



May 8, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

**RE: Recommendations by the National Alliance for Care at Home
Regarding the Upcoming CY 2027 Medicare Home Health Prospective
Payment System Proposed Rule**

Dear Administrator Oz:

The National Alliance for Care at Home (the Alliance) appreciates the Centers for Medicare & Medicaid Services' (CMS') consideration and resulting changes made in response to stakeholder comments for the **Calendar Year (CY) 2026 Medicare Home Health Prospective Payment System Rate and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program Updates Final Rule** last year. However, several methodological issues and confounding factors raised in the public comments in response to last year's proposed rule remain and continue to result in inappropriate payment rate reductions.

The Alliance is the unified voice for providers delivering high-quality, person-centered skilled 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, health system-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 caregivers and other staff. Formed through the joint affiliation of the National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO), the Alliance is dedicated to advancing policies that support care in the home for millions of Americans, including individuals with disabilities, persons with chronic and serious illnesses, those requiring post-hospital skilled care, as well as dying Americans who depend on these critical services.

The final rule, while a welcome reprieve for Medicare-certified home health agencies (HHAs) compared to the proposed version, still failed to adequately address persistent methodological problems. As a result, HHAs are facing a precarious economic situation that is impacting the provision of high-quality skilled care in the home. A viable and sustainable home health benefit is critical for the Medicare program and its beneficiaries. Home health is the preferred site to receive skilled nursing and therapy care for beneficiaries recovering from a serious illness or injury. Home health is a lower cost alternative to institutional-based care in a skilled nursing facility or other post-acute setting.¹ In fact, the home health benefit is an important element of recent CMS innovation models that include post-acute care aimed at reducing expenditures and improving quality.^{2,3} Years of payment cuts in the face of rising labor and other costs are threatening to erode an already struggling home health benefit and the services that beneficiaries rely on for their care. The Alliance encourages CMS to consider our recommendations carefully so it can preserve this important benefit for Medicare and its beneficiaries now and in the future.

Considerations for 2027

The Alliance appreciates CMS' consideration of our comments in response to the CY 2026 Home Health Prospective Payment System (HH PPS) proposed rule (90 FR 29108),⁴ and the Agency's subsequent decision to modify its approach in determining permanent and temporary adjustments in the final rule (90 FR 55342). While CMS finalized a lower reduction to the home health 30-day payment rate for CY 2026, the final rule still resulted in an estimated decrease in aggregate payments of -1.3%, or \$220 million. In addition, an estimated \$4.5 billion in temporary adjustments remain and CMS has implemented almost -10% in permanent rate reductions since CY 2023.

1. Permanent and Temporary Adjustments

The Alliance remains deeply concerned with the way CMS determines the permanent and temporary adjustments that have reduced home health

¹ Geng F, McGarry BE, Rosenthal MB, Zubizarreta JR, Resch SC, Grabowski DC. Preferences for Postacute Care at Home vs Facilities. *JAMA Health Forum*. 2024;5(4):e240678

² <https://www.cms.gov/priorities/innovation/innovation-models/team-model>

³ <https://www.cms.gov/priorities/innovation/innovation-models/cjr-x>

⁴ <https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf>

payments since CY 2023. The law directs CMS to determine the impact of differences between assumed and actual behavior change on estimated aggregate expenditures directly resulting from the implementation of the 30-day unit of payment and PDGM case-mix adjustment methodology implemented in 2020.⁵

This determination, which requires analysis of data for CYs 2020 through 2026, allows CMS to establish whether payments under PDGM are budget neutral to those that would have otherwise been made under the former or pre-PDGM payment system. In other words, the statute contemplates those expenditure differences that are directly attributable to PDGM-related behavior changes. It does not authorize CMS to treat the entire gap between simulated pre-PDGM payments and actual post-PDGM payments as PDGM behavior change.

Based on the results, CMS may make either permanent (prospective) adjustments or temporary (retrospective) adjustments to the payment rates. However, CMS's approach relies on a comparison of **simulated** payments under the pre-PDGM payment system and actual payments for a year and has attributed the **entire** difference in payments to provider behavior changes related to the introduction of PDGM. The Alliance and other home health stakeholders have consistently stated since 2023 rulemaking that bias resulting from the methodology and data limitations make the simulation highly imprecise and that there is no basis to assert that the **entire** difference is related to PDGM behavior-related effects given the wide range of factors impacting payments in any given year.

We appreciate CMS' acknowledgement of several of these concerns in the CY 2026 HH PPS final rule, where the Agency concluded that it could not accurately make its determination using data after CY 2022 due to a range of confounding factors that resulted from other CMS program changes. The CY 2026 HH PPS final rule stated the following:

CMS policy changes implemented in CYs 2023 through 2025 might make it difficult to precisely distinguish the behavior changes related to the extenuating factors such as those mentioned by commenters and those behavior changes related to the implementation of the PDGM, based on analysis included in the proposed rule. These policy changes

⁵ Section 1895(b)(3)(D) of the Social Security Act

include recalibration of case-mix weights and LUPA visit thresholds finalized in the CY 2023, 2024, and 2025 final rules; reassignment of certain ICD–10–CM codes related to the PDGM clinical groups and comorbidity groups in the CY 2023 final rule; finalizing permanent adjustments in the CY 2023, 2024, and 2025 final rules; and the introduction of OASIS–E in 2023 and finalized mapping of OASIS–E to OASIS–D in the CY 2025 final rule for calculating functional points for functional impairment levels during repricing; and the expanded HHVBP Model. Because it is difficult to definitively isolate the behaviors directly related to the PDGM implementation after CY 2022, we are only finalizing a permanent adjustment based on data from CYs 2020 through 2022.⁶

While CMS' acknowledgement of these confounding factors, and its resulting decision to limit the permanent and temporary adjustments to determinations based on CYs 2020 through 2022 data is a welcome step toward more accurate payments, we point out that certain key confounding factors cited by CMS as impacting only years after CY 2022 **also apply** to CY 2022. As noted in our comments to the CY 2026 HH PPS proposed rule,⁷ these include: (1) recalibration of the case-mix weights (see 86 FR 62265 through 62281); and (2) reassignment of certain ICD–10–CM codes related to the PDGM clinical groups and comorbidity groups (see 86 FR 62253 through 62265).⁸ It is also important to note that in 2022, our nation continued to grapple with the global COVID-19 pandemic, which dramatically reshaped care delivery in ways that have nothing to do with PDGM-related behavior change.

The recalibration for CY 2022 rate-setting (using claims data from CY 2020) produced significant shifts in case-mix weights, heavily influenced by visit patterns that deviated greatly from past practice due to the COVID-19 pandemic, with changes in weights ranging from +16% to –26% across case-mix groups compared to CY 2021. In addition, changes in ICD-10-CM code assignments by CMS under PDGM make any conclusions about behavioral change tenuous, as CMS itself notes in the context of years 2023 and after. The

⁶ 90 FR 55364

⁷ <https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf>

⁸ For changes to the clinical group assignments for certain ICD-10-CM codes, CMS typically implements those changes without going through notice and comment rulemaking, and the quarterly files that update these changes can be found at: <https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health/home-health-grouper-software>

Agency's assertion that 2022 is somehow unaffected by these same changes is not correct.

As a result, we urge CMS to act consistently and apply the same rationale from the CY 2026 HH PPS final rule and reverse any permanent adjustments applied to 30-day payment rate calculated using data from CY 2022 in the upcoming proposed rule. In addition, other confounding factors impact earlier years (2020 and 2021), also noted by the Medicare Payment Advisory Commission (MedPAC), making any determination related to the impact of PDGM during the period of CYs 2020 to 2026 suspect and unreliable. Therefore, any permanent and temporary adjustments based on years 2020 and 2021 data should also be eliminated.

In MedPAC's March 2026 Report to Congress,⁹ the commission includes a report mandated by the Bipartisan Budget Act of 2018 assessing the impact of changes to the home health case-mix methodology (PDGM) and 30-day unit of payment. This report echoes concerns made by the Alliance and home health stakeholders regarding the ability to assess and attribute changes in payment and services as related to PDGM given other driving forces at play.¹⁰ MedPAC notes:

[I]t is notable that even though the payment methodology for skilled nursing services did not change, there were also fewer visits for these services associated with the PDGM – which raises questions as to whether other factors account for some of the difference in therapy visits that the model attributed to the PDGM.

In addition, MedPAC states:

The absence of a clear incentive in the PDGM for reduced nursing visits suggests that broader, non-PDGM factors—such as labor market pressures or post-pandemic operational changes—may have influenced visit intensity for skilled nursing, and it is reasonable to

⁹ Medicare Payment Advisory Commission's March 2026 Report to the Congress: Medicare Payment Policy, Chapter 14, Mandated report: The impact of recent changes to the home health prospective payment system, March 12, 2026. Available at: https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch14_MedPAC_Report_To_Congress_SEC.pdf [hereinafter MedPAC March 2026 Report]

¹⁰ <https://allianceforcareathome.org/wp-content/uploads/Alliance-CY-2026-Home-Health-NPRM-Comment-FINAL.pdf>

expect that therapy also could have been affected. Accordingly, while the PDGM may have contributed to the decline in therapy visits, the concurrent decline in nursing visits suggests that not all of the observed reduction in therapy can be attributed solely to the payment model's incentive changes.

Because PDGM implementation coincided with the pandemic and other systemic changes, our results may not fully account for all non-PDGM factors influencing utilization. Even in 2023, lingering effects such as staffing shortages could contribute to the differences in visits per stay for nursing and therapy.

The decline in therapy visits in 2020 and 2021 is the key factor driving the permanent and temporary adjustments determined by CMS for these years. However, MedPAC, in its Report to Congress, raises significant concerns about how much of that is actually related to PDGM versus other forces impacting the provision of home health services. As MedPAC made clear in its conclusion, the observed changes “suggest[] that broader factors, such as pandemic-related workforce challenges and operational adjustments, also influenced service delivery, including therapy visits.”¹¹ However, CMS has failed to acknowledge that other factors have impacted the Agency's calculations and reflect changes unrelated to PDGM. The Agency's assertion that **all** changes in services and payments are PDGM-related is therefore fundamentally flawed.

2. Fraud Related Concerns

The Alliance appreciates CMS' strong efforts to eliminate fraud, waste, and abuse across Medicare, including home-based benefits like home health and hospice. We were very pleased to join Administrator Oz in Washington DC last year as well as in Los Angeles, California in January of this year to discuss these important issues and will continue to support CMS' efforts to address them. We do remain concerned that the fraud identified by the Agency and others and associated inclusion of highly suspect claims data in CMS' calculations has corrupted CMS' data and analysis used for rate setting purposes, including the determination of permanent and temporary adjustments.

¹¹ *Id.*

The inclusion of Medicare claims data from HHAs with anomalous and aberrant billing patterns, particularly from Los Angeles County where the number of HHAs has increased exponentially between 2019 and 2025, inflates the calculated permanent adjustments and temporary adjustment dollar amounts and impacts other rate-setting updates. CMS has taken steps to exclude fraudulent data in other programs, such as adjusting benchmarks in the Medicare Shared Savings Program to remove highly suspect and anomalous data but has failed to take similar steps for home health. This concern, along with the other issues outlined above, provides further rationale to eliminate all permanent and temporary adjustments, resulting in a positive permanent adjustment in 2027.

3. Medicare Advantage Impacts

About half of beneficiaries receiving home health services do so through enrollment in Medicare Advantage (MA) plans. Neither CMS nor MedPAC have sufficiently assessed the financial impact of MA contract rates on provider sustainability. When MA plans pay HHAs based on the payment rates set for Traditional Medicare, HHAs are, once more, penalized by a flawed methodology that fails to accurately account for the confounding factors discussed above, which amounts to a “double cut”.¹² The Alliance recommends that the 2027 rulemaking cycle consider the adverse impact of these fee-for-service payment reductions on the sustainability of home health care covered under MA.

4. Recommendation

Accordingly, given the unreliability of the data and CMS’ determinations around budget neutrality, the impact of localized fraud impacting CMS’ data and analysis, we urge CMS to eliminate all permanent and temporary adjustments determined and applied by the Agency to date in 2027. While CMS narrowly addressed some concerns related to its methodology submitted by the Alliance in the CY 2026 HH PPS final rule, it did not sufficiently respond to other issues raised in our comment letter. These included technical errors in the methodology, such as assumptions related to

¹² Note that home health agencies are not among the provider and facility types subject to MA network adequacy time and distance or minimum number standards under 42 CFR § 422.116. The absence of a specific network adequacy standard for home health could mean the absence of regulatory backstop that would otherwise help facilitate more competitive rates necessary to ensure a sufficient supply of HHAs in a particular market. This compounds the concern with the downstream impact of reduced payment rates under Traditional Medicare.



outlier payments in its payment simulation and structural LUPA assignments, issues identified with using data from CYs 2020 through 2022 where other factors influenced changes in provider behavior, and the impact of using data from fraudulent HHAs that inflated CMS' calculated permanent and temporary adjustments.

We remind CMS that the Administrative Procedure Act (APA), 5 U.S.C. § 551-559, requires federal agencies, including CMS, to exercise informed decision making that includes public input like that set forth in the Alliance's letter that reveal important considerations, data, and perspectives that the Agency may have overlooked or not previously considered. Agencies that do not substantively 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.¹³

Thank you for your consideration of these important issues. The Alliance's recommendations are intended to ensure that a viable and sustainable home health care benefit remains available for Medicare beneficiaries; a goal I know we share.

Sincerely,

A handwritten signature in black ink that reads "Jennifer Sheets". The signature is written in a cursive, flowing style.

Jennifer Sheets
Chief Executive Officer
National Alliance for Care at Home

¹³ In cases where agencies failed to adequately address comments, courts, including the Supreme Court in decisions like *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29 (1983), have rejected Agency action as arbitrary and capricious for failing to provide a reasoned explanation and demonstrate a connection between the facts found and the choices made.