August 28, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Subject: CMS-1828-P Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies

Submitted electronically via https://www.regulations.gov

Dear Administrator Oz,

We represent more than 5,400 nonprofit aging services providers and other mission-driven organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use advocacy, education, applied research, and community-building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, hospice, and home-based care including Medicare home health agencies. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. On behalf of these members, LeadingAge is pleased to offer the following comments in response to the CY2026 Home Health Prospective Payment System Proposed Rule.

Since President Trump took office, LeadingAge has applauded his strong leadership on reducing administrative burdens and reversing certain harmful policies of the Biden administration such as the Special Focus Program for hospice agencies. For the last three consecutive rulemaking cycles, the previous administration added burdensome regulations and implemented devastating cuts which have had unprecedented impacts on the long-term care sector. The Biden administration implemented a total 8.8% permanent cut to the home health base payment rate in just three short years. We urge the Trump administration to reverse the disastrous path home health is on and use all authorities available to provide a reprieve to home health agencies (HHAs).

As we detail below, these cuts are coming at times when our members' costs and demand for services are rising and cannot be met. Continuing to implement these cuts will have a disastrous effect on older adults who rely on these services. The combined impact of the proposed payment changes and current workforce and inflationary pressures will lead to more closures of home health agencies and the inability of providers that remain to take on new referrals.

LeadingAge remains gravely concerned with the continued proposed decreases associated with the Patient-Driven Groupings Model (PDGM). LeadingAge members are already looking at reducing services or service areas, laying off staff, or closing branches. Members have already taken these steps to reduce expenditure and remain operational in response to the 8.8% cut in base payments since CY2023. With few places left to cut back, many of our nonprofit, mission driven members are seriously considering shutting down their home health lines of service if these proposed cuts are finalized.

Members also shared they were facing current negative all payer margins with nearly having five or more years of negative margins. The impact could be even more devastating than service cutbacks -- the combination of these proposed payment cuts will coincide with the second year of payment adjustments resulting from the home health value-based purchasing (HHVBP) model which, as we will detail later, is flawed and resulting in payment reductions for our members that we believe are not in line with the intent of the model. According to our analysis of the HHVBP data released in January 2025, 54% of nonprofit home health agencies received a negative HHVBP model payment adjustment in CY2025. This amalgam of Medicare FFS payment cuts will only create more access issues for vulnerable Medicare beneficiaries, which is the opposite of what people say they want – high quality care at home.

General Comments on the State of Fee-for-Service Home Health Care

The role home health providers play in reducing costs for the full system is evident from the expansion of the home health value-based purchasing (HHVBP) model. HHVBP remains one of only a handful of programs designed by the Center for Medicare and Medicaid Innovation to meet the criteria for nationwide expansion: improving quality of services while also reducing costs. While we have grave concerns with the construction of the expanded model, the initial demonstration, which ran for seven years in only nine states, resulted in an average 4.6% improvement in home health agencies' quality scores and average annual savings of $141 million to Medicare.[1]

Despite the obvious role home health agencies play in improving care for Medicare fee-for-service beneficiaries and reducing total system costs, CMS' own monitoring data bares out our fears that home health use is in decline and the sector could be destabilized by the 6.4% aggregate reduction in payments proposed for CY2026. Information provided in the CY2026 Home Health Proposed Rule reviews the utilization trends between the simulated CY2018 and CY2019 30-day episodes and all episodes following the implementation of the PDGM. While CMS may argue this trend was in process before PDGM, we would argue that the removal of therapy caps in CY2019 deeply impacted home health agencies. Additionally, we would argue that CY2021 was an anomaly among the periods of care and number of unique beneficiaries (since the health care systems attempted to keep patients out of skilled nursing and hospitals). This table illustrates our continued concerns regarding the decline in use of home health services:

[1] Centers for Medicare & Medicaid Services. (2021, January 8). *CMS takes action to improve home health care for seniors, announces intent to expand home health value-based purchasing*. https://www.cms.gov/newsroom/press-releases/cms-takes-action-improve-home-health-care-seniors-announces-intent-expand-home-health-value-based

TABLE 2: OVERALL UTILIZATION OF HOME HEALTH SERVICES, CYs 2018-2024

Volume of Periods and Number of Beneficiaries	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
30-Day Periods of Care	9,336,898	8,744,171	8,423,688	9,269,971	8,593,266	8,319,064	8,118,120
Unique Beneficiaries	2,980,385	2,802,560	2,850,916	3,017,464	2,831,138	2,715,010	2,620,520
Average Number of 30-Day Periods per Unique Beneficiary	3.13	3.12	2.95	3.07	3.04	3.06	3.10

Source: CY 2018 and CY 2019 simulated PDGM data with behavioral assumptions came from the Home Health Limited Data Set (LDS). CY 2020 data was accessed from the Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC) on July 12, 2021. CY 2021 data was accessed from the CCW VRDC on July 14, 2022. CY 2022 data was accessed from the CCW VRDC on July 13, 2023. CY 2023 data was accessed from the CCW VRDC on July 11, 2024. CY 2024 data was accessed from the CCW VRDC on March 13, 2025.
Note: All 30-day periods of care claims were included (for example LUPAs, partial episode payments (PEPs), and outliers).

The impact on acute-care partners if these trends continue is equally as concerning. While only a snapshot of larger concerns, a July 2025 report from Massachusetts Transitions from Acute Care to Post-Acute Care (TACPAC) Task Force found more than 2,000 individuals remain in acute settings daily despite being clinically ready for discharge, with some waiting over 30 days for post-acute placement.[2] Reductions in access will hit rural communities hardest, and these regions already face long wait times and provider shortages. According to the Center for Healthcare Quality and Payment Reform, over 700 rural hospitals (one-third of all rural hospitals) are at risk of closing in the near future – a problem that will be compounded by a lack of discharge partners.[3] The result of lack of access to post-acute providers like home health is the rise in system-wide costs including longer hospitalizations and increased skilled nursing care.

The narrative of health care often pits post-acute care providers against each other, but the reality is these providers create a fragile ecosystem of collaborative support for older adults. From LeadingAge's unique vantage point as the only association representing nonprofit and mission driven aging services providers including home health and skilled nursing, we can see how critical each setting is to the prosperity of older adults. Multiple studies have shown that coordinated discharge from skilled nursing to home health care reduces risk of readmission.[4] [5] [6] Our providers are not in competition, they are partners in supporting older adults and the loss of access to one hurts the entire system, whether it is a skilled nursing home or a home health agency.

The decline in the number of home health agencies is an increasing concern with mounting evidence. While the metric of access the Medicare Payment Advisory Commission (MedPAC) uses still identifies access as being high (nearly 98% of beneficiaries living in a zip code with at least two agencies) there is growing concerns this is an outdated and harmful definition of access. This definition was first established in 2003. Between 2019 and 2023, the number of skilled home health agencies that treated more than 10 fee-for-service patients annually decreased or remained the same in 94.1% of U.S.

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[2] Massachusetts TACPAC Task Force. (2025, July 31). *Transitions from Acute Care to Post-Acute Care (TACPAC) Task Force Report*. https://www.mass.gov/doc/tacpac-task-force-report-final-7-31-2025-0/download

[3] Center for Healthcare Quality and Payment Reform. (n.d.). *Rural hospitals at risk of closing*. https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

[4] Weerahandi H, Bao H, Herrin J, Dharmarajan K, Ross JS, Jones S, Horwitz LI. Home Health Care After Skilled Nursing Facility Discharge Following Heart Failure Hospitalization. J Am Geriatr Soc. 2020 Jan;68(1):96-102. doi: 10.1111/jgs.16179. Epub 2019 Oct 11. PMID: 31603248; PMCID: PMC6964248.

[5] Simning A, Orth J, Wang J, Caprio TV, Li Y, Temkin-Greener H. Skilled Nursing Facility Patients Discharged to Home Health Agency Services Spend More Days at Home. J Am Geriatr Soc. 2020 Jul;68(7):1573-1578. doi: 10.1111/jgs.16457. Epub 2020 Apr 15. PMID: 32294239; PMCID: PMC7363542.

[6] Shi S, Olivieri-Mui B, Oh G, McCarthy E, Kim DH. Analysis of Functional Recovery in Older Adults Discharged to Skilled Nursing Facilities and Then Home. JAMA Netw Open. 2022 Aug 1;5(8):e2225452. doi: 10.1001/jamanetworkopen.2022.25452. PMID: 36006647; PMCID: PMC9412223.

counties.[7] Half of U.S. counties have five or fewer home health agencies per 1,000 square miles, with many rural areas having access to only one agency or no agencies serving more than 10 patients.

Other recent research highlights growing access issues that are not taken into consideration as part of MedPAC's definition:

- Over a third of patients referred to home health care after hospitalization never receive it despite clear medical need.[8]
- According to the same research, for those who are able to access care, delays in access have increased a full day since 2019 and 10% of referrals are currently waiting at least five days to receive a visit, with longer wait times more likely in rural areas.
- The lack of access increases the likelihood of readmissions by 35%, emergency department use by 16%, mortality rates by 43%, and overall total healthcare spending by 5.4%.

These are concerning statistics considering the growth in the older adult population and the focus on receiving care in the home. A new definition of access that looks at a multitude of factors needs to be developed in consultation with stakeholders to paint a true picture of beneficiary access to care.

Proposed CY2026 Home Health Payment Rate Updates

LeadingAge remains gravely concerned with the continued proposed decreases associated with PDGM. In the CY2026 Home Health Proposed Rule, CMS is proposing to apply an additional -4.059% permanent adjustment in addition to a -5% temporary adjustment.

For the past three years of rule cycles, we have conveyed our concerns to CMS regarding the impact of permanent behavior adjustments – which currently total -8.8% since CY2023 – on the entire home health sector and the fee-for-service beneficiaries served.

PDGM was developed to better align patient characteristics to how home health agencies were paid. In previous iterations of the payment methodology for home health providers, certain services took priority in payments and led to overutilization of physical therapy visits in pursuit of maximizing profits. PDGM attempts to move home health away from this payment practice and focus on matching payment to clinical characteristics of the actual patient. We would argue PDGM's focus on patient characteristics is crucial to the future of home health care.

While we support the development of a payment methodology based on clinical characteristics, the accompanying legislated requirements regarding budget neutrality raise significant concerns with the sustainability of home health services. The previous administration first implemented permanent and temporary adjustments to provider payments, and we strongly believe the interpretation of the adjustments was incorrect.

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[7] Trella Health. (2024, December). *Home health accessibility among Medicare fee-for-service (FFS) beneficiaries* [Special report].

[8] CareJourney. (2025, June). *Home health access Q3 2024*. https://carejourney.com/wp-content/uploads/2025/06/Home-Health-Access_2024-Q3-_2025.02.pdf

We ask that you use your Congressional authority to not implement the permanent and temporary adjustments under the budget neutrality clause for CY2026 and allow your staff time to review the previous Administration's interpretation of the required adjustments and correct the approach used to determine the permanent and temporary adjustments. We believe that if CMS looks at the methodological suggestions made in our comment letter, the payment adjustment for CY2026 should be positive.

All Payer Margins

CMS has been unwaveringly clear in their discussion of margins, consistently citing section 1861(v)(1)(A) of the Act which states "under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs."

With all due respect to CMS, LeadingAge has never said "Medicare payments should subsidize payments from other payers (Medicare Advantage and Medicaid)" as the CY2023 Home Health Final Rule summary claims. However, we have repeatedly asked CMS to look at home health agency overall financial conditions as a metric to determine the stability of the sector and if adjustments needed to be delayed in order to maintain that stability.

We have clear evidence from CMS' own Office of Actuary that the agency does take into consideration total payer margins as part of broader sustainability considerations in the work of the Board of Trustees for the Medicare Trust Fund. Appendix C of the *2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* report found in 2023 36% of HHA's have negative total margins, and the CMS Office of Actuary estimates that by 2040 that number will rise to 54%.[9]

Table 1. Simulated Proportion of Part A Providers with Negative Total Facility Margins

Provider Type	2011	Current Base Year 2023	Historical Experience		Achievable Productivity Scenario	
			2027	2040	2027	2040
Hospital*	30%	37%	39%	44%	38%	40%
SNF	40%	51%	51%	57%	51%	56%
HHA	36%	36%	44%	56%	43%	54%

* The percentage of hospitals with negative Medicare margins was 66 percent in 2011 and 79 percent in 2023, increasing under the historical scenario to 85 percent in 2027 and to 93 percent in 2040, and under the achievable productivity scenario to 83 percent in 2027 and to 87 percent in 2040.

The memo states that "Over the long range, however, the simulations suggest that absent other modifications, significant financial pressures will arise for providers, increasing the possibility of access and quality of care issues for Medicare beneficiaries." This is a clear indication that the Trustees of the

[9] Centers for Medicare & Medicaid Services. (2025). *Simulations of Affordable Care Act Medicare payment update provisions: Part provider financial margins*. https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf-0

Medicare Trust Fund along with the CMS Office of Actuary feel it is their obligation to look at the overall financial pressures faced by providers as it relates to potential effects on fee-for-service Medicare beneficiaries' access and quality of care.

We were clear in our CY2024 Home Health Rule comments that the government needs to work on ensuring rate adequacy across all payers before disrupting overall access to care through further cuts to fee for service Medicare. CMS must evaluate payment adequacy across all payers under federal jurisdiction, including Medicaid and Medicare Advantage and should work with Congress to seek any needed additional authority to ensure rate adequacy across payers.

Time and Manner Authority

CMS has been abundantly clear that they are legally required to make these adjustments based on statutory language. As LeadingAge has commented in previous rulemaking cycles, the language of the statute, in our view, gives the Secretary flexibility in use of the administrative process to make these adjustments. However, CMS has not sufficiently explained in any previous notice and comment rulemaking why they are not using the statutory authority to apply the permanent and temporary cuts "at a time and in a manner determined appropriate."

In the CY2025 Home Health Final Rule, we recognize that CMS attempted to address this concern in the sector by stating:

> *As for the suggestion that access to care issues justify delaying implementation of the permanent behavioral adjustments, our analysis has not identified sufficient evidence that delaying the implementation of the permanent adjustment will have a significant effect on access to care or the issues commenters describe as destabilizing the home health benefit.*

We do not believe this sufficiently answers stakeholder concerns regarding the "time and manner" authority granted to CMS. It is evident that CMS has used its authority to delay the implementation of temporary adjustments and has used the authority to decrease previous year's permanent adjustments. **We ask for clarification on what constitutes "sufficient evidence" to demonstrate the permanent adjustments will have a significant effect on access to care or the destabilizing of the home health benefit in order for CMS to delay permanent adjustments.**

Forecasting Error Correction

The accuracy of annual payment updates, which are statutory required, is an essential piece of the payment structure for home health agencies and critical for ensuring that payments keep pace with rising costs, especially those related to labor and resources necessary to provide patient care. Every year, CMS provides an annual update to home health payments based on forecasts of market basket increases for the upcoming payment year, as actual measures of price growth are not available until after rulemaking is required to be completed. Unfortunately, over the past four years, CMS's forecasts for the market have routinely and significantly underestimated actual price growth and caused additional, unintentional cuts on top of the already devasting -8.8% in permanent adjustments.

According to our review of the Office of the Actuary's summary market basket history and forecasts[10] compared to finalized market basket rates from CY2021 to CY2024 (the most recent year of complete data), the home health market basket has had a cumulative forecast error of -6.7% points as illustrated below.

MB Forecast Error Impact	CY2021	CY2022	CY2023	CY2024	Cumulative
Projected Market Basket (Final Rules)	2.30%	3.10%	4.10%	3.30%	13.42%
Actual Market Basket	3.90%	6.20%	4.70%	4.00%	20.15%
Percent Point Difference	-1.60%	-3.10%	-0.60%	-0.70%	-6.7%

Unless corrected, this forecast error remains in the payments rates contributing to the chronic under funding of the home health benefit resulting from combined policies to cut payments. The cost of providing care has grown dramatically over this period, especially with regards to growing labor costs caused by increased competition for limited staff.

LeadingAge recommends that CMS finalize a one-time forecast error correction to the CY2026 payment to increase the base payment rate 9.6% to account for the underestimated market basket for CY 2021 through CY 2024. While we understand CMS previously addressed comments on forecasting errors by stating, "There is currently no mechanism to adjust for market basket forecast error in the home health payment update," we do not believe a one-time adjustment would conflict with the prospective nature of the home health payment going forward or generate uncertainty.

Fraud Impacting Behavioral Assumptions Methodology

In LeadingAge's comments on the CY2025 Home Health Proposed Rule we raised concerns regarding fraudulent practices in California. The lack of response from CMS on these fraud concerns is alarming. Unfortunately, the home health sector has a history of fraud dating back to the early 1990s when Operation Restore Trust targeted agencies in California, Illinois, New York, and Texas which were enrolling ineligible beneficiaries, submitting claims for unreasonable and unnecessary services, or did not have the proper orders or documentation.[11] This resulted in $2.6 billion in unallowable claims and led to the revision of the payment system to a prospective payment system.

A decade later, in 2013, similar aberrant patterns emerged, and CMS used their newly legislated authority under the Affordable Care Act to establish a temporary moratorium on new enrollments of home health agencies which lasted until 2019.[12] At the time of the moratorium and after it concluded, there was no evidence of access to care issues for Medicare beneficiaries.

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[10] Centers for Medicare & Medicaid Services. Office of the Actuary, July 15, 2025, 1st quarter 2025 forecast data. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data To arrive at the recommended 9.6% correction to the base rate, we incorporated the market basket forecast error corrections described in the above table to relevant previous payment updates. Once this is incorporated in the rulemaking base rate formulas and caried forward, the 6.7% forecast error incurs a 9.6% impact.

[11] Office of Inspector General. (1997). *Operation Restore Trust: Audit of Medicare home health services in California, Illinois, New York, and Texas*. https://oig.hhs.gov/reports/all/1997/operation-restore-trust-audit-of-medicare-home-health-services-in-california-illinois-new-york-and-texas/

[12] Centers for Medicare & Medicaid Services. (2013). *Survey and certification letter 13-53*. https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/policy-and-memos-to-states-and-regions-items/survey-and-cert-letter-13-53

LeadingAge's concerns regarding the resurgence of fraud in the home health program is not without evidence.

According to MedPAC's 2025 Health Care Spending and the Medicare Program Databook, much of the growth in home health agencies since 2018 has been concentrated in California. When California is excluded from overall industry growth, the supply of agencies actually declined by about 2% between 2018 and 2023.[13] Furthermore, in MedPAC's 2025 Report to Congress the commission noted, "A large spike in the number of HHAs in Los Angeles County, California, in 2023 drove an increase in the overall number of participating HHAs of 3.4 percent, but after excluding this county, the number of HHAs decreased by 2.8 percent relative to the prior year." During the Commission's discussion of the 2025 draft chapter, multiple commissioners raised concerns with the increase in home health agencies in LA County, to which MedPAC replied they did not believe there was an access problem and that "the pattern is suggestive that there could be some program integrity concerns." Staff believed more research was necessary to confirm that suspicion. We believe both things can be true – that there is an access problem and potential fraudulent actors. We hope MedPAC acts upon this observation as they have a history of supporting program integrity actions including a 2013 recommendation pushing for OIG "medical review activities in counties that have aberrant home health utilization and suspend[ing] payment and enrollment of new providers if they indicate significant fraud."[14] We ask that CMS also look into the impacts of fraud on home health.

In 2022, the California State Auditor released a report, predominately targeting growing concerns regarding hospice fraud in California. However, the auditor's report included concerns about home health agencies as well:[15]

- Page 14: These same schemes have frequently also involved home health agencies, which are similar to hospice agencies in that they also provide care to patients in their homes…
- Page 21: In addition to the hospice agencies, Public Health's licensing data as of January 2022 show 49 home health agencies with business offices located in Building A.
- Page 22: In addition, Public Health's inspections included troubling observations of staff being unavailable and patients unknowingly being admitted or not qualifying for services at certain home health agencies. Nonetheless, because Public Health indicated that it could not substantiate the occurrence of fraudulent activities at the investigated agencies, the investigation concluded with Public Health taking no action to suspend or revoke any of the licenses in question. Instead, it provided DOJ with a letter in February 2021 that identified several home health agencies and one hospice agency that it had begun investigating because of "patient care concerns and possible fraud." Public Health stated in the letter that it believes the allegations of fraud are within DOJ's jurisdiction, but it did not provide an investigation report or details about the allegations. According to DOJ, it has no record of receiving the letter. Consequently, DOJ did not pursue it.

[13] Medicare Payment Advisory Commission. (2025, July). *Health care spending and the Medicare program databook*. https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC.pdf
[14] Medicare Payment Advisory Commission. (2013, March). *Chapter 9: Medicare program integrity*. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar13_ch09.pdf

[15] California State Auditor. (2022). *California Department of Public Health: Hospice and home health agency oversight*. https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf

- Page 49: Because the fraud indicators we identified frequently also involved home health agencies, the four departments should also consider risks related to home health agencies. These departments should adjust their fraud prevention and detection efforts based on the results of this assessment.

We believe, despite the need and best intentions of the first Trump administration to waive enrollment barriers during the COVID-19 Public Health Emergency, fraudulent actors in California took advantage of expedited review of new applications and pauses on revalidation activities.[16] While California took decisive actions regarding hospice fraud with a statewide moratorium, they have failed to address concerns with home health agencies.[17]

When CMS first implemented the 2013 moratorium in Miami-Dade County, data showed that from 2008 to 2012 the total number of agencies increased from 385 to 662, or a 71% increase.[18] At that time, there were 37.6 HHAs per 10,000 Medicare FFS beneficiaries. From 2019 (before COVID flexibilities) to 2024, the total number of home health agencies in Los Angeles County increased from 781 to 1,588, or a 103% increase in providers.[19] This means there are currently 18.7 HHAs per 10,000 FFS beneficiaries in LA County. Additionally, CMS' data shows 44% of all home health payments in California in 2024 went to HHAs in LA County despite the average number of users per agency in LA was lower than the state as a whole. LA County accounted for 9% of all home health FFS payments nationally in 2024.

The difference between this current period of fraudulent activity in home health and previous periods is that previous payment systems did not have an aggregate impact on all agencies. When CMS developed the PDGM payment system they relied on a fixed effects model, which accounts for the average variation in resource use within a particular agency as opposed to accounting for the variation across all agencies.[20] We generally support this approach because it is a better indication of individual recipient needs. Unfortunately, as previous periods of fraudulent activity indicate, agency level post claim review is not an effective tool to fight systemic fraud. In the final report following the end of Operation Restore Trust, the OIG stated:

> Medical reviews of claims for HHA services were not effective in curbing abuse. The [Health Care Financing Administration] HCFA, as a result of funding constraints, instructed intermediaries to reduce medical reviews and focus on aberrant providers. The intermediary medical review effort was reduced because the reviews resulted in low denial rates and were therefore considered ineffective. However, the reviews will continue to produce limited results because the focused medical reviews do not include beneficiary and physician interviews. [21]

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[16] Centers for Medicare & Medicaid Services. (2020). *Provider enrollment relief FAQs – COVID-19*. https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

[17] California Health and Safety Code § 1751.70. https://california.public.law/codes/health_and_safety_code_section_1751.70

[18] Centers for Medicare & Medicaid Services. (2013). *Federal Register: Medicare program; moratoria on enrollment of home health agencies*. https://www.federalregister.gov/d/2013-18394/p-43

[19] Centers for Medicare & Medicaid Services. (2025, August 18). *Market saturation & utilization state-county dataset*.

[20] Centers for Medicare & Medicaid Services. (2016). *HHGM technical report*. https://downloads.cms.gov/files/hhgm%20technical%20report%20120516%20sxf.pdf

[21] Office of Inspector General. (1997). *Operation Restore Trust: Audit of Medicare home health services*. https://oig.hhs.gov/reports/all/1997/operation-restore-trust-audit-of-medicare-home-health-services-in-california-illinois-new-york-and-texas/

Assumptions of good-faith participation of home health agencies, unfortunately, were unrealistic. With the implementation of the PDGM came the requirement of budget neutrality adjustments and the aggregate application of all decreases or increases. We believe the proliferation of fraudulent agencies in LA county, and their outsized impacts on payments compared to national trends, has impacted the behavioral adjustment calculations and led to an increase in the assumed overpayments to the home health sector which are being recouped in aggregate without targeting agencies which may have falsified their cost reports or provision of services. Knowing the history of fraudulent activity and the ease to which all home health payments systems before were manipulated, PDGM should never have moved forward without clear analytical safeguards for program integrity.

LeadingAge implores CMS to conduct analysis into the home health agency growth in Los Angeles County, California, assessing and publicly reporting the real and ongoing potential impacts on the aggregate adjustments since the implementation of PDGM and HHVBP. Given this administration's focus on crushing fraud, waste, and abuse, we sincerely hope these concerns will not go unanswered for another rule making cycle, endangering more honest providers and their community's access to services.

Increasing Acuity of the Home Health Population

In our comments to the CY2023 Home Health Proposed Rule, we raised the issue of CMS not properly accounting for higher acuity beneficiaries and raised the opportunity to integrate Hierarchical Condition Categories (HCC) scores into the behavioral assumptions methodology to create a more holistic view of the full home health patient population. As with the evaluation of the impact on fraud, this would be in addition to the fixed effects model of agency level data to look at the whole picture and identify anomalies in the data to protect integrity, but also to ensure agencies that are in fact serving highly acute populations are not at higher risk of closure and to make appropriate adjustments in the system to account for and protect these critical access agencies. CMS responded:

> *We appreciate the commenter's recommendation; however, we note that the HCC scores are dependent on beneficiaries having a claims history (which may be limited for those newly enrolled in Medicare), and therefore, do not think they would be appropriate to use in this methodology as it may limit our ability to capture beneficiary characteristics needed for case-mix adjustment.*

We respectfully disagree with CMS' assumption that traditional fee-for-service home health beneficiaries would not have enough claims history to adequately utilize HCC in the behavioral adjustment methodology. According to two studies published in 2025, the average age of fee-for-service home health beneficiaries from 2010 to 2022 was 79 to 80 years old.[22] [23] That's nearly 15 years' worth of claims history. The Transforming Episodes Accountability Model (TEAM) is already preparing home health agencies and other post-acute providers to use HCC scoring to risk adjust payments for certain patients.[24]

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[22] Werner RM, Kim S, Konetzka RT. Trends in Home Health Care Among Traditional Medicare Beneficiaries With or Without Dementia. JAMA Netw Open. 2025;8(5):e2510933. doi:10.1001/jamanetworkopen.2025.10933

[23] Kim S, Qi M, Konetzka RT, Werner RM. Home Health Care Use Among Medicare Beneficiaries From 2010 to 2020. Med Care Res Rev. 2025 Jun;82(3):260-268. doi: 10.1177/10775587251318407. Epub 2025 Feb 19. PMID: 39972931; PMCID: PMC12018719.

[24] Centers for Medicare & Medicaid Services. (2025). *Transforming Episodes Accountability Model (TEAM)*. https://www.federalregister.gov/d/2025-14681/p-4463

LeadingAge remains concerned that the current evaluation of the PDGM does not accurately account for the growing acuity of home health patients and that makes it difficult to accurately understand increasing costs in the system as well as realistic access. **Once again, LeadingAge requests CMS incorporate HCC scoring into the behavioral adjustment assumptions. At the very least, CMS should articulate exactly why incorporating HCC into the methodology would not be possible, as the first rejection regarding lack of claims history is not borne out in recent research.**

Claims Excluded from Calculations

In the CY2023 Final Rule, CMS reviewed the reasons for the exclusions of certain claims such as those that overlapped or three or more claims being linked to the same OASIS.[25] CMS eventually determined to exclude 9.5% of 30-day claims for CY 2020 and 16.3% of 30-day claims for CY 2021. While CMS felt such a small number of excluded claims would not significantly bias their results, we disagree. While CMS excluded 25.8% of claims in their calculation of 30-day episode changes for those first two years of PDGM, there was no consideration given to only applying the methodology those claims not exclude. More specifically, we believe CMS should have only applied the calculation to the remaining 90 percent of claims for CY 2020 and 83 percent of claims for CY 2021. Instead, CMS calculated the temporary retrospective adjustment based on the total claims.

We believe the permanent adjustments are overestimated and should be corrected along with the 5% temporary retrospective adjustment proposed for the CY2026 payments. LeadingAge asks CMS to explain why the adjustment was applied to all claims instead of those which were not excluded.

Methodological Errors in the Behavioral Adjustment Assumptions

As CMS has repeatedly stated over the last three rulemaking cycles, they "are not required to correct or quantify each original assumption regarding home health agency behavior change, but rather, ensure that the payment rate is accurately accounting for all behaviors that actually occurred in a given year." However, the original assumptions can never account for actual behavior if elements of the assumptions change or new behavioral incentives are introduced. Specifically, there were numerous changes in the CY2022 and CY2023 Home Health Final Rule which could have impacted provider behavior beyond original assumptions:

- **Case-Mix Weights Recalibration**: in the CY2022 Home Health Final Rule, and every subsequent year since, CMS has recalibrated the PDGM case-mix weights. The recalibration for CY2022 produced significant shifts in case-mix weights, influenced by care patterns from the COVID-19 pandemic as 2020 data was used to recalibrate the weights in 2022. The changes in weights ranged from +16% to –26% across case-mix groups compared to CY 2021. Changes in payments at the case-mix group level ultimately influence how agencies structure service delivery to remain viable.

- **Behavioral Permanent Adjustment:** In the CY2023 Home Health Final Rule, and every subsequent year since, CMS has finalized cuts that total -8.8% in adjustments to the base payment of PDGM payments. These adjustments have absolutely changed provider behavior, from reducing service areas to closing branches. This impacts the overall assumptions of the methodology and were not taken into account in the original behavioral assumptions.

[25] Centers for Medicare & Medicaid Services. (2022). *Federal Register: CY2023 Home Health Final Rule*. https://www.federalregister.gov/d/2022-23722/p-171

- **LUPA Rate Recalibration:** In the CY2023 Home Health Final Rule, after holding the adjusted Low Utilization Payment Adjustment (LUPA) steady since CY2020, the thresholds were updated. This decision to hold changes for so long was made due to visit patterns, especially those that saw decreases in CY 2020, not being representative of visit patterns in CY2022.[26] However, there was no conversation in the CY2023 Final Rule about revising the assumptions due to the update in the LUPA thresholds and since then the LUPA rates have been routinely updated influencing provider decisions about which cases to take and not.

- **Fix-Dollar Loss Ratio Recalibration:** Similar to the LUPA rate changes, in the CY2023 Home Health Final Rule, CMS moved the fix-dollar loss ratio (FDL) from 0.56% to 0.40%. For the first three years of PDGM implementation (CY2020, CY2021, and CY2022) the FDL was held steady.[27] This change to the FDL ratio in CY2023 payments would have influenced provider behavior beyond the original assumptions of the original methodology. Additionally, in CY2025 Final Rule, CMS updated the CY2024 FDL of 0.27 to a ratio of 0.35 and as CMS noted "A higher FDL ratio reduces the number of periods that can receive outlier payments, and as a result there is a slight decrease to total payments."[28] We believe this would have a profound effect on provider behavior beyond the original methodological assumptions.

We therefore urge CMS not to finalize the proposed permanent and temporary adjustments and instead recalculate the adjustments determined for CY2020 to CY2024 correcting for these methodological flaws.

Proposed Regulation Change to Face-to-Face Encounter

On June 11, 2025, LeadingAge submitted extensive comments on the CMS Request for Information regarding regulations that could be considered for elimination from the Medicare program for home health agencies. In those comments, and a similar letter to the Office of Management and Budget on May 12, 2025, LeadingAge requested CMS update 42 CFR 424.22(a)(1)(v) to align with the flexibilities granted by the CARES Act and eliminate unnecessary barriers to Medicare home health certification. The CARES Act clearly reflects Congressional intent to authorize non-physician practitioners (NPPs) to certify and order home health services for Medicare beneficiaries in accordance with state laws. Furthermore, Congress explicitly granted flexibility regarding who may conduct the F2F encounter, ensuring greater access to care. **LeadingAge is grateful for CMS' consideration of this request and fully supports the revisions proposed in the CY2026 Home Health Proposed Rule.**

Home Health Quality Reporting Program (HH QRP)

On June 11, 2025, LeadingAge submitted extensive comments on the CMS Request for Information regarding regulations that could be considered for elimination from the Medicare program for home health agencies. As part of these comments, LeadingAge identified the increasing complexity and redundancy of OASIS-E1 as a regulatory burden to providers. We have consistently cited concerns with increasing the burden to clinicians when additional questions are added to the already complex and

[26] Centers for Medicare & Medicaid Services. (2022). *Federal Register: CY2023 Home Health Final Rule*. https://www.federalregister.gov/d/2022-23722/p-256
[27] Centers for Medicare & Medicaid Services. (2022). *Federal Register: CY2023 Home Health Final Rule*. https://www.federalregister.gov/d/2022-23722/p-396
[28] Centers for Medicare & Medicaid Services. (2024). *Federal Register: CY2025 Home Health Final Rule*. https://www.federalregister.gov/d/2022-23722/p-374

time-consuming OASIS. We are grateful for the administration's attention to our concerns and their willingness to remove items that will not serve to improve the care our home health members offer patients and only add more burden.

Proposed Removal of the "COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date"

In our CY2024 Home Health Proposed Rule comment letter, LeadingAge clearly outlined revisions which were necessary to make the adoption of the "COVID-19 Vaccine: Precent of Patients/Residents Who Are Up to Date" meaningful for home health agencies and patients. These included exclusions for refusal to get vaccinated, refusal to share vaccination status, or contraindications for vaccination. We also highlighted issues with the process measure not truly evaluating the care a patient received from the home health provider but rather the individual's decision to stay up to date with their COVID vaccinations. The most significant issue we had with this measure was placing the accountability of vaccination on agencies which could not offer patients a way to become vaccinated if they wanted to due to the complicated process of maintaining and storing the COVID vaccine itself.

For these reasons, LeadingAge supports the proposal to remove the "COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date" from the HH QRP beginning with the CY2026 HH QRP. LeadingAge also supports the proposal that the Patient/Resident COVID-19 measure rates be publicly reported for the last time with the January 2026 Care Compare.

Removal of Social Determinants of Health (SDOH) Measures

LeadingAge has consistently supported eliminating health disparities and adding proper risk adjustment for the home health population payment. However, as we stated in our comment letter on the CY2025 Home Health Proposed Rule, in contrast to facility-based settings like nursing homes or hospitals, home health agencies often walk into the home where these SDOH situations are currently happening and may be at a crisis level not addressed by the system upstream before discharge. There no guarantee that the home health agency would be able to mitigate the existing issue for the patient and their family. At this time, home health agencies do not necessarily have the capacity to help remediate many of the experiences captured in the items finalized for inclusion in OASIS in CY2027. There are no action steps for providers after these questions are asked. Presumably, one would not be asking questions if one was not able to intervene in some way to help address problems identified. If a home health agency were to undertake information gathering and referral for ancillary services such as organizing home delivered meals or housing stability supports, this would surely take significantly more time than simply conducting the assessment-- more commitment from the agency, at a time when their base rates in fee for service and contracted rates in Medicare Advantage are being depleted. Additional funding would need to be made available to home health agencies to ensure they could appropriately engage in social support services beyond the scope of the current benefit.

For these reasons, LeadingAge supports the proposal to remove the four standardized patient assessment data elements collected under the SDOH category from the HH QRP beginning with the CY 2026 HH QRP.

LeadingAge would like to take this opportunity to reiterate ways CMS can expand the role and billing for medical social work services to ensure the right member of the team is addressing the needs of patients:

- The current OASIS manual clearly states that medical social workers are not a discipline authorized to complete the comprehensive assessment or collect OASIS data.[29] CMS should allow medical social workers to collect OASIS data elements. While they do not necessarily need the authority to conduct the initial or comprehensive assessment, allowing medical social workers to collect relevant OASIS data on behalf of the team will help alleviate the burden of more data items on RNs who conduct the majority of OASIS assessments. It would also help jumpstart the social work intervention.
- 42 CFR 484.60(a)(2)(xiii) establishes that training of caregivers is a required element of the home health care plan but does not specify which professionals are allowed to conduct this training. However, the Medicare Claims Processing Manual restricts training to only RNs and LPNs.[30] A clinical social worker is the appropriate staff to train and/or educate a patient or family member on accessing services to support SDOH especially in the context of discharge planning. Therefore, CMS should add a G-Code for medical social services to provide training to patients and families within the context of 42 CFR 409.45(c).
- LeadingAge strongly encourages CMS to allow home health agencies to bill for social worker phone calls consistent with the billing requirements established in hospice: *Social worker phone calls made to the patient or the patient's family should be reported using revenue code 0569, and HCPCS G-code G0155 for the length of the call, with each call being a separate line item…Report only social worker phone calls related to providing and or coordinating care to the patient and family and documented as such in the clinical records."* [31]

Data Non-Compliance Reconsideration Request Policy and Process

LeadingAge is grateful to CMS for their attention to policy regarding non-compliance reconsideration requests. Formally codifying the subregulatory timelines for requesting an extension and the bases on which CMS can grant a reconsideration request will help providers better understand their responsibilities and rights in this process. In codifying this process, we ask CMS to clarify in the final rule how they intend to amend surveyor guidance around the change. Specifically, we would ask that surveyors are not expected to cite providers for not following the timelines and process set forth which are voluntary and only fit "very limited circumstances" of non-compliance with HH QRP. **LeadingAge supports the proposals to amend the HH QRP Reconsideration policy to permit HHAs to request an extension to file a reconsideration request and the bases on which CMS can grant a reconsideration request.**

Updates to Requirements for OASIS All-Payer Data Submission

Despite continued concerns regarding the burden of OASIS all-payer data collection and submission, CMS' proposal to remove the term beneficiary and replace it with patient at § 484.45(a) indicates there is no intention from the administration to revisit the decision to move forward with all payer data collection. Data collection on all-payer OASIS officially began for all agencies July 2025. **Based on this implementation, LeadingAge supports the change in regulatory language to reflect the population**

[29] Centers for Medicare & Medicaid Services. (2024). *Draft OASIS-E1 manual*. https://www.cms.gov/files/document/draft-oasis-e1-manual-04-28-2024.pdf
[30] Centers for Medicare & Medicaid Services. (n.d.). *Medicare Claims Processing Manual, Chapter 10*. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c10.pdf
[31] Centers for Medicare & Medicaid Services. (n.d.). *Medicare Claims Processing Manual, Chapter 11*. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c11.pdf

that is currently being assessed by the OASIS instrument. However, LeadingAge recommends, to mitigate concerns about measure calculation issues and to better inform the public on the care provided by home health agencies, CMS publicly publish data through Care Compare on the proportion of non-Medicare/non-Medicaid patients a home health agency serves.

Home Health CAHPS Survey Updates

LeadingAge strongly supports the efforts of CMS to update and shorten the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey. The revised survey is shorter than the current survey and includes new questions on topics. If CMS has all required materials finalized for publishing and use by survey vendors by the beginning of CY2026, our members do not see any issues with the implementation date of April 2026.

CMS states that in testing process, a web-mail mode was tested in addition to a revised survey instrument. However, the outcomes of that testing and the reasons for not moving forward with a web-based mode were not disclosed. Currently, CMS makes no changes to the survey administration. The survey administration changes for hospice CAHPS were implemented as of April 1, 2025, and there should be data on the effectiveness of the administrative changes that could translate to a similarly positioned home health population. **LeadingAge strongly encourages CMS to consider in future rulemaking changes to the survey administration consistent with the Hospice CAHPS changes finalized in the FY2025 Hospice Wage Index Final Rule including a web-mail mode.**

HH QRP Quality Measure Concepts Under Consideration for Future Years—Request for Information

We are grateful for the opportunity to provide feedback on new quality measure concepts for home health. LeadingAge is supportive of additional measure concepts to maintain measures that are meaningful and relevant. However, generally we cannot support inclusion in the HH QRP program without measure specifications. Additionally, LeadingAge feels that any measures proposed for adoption should be endorsed by the consensus-based entity prior to proposal.

Interoperability

As our comments on the rule's section on Advancing Digital Quality Measurement in HH QRRP indicate, we do not feel that at this time home health agencies are at the appropriate level of technology adoption for interoperable data exchange or measures that evaluate the ability of data systems to securely share information across the spectrum of care. We do not believe such measures would be meaningful to home health agencies with limited expertise, staff, and financial resources to implement such systems. **LeadingAge cannot support the adoption of measures for interoperability in home health at this time.**

Cognitive Function

As CMS states in their discussion of this measure concept, the BIMS and CAM have already been incorporated into the OASIS assessment. However, we want to reiterate that beneficiaries qualify for home health services by being homebound and having a skilled need. At this time, the statute does not define cognitive function as a skilled need. While many home health patients struggle with cognitive issues, especially after traumatic acute care episodes, that alone does not qualify them for home health services. Agencies have limited reimbursement to work closely with patients on cognitive issues and must focus on issues that make the individual eligible for services, nursing or therapeutic. Often our

members find themselves working around cognitive issues by working with family caregivers to help coordination of care. If the patient has a cognitive diagnosis, we do not believe it should not be used in any measure calculations.

Given that 32.5% of fee-for-service home health patients are 85 years of age or more, the likelihood of a patient having a cognitive issue is substantially higher than other settings.[32] While some specific home health services can improve cognition, such as speech therapy, not all agencies offer speech therapy (and are not required to) and therefore it would be difficult to adequately judge the quality of their care across providers. **Without more thorough measure specifications or adjustments to qualifying services, LeadingAge cannot support a cognitive measure for HH QRP. We would like to work with CMS and Congress on modifications to the home health benefit to better support those with cognitive impairment but this work must occur before a measure is added to the HH QRP.**

Well-Being

In the OASIS, measures to assess mood already exist through the D0150. PHQ-2 to 9 and D0160. Total Severity Score as well as D0700. Social Isolation. We believe these are sufficient to understand a beneficiary's mental and social well-being that can be influenced by the agency.

In our comments responding to the CY2025 Home Health Proposed Rule, LeadingAge commented on the RFI on the Universal Foundation measure referenced in the rule which was used in the Medicaid Home Health Services measure set. Overall, LeadingAge strongly supports services for individuals experiencing depression and behavioral health issues in general. But the specific measure raised concerns about access to treatments especially in underserved communities both in rural and urban areas as home health agencies are currently not reimbursed to support mental and behavioral health issues beyond a social worker identifying additional, external resources. Any ordering for pharmacological interventions is outside the scope of the home health agency and requires the referring physician to change the plan of care. **LeadingAge does not support additional measure concepts around well-being at this time.**

Nutrition

LeadingAge does not feel that a measure regarding nutrition, as described in the request for information, is appropriate for home health.

OASIS currently includes items that look at physical activity and sleep. In fact, the majority of the OASIS focuses on physical activity as a product of home health's goal to improve or maintain function.

- GG0130A. Self-Care, Eating looks at the ability to eat which for many home health patients is lacking and can affect overall nutrition.
- M1870. Feeding or Eating also looks at the ability to eat food in terms of rehabilitation
- J0510. Pain Effect on Sleep specifically looks at how the conditions for which an individual qualifies for home health effect their sleep.

[32] Research Institute for Home Care. (2024). *2024 Home Health Chartbook*. https://researchinstituteforhomecare.org/wp-content/uploads/2024-RIHC-Chartbook-12122024-FINAL-2.pdf

We recognize the importance of these items but as with our comments on the CY2025 Home Health Proposed Rule which incorporated SDOH measures looking at access to food, we caution CMS to remember the purpose of HH QRP and other quality measures. These metrics are all meant to measure and inform the public about home health quality. Incorporating metrics that measure access to nutrition are important considerations when looking holistically at the health of a homebound patient but are not impacted by the care provided during the home health episode and are therefore inappropriate for inclusion in the HH QRP.

Potential Revision of the Final Data Submission Deadline Period From 4.5 Months to 45 Days—Request for Information

CMS requests feedback on a potential future policy revision to reduce data submission timelines for HH QRP from the current 4.5 months after the end of the data collection period to 45 days. This change would shorten the amount of time it takes for quality measures data to be posted publicly on Care Compare. Currently, quality measures data is posted approximately nine months after the end of the data collection period.

This same request for information was made in the FY2026 proposed rules for skilled nursing facilities, inpatient rehab facilities, and long-term care hospitals. While LeadingAge supported the revision of the final data submission deadline from 4.5 months to 45 days for skilled nursing facilities, that support is based on the 45-day data submission timeframe for SNF QRP being consistent with other data submission timeframes, such as the timeframe for submitting payroll-based journal data for staffing measures.

No 45-day timeframes exist for home health agency data submission. Per regulations home health agencies are responsible for updating the comprehensive assessment the last 5 days of every 60 days (42 CFR 484.55(d)(1)), and having the physician or allowed practitioner review and revise the individualized care plan no less frequently than once every 60 days (42 CFR 484.60(c)(1)).

In fact, CMS' own analysis in the proposed rule cites 60 day timeframes. Based on 2023 data, only 1.3 percent of all OASIS assessments were submitted after 60 days and would thus be potentially negatively impacted by this change. An additional 0.9 percent of all OASIS assessments were submitted between 60 days and 4.5 months after the end of the data collection period. However, CMS gave no indication how many OASIS assessments were submitted between 45 days and 60 days.

While we understand CMS' intent in requesting feedback on this issue, and we have heard concerns from our members in the past about how outdated publicly reported measures are, we do not believe an arbitrary deadline of 45 days is appropriate. If this were to be implemented, the timing must match the expectations in providers' conditions of participation – 60 days.

Providers do occasionally miss these data submission deadlines due to technology issues, submitter error, or circumstances outside their control. We would expect the existing reconsideration exceptions and extensions to be available to providers with the changes in submission deadlines.[33] Additionally, it is our hope that CMS would work to clearly communicate the change, then put in place helpful reminders such as email blasts like those that are sent for other data submission deadlines.

[33] Centers for Medicare & Medicaid Services. (2025, August 6). *Home Health Quality Reporting Reconsideration and Exception & Extension*. https://www.cms.gov/medicare/quality/home-health/home-health-quality-reporting-reconsideration-and-exception-extension

LeadingAge would support this proposal if the timeline were 60 days instead of the proposed 45 days to accommodate home health regulations, if CMS allowed the same existing reconsiderations for delayed data submission, and if helpful reminders were sent regarding deadlines.

Advancing Digital Quality Measurement in the HH QRP—Request for Information

LeadingAge appreciates the opportunity to comment on the adoption of health information technology (IT) in the home health space. However, we write to express our concerns regarding the feasibility of implementing health IT with the specifications outlined in the RFI and the impact it would have on home health providers, including significant burdens on staff and budgets.

To our knowledge, all LeadingAge home health members utilize health IT systems to maintain patient records and specifically utilize electronic records. However, part of the longstanding work of the LeadingAge Center for Aging Services Technology, or CAST, has been to annually review how sophisticated our provider members are in using their electronic health records (EHR).[34] CAST reaches out to EHR vendors each year to assess how the vendors' clients are using EHRs, as well as the percentage of their clients along the scale of EHR adoption. The tenth annual survey results show little to no advancement in the use of higher interoperable functionalities of EHRs in 2025. Most providers (25%) are in Stage 5 of the scale, using a basic integration between the EHR and other external and ancillary systems. Nearly 20% of providers are in Stage 6, which enables providers to engage different members of the care team, including the physician and possibly the patient/resident/client, and offers basic information exchange capabilities. Yet only 8% fall into Stage 7, which represents the ideal full interoperability stage.

Additional research by the Assistant Secretary of Evaluation and Planning published in 2023 confirms LeadingAge's findings that over time the adoption of EHR technology has increased in the post-acute care sector, however the interoperability of that technology remains limited.[35] This research alone leads us to believe that CMS is starting from the wrong place in asking these questions of home health providers.

The HITECH Act of 2009, which established federal program or requirement for incremental progress toward interoperability for have care providers, excluded long-term care and post-acute care (LTPAC) providers like hospices. Unlike with the Meaningful Use/Promoting Interoperability program in this original legislation, there are no levers or drivers requiring LTPAC providers to share information with hospitals and office-based settings, making the likelihood of adoption small.

In response to the January 6, 2025, HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information, LeadingAge submitted extensive comments on the realities of complying with

[34] LeadingAge. (2025, June 16). *CAST Survey: Providers make meaningful use of EHR systems*. https://leadingage.org/cast-survey-providers-make-meaningful-use-of-ehr-systems/

[35] Assistant Secretary for Planning and Evaluation. (2023). *Health information technology adoption and utilization in long-term and post-acute care settings*. https://aspe.hhs.gov/sites/default/files/documents/cf9c988536e481d688f224b7653704f9/hit-adoption-utilization-ltpac-settings.pdf

the proposals.[36] While supporting the rule's goal of better protecting the confidentiality, integrity, and availability of electronic Personal Health Information (ePHI), our letter voiced concerns regarding the feasibility, cost, and administrative burden of the proposed requirements for aging services providers.

LeadingAge emphasized flaws with the one-size-fits-all nature of the proposed rule. The Office of Civil Rights (OCR) proposal would treat all HIPAA-covered entities the same, despite differences in size, resources, and risk levels. Aging services providers, for example, were excluded from federal HITECH incentives for health information technology (IT) adoption and have less mature digital infrastructure in place, as well as fewer resources generally, compared to hospitals and larger health systems. Further, OCR acknowledges that smaller and rural providers face unique challenges, yet, the agency still assumes that all providers equally should and can comply.

Our letter also argued that OCR has significantly underestimated the costs of compliance. The proposal's required Regulatory Impact Analysis estimates implementation costs at $183 million annually, but LeadingAge believes that actual costs would be much higher. We cited several examples where agency calculations of the time and cost that would be needed to complete certain actions are much lower than is realistic.

In addition to the complexity of the proposed requirements, a major issue is that the proposed timeline for implementation is unrealistic. The proposed rule would require full compliance within 240 days (8 months) after publication of a final rule, which is impractical for most organizations. LeadingAge called for a longer, phased approach if OCR issues a final rule, so that regulated entities would have sufficient time to establish and implement policies, procedures, and practices to achieve compliance with new or modified standards.

We reiterate similar recommendations from that letter here:

CMS should conduct further engagement with home health agencies beyond this RFI in the proposed rule, to build deeper understanding of feasibility and consider flexibilities for organizations with fewer resources and less mature systems.

Endorse legislation and work to provide positive supports to help home health agencies implement these changes, such as federal funding similar to "meaningful use" dollars that incentivized the use of industry IT standards in hospitals.

[36] LeadingAge. (2025, March 7). *Comments on HIPAA Security Rule revisions (RIN Number 0945-AA22)*. https://leadingage.org/wp-content/uploads/2025/03/LeadingAge-Comments-on-HIPAA-Security-Rule-Revisions_03.07.2025.pdf

General Concerns with the Expanded Home Health Value Based Purchasing (HHVBP) Model

LeadingAge is deeply concerned regarding the proposals to substantially alter the HHVBP model for the third time since its implementation. The constant changing of baselines and quality measures has meant that home health agencies have had no time to catch up to the rules of the framework and are suffering at the lack of complete and timely information provided by the program to effectively improve their scores. The expanded demonstration was expanded the CY2022 Home Health Final Rule with the first performance year of CY2023. Data from the first year of quality related payment adjustments was released in January 2025 and this data raises concerns regarding the design of the program generally.

In an April 29, 2025, letter to Administrator Oz and Director of the Office of Management and Budget, Russell Vought, LeadingAge articulated our concerns regarding the model's design and, specifically, how it is incentivizing non-compliance with quality reporting requirements, creating inequity based on cohorts, and the unintended consequences of no risk adjustment.

LeadingAge urges CMS to not make any further changes to the HHVBP program in order to address serious flaws in the program currently. We also recommend CMS pause all future payment adjustments until the structural issues are resolved.

Agency Non-Compliance with HHVBP Requirements

A main concern of ours relates to compliance with reporting requirements. We have reason to believe certain agencies are manipulating HHVBP by simply bypassing their HH QRP requirements. This is highly evident in the number of agencies which received significant increases in their payment, despite not complying with HH QRP requirements and receiving a 2% annual payment update (APU) reduction for that non-compliance.

Part of the reason for CMS to define cohorts by the 60-patient threshold is due to the requirement that agencies participate in the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS), which requires a patient count of 60 or more. However, when we look at the first year of data on performance of large cohort agencies in the HHCAHPS measures, 71% of participating agencies did not have any HHCAHPS data. Among the top performing agencies – those that received the highest possible payment adjustment of +5% – there were 253 out of 401 that had no HHCAHPS data used in their total performance score calculations. When we reached out to CMS regarding this lack of data, it was explained that 40 completed surveys for agencies in the larger-volume cohort are the minimum threshold of data an agency must have for *each applicable* HHCAHPS measure to receive a measure score. However, CMS did not delineate between agencies that had no HHCAHPS, meaning they did not participate in the requirement, and too few HHCAHPS responses to calculate a score, meaning they had fewer than 40 unique surveys completed. CMS stated that for the purposes of the expanded HHVBP model, having insufficient HHCAHPS data and having no HHCAHPS data have the same results in CMS' calculations and therefore these differences are not delineated in the model.

Respectfully, we disagree with this assertion. The regulations governing the HHVBP program clearly state:

> *42 CFR 484.355(b) Competing home health agencies are required to collect and report such information as the Secretary determines is necessary for purposes of monitoring and evaluating the expanded HHVBP Model under section 1115A(b)(4) of the Act (42 U.S.C. 1315a).*

The regulations go further as to grant agencies an exception with respect to quality data reporting in the event of extraordinary circumstances. This language provides a clear expectation that agencies who fail to comply with collecting and reporting the necessary information or fail to reach out to CMS if unforeseen circumstances prevent them from collecting and reporting the required information are in fact not compliant with the model's expectations.

We reviewed the top performing home health agencies which did not have HHCAHPS scores to calculate and compared them to the list of agencies which received a reduction in their APU for not complying with HH QRP reporting requirements in CY2023, the first performance year for HHVBP.[37] This identified 36 agencies, or roughly 14% of top earners without HHCAHPS scores, which received the highest payment increase of +5% despite not complying with HH QRP requirements. All told, 75% of these non-reporting agencies were located in California, and mostly in Los Angeles County, which as we examined earlier in our comments has significant program integrity concerns. This does not account for the potentially countless other agencies at other payment adjustment levels who earned an increase despite not fully complying with basic HH QRP requirements. This cannot be allowed to continue.

We request CMS update the program requirements to state that agencies who are not in compliance with the HHVBP reporting requirements per 484.355(b) during the performance year will not be eligible to receive any payment adjustment due to their non-compliance.

Expand Number of Cohorts Based on Size

The original demonstration of the Home Health Value Based Purchasing (HHVBP) model, which occurred in only nine states, was highly positive and correlated with considerable savings and improved quality of services. In the initial demonstration, cohorts were organized by states, not sizes of agencies. Generally, this allowed participants to compare themselves against agencies with similar client populations, regulatory burden from states, and allowed for a fair distribution of sizes. The expanded model created two simple cohort sizes: the small-volume cohort, which includes agencies with fewer than 60 unique beneficiaries in the baseline year, and the large-volume cohort, which includes agencies with 60 or more unique beneficiaries in the baseline year.

In our review of the data published from the first year of payment adjustment, we found that 54% of home health agencies fell into the large cohort, only 5.7% fell into the small cohort, and 40% of agencies did not participate due to availability of data and newness (certified on or after January 1, 2022). That means that the majority of agencies were compared to each other in the large cohort. The small cohort had a cap on the number of beneficiaries an agency had while the large cohort had no cap on the volume of patients. In the most recently available federal data on the size of home health agencies, 42.9% served 100 or fewer people annually, 25.8% served between 101 and 300, and 31.3% served 300 or more people annually.[38] This means that relatively small agencies with just 60 beneficiaries could be compared to large agencies, which can have up to 300 patients. This puts agencies at a disadvantage by not being comparable in economies of scale with their program competitors.

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[37] Centers for Medicare & Medicaid Services. (2025). Home Health QRP compliance data. (Internal communication). LeadingAge reached out to CMS again to confirm if there was a list of agencies by reason for non-compliance, be it not fully participating in HHCAHPS, as the numbers above might suggest, or not meeting the 90% threshold for reporting for OASIS assessments. CMS stated this information was not available.

[38] Centers for Disease Control and Prevention. (2023). *National Health Statistics Report No. 208: Characteristics of home health agencies*. https://www.cdc.gov/nchs/data/nhsr/nhsr208.pdf

Changing the cohort sizes would not only make the program more equitable, but it would also work to eliminate the earlier concerns regarding missing HH CAHPS data, as agencies that are of a smaller size in the larger cohort (60-100 patients) struggle to get 40 returned surveys despite their compliance with HH QRP requirements. **We request CMS redesign the cohort distribution based on average daily census of home health agencies or on their number of OASIS episodes during the baseline year.**

Explore Further Risk Adjustment

We remain concerned that the current HHVBP model does not appropriately adjust for agencies that serve high need, complex populations – both based on clinical characteristics and also based on environmental factors such as the lack of a family caregiver that contribute to making a population harder to serve effectively. Part of the goal of value-based care is to ensure that providers can spend their dollars on what would be most effective to improve quality and control costs. In the final report on the original HHVBP model, CMS acknowledged needing to continue monitoring patient selection by agencies and its potential impact on access to home health care for medically complex patients. While nearly all the measures used for the program are risk adjusted, it is unclear if the risk adjustment of these model measures adequately mitigates incentives that agencies may face to avoid patients for whom a goal of stabilizing function may be more appropriate than a goal of improving function. Even for those for whom improving function is the goal, their health and environmental status prior to needing home health will impact how expensive it is to care for that patient.

We believe there is a tendency for agencies to "cherry-pick" patients who will do well on the quality measures of the program, the majority of which look at functional improvement and not maintenance of function. There are clinical characteristics regarding the complexity of an individual's medical needs that agencies look at before admitting someone to service.

We therefore believe CMS should review the current data for those types of patients and determine a risk adjustment methodology based on the patients who may not see improved function. This approach does not bias the payment system in favor of one demographic group but ensures that providers cannot ignore patient populations with clinical characteristics that may lower their scores in the program due to lack of improvement. This is also consistent with the 2013 Jimmo Settlement Agreement.

Proposed Changes to the HHVBP Model for CY2026

With two exceptions regarding removal factors and the HHCAHPS measures, we reiterate of initial statement regarding the HHVBP program; LeadingAge urges CMS to not make any further changes to the HHVBP program in order to address serious flaws in the program currently.

Proposed Changes to the Expanded HHVBP Model's Applicable Measure Set

CMS stresses in the CY2026 proposed rule that the addition of quality measures to the program will mean that more agencies will be eligible for participation. We are deeply concerned by this shortsighted approach when many agencies are not meeting the full expectation of quality measure participation as we stated above. We request that CMS provide evidence that the agencies currently ineligible for HHVBP participation would be made eligible by the addition of these measures.

Removal Factors for HHVBP Quality Measures

LeadingAge understands the need for codification of measure removal factors that clearly under what circumstance a measure for this program will be removed and we appreciate CMS' transparency to include this in the CY2026 proposed rule. **We support this codification.**

Proposed Removal of Three HHCAHPS Survey-Based Measures From the Expanded HHVBP Model Applicable Measure Set

As we state in our response to the HH QRP section above, LeadingAge strongly supports the efforts of CMS to update and shorten HHCAHPS survey. The revised survey is shorter than the current survey and includes new questions on topics suggested by interested parties. Additionally, if CMS has all required materials finalized for publishing and use by survey vendors by the beginning of CY2026, our members do not see any issues with the implementation date of April 2026.

If CMS' proposal to update the HHCAHPS survey-based measures is finalized and CMS adopts the HHVBP proposed removal factor, **LeadingAge would support the proposal to remove the Care of Patients, Communication between Providers and Patients, and Specific Care Issues from the HHVBP program in CY2026. Based on the potential need, given the final rule to remove these measures, we also support necessary modifications to the measure weights.**

Proposed Addition of Medicare Spending Per Beneficiary Post-Acute Care (MSPB-PAC) to the Expanded HHVBP Model Applicable Measure Set

As LeadingAge stated in our comments on the CY2025 Home Health Rule, we cannot support the inclusion of this measure in HHVBP without understanding how this will be applied and its impact on the overall score for claims-based measures. We provided a list of questions to CMS to better understand how this measure would be applied. However, CMS did not response to those questions in the CY2025 Home Health Final Rule. We are deeply troubled by the lack of response and transparency on the part of CMS in decision making around HHVBP. The lack of detail provided along with the focus on savings over the quality of care leave us concerned that this is not the correct direction for the program. Additionally, we wish to note that according to the technical expert panel report, only two members of the panel were in full support of using this measure, that is in no way a majority consensus.[39] We reiterate our questions here:

- If a home health agency spends above the national average of MSPB, which is how the measure is currently reported publicly, will they receive a lower score?
- Alternatively, if they are above their cohort in MSPB will that have a negative impact on their score?
- Will this be risk adjusted to the patient populations served by the particular provider?

We do not support the inclusion of this measure in the HHVBP program for CY2026.

[39] Centers for Medicare & Medicaid Services. (2024). *HHVBP Expanded Technical Expert Panel Report*. https://www.cms.gov/files/document/hhvbp-exp-tech-exp-panel-rpt-2024.pdf

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

In the CY2025 Home Health Proposed Rule, CMS requested feedback on adding functional measures to complement the existing cross-setting Discharge Function Measure. LeadingAge responded to that RFI that we would support the expansion of the Discharge Function measure to include GG0130E-GG0130G for dressing and bathing functions. Many of our members take explicit time in providing these supports and education for these activities of daily living. Especially for individuals without family caregivers, being able to complete these more physically demanding tasks without support is essential for their success post-discharge.

In the CY2025 RFI CMS did not provide the explicit functional measures they were considering. OASIS M1830, M1810, and M1820 are asking very different questions than the GG0130E-GG0130G measures. We do not see these as complements to the Discharge Function Measure but as distinct new measures. Additionally, of the three proposed OASIS-based measures, only M1830 is publicly reported on Care Compare, meaning M1810 and M1820 would not have any publicly available reporting trends for providers which was a significant concern with the original Total Normalized Composite Change measures. In the February 2025 TEP report, the panel expressed support for new GG measure items as being even more useful than M-based measures. As we stated above, we cannot support additional measures in the program at this time until the underlying issues with the program's structure are corrected. Furthermore, we do not think this approach to adding whatever measures are available until new ones can be developed is a prudent exercise and one that will improve care of patients.

We do not support the addition of OASIS-based function measure to the expanded HHVBP model for CY2026 and encourage CMS to continue with the development of new GG measures for bathing and dressing.

RFI: Future Performance Measure Concepts for the Expanded HHVBP Model

With the recognition that quality measures need to be paired with a robust risk adjustment methodology for disadvantaged populations as well as formally endorsed by the consensus-based entity contracted by CMS, we provide the following comments on future performance measure concepts.

Falls with Injury (claims-based)

Per our CY2025 comments regarding future quality measures, LeadingAge reiterates that we strongly agree with the TEP on the need for a measure that assesses falls with injury based on claims and not OASIS data based on the manipulation found by the Office of Inspector General in 2023.[40] The manipulation of assessment data in OASIS, or any other care setting assessments for that matter, can lead to misinformation for consumers on resources like Care Compare.

However, CMS released the report which was cited in the CY2026 Home Health Proposed Rule with only two weeks to read and consider the technical specification prior to the comments on the rule being due. This is simply not enough time to form an opinion regarding the measure. Additionally, we are deeply

[40] Office of Inspector General. (2023). *Manipulation of OASIS data in home health.* https://oig.hhs.gov/oei/reports/OEI-05-22-00290.asp

concerned that this measure is meant to be a cross-setting measure, yet only the HHVBP program is asking for feedback on future use. This measure has not been tested, validated, approved by the consensus-based entity, or publicly reported in any other setting let alone the HH QRP. It is deeply inadvisable for CMS to adopt any measure that has not been thoroughly vetted across settings, and we are deeply concerned that it would be considered for this program first. **Based on all these factors, LeadingAge does not support this measure's inclusion in HHVBP.**

Potential Future Changes to HHCAHPS Scoring Rules and Applicable Measure Set

As we state in our response to the HH QRP section and the HHVBP proposed applicable measure set changes above, LeadingAge strongly supports the efforts of CMS to update and shorten the HHCAHPS survey. Additionally, if CMS has all required materials finalized for publishing and use by survey vendors by the beginning of CY2026, our members do not see any issues with the implementation date of April 2026.

We do feel that the HHCAHPs measures being proposed for removal due to the substantial changes in their structure are incredibly important for understanding the quality of care provided by agencies participating in HHVBP. Therefore, LeadingAge would support CMS measuring agency performance on the future HHCAHPS survey-based measures solely on achievement starting in CY2028 rather than both achievement and improvement. Additionally, we would support CMS proposal to include the three new measures which originally made up the Specific Care Issues measure as separate measures with the original Specific Care Issues measure weight divided equally between the three new measures.

If CMS' proposal to update the HHCAHPS survey-based measures is finalized and CMS adopts the HHVBP proposed removal factor, **LeadingAge would support future changes to HHCAHPS scoring rules and applicable measure set outlined in the proposed rule.**

Medicare Provider Enrollment

LeadingAge supports CMS' efforts to enhance provider enrollment oversight and protect against further program integrity issues from fraudulent actors. However, we have concerns with CMS' proposal to expand the current authority for provider enrollment deactivation. Specifically, CMS proposes to update authorities at §424.547 which would allow for the deactivation of physicians and nonphysician practitioners who order, certify, or refer to Medicare services like home health and hospice. The conditions for deactivation require that the allowable clinician in question has not appeared on a Medicare Part A or B claim within the past 12 consecutive months.

If a certifying or ordering provider is deactivated, it would cause a ripple effect and prevent HHAs and hospices from billing Medicare for any claims that include that deactivated practitioner. In the case of hospices, there are often physicians employed by and working only for the hospice and not in a position that they would routinely or even occasionally certify a patient. These are physicians who are not the Medical Director or the normal Medical Director designee who only cover on-call hours or cover the vacations/absences of other hospice physicians. In these instances, the on-call/covering physician may not have certified a hospice patient in the last 12-months due to their unique role in the organization and, therefore, would not be listed on a claim in a 12-month period despite being employed by the hospice.

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

We are equally concerned that there are likely ordering and certifying practitioners who do not bill Medicare directly for services. While our home health and hospice members verify provider eligibility through the available databases to ensure all practitioners certifying home health and hospice services are authorized, if this proposal were to move forward and clinicians were removed for unbilled services after 12-months, some providers could be caught unaware of their deactivation status when ordering and certifying services. This lack of awareness could lead to unexpected claim denials and disruptions in patient care.

LeadingAge recommends CMS institute a reactivation process that is efficient and minimizes any delays in restoring ordering and certifying privileges for those practitioners that have been deemed eligible to certify /order home health services or hospice services. We also recommend CMS provide training and education home health agencies, hospices, and clinicians about the process along with notices to clinicians when they may be nearing deactivated allowing them to independently attest that they want to remain active in the ordering and referring database.

Conclusion

In sum, LeadingAge appreciates the opportunity to provide comments on the proposed payment cuts, face-to-face conditions of participation, home health quality reporting, and the home health value-based purchasing program. Implementing the payment cuts as proposed will exacerbate an already dire environment for home health – and additional changes to the HHVBP program will add fuel to that fire as well. CMS needs to consider ours and other comments on adjustments that can be made in both the FFS payment model and the HHVBP in order to ensure that home health remains a viable post-acute care options for the millions of Medicare beneficiaries who need and want the service. We appreciate CMS' commitment to reducing administrative burdens for agencies by adjusting face-to-face regulations and reducing the number of items in OASIS. We hope CMS continues the dialogue with stakeholders to fully understand the effects of proposed changes. LeadingAge along with our members stand ready to be a resource for CMS.

Sincerely,

Katy Barnett

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About LeadingAge: *We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.*