, it is possible that the SNF's legal counsel will be involved in reviewing this information" and include it in the burden estimate.

The contrast in handling the PE/REIT reporting and the affiliation/managing employee disclosures within this proposed home health rule, combined with the pivot CMS has taken in acknowledging the complexity and burden of reporting this data from one provider type, SNFs, to all providers is remarkable. Treating as costless both a new affiliation category reaching "any marketing, business, fulfillment, financial, managerial, or beneficiary relationship" on an unlimited lookback and seven new categories of reportable personnel for approximately 2 million providers is truly baffling.

As stated previously within this proposed rule, CMS does not propose revisions to the family of CMS-855 forms, to the PECOS, nor does the Agency propose another form for reporting. However, if the proposals are finalized, they would significantly expand the types of relationships for which CMS could deny or revoke enrollment.

PECOS Cannot Support the Expansions

CMS has already tested expanded disclosure requirements. In 2023, CMS finalized requirements for skilled nursing facilities to disclose governing body members, officers,

[97] 84 Fed. Reg. at 47794.
[98] https://www.cms.gov/files/document/se21003.pdf
[99] https://www.cms.gov/files/document/2026-cms-keynote-present-future-provider-enrollment.pdf
[100] 88 Fed. Reg. at 9820.
[101] 88 Fed. Reg. at 80141.

directors, trustees, managing employees, and additional disclosable parties, together with the organizational structure of each such party.[102] CMS revised the Form 855-A, added a dedicated SNF attachment, and launched an off-cycle revalidation of every enrolled SNF in October 2024 with a December 1, 2024 deadline. This deadline was moved to May 1, 2025, then to August 1, 2025, then to January 1, 2026.

In December 2025, following reports from hundreds of providers of "new, serious technical problems" with PECOS and the attendant risk of payment suspension for system-caused failures, CMS suspended the deadline indefinitely. This suspension remains in force. The reporting architecture that could not accept the data it demanded. What CMS is now proposing is the same data for additional provider types which exponentially increases the technical burden of processing the data let alone the burden on contractors of verifying the information. There were approximately 15,000 SNFs; however, there are two million+ providers. CMS has not stated that the PECOS defects identified in 2025 have been remediated, has not published a system readiness assessment, and has not lifted the SNF suspension.

Finalizing a materially broader collection through the same system, while the narrower predecessor collection sits suspended for technical failure would ask the entire provider community to absorb a risk CMS has already determined a single sector could not bear. And, because the mechanism failed, CMS has neither the data nor the enforcement posture it sought, roughly three years after the final rule. An unbounded collection that providers cannot complete accurately does not yield better program integrity intelligence; it yields a larger volume of unreliable data and more technical violations that bear no relationship to fraud.

This is a program integrity net cast far beyond the program integrity problem. CMS's own figures frame the proportionality question. Roughly three percent of enrolled providers are revoked at least once during their enrollment, and the retroactive revocation proposal is projected to affect 337 providers annually out of a universe exceeding 2 million. The disclosure obligations at issue, by contrast, would fall on 100 percent of that universe, continuously, without an outer limit.

The Alliance does not question that hospice fraud has occurred, that it has been serious, or that CMS is obligated to respond. CMS has adopted measures since 2023 which include the fingerprint based background checks for five percent owners, the certifying physician enrollment requirement, the 36-month change of majority ownership rule, provisional period of enhanced oversight, and the special focus program. What CMS is now proposing goes far beyond these tools and does not advance program integrity.

[102] Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities; Medicare Providers' and Suppliers' Disclosure of Private Equity Companies and Real Estate Investment Trusts, 88 Fed. Reg. 80141 (Nov. 17, 2023)

When every clinical supervisor and every historical vendor relationship is reportable, the disclosures that actually matter are buried in volume, and screening resources are consumed validating relationships that carry no risk. With all revocation grounds retroactive and reapplication bars extended to ten years, the sanction for a clerical omission converges with the sanction for fraud. Sophisticated bad actors, who structure specifically to defeat disclosure, are the least likely to be caught by a rule of this design.

The infrastructure required to track lifetime affiliations for a continuously expanding roster of managing employees is not available. And, reporting is actually the smallest part of the compliance obligation. Satisfying the provisions in good faith would require a standing process that does not exist in any provider organization today. Such a process would include a defensible methodology for determining on an ongoing basis which clinical personnel are reportable, a trigger linking every hire, promotion, title change, and departure to an enrollment review within the § 424.516(e) timeframes; collection and periodic refresh of the complete prior relationship history of each newly reportable individual, with no limit and no available screening product; ongoing surveillance of the enrollment status and adverse action history of every vendor, referral source, lender, landlord, and contractor, information held by CMS and not by the provider; and documentation sufficient to defend each inclusion and exclusion decision, given that an erroneous exclusion is now a retroactive revocation exposure.

For small providers, this work would fall on an administrator who carries clinical and operational responsibility. For the mid-sized provider, it would consume a meaningful share of a compliance function currently devoted to conditions of participation, quality reporting, and survey readiness. For the larger organizations, it is a staffing decision, which is precisely what we ask CMS to weigh here. Three outcomes will likely follow if these proposals are finalized:

- Defensive over-reporting spurred by facing revocation exposure for under inclusion and no penalty for over inclusion, prudent providers will report expansively. CMS will receive substantially more data of substantially lower program integrity value.
- Structural noncompliance among the smallest providers. Organizations without a dedicated enrollment function will not achieve full compliance, not from indifference but from the absence of the records and systems the obligation presumes. Retroactive revocation converts this gap into an existential risk.
- Withdrawal from shared clinical leadership. Lifetime affiliation disclosure, combined with the proposed hospice medical director denial ground, gives providers reason to reconsider shared and contracted clinical leadership arrangements. Those arrangements are how rural communities obtain medical direction at all.

None of these outcomes advances program integrity. Each is a foreseeable result of the design, and each falls hardest on the providers CMS has no reason to be concerned about.

The Alliance strongly opposes these proposals and urges the Agency to withdraw them. The Alliance agrees that disclosure requirements that identify real control relationships would allow CMS to investigate a substantiated undue risk. The proposed expansion, however, abandons manageable limits. It would require organizations to reconstruct indefinite historic relationships and to characterize ordinary vendor, referral, and service relationships without clear definitions. It also risks treating clinicians with limited departmental or clinical responsibilities as managing employees whose historic affiliations, debts, or adverse actions become the entire organization's enrollment risk.

Recommendations:

- Do not finalize elimination of the five-year lookback for affiliation disclosures.
- Retain the existing definition of managing employee.

V. Conclusion

The Alliance believes strongly in working with CMS to achieve a payment system sufficient to support the delivery of high-quality skilled care at home. Data increasingly show the proliferation of care deserts and access challenges for beneficiaries who depend on the services home health agencies provide. If CMS's proposed temporary adjustment is finalized, this will further constrain access at a time when demand is rising. Accordingly, the Alliance urges CMS not to finalize the proposed temporary adjustment for 2027 and to provide a sufficient rate update to support quality care delivery. We also urge the Agency not to move forward with provider and supplier enrollment proposals that will have serious and deleterious impacts for beneficiaries and providers alike.

We appreciate your consideration of our comments and look forward to ongoing dialogue to enhance care quality and access for Medicare beneficiaries. If you have questions or would like to schedule a meeting, your staff should feel free to contact Denis Fleming Jr., Chief Government Affairs Officer, at: dfleming@allianceforcareathome.org.

Sincerely,

Jennifer Sheets
Chief Executive Officer
National Alliance for Care at Home

Evaluation of Medicare Home Health Services under PDGM and Implications for CY 2027 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

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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 2027 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 2019 through CY 2026 HH PPS Proposed and Final Rules, and available claims data.

We first evaluated CMS' methodology for determining budget neutrality, as well as the proposed effects of past and projected permanent and temporary behavioral adjustments on home health agency (HHA) revenues. Key conclusions from our analysis are outlined below.

1. **As noted in our prior technical reports and analyses, we reiterate that CMS's conclusion that home health base payment rates for CY 2020 through CY 2022 were too high and resulted in cumulative overpayments of 9.36 percent is overstated because its budget-neutrality methodology contains several limitations.** We evaluated the effects of these limitations on the permanent adjustments calculated for the CY 2021 and CY 2022 claim years, and the results indicate that addressing these concerns could reduce the magnitude of the estimated permanent adjustments by as much as 2.57 percentage points for CY 2021 and 2.01 percentage points for CY 2022.

2. **In the absence of any corrections, CMS' existing and proposed permanent and temporary behavioral adjustments could lead to a reduction of approximately $23.9 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 $23.9 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, which equate to an $18.9 billion reduction, and an estimated $4.9 billion reduction due to the temporary reductions to reconcile CY 2020 through CY 2026 aggregate payments.

3. **For CY 2027, CMS projects an aggregate 2.4 percent payment increase in Medicare payments across all agencies, with impacts varying significantly by state and geographic region.** At the agency level, percent impacts range from -11.4 percent to 72.2 percent, with a 5th to 95th percentile range of -0.9 percent to 5.3 percent. We also estimate that roughly 49.4 percent of home health agencies (HHAs) will experience payment increases smaller than the average 2.4 percent.

We also examined trends in beneficiary utilization and access, along with trends in the supply and staffing of HHAs during the period of PDGM implementation. Conclusions from those analyses are below.

4. **Overall utilization of home health services among Medicare FFS beneficiaries continued to decline between 2019 and 2025, while patient severity appears to be increasing during the same period.** Despite a continued decline in the number of Medicare FFS beneficiaries (-11.6 percent between 2019 and 2025), the number of FFS beneficiaries using home health declined more

sharply over the same period (-18.7 percent). In addition, the share of FFS beneficiaries receiving home health services declined from 8.6 percent in 2019 to 7.9 percent in 2025. However, patient severity appears to have increased, as reflected by a higher share of 30-day periods receiving a high comorbidity adjustment and an increase in the average DRG weight among beneficiaries with a prior hospitalization. Additionally, home health remained a prominent post-hospitalization destination, even in the post-pandemic period.

3. **Although the number of HHAs billing Medicare for FFS beneficiaries increased nationally by 1.1 percent between 2019 and 2025, this modest overall growth masks significant variation across states.** After excluding California, where the number of HHAs grew substantially, the number of HHAs declined by 14.8 percent (1,261 agencies) over the same time period. Further excluding states that previously had moratoriums on new HHA enrollments (Florida, Michigan, Illinois, and Texas), the number of HHAs declined by 13.9 percent (661 agencies), underscoring that the national upward trend is largely driven by growth in California.

4. **Home health staffing remained relatively stable, although recent growth in clinical staffing was limited.** Our analysis of Medicare cost reports for a consistent panel of 3,075 HHAs found that total clinical full-time equivalent (FTEs) increased from 88,053 in 2022 to 90,672 in 2024, representing compound annual growth of 1.5 percent. Growth slowed considerably in the most recent year, from 2.3 percent between 2022 and 2023 to 0.7 percent between 2023 and 2024. These findings are generally consistent with broader BLS employment trends cited by MedPAC, which show modest employment growth in the home care sector, while also suggesting that aggregate employment measures may mask staffing constraints experienced by individual agencies or local labor markets.

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 2027 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 CY 2027 proposed rule (DUA 73227), the CY 2021 Final Rule (DUA 58177), the CY 2022 Proposed Rule (DUA 59233), and the CY 2027 HH PPS Proposed Rule. We also draw from our work in prior rulemaking cycles. We commend CMS for making these data available.

Effective January 1, 2020, CMS overhauled and replaced the 60-day episode and 153-group case-mix system with the Patient-Driven Groupings Model (PDGM), which uses a 30-day unit of payment and 432 case-mix groups. PDGM evolved from the Home Health Groupings Model proposed during the CY 2018 rulemaking cycle and was finalized in the CY 2019 HH PPS final rule. When implementing PDGM in the CY 2020 Final Rule, CMS prospectively reduced the CY 2020 national standardized 30-day payment rate by 4.36 percent based on analytic assumptions about how providers might change their behavior once PDGM was implemented (behavioral assumptions).

During the CY 2022 rulemaking cycle, CMS first presented and solicited comments on a methodology for comparing actual PDGM expenditures with estimated expenditures under the former payment system. CMS finalized the methodology in the CY 2023 HH PPS final rule using CY 2020 and CY 2021 claims. Although CMS calculated that a 7.85 percent permanent reduction was required, it applied half of the adjustment, or 3.925 percent, and deferred a temporary adjustment. CMS subsequently applied permanent reductions of 2.890 percent in CY 2024 and 1.975 percent in CY 2025, representing half of the calculated 3.95 percent adjustment.

In the CY 2026 final rule, CMS limited the remaining permanent adjustment to findings based on CY 2020 through CY 2022 claims. CMS concluded that behavior observed after CY 2022 could not be reliably attributed to PDGM because it may also reflect other factors, including implementation of OASIS-E, expansion of the Home Health Value-Based Purchasing Model, and increased Medicare Advantage penetration. CMS therefore applied the remaining 1.023 percent permanent adjustment associated with CY 2020 through CY 2022 and implemented a 3.0 percent temporary reduction to begin recouping retrospective overpayments.

Consistent with this position, the CY 2027 proposed rule does not include an additional permanent adjustment based on later claim years. However, CMS proposed to continue the 3.0 percent temporary reduction to recoup retrospective overpayments calculated for CY 2020 through CY 2025. CMS estimates that these overpayments total approximately $4.9 billion before accounting for amounts recouped in CY 2026 and that the proposed CY 2027 reduction would recover approximately $500 million. Nevertheless, CMS projects an aggregate increase of 2.4 percent, or roughly $420 million in home health payments, relative to CY 2026. The proposed increase reflects a 2.1 percent payment update, a 0.3 percent increase from Fixed-Dollar Loss (FDL) updates, no additional permanent behavioral adjustment, and a -3.0 percent temporary adjustment to the CY 2027 national standardized 30-day payment rate.

Detailed Findings

1. Impact of Budget Neutrality Methodological Flaws on Permanent Adjustments

We conducted analyses to assess the impact of the limitations and flaws in CMS' budget-neutrality assessment methodology on the cumulative proposed permanent adjustment based on CY 2020 through CY 2022 claim years. We did not assess CY 2020 data individually. Our results show that adjustments to account for methodological concerns could reduce the proposed permanent adjustment by up to 2.57 percentage points for the CY 2021 analysis and up to 2.01 percentage points for the CY 2022 analysis. **Exhibit 1** below summarizes and quantifies the impact of each methodological issue, and **Exhibit A** in the appendix summarizes our methodology. We refer readers to our CY 2025 technical report for a detailed description of each methodology.

Exhibit 1: Impact of Correcting Methodological Issues in Assessing CY 2020 – CY 2022 Budget Neutrality on the Cumulative Permanent Adjustment

Analytic Claim Year	**CY 2020 Claims**	**CY 2021 Claims**		**CY 2022 Claims**	
Calculated Cumulative Permanent Adjustment	**-6.52%**	**-7.85%**		**-9.36%**	
		Percentage Point Impact on CY 2022 Related Permanent Adjustment	**New DD Calculated Permanent Adjustment (As Compared to cumulative -7.85%)**	**Percentage Point Impact on CY 2022 Related Permanent Adjustment**	**New DD Calculated Permanent Adjustment (As Compared to -9.36%)**
1. Excluded Claims: Excluded claims may have complex billing patterns; therefore excluding approximately 20 percent of claims disproportionately removes higher-acuity or atypical cases. Accounting for the impact of reduced therapy utilization due to the excluded claims results in a lower permanent adjustment.	Not Determined	-1.95	-5.90%	-1.31	-8.05%
2. Structural LUPA Assignments: Given the static LUPA threshold of <4 visits under the 60-day system, there are instances where cases are flagged as LUPAs under the old system when they otherwise would have been non-LUPAs under the PDGM**.**		-2.57	-5.28%	-1.53	-7.83%
3. **Outlier assumptions:** When simulating 60-day episodes from 30-day periods, CMS applies a static fixed-dollar loss (FDL) ratio of 0.51 to calculate the outlier threshold. This is substantially higher than the FDL ratios identified in the CY 2021 and CY 2022 Final Rules. The inflated FDL ratio results in total outlier payments falling well below the 2.5% statutory target, thereby understating counterfactual aggregate payments.		-0.99	-6.85%	-0.66	-8.70%
4. Case-Mix Update Factors: CMS omits case-mix recalibration when determining the 60-Day System payment rates (which historically increased payment rates by 1–2%). Applying CY 2022 PDGM case-mix updates increases counterfactual payments and lowers permanent adjustment.		NA (Case mix not recalibrated for CY 2021)		-2.01	-7.35%
5. 60 Day Episode Structure: The overall number of episodes, proportion of LUPAs, PEPs, outliers and visit patterns do not reflect the counterfactual 60-day payment system episodes. Applying the 60-day case-mix from pre-PDGM 2019 claims lowers the permanent adjustment.		-0.08	-7.77%	-0.39	-8.97%
6. Clinical Group Assignments: There are consecutive 30-day claims where the clinical domain is different, resulting in CMS making assumptions but the clinical domain designation for the 60-day payment ystem.		Not Determined			
7. OASIS Assumptions: Under PDGM, data collection at certain time points for 23 existing OASIS items is optional. CMS assumptions and crosswalk of OASIS items could impact the counterfactual payments.		Not Enough Data to Quantify			

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUAs 58177 and 59233

2. Overall Impact of Permanent and Temporary Reductions

In aggregate, without corrections, we estimate that payment reductions due to permanent and temporary adjustments will lead to an approximate reduction of $23.8 billion in cumulative home health-related payments from 2020 through 2030. This amount includes the cumulative impacts of the CY 2020 behavioral adjustment of -4.36 percent, the cumulative impacts of CY 2023 through CY 2026 permanent adjustments, which equate to an $18.9 billion reduction, and a $4.9 billion reduction due to calculated temporary adjustments for CY 2020 through CY 2026.

We determined the impact of the assumed behavioral, permanent, and temporary adjustments on home health payments between 2020 and 2030 through the methodology outlined in our CY 2025 technical report.

The results of our analysis are summarized in **Exhibits 2** and **3** below.

Exhibit 2: Projected Impact of Permanent Adjustments in CY 2020 through CY 2030

Year	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	($2,278,952,163)
2027	($2,319,220,729)
2028	($2,360,243,210)
2029	($2,404,255,458)
2030	($2,446,700,855)
Total Impact of Permanent Adjustments	**($18,936,572,113)**

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 73227

Exhibit 3: Proposed & Projected Temporary Adjustments, CY 2020-2026

Year	Overpayments
2020	($873,073,121)
2021	($1,211,002,953)
2022	($1,405,447,290)
2023	($836,208,180)
2024	($430,435,218)
2025	($152,365,174)
2026	TBD
TOTAL (2020-2026)	($4,908,531,936)

Source: CY 2027 HH PPS Proposed Rule

3. Impact of the CY 2027 HH PPS Proposed Rule on HHA FFS Medicare Payments

BACKGROUND

CMS projects in the CY 2027 HH PPS proposed rule that home health agencies (HHAs) will experience an aggregate increase of $420 million, or a 2.4 percent increase, in payments between CY 2026 and CY 2027. This aggregate increase includes a 2.1 percent increase from the proposed home health payment update and an estimated 0.3 percent increase associated with the proposed Fixed-Dollar Loss (FDL) update.

CMS does not propose an additional permanent behavior adjustment for CY 2027 but proposes a -3.0 percent temporary adjustment which effectively has a 0.0 percent impact on aggregate payments relative to CY 2026. [1]

METHODOLOGY

We examined the impacts of the CY 2027 HH PPS proposed payment rates on HHA Medicare payments by comparing current law (Dobson | DaVanzo estimated CY 2026) payments to the projected CY 2027 payments provided by CMS in the OASIS LDS files through the following steps.

Step 1: We obtained CY 2027 projected case-level payments from the CY 2027 CMS OASIS-LDS impact file dataset. We then aggregated the cases for each agency using the provider CCN.

Step 2: We modeled CY 2026 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 2026 claim-level payments by adjusting the CY 2026 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 2026 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 2026 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 2026 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 2026 payments and the projected CY 2027 payments for each agency.

We note that the CY 2027 and estimated CY 2026 payments determined from the CMS OASIS-LDS impact dataset were lower than the figures cited in the proposed rule, resulting in a calculated $370 million increase in payments, or a 2.3 percent increase. Specifically, we calculated CY 2027 payments of $16.51 billion and CY 2026 payments of $16.14 billion. We therefore applied adjustments at the agency level so that the CY 2026 and CY 2027 payment differences for each agency summed to a $420 million increase. For each agency, we first determined the agency's calculated payment increase as a proportion of the overall payment increase determined from the OASIS-LDS dataset. We then applied that proportion to the overall projected increase of $420 million to determine the adjusted payment change. We used the same method to adjust the CY 2026 and CY 2027 payments for each agency.

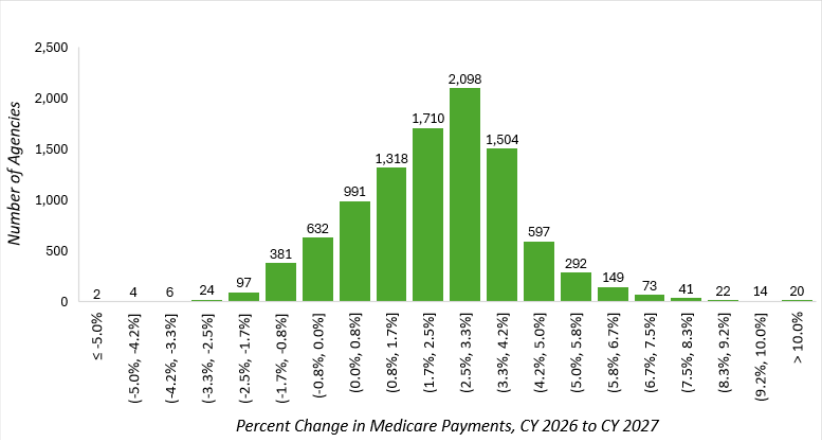
1 As CMS notes in the CY 2027 HH PPS proposed rule, the −3.0 percent temporary adjustment is applied to the 30-day payment rate, but not to LUPA per-visit rates. Because the CY 2026 payment rate already reflects a −3.0 percent temporary adjustment, the proposed CY 2027 temporary adjustment has no additional impact on aggregate payments relative to CY 2026.

RESULTS

Agency Impacts

When comparing the percent impact (i.e., the percent change between modeled CY 2026 and projected CY 2027 payments) at the agency level, we find that HHA impacts are slightly right-skewed. The percent impact for all agencies ranges from -11.4 percent to 72.2 percent, with a 5th to 95th percentile range of -0.9 percent to 5.3 percent. We also estimate that roughly 49.4 percent of HHAs will experience payment increases smaller than the average 2.4 percent, and 11.5 percent will experience negative payment changes from 2026 to 2027. The full distribution of projected agency percentage impacts is shown in **Exhibits 4** and **5** below**.**

Exhibit 4: Distribution of Agencies by Percent Change in Medicare Payments between CY 2026 and CY 2027



Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 73227

Exhibit 5: Distribution of Agencies with Larger or Smaller than Average Percent Change in Medicare Payments

	Number	Percent
Number of agencies with larger than average Increase (>2.4%)	5,043	50.6%
Number of agencies with smaller than average Increase (<2.4%)	4,932	49.4%
Total Number of Agencies	**9,975**	**100.0%**

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 73227

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 13 percent of agencies with approximately 12 percent of HH cases are located in rural areas and those agencies will experience a greater percent increase (2.8 percent) in projected CY 2027 payments compared to agencies in urban areas (2.3 percent). These results are shown in **Exhibit 6** below. Despite the trends at the national level, urban HHAs will experience a larger increase in Medicare payments compared to rural HHAs in sixteen states (results not shown).

Exhibit 6: Percent Impact between CY 2026 and CY 2027 for Agencies in Rural vs. Urban Areas*

Location	Percent of Agencies	Percent of Cases	Projected 2027 Payment	Projected Payment Impact (Dollar Amount Change) Per Case	Average Percent Impact (Change)
Rural	13%	12%	$1,840,740,080	$50	2.8%
Urban	86%	88%	$16,087,719,747	$52	2.3%

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 73227; Flags for Rural Agencies obtained from the Q4 2025 Provider Services File

State-Level Impacts

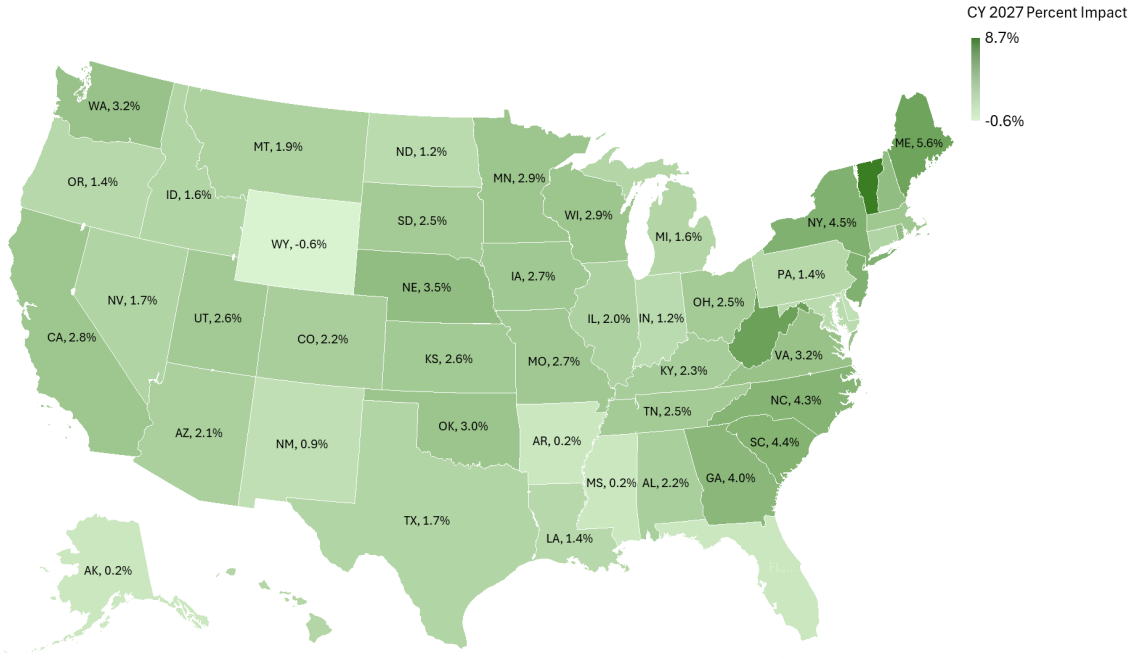
In **Exhibits 7** and **8** below, we show the projected changes in Medicare payments for HHAs across states. As shown, while CMS estimates an aggregate percent increase of 2.4 percent, the 10 states with the lowest projected payment changes are expected to experience impacts ranging from a 0.6 percent decrease to a 1.2 percent increase.

Exhibit 7: Top 10 States with Lowest Projected Revenue Changes between CY 2026 and CY 2027[2]

State	Impact of 2027 Proposed Payments	Percent Impact	Range of Agency Impacts (Min – Max)	Range of Agency Impacts (5th - 95th Percentile)
Total	**$420,000,000**	**2.4%**	**-11.4%, 72.2%**	**-0.9%,5.3%**
WY	-$145,034	-0.6%	-2.6%, 2.8%	-2.1%, 1.0%
MS	$521,209	0.2%	-1.1%, 2.3%	-0.7%, 1.8%
AK	$44,136	0.2%	-0.9%, 3.5%	-0.8%, 3.2%
AR	$338,565	0.2%	-1.7%, 3.1%	-1.3%, 2.0%
FL	$4,090,081	0.3%	-4.7%, 71.3%	-1.7%, 3.3%
NM	$723,879	0.9%	-2.3%, 2.6%	-1.5%, 2.4%
DE	$621,055	0.9%	-3.0%, 2.9%	-1.9%, 2.8%
IN	$2,651,469	1.2%	-2.0%, 6.2%	-1.1%, 3.6%
ND	$188,644	1.2%	-1.6%, 5.9%	-1.0%, 5.5%
MD	$3,808,832	1.2%	-1.1%, 14.8%	-0.5%, 5.5%

Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 73227

Exhibit 8: Distribution of Projected Medicare Revenue Changes by State, CY 2026 – 2027



Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 73227

4. Trends in Medicare FFS Home Health Utilization

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

TRENDS IN FFS HOME HEALTH USE

We examined data on the utilization of home health services among Medicare FFS beneficiaries to explore longitudinal trends between 2019 and 2025.

METHODOLOGY

We identified the number of unique beneficiaries with at least one home health episode from the 100 percent Medicare claims data between 2019 and 2025. We also obtained the number of Medicare FFS enrolled beneficiaries between 2019 and 2025 from the publicly available Medicare enrollment files.

RESULTS

As shown in **Exhibit 9**, Medicare FFS beneficiaries received fewer home health services in 2025 than in 2019. While the number of Medicare FFS beneficiaries declined by 11.6 percent between 2019 and 2025, the number of FFS beneficiaries using home health declined more sharply over the same period, by 18.7 percent. The percent of FFS beneficiaries receiving home health services declined from 8.6 percent in 2019 to 7.9 percent in 2024 and remained steady in 2025.

Exhibit 9: Trends in Percent of FFS HH Beneficiaries with ≥1 HH Episode, 2019-2025

Year	2019	2025	Percent Difference 2019-2025
Number of Unique FFS Beneficiaries with ≥ 1 HH Claim	3,310,007	2,689,861	-18.7%
Total Number of FFS Beneficiaries	38,577,012	34,116,651	-11.6%
Percent of FFS Beneficiaries with ≥ 1 HH Claim	8.6%	7.9%	-8.1%
Number of Unique Rural FFS Beneficiaries with ≥ 1 HH Claim	443,891	425,185	-4.2%
Total Number of Rural FFS Beneficiaries	7,687,639	6,249,396	-18.7%
Percent of Unique Rural FFS Beneficiaries with ≥ 1 HH Claim	5.8%	6.8%	17.8%

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

From 2019 to 2025, the percent of Medicare FFS rural beneficiaries with at least one home health claim increased slightly from 5.8 percent to 6.8 percent, although there was substantial variation across states. In **Exhibit 10**, we show state-level changes in the percent of rural FFS beneficiaries with at least one HH claim from 2019 to 2025. The five states experiencing the largest declines ranged from a 1.24 percentage-point decrease in Vermont to a 0.22 percentage-point decrease in New Mexico.

Exhibit 10: Percent of Rural Medicare FFS Beneficiaries with at least one HH claim by State, 2019 to 2025

	Number of Rural Medicare FFS Beneficiaries Per State, 2019 to 2025		Number of Rural FFS Benes with ≥ 1 HH Claim Per State, 2019 to 2025		Percent of Rural FFS Benes with ≥ 1 HH Claim Per State, 2019 to 2025		Percent-age Point Change, 2019 - 2025
STATE	**2019**	**2025**	**2019**	**2025**	**2019**	**2025**	
Vermont	93,035	83,936	8,088	6,260	9%	7%	-1.24%
Colorado	115,385	105,254	4,879	3,295	4%	3%	-1.10%
Maine	102,563	71,082	6,696	4,070	7%	6%	-0.80%
Montana	128,115	96,470	3,246	2,165	3%	2%	-0.29%
Connecticut	26,402	23,251	2,656	2,287	10%	10%	-0.22%

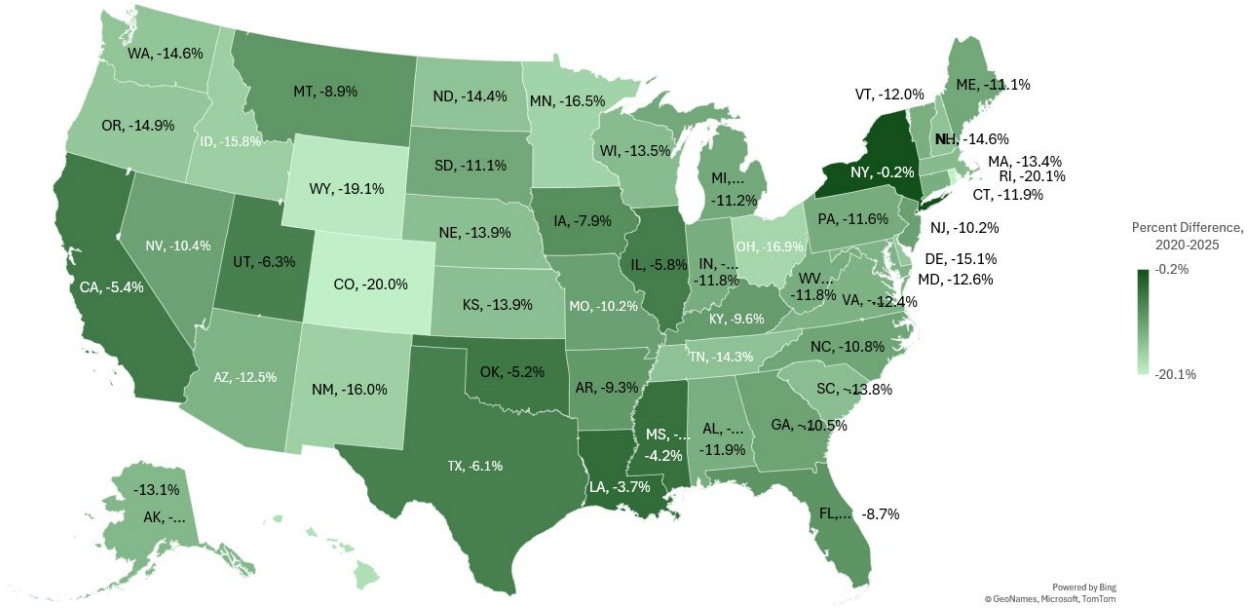
Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 73227

TRENDS IN FFS AVERAGE NUMBER OF VISITS PER EPISODE

We reviewed additional data to explore changes in the number of home health visits delivered and whether those changes varied by state and clinical grouping. As shown in **Exhibit 11**, from 2020 to 2025, the average number of home health visits decreased in every state, indicating a broad-based decline in home health service use over the study period. The magnitude of the decline varied geographically, ranging from -0.2 percent in New York to -20.1 percent in Rhode Island.

In 2025, Utah had the highest average number of home health visits, at 11.29 visits per episode, while Oregon had the lowest, at 6.40 visits per episode. Overall, the consistent decrease across all states suggests that beneficiaries receiving home health services had fewer visits in 2025 than in 2020, although the degree of decline differed by state.

Exhibit 11: Percent Change in Average Number of Home Health Visits Per Episode Per State, 2020 to 2025



Source: Dobson | DaVanzo Analysis of HH Claims in LDS DUA 73227

When examined by clinical grouping, average visit utilization declined across the MMTA-Surgical Aftercare, MS Rehabilitation, and Neuro clinical groups, with beneficiaries receiving approximately one fewer visit on average in 2025 than in 2020 (**Exhibit 12**). These descriptive findings warrant further analysis to determine whether certain patient groups are experiencing continued reductions in service intensity or broader access-to-care concerns, although we recognize that assigned case mix and recalibration changes can affect relative payments and drive incentives across clinical groups.

Exhibit 12: Percent Change in Visits, Cases and Beneficiaries by Diagnostic Category and Other Case Mix Factors, 2020-2025

	Percent Change 2020-2025		
	Absolute Change in Visits per Episode	# Episodes	# Beneficiaries
Overall Change	-0.7	-8.5%	-10.8%
Clinical Grouping			
Behavioral Health	-0.2	-15.5%	-15.5%
Complex	-0.6	-18.3%	-25.7%
MMTA - Cardiac	-0.6	-18.5%	-16.6%
MMTA - Endocrine	-0.5	-7.0%	-13.0%
MMTA - GI/GU	-0.7	1.2%	-0.1%
MMTA - Infectious	-0.4	-7.7%	-3.4%
MMTA - Other	-0.7	13.8%	10.4%
MMTA - Respiratory	-0.6	-24.7%	-25.9%
MMTA - Surgical Aftercare	-1.1	-7.9%	-9.1%
MS Rehab	-1.1	1.9%	0.2%
Neuro	-1.2	-6.1%	-9.7%
Wound	-0.8	-7.9%	-12.1%

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

TRENDS IN PATIENT SEVERITY

We also conducted analyses to assess whether the observed reductions in home health service utilization were accompanied by changes in patient severity between 2019 and 2025. As shown in **Exhibit 13**, CMS' analysis shows that the proportion of home health episodes with any comorbidity adjustment has increased since 2020. Further, the proportion of episodes with a high comorbidity adjustment increased by 29 percent from 2020 to 2025. 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 increased from 1.89 to 1.94 between 2019 and 2025 (**Exhibit 14**).

In summary, the reduction in home health utilization does not appear to be accompanied by a decline in patient severity, suggesting that utilization trends raise questions about whether access constraints may be a contributing factor.

Exhibit 13: Distribution of 30-Day Periods of Care by Comorbidity Adjustment Category, 2019-2025

Comorbidity Adjustment	2019 (Simulated)	2020	2021	2022	2023	2024	2025	Percent Difference 2020-2025
None	52%	49%	50%	37%	31%	29%	24%	-51%
Low	38%	37%	37%	48%	53%	55%	58%	57%
High	10%	14%	14%	15%	17%	15%	18%	29%

Source: CY 2027 HH PPS Proposed Rule

Exhibit 14: Average DRG Weight for Home Health Beneficiaries with Prior Hospitalization

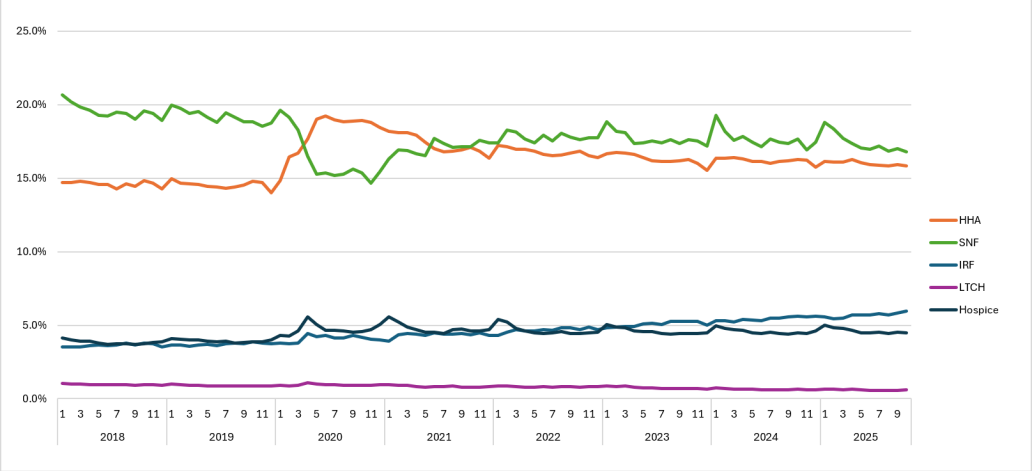
	2019	2020	2021	2022	2023	2024	2025
Average DRG Weight	1.89	1.95	1.95	1.97	1.93	1.93	1.94

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

TRENDS IN HOME HEALTH UTILIZATION FOLLOWING HOSPITALIZATION

As shown in **Exhibit 14**, the proportion of hospital discharges to home health increased between 2019 and 2020 and then began to decline between 2020 and 2024, although the proportion of discharges remained above pre-pandemic levels. This proportion corresponds to the substitution effect observed during the pandemic, when SNF admissions declined and home health use increased; however, these trends began to reverse between 2021 and 2024.

Exhibit 14: Trends in Hospital Discharges to Post-Acute Care Settings, 2018-2025



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

Exhibit 15 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 2018 and 2025, overall STACH discharges declined by 26.6 percent. Even steeper reductions are observed in 1st PAC case volume for other inpatient settings (-51.7 percent), LTCHs (-54.4 percent), SNFs (-35.0 percent), and patients returning to the community (-28.8 percent). By contrast, discharges to HHAs declined more slowly (-20.1 percent), suggesting that home health has remained a relatively prominent post-acute destination in the post-pandemic period.

Exhibit 15: Annual Volume of STACH Discharges by 1st PAC Destination*

Site of Service	2018	2019	2020	2021	2022	2023	2024	2025	Percent Difference 2018-2025
All Discharges	**9,014,447**	**8,823,723**	**7,365,087**	**6,927,626**	**6,641,479**	**6,544,774**	**6,500,370**	**6,612,527**	**-26.6%**
Other Inpatient	47,917	45,102	37,170	31,014	26,006	23,759	23,048	23,165	-51.7%
LTCH	87,459	78,685	68,698	58,054	54,384	48,845	41,507	39,851	-54.4%
SNF	1,763,728	1,693,095	1,207,712	1,181,712	1,180,658	1,157,656	1,149,289	1,145,686	-35.0%
Home (Community)	4,458,477	4,389,000	3,546,126	3,332,306	3,183,417	3,139,623	3,107,370	3,173,316	-28.8%
Hospital	666,628	660,965	536,926	494,412	463,928	469,445	475,533	497,638	-25.3%
HHA	1,316,173	1,282,846	1,324,362	1,198,733	1,113,825	1,072,887	1,052,621	1,050,974	-20.1%
Hospice	346,475	347,099	344,248	329,589	308,813	300,541	297,983	304,603	-12.1%
IRF	327,590	326,931	299,845	301,806	310,448	332,018	353,019	377,294	15.2%

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

5. 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 2025.

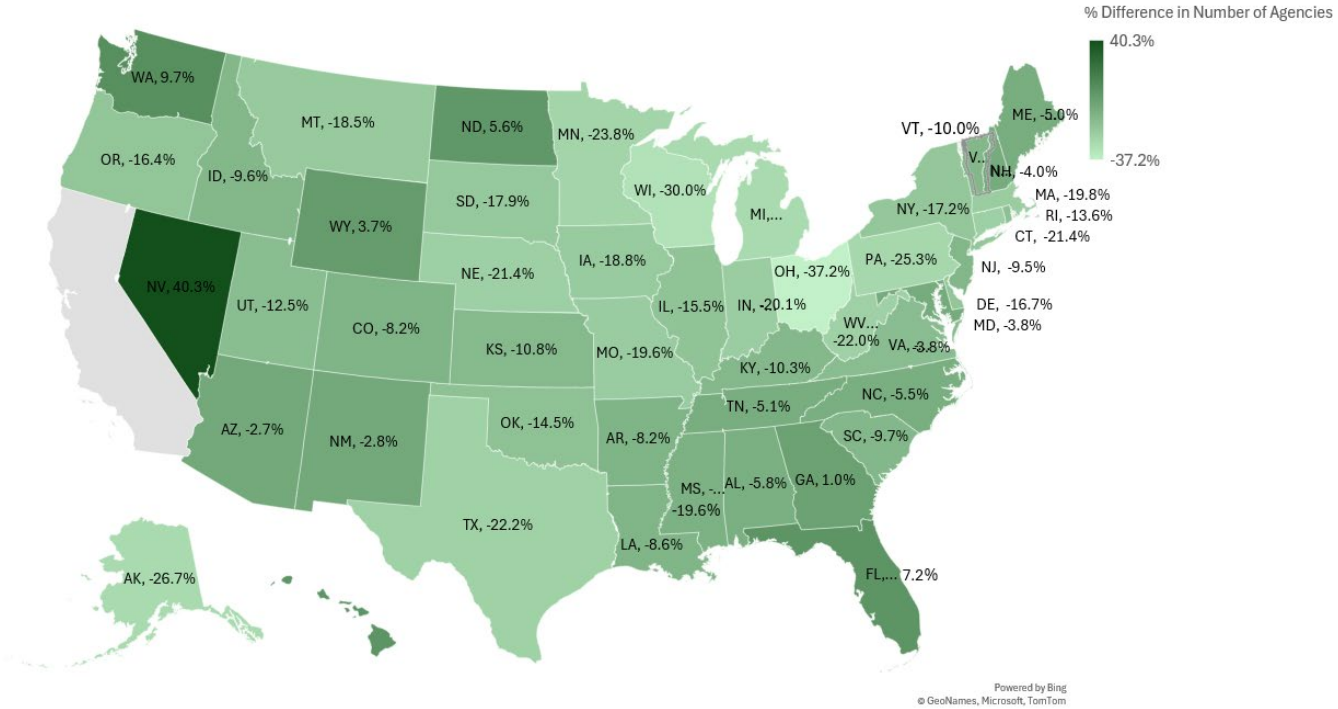
Between 2019 and 2025, the number of HHAs billing Medicare for FFS beneficiaries increased nationally by 1.1 percent (108 agencies). However, this modest overall growth masks significant variation: excluding California, where the number of HHAs grew substantially, the decline was 14.8 percent (1,261 agencies). Further excluding states that previously had moratoriums on HHAs (Florida, Michigan, Illinois, and Texas) produced a similar decline of 13.9 percent (661 agencies), underscoring that the national trend is largely driven by growth in California. **Exhibits 6** and **7** show these results.

Exhibit 6: Top 10 States with Largest Reductions in the Number of Medicare Billing HHAs

State	2019	2025	Percent Difference
All States	9,965	10,073	1.1%
All States (Excluding CA)	8,512	7,251	-14.8%
All States (Excluding CA, FL, IL, MI, TX)	4,744	4,083	-13.9%
Ohio	462	290	-37.2%
Wisconsin	100	70	-30.0%
Alaska	15	11	-26.7%
Pennsylvania	304	227	-25.3%
District of Columbia	21	16	-23.8%
Minnesota	143	109	-23.8%
West Virginia	59	46	-22.0%
Connecticut	84	66	-21.4%
Nebraska	70	55	-21.4%
Indiana	184	147	-20.1%

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

Exhibit 7: Percent Change in Number of FFS Medicare Billing HHAs by State, 2019-2025*



**Note that only CA, FL, GA, HI, ND, 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*

6. Analysis of HH Labor Trends

TRENDS IN LABOR SUPPLY FOR RELEVANT HHA STAFFING DISCIPLINES

Despite reports of growth in employment in the broader home health sector, our analysis shows a slight decline in employment of the staff most relevant to delivering home health services between 2022 and 2024.

In the March 2024 Report to Congress[3], 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[4] 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 2022, 2023, and 2024 Medicare Cost Report (MCR) data for free-standing HHAs to understand these trends through the following steps.

METHODOLOGY

Step 1: We obtained CY 2022, 2023, and 2024 MCR data from the CMS website.[5] Broad clinical staff categories were identified from HHA MCR Form CMS-1728-20, S-3, Part 1 and detailed clinical staff categories were identified from HHA MCR Form CMS-1728-20, S-3, Part II.

Step 2: The panel of HHAs was constructed from 22,163 MCRs including 7,322 reports in 2022, 7,362 in 2023, and 7,479 in 2024. Panel inclusion was based on the most recently filed report for each year and required that HHAs meet the following criteria in each of the three years:

- Filed an MCR for 2022, 2023, and 2024;
- The MCR covered a 12-month reporting period;
- Reported more than zero visits; and
- Had a calculated annual number of visits per Full-Time Employee (FTE) greater than 480 and less than 1,920.[6]

After applying these criteria, 3,075 HHAs remained in the final analytic panel.

RESULTS

As shown in **Exhibit 16**, we found that staffing for a panel of 3,075 HHAs was relatively stable from 2022 to 2024, with clinical staff FTEs of 88,053 for 2022, 90,068 in 2023, and 90,672 in 2024. The change in total clinical FTEs between 2022 and 2023 was 2.3 percent and 0.7 percent between 2023 and 2024, as well as compound annual growth of 1.5 percent between 2022 and 2024.

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

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

[5] https://www.cms.gov/data-research/statistics-trends-reports/cost-reports/home-health-agency-1728-2020-form

[6] The calculated number of annual visits by FTE was identified based on 240 assumed working days per year (48 working weeks * 5 days per working week) and 2 visits per FTE per working day for the lower bound and 8 visits per FTE per working day for the upper bound.

Exhibit 16: Number of FTEs by Occupation, CY 2022 - 2024

HHA Staffing Discipline	2022	2023	2024	Percent Change, 2022-2023	Percent Change, 2023-2024	Compound Annual Growth Rate (CAGR)
Registered Nurses	31,118	31,384	31,875	100.9%	101.6%	101.2%
Licensed Practical Nurses	10,177	10,204	10,219	100.3%	100.1%	100.2%
Physical Therapy Supervisor	411	327	297	79.4%	90.9%	85.0%
Physical Therapists	17,868	17,971	18,282	100.6%	101.7%	101.2%
Physical Therapy Assistants	8,191	9,109	8,843	111.2%	97.1%	103.9%
Occupational Therapy Supervisor	131	113	84	86.4%	74.2%	80.1%
Occupational Therapists	6,581	6,626	6,678	100.7%	100.8%	100.7%
Occupational Therapy Assistants	1,878	1,884	1,860	100.3%	98.7%	99.5%
Speech-Language Pathology Supervisor	32	33	27	101.0%	83.1%	91.6%
Speech-Language Pathologists	1,948	1,858	1,872	95.3%	100.8%	98.0%
Medical Social Services Supervisor	65	60	45	92.2%	75.6%	83.5%
Medical Social Services	1,488	1,449	1,389	97.4%	95.9%	96.6%
Home Health Aide Supervisor	220	244	126	110.5%	51.6%	75.5%
Home Health Aides	7,945	8,809	9,074	110.9%	103.0%	106.9%
Total	**88,053**	**90,068**	**90,672**	102.3%	100.7%	101.5%

Source: Dobson | DaVanzo analyses of 2022, 2023, and 2024 Medicare Cost Report data for free-standing Home Health Agencies

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". Our findings are generally consistent with MedPAC's assessment that employment in the broader home care sector had recovered above pre-pandemic levels by 2023. However, our analysis of MCR data suggests relatively limited growth in clinical staffing between 2022 and 2024, with the annual increase slowing from 2.3 percent between 2022 and 2023 to 0.7 percent between 2023 and 2024. Taken together, these findings suggest that national staffing levels have remained stable or increased modestly, although aggregate measures may mask staffing constraints experienced by individual agencies or within specific local labor markets.

We note that the 9,225 cost reports included in our analysis represent 41.6 percent of the cost reports in the three-year dataset. More than half of the available cost reports were excluded due to S-3 data quality concerns, the absence of a cost report for one or more study years or reporting periods that covered less or more than 12 months.

Appendix

Exhibit A. Methodology for Assessing Limitations of CMS' Budget Neutrality Calculations in Brief

Analytic Issue and Rationale	Analytic Methods in Brief
1. **Excluded claims.** CMS excludes a substantial share of claims before constructing the analytic samples. For CY 2022, excluded periods had higher average therapy use than retained periods. Since therapy utilization was a key payment driver under the former system, excluding these periods may understate counterfactual 60-day payments and overstate the permanent adjustment.	We compared included and excluded periods and repriced the retained claims after increasing therapy visits by the observed difference in average therapy use.
2. **Structural LUPA assignments.** Under PDGM, LUPA thresholds vary by HHRG and may be as low as two visits. Under the former system, episodes with four or fewer visits were paid as LUPAs. Consequently, CMS's simulated 60-day methodology can classify an episode as a LUPA even when all of its constituent 30-day periods received full-period payments. This is a structural difference between the payment systems rather than evidence of provider behavior. Correcting these assignments increases counterfactual payments and lowers the permanent adjustment.	We linked each simulated 60-day episode to its constituent 30-day periods and identified 60-day LUPAs composed entirely of non-LUPA 30-day periods. We then removed the 60-day LUPA designation for these episodes, recalculated counterfactual payments, and resolved the budget-neutral 30-day rate and permanent adjustment.
3. Outlier assumptions. CMS used a fixed FDL ratio of 0.51 when calculating outlier payments under the counterfactual 60-day system. CMS ordinarily calibrates the FDL so projected outlier payments approach, but do not exceed, 2.5 percent of total payments. CMS's regrouping methodology also produces fewer simulated 60-day outlier episodes, including episodes composed of outlier 30-day periods. As a result, counterfactual outlier payments fall below 2.5 percent, potentially understating counterfactual payments and overstating the permanent adjustment.	We calculated actual outlier payments and shares for the 30-day periods and simulated 60-day episodes. We then held non-outlier payments constant, increased counterfactual outlier payments to 2.5 percent of adjusted total payments, and resolved the corresponding budget-neutral 30-day rate and permanent adjustment.
4. Lack of 60-day case-mix recalibration. CMS did not recalibrate the former 153-group case-mix system when estimating counterfactual 60-day payments. Historically, case-mix recalibration factors often increased the applicable payment rate. Applying a comparable recalibration factor would increase counterfactual payments and reduce the permanent adjustment.	We applied the CY 2022 PDGM case-mix budget-neutrality factor to the counterfactual 60-day payment rate, recalculated aggregate payments, and resolved the permanent adjustment. CMS did not recalibrate PDGM case-mix weights for CY 2021, so no corresponding CY 2021 factor was available.
5. 60-day episode structure. Descriptive analyses show differences between the simulated 60-day episodes and actual pre-PDGM 2019 episodes in LUPA, PEP and outlier rates, case mix, and visit patterns. In particular, lower therapy use in the simulated episodes may reduce counterfactual payments under the therapy-sensitive former system and increase the estimated permanent adjustment.	Therapy sensitivity completed for CY 2021 and CY 2022. We compared average therapy visits in the simulated 60-day episodes with actual 2019 episodes. We then increased therapy visits in the simulated episodes by the observed difference, recalculated counterfactual payments, and the permanent adjustment.
6. Clinical-group assignments. When a simulated 60-day episode contains two consecutive 30-day periods with different clinical groups, CMS assigns the first period's diagnosis and clinical group to the entire episode. This may understate counterfactual case mix when the second period reflects greater acuity and does not capture mid-episode case-mix changes permitted under the former system.	We quantified episodes with differing clinical groups and identified cases in which the first period had a lower case-mix weight than the second period. Analyses not completed because it would require alternative legacy-grouper results reflecting the second period's clinical information.
7. OASIS assumptions. OASIS-E, implemented January 1, 2023, changed the availability and coding of several items used by the former 153-group system. Mapping OASIS-E responses back to earlier OASIS specifications could understate severity or misclassify counterfactual case-mix groups.	Not applicable to the current CY 2021 and CY 2022 analyses. Both years predate OASIS-E implementation.