August 31, 2026

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-1844-P Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies

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

Dear Administrator Oz,

LeadingAge, together with our state partners, represents more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with state partners whose members are active in 50 states, the District of Columbia, and Puerto Rico, 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, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care including Medicare home health agencies.

On behalf of these members, LeadingAge is pleased to offer the following comments in response to the CY2027 Home Health Prospective Payment System Proposed Rule.

We wish to thank the administration for taking into consideration our comments on the CY2026 Home Health Proposed Rule regarding the calculation of the permanent and temporary adjustments required by the Bipartisan Budget Act of 2018. The resulting reduction of overall permanent and temporary adjustments was crucial to keeping our nonprofit, mission-driven home health agencies open to serve the most vulnerable Medicare beneficiaries. However, as we detail below, the proposed cuts and outstanding temporary adjustments should also be eliminated completely. Continuing to implement these cuts in any form or manner, beyond being methodologically incorrect, will have a disastrous effect on older adults who rely on these services. The combined impact of the proposed payment changes and proposed Medicare provider enrollment changes may lead to more closures of home health agencies and the inability of providers that remain to take on new referrals.

With regard to the Medicare provider enrollment provisions of this rule, LeadingAge is deeply concerned that the expanded authority CMS is seeking has the potential to introduce significant uncertainty and impose excessive burdens on providers. This concern applies not only to the

collection and submission of excessive information on staff and affiliations, but also to the due diligence required to prevent unintended affiliations that could jeopardize a provider's enrollment. We strongly believe that CMS should address its Medicare provider enrollment proposals in a separate rulemaking that targets the provider community more broadly and that properly accounts for the costs and benefits of these proposals.

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

Despite the role home health agencies play in improving care for Medicare fee-for-service (FFS) beneficiaries and reducing total system costs, CMS's own monitoring data bears out our fears that home health use is in decline and continued long-term reductions will destabilize this critical setting. Information provided in the CY2027 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 Patient Driven Groupings Model (PDGM). The initial goals of PDGM were to better measure the case mix of home health care beneficiaries, minimize the potential for patient selection, and better align provision of services with patient needs. However, according to the Medicare Payment Advisory Commission's (MedPAC) Congressionally mandated report on the implementation of the PDGM, the payment change:

- Was not associated with a higher probability of FFS home health care use. This is at a time when the vast majority of older adults, 93%, live in their own homes and want to maintain that independence.[1]
- Resulted in fewer visits per FFS stay. MedPAC found this drop in visits was similar for most groups, and across all disciplines, not just therapy, signaling that the goal of aligning service provision with patient needs was not necessarily obtained. There were also fewer visits among beneficiaries who are dual eligibles or receiving the low-income subsidy who are groups that are highly in need of services.
- Did not substantially improve the quality of care for beneficiaries. MedPAC's analysis offered a mixed picture of quality, with fewer preventable hospitalizations but worse post-discharge outcomes.
- Did not substantially impact FFS Medicare margins. While we do not agree with margins alone as an indicator of payment adequacy, this was undoubtedly a key rationale for changing the payment system given the misuse of therapy thresholds. However, MedPAC's analysis found only a 0.6-percentage-point decrease in FFS margins.

This table illustrates our continued concerns regarding the decline in use of home health services:

[1] Parker, K., & Menasce Horowitz, J. (2026, February 26). *Most older adults who live at home want to age in place, but they aren't entirely confident they'll get to*. Pew Research Center. https://www.pewresearch.org/short-reads/2026/02/26/most-older-adults-who-live-at-home-want-to-age-in-place-but-they-arent-entirely-confident-theyll-get-to/

TABLE 2: OVERALL UTILIZATION OF HOME HEALTH SERVICES, CYs 2018-2025

Volume of Periods and Number of Beneficiaries	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
30-Day Periods of Care	9,336,898	8,744,171	8,423,688	9,269,971	8,593,266	8,319,064	8,275,089	7,719,986
Unique Beneficiaries	2,980,385	2,802,560	2,850,916	3,017,464	2,831,138	2,715,010	2,657,261	2,501,044
Average Number of 30-Day Periods per Unique Beneficiary	3.13	3.12	2.95	3.07	3.04	3.06	3.11	3.09

Source: CY 2018 and CY 2019 simulated PDGM data with behavioral assumptions came from the Home Health 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 July 11, 2025. CY 2025 data was accessed from the CCW VRDC on March 12, 2026. **Note:** All 30-day periods of care claims were included (for example LUPAs, partial episode payments (PEPs), and outliers)). There are approximately 540,000 60-day episodes that started in CY 2019 and ended in CY 2020 that are not included in the analysis.

Based on this information from MedPAC's analysis and CMS's monitoring data, LeadingAge would argue that PDGM is not having the intended effect on services and in fact is leading to a decrease in access to home health services. As we have stated in previous years' comment letters, there is not just a noticeable decline in unique beneficiaries and visits but also a decline in the number of home health agencies. For the past three years, MedPAC has acknowledged that all growth in new home health agencies has been concentrated in Los Angeles County, California.[2]

Proposed CY2027 Home Health Payment Rate Updates

We are grateful for CMS's consideration of the public comments in the CY2026 Home Health Final Rule, which allowed CMS to use their time and manner authority to not apply permanent adjustments to the CY2023 or CY2024, and subsequently in this year's rule, the CY2025 data. We strongly agree with CMS's determination that behavior changes in these years were not attributable strictly to the change in payment to PDGM and a 30-day unit of payment.

Additionally, there is evidence that CMS's decision to reevaluate the behavioral adjustments without CY2023, CY2024, and now CY2025 has contributed to some stabilization in the home health negative margin projections and therefore, continuing to make changes to stabilize the FFS payment system is critical to maintaining home health access. In a yearly appendix to the *2026*

[2] Medicare Payment Advisory Commission. (2024, 2025, 2026). *Report to the Congress: Medicare payment policy*.

Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, the CMS Office of Actuary states that in 2024 36% of HHAs had negative total all payer margins. This finding is consistent with their analysis from 2025.[3] However, the updated analysis estimates that by 2040, that number will rise to only 41% instead of the 57% estimated in 2025. That is a 16-percentage-point decrease in the number of agencies that could have negative total margins by 2040. We believe this provides strong evidence that FFS margins are critical to the stability of the home health sector.

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

Provider Type	2011	Current Base Year 2024	Historical Experience		Achievable Productivity Scenario	
			2027	2040	2027	2040
Hospital*	30%	30%	31%	35%	31%	32%
SNF	40%	40%	41%	47%	40%	46%
HHA	36%	36%	39%	52%	39%	50%

* The percentage of hospitals with negative Medicare margins was 66 percent in 2011 and 74 percent in 2024, increasing under the historical scenario to 80 percent in 2027 and to 90 percent in 2040, and under the achievable productivity scenario to 79 percent in 2027 and to 84 percent in 2040.

Since Medicare Advantage (MA) enrollment has only continued to increase from 34 million beneficiaries in 2025 to 35 million in 2026, it is unlikely that MA payment changes influenced any of the stabilization. Based on our members' experiences with MA payments, we have no reason, and unfortunately no empirical evidence, that MA payments for home health services are improving. However, as with last year, 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 Medicare Trust Funds, along with the CMS Office of the Actuary, believe it is their obligation to look at the overall financial pressure faced by providers as it relates to potential effects on Medicare beneficiaries' access and quality of care.

LeadingAge continues to believe that the government needs to work on ensuring rate adequacy across all payers before disrupting overall access to care through further cuts to FFS Medicare. CMS must evaluate payment adequacy across all payers under federal jurisdiction, including Medicaid and Medicare Advantage. LeadingAge offers our support to advocate for additional authority required by CMS to ensure rate adequacy across payers.

[3] Centers for Medicare & Medicaid Services. (2026). *Simulations of Affordable Care Act Medicare payment update provisions: Part A provider financial margins*. https://www.cms.gov/files/document/simulations-affordable-care-act-medicare-payment-update-provisions-part-provider-financial-margins.pdf-0

Methodological Errors in the Behavioral Adjustment Assumptions

Neither CMS nor MedPAC can disaggregate behavior caused by PDGM from other factors: As we previously stated, we appreciate CMS's acknowledgement of the difficulties in attributing behavioral changes directly to the PDGM in 2023 through 2025. And, subsequently, based on those challenges, CMS's decision not to propose any permanent adjustments for CY2027. In the CY2026 Home Health Final Rule, CMS noted several policy changes which made calculating permanent adjustments for 2023 and beyond difficult and therefore reversed those permanent adjustments. However, we maintain that these difficulties also existed in 2020, 2021, and 2022. CMS also has clearly indicated that the fraud present in the program starting in 2020 cannot be precisely distinguished from other behavioral changes. In addition to CMS's difficulty in attributing behaviors to the change in payment, MedPAC struggled to determine the behavioral changes related to PDGM vs. patient behaviors associated with COVID-19. As we will illustrate below, we believe based on CMS's rationale to eliminate the permanent adjustments applied in CY2023-CY2025, the same rationale applies to CY2020-CY2022.

Fraudulent Behaviors: LeadingAge has repeatedly requested that CMS evaluate the impact of fraudulent activity on the calculation of the aggregate adjustments since the implementation of PDGM and the expanded Home Health Value Based Purchasing (HHVBP) model. From 2019 (before COVID flexibilities and the implementation of PDGM) 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. This means there are currently 18.7 HHAs per 10,000 FFS beneficiaries in LA County. Additionally, CMS's 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 also accounted for 9% of all home health FFS payments nationally in 2024. We know CMS is focused on Los Angeles County from an enforcement perspective, especially as it relates to home health and hospice. CMS has also implemented a six-month moratorium on new home health enrollments. While we supported the moratorium as a short-term measure, it is clear CMS is focused on additional enforcement mechanisms and therefore, a moratorium will no longer be necessary. We see CMS applying this logic in the durable medical equipment space (DME) where the moratorium was lifted after 6 months on August 27.[4]

In a letter to CMS Administrator Oz, Senator Susan Collins (R-ME) requested that CMS analyze the impact of alleged fraudulent behavior in LA County on the aggregate behavioral adjustment for home health. In a letter responding to the request, CMS states they "cannot precisely distinguish agencies that engage in abusive coding and other behaviors from all others."[5] Notably, this response underscores that CMS cannot disaggregate behaviors like fraudulent activity from PDGM related activities.

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[4] Golinghorst, D., & Wallace, M. (2026, August 28). *CMS Medicare DMEPOS supplier enrollment moratorium expires: Suppliers may submit new initial enrollment applications*. JD Supra. https://www.jdsupra.com/legalnews/cms-medicare-dmepos-supplier-enrollment-9731633/

[5] Dr. Mehmet Oz, Administrator, Centers for Medicare & Medicaid Services to the Honorable Senator Susan Collins. Washington, DC. (July 20, 2026).

CY2022 Case-Mix Weights Recalibration: As we stated in our CY2026 comment letter, we believe that the changes in case mix weights in CY2022 influenced provider behavior and, therefore, that the calculation of permanent adjustments was not attributable strictly to the change to PDGM and a 30-day episode. 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. While we understand CMS's position that "the impact of any reduction in resource use caused by the COVID-19 PHE on the calculation of the case-mix weight would be minimal since the impact would be accounted for both in the numerator and denominator of the formula used to calculate the case-mix weight", there is an additional consideration that CMS has not accounted for in their previous rule comments. The case-mix weights had not been recalibrated for two consecutive years, meaning the shifts in the rates were more significant and could have an outsized effect on provider behavior. The changes in weights ranged from +16% to –26% across case-mix groups compared to CY 2020. While the changes made to case-mix due to practice patterns during COVID-19 may have been mitigated, changes in payments at the case-mix group level after two full years of locked changes ultimately influenced how agencies structured service delivery to remain viable.

2020 and 2021 COVID-19 Impacts: We have stated our concerns before regarding the calculation of COVID-19 claims and their outsized impact on the aggregate behavioral adjustment methodology. However, previously we have focused on the role of COVID-19 in changing practice patterns that influenced case-mix. After further review, we believe COVID-19 had a much larger impact on the rate of LUPA payments than any other time before or since the implementation of PDGM. These impacts on LUPA rates were outside the provider's control due to individual choices to deny access to home health staff, forcing the agency to take a LUPA payment instead of the full case-mix payment. In the CY2023 Home Health Final Rule, when CMS discussed their decision to not adjust LUPA payments for CY2022 they stated:

> However, in contrast, [to the impact on case-mix weight adjustments] the LUPA thresholds are based on the number of overall visits in a particular case-mix group (the threshold is the 10th percentile of visits or 2 visits, whichever is greater) instead of a relative value (like what is used to generate the case-mix weight) that would control for the impacts of the COVID-19 PHE. We noted that visit patterns and some of the decrease in overall visits in CY 2020 may not be representative of visit patterns in CY 2022. Therefore, to mitigate any potential future and significant short-term variability in the LUPA thresholds due to the COVID-19 PHE, we finalized the proposal to maintain the LUPA thresholds finalized and displayed in Table 17 in the CY 2020 HH PPS final rule with comment period (84 FR 60522) for CY 2022 payment purposes.

The impact of COVID-19 on home health services in 2020 and 2021 was considerable. While CMS has accounted for some aspects of the impact as part of the case-mix distributions, it has not accounted for other factors such as the increased LUPA rate. Additionally, MedPAC noted that it was unable to determine behavior changes related to PDGM versus other factors in its analysis.[6] Specifically, MedPAC

[6] Medicare Payment Advisory Commission. (2026). The impact of recent changes to the home health payment system. In *Report to the Congress: Medicare payment policy* (Chap. 14). Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch14_MedPAC_Report_To_Congress_SEC.pdf

noted declines in the use of HHA services due, as we noted, to beneficiaries' reluctance to allow HHA staff into their homes during the early months of the pandemic. MedPAC also noted a decline in elective surgeries during this time that would have resulted in post-acute home health referrals. The behavioral adjustments required by statute focus specifically on provider behaviors and, to our knowledge, CMS has not considered adjustments for patient behaviors that could have impacted the implementation of PDGM including an increase in LUPA rates seen in 2020 and 2021.

For all of these reasons, CMS should remove all permanent adjustments applied previously (including CY2020-CY2022) and correct the home health 30-day payment rate for CY 2027. CMS should not finalize the -3.0% temporary adjustment for CY2027 as the removal of the permanent adjustments in CY2020-CY2022 would eliminate the $4.9 billion estimated overpayments which are attributable to the current assumptions.

Forecasting Error Correction

LeadingAge would like to take this opportunity to again stress the compounding nature of market basket forecasting errors. As we stated in our CY2026 Home Health Proposed Rule comments, the accuracy of annual payment updates 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. Each year, CMS provides an annual update to home health payments based on forecasts of market basket increases for the upcoming payment year because actual measures of price growth are not available until after rulemaking must be completed. While we understand that these forecasting errors have been a result of economic uncertainty and the health care sector specifically, the impact to providers is no less pronounced. For yet another year, the forecast fell short of actual price growth.

According to our review of the Office of the Actuary's summary of market basket history and forecasts[7] compared to finalized market basket rates from CY2021 to CY2025 (the most recent year of complete data), the home health market basket has had a cumulative forecast error of -7.3% points as illustrated below.

MB Forecast Error Impact	CY2021	CY2022	CY2023	CY2024	CY2025	Cumulative
Projected Market Basket (Final Rules)	2.30%	3.10%	4.10%	3.30%	3.20%	16.62%
Actual Market Basket	3.90%	6.20%	4.70%	4.00%	3.80%	23.95%
Percent Point Difference	-1.60%	-3.10%	-0.60%	-0.70%	-0.60%	-7.3%

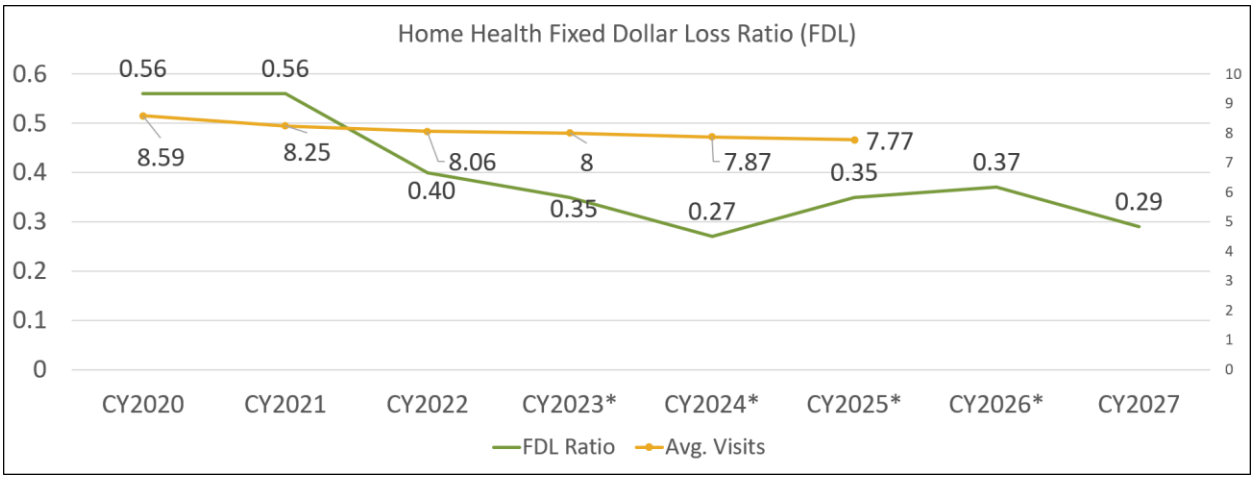
[7] Centers for Medicare & Medicaid Services. Office of the Actuary, July 15, 2026, 2025 Four-Quarter Moving Average Percent Change data. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data

We remain concerned that, unless corrected, this forecast error remains in the payment rates contributing to the chronic underfunding of the home health benefit resulting from combined policies to cut payments. CMS stated in response to comments in the CY2026 Home Health Final Rule, that any changes in a market basket error recalculation "would require careful consideration of the statutory and regulatory frameworks specific to the HH PPS, and any changes deemed necessary would be proposed through notice and comment rulemaking." This is an indication that CMS has the appropriate authority to make one-time adjustments to the market basket forecasting errors. However, CMS did not propose any one-time adjustments in the market basket to account for the compounding errors.

LeadingAge recommends that CMS adjust the final market basket for CY2027 payment to account for a one-time forecast error correction and increase the base payment rate to account for the underestimated market basket for CY 2021 through CY 2025.

Fixed Dollar Loss Ratio

In each calendar year update for home health payments since the implementation of the PDGM, CMS has included a monitoring report which includes all the critical changes to the yearly payment rules and how they impact utilization of services. However, CMS has never included data on the impact of changes to the Fixed Dollar Loss (FDL) Ratio or outlier payment. The intent of this payment is to incentivize home health agencies to accept more difficult and costly patients and to avoid "cherry-picking" of patients. Over the last several years, CMS has continued to decrease the FDL ratio, which we believe is counterintuitive to the purpose of the outlier payment. In our analysis of the consecutive years of decreases to the FDL ratio, we see a pattern of continued decline in visits consistent with the decrease in the FDL ratio.



We have concerns that the ratio is not working as intended and instead of incentivizing care for costly patients, it is creating an unintended incentive to provide fewer visits to avoid exceeding case-mix costs and actually qualifying for an outlier payment. In addition to the FDL ratio, there is an overall 10% cap on fee-for-service payments for outliers, meaning agencies cannot have more than 10% of their revenue come from outlier payments. If that happens, then agencies cannot earn any more outlier payments for the remainder of the calendar year unless their overall payments

increase and reduce the 10% of revenue from outliers. From the data available to LeadingAge, we found that only 6.8% of agencies hit the 10% cap on outlier payments in 2025. Of those, 20% were agencies with total FFS payments under $50,000 and 40% had FFS payments between $1,000,000 and $2,000,000. This seems to suggest that the majority of agencies are not incentivized to serve more costly patients, but we believe CMS should gather more data on this.

LeadingAge requests CMS conduct a thorough analysis of how the FDL ratio is functioning including which patients are receiving outlier payments, the characteristics of the agencies hitting the 10% cap on overall outlier payments, and if there is a correlation between the FDL ratio decreases and average visits.

Request for Information on the Construction of a Home Health Specific Wage Index

LeadingAge conceptually supports the development of an independent home health wage index as we did for other provider settings we represent in the FY2027 Hospice Wage Index and FY2027 Skilled Nursing Facility (SNF) Prospective Payment System Proposed Rule. We appreciate CMS' willingness to seek additional feedback from stakeholders and we hope that CMS continues to publish additional information and seek feedback in the coming comment cycles before any implementation of a new home health specific wage index.

As with hospices and SNFs, home health and hospitals are vastly different settings, employing different mixes of workers and utilizing them in different ways making the use of the Inpatient Prospective Payment System (IPPS) wage index less responsive to the needs of home health providers. As LeadingAge has noted in previous rulemaking cycles, the IPPS wage index also includes several exceptions when determining the wage index for hospitals which are not granted to other provider types and create inaccuracies. These exceptions include reclassifications, floors, outmigration, and a low-wage exception. Due to the statutory nature of these exceptions, the most appropriate course forward to accurately account for labor costs is creating new wage indices for post-acute settings.

Incorporating a home health-specific labor mix offers a more accurate representation of the occupational categories actually found in home health settings, improving the relevance of the data in comparison to the current wage index which is based on hospital occupational mix. This data also has the potential to be more recent wage data, allowing for wage index calculations to better reflect the current labor market instead of the two-year lag time with hospital-based cost reports. The cross-industry data available through the BLS dataset is also much larger than only hospital data.

We therefore encourage CMS to seek data sources that provide the most accurate representation of the costs of labor in home health agencies. Recognizing that data sources like Medicare Cost Reports and Bureau of Labor Statistics data each have both advantages and limitations,

LeadingAge provides the following comments on a potential new home health wage index. There are several significant concerns with using a wage index methodology similar to that employed in the End-Stage Renal Disease (ESRD) setting, which is based on Bureau of Labor Statistics (BLS). These issues require resolutions as discussed below.

Data Sources for Home Health Wage Index

First, we want to express concerns with any potential labor mix methodology and how cost reports are incorporated. The use of unaudited cost report data introduces the risk of inaccurate allocations and potential data manipulation. As we have made clear, LeadingAge remains deeply concerned regarding home health fraud across the country and the easy manipulation of cost report data for profit. If CMS pursues a new wage index, they must regularly audit the cost reports. Unlike hospices, home health agencies report full-time employment on their cost reports, which will ease calculation of staff.

Second, using hourly wage rates for home health aides from the BLS "Home Health and Personal Care Aides" category (31-1120) should be revisited as home health aides have specialized training for health-related tasks (e.g., monitoring vitals, assisting with the administration of medication, simple wound dressing changes, etc.) that personal care aides are not qualified to perform, under the direction and supervision of a nurse. Additionally, home health agencies often compete with other occupations, like food service and retail, for entry-level home health aides, and these categories of wages should be considered in constructing a wage index.[8]

Occupational Mix for Home Health

The BLS-based wage indices implemented and proposed for ESRD and hospice respectively included a weighting methodology for occupations which raise concerns for LeadingAge. In this rule's "Monitoring the Effects of the Implementation of the PDGM", CMS looks at visits by discipline. While overall CMS raises concerns about the decrease in the total number of visits, for the purpose of developing a wage index methodology for home health, we would like to point out concerns about the consistent decreases in visits for disciplines beyond the qualifying services of nursing and therapy.

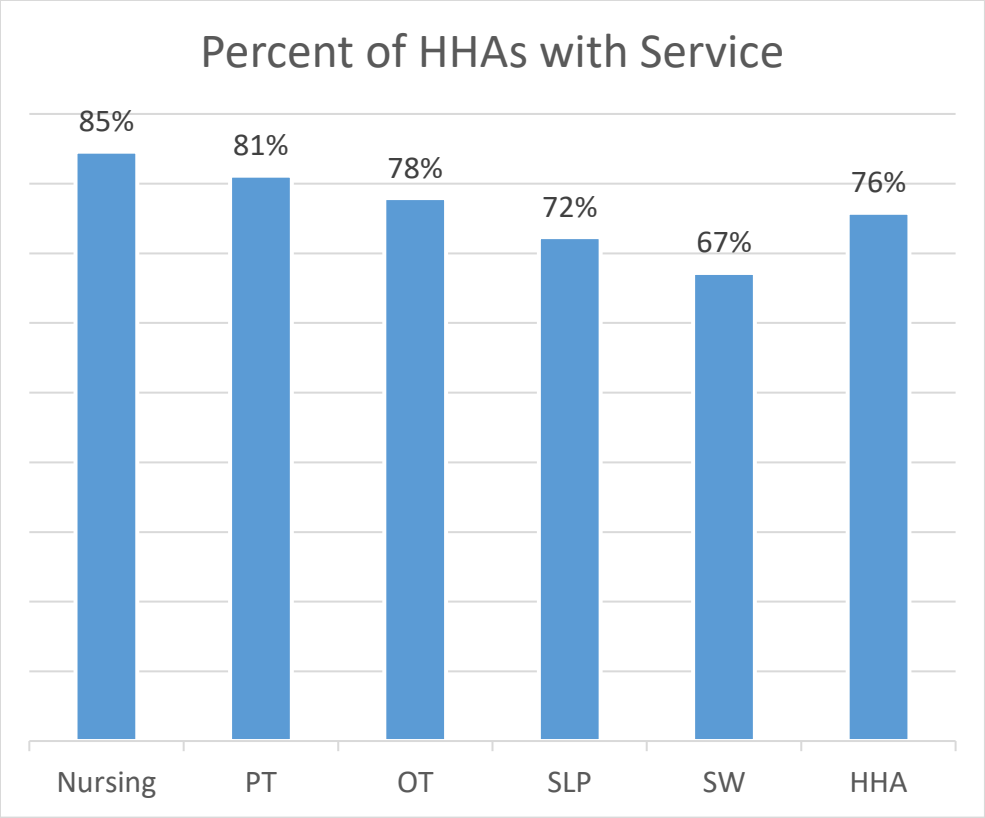
[8] U.S. Government Accountability Office. (2021). *Health care workforce: Key issues, challenges, and the path forward* (GAO-21-72). https://www.gao.gov/assets/gao-21-72.pdf

TABLE 3: UTILIZATION OF VISITS PER 30-DAY PERIODS OF CARE BY HOME HEALTH DISCIPLINE, CYs 2018-2025

Discipline	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Skilled Nursing	4.53	4.49	4.35	4.05	3.90	3.87	3.84	3.81
Physical Therapy	3.3	3.33	2.70	2.74	2.77	2.77	2.73	2.71
Occupational Therapy	1.02	1.07	0.79	0.78	0.77	0.76	0.73	0.71
Speech Therapy	0.21	0.21	0.16	0.15	0.14	0.14	0.13	0.13
Home Health Aide	0.72	0.67	0.54	0.48	0.43	0.42	0.39	0.37
Social Worker	0.08	0.08	0.06	0.05	0.05	0.05	0.04	0.04
Total (all disciplines)	**9.86**	**9.85**	**8.59**	**8.25**	**8.06**	**8.00**	**7.87**	**7.77**

Source: CY 2018 and CY 2019 simulated PDGM data with behavioral assumptions came from the Home Health 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 July 11, 2025. CY 2025 data was accessed from the CCW VRDC on March 12, 2026. **Note:** All 30-day periods of care claims were included (for example LUPAs, PEPs, and outliers). There are approximately 540,000 60-day episodes that started in CY 2019 and ended in CY 2020 that are not included in the analysis.

Home health agencies per regulations (42 CFR 484.105(f)(1)) are only required to provide skilled nursing services and at least one other therapeutic service. As evidenced by the decreasing visits associated with non-qualifying services (social work and home health aides), we are concerned that agencies which provide access to all services under the benefit may be put at a disadvantage if CMS establishes a national occupational mix consistent with current visit trends. Agencies who do not provide the full scope of services under this home health would benefit from a wage that more accurately matches their costs while those providing home health aide and social work services would struggle to maintain staffing that is not representative of national trends but unquestionably invaluable to the beneficiaries receiving the services. In our analysis of home health services using data on Care Compare (which is based not on cost reports or claims but survey data), we found that many agencies did not offer social work or home health aide services.



Additionally, CMS must consider how to incorporate Low Utilization Payment Adjustment (LUPA) visits into the calculation of any wage index. While LUPA visits remain a small portion of overall 30-day periods – and like other visits are trending down – the visits by discipline are not distributed in the same way as average 30-day period visits according to CMS' own data in this proposed rule. This will need to be accounted for in the weighting of visits as well.

Mismatch of Provider Location and Service Delivery Location

By definition, home health is a home-based service and there is a potential mismatch between where home health agencies pay for labor (provider location) and where services are delivered (beneficiary location). Especially, in rural and rural-adjacent areas, agencies may be pulling employees from more expensive suburban and urban areas but only are reimbursed the wage index associated with the rural area where the patient is receiving care. This creates a disincentive for agencies to serve rural areas where wage indices are considerably lower than urban or suburban areas.

Incorporation of Contract Labor

The exclusion of contract labor costs from BLS data fails to account for a significant portion of home health labor expenses, undermining the completeness and accuracy of the wage index. Home health agencies per regulations (42 CFR 484.105(f)(1)) are only required to provide one of the qualifying services directly but the second required service and any additional services can be provided by contract. While the home health cost reports do capture contract labor, those costs

can vary widely based on the provider location and the scarcity of contract labor which can drive up costs. When we spoke with our members, a significant number struggled with attracting speech-language pathologists and many are relying on contracted labor to provide that service. Any future methodology must accurately capture the cost of average contracts with the occupational mix identified for the wage index.

Transparent Implementation Process

Consistent with our comments on the FY2027 Hospice Wage Index Proposed Rule, implementation of any changes to wage indices should be approached with careful consideration to ensure stability and transparency, including publicly publishing the methodology and resulting wage index values before notice and comment rulemaking to allow all providers to share feedback. This includes being transparent about the wage index values produced using the BLS-based approach before and after the application of the 5% cap on wage index decreases.

During the transition period from using the hospital wage index to a BLS-based wage index for home health, several protections should be put in place. These include implementing a Fixed Dollar Loss cap hold-harmless provision to prevent significant reductions in overall payments if a home health agency were to exceed their FDL cap due to an increase in their wage index, which is beyond their control. Additionally, CMS should carefully address the disproportionate effects of the BLS-based approach, limiting decreases to no more than 0.5% per year in any region to avoid destabilizing home health care in affected areas. It is also important to assess the potential impact on state Medicaid budgets, as states must statutorily base Medicaid payment rates on the Medicare rates. Additionally, the revised methodology must be transparent, replicable, and capable of being validated by home health providers. Ample lead time before any changes to the home health wage index are implemented is critical for agencies to effectively plan, adjust budgets, modify staffing strategies, and ensure continued access to quality care without disruption.

Palliative Care Services as Home Health Services

As we noted in our response to the palliative care request for information in the hospice proposed rule (CMS-1851-P), certified home health agencies are uniquely positioned to support palliative care needs of Medicare beneficiaries, particularly if the current structure of the payment and quality incentives are changed. We applaud your guidance that palliative care needs are skilled needs and that home health can provide care to patients with serious illness under the existing regulatory guidelines. We look forward to seeing the updated Medicare Benefit Policy Manual that CMS releases after the final rule is published later this year. We have included some examples of palliative care patients that could be incorporated into these updates to ensure patients receive the care that is afforded to them.

We would like to take this opportunity to provide additional feedback on the role of palliative care services in home health and the barriers agencies currently face to support patients needing these services. As CMS outlines in this rule, a significant portion of Medicare beneficiaries dealing with

serious illness meet the homebound and skilled need requirements of home health eligibility. However, most agencies struggle to serve these patients or purposefully avoid these individuals due to the mismatched incentives in the current home health payment and quality structure.

Finally, given some of the narrative in this section of the proposed rule, to clarify that LeadingAge does not believe home health agencies are the sole place where community-based palliative care is acceptable in the Medicare program. Many of our mission-driven, nonprofit members who are not home health agencies serve palliative care patients through outpatient, clinic-based, or home-based palliative care programs. The statutory requirements of home health eligibility, homebound status and skilled need, also restrict the patients who can access these services, making other forms of palliative care necessary to meet the needs of the whole Medicare population. We firmly believe, given CMS's requests for information in other payment rules that it is CMS's intention in providing clarification around home health and palliative care was not to imply that home health is the only appropriate setting for community-based palliative care but rather clarify that services should not be denied for individuals whose needs are predominantly palliative in nature. We request CMS clarify their position in the final rule.

Payment and Billing Barriers Solutions for Home Health Palliative Care

Payments to home health agencies have decreased over the last five years since the implementation of the Patient Driven Groupings Model (PDGM). This has led to the shortening of home health stays and decreases in the number of visits overall. It is difficult to adequately address all the issues associated with the interdisciplinary needs of a palliative care patient with this limited reimbursement. In this rule, CMS states "The structure of the PDGM allows, in general, for palliative care services to be most appropriately grouped into the medication, management, teaching, and assessment (MMTA) clinical group." This seems to imply that MMTAs are the only clinical groupings that would be eligible for palliative care services under the home health benefit. We strongly disagree with this assessment and believe that any additional guidance should include all clinical groupings under PDGM as eligible for palliative services. In our examples below we provide several scenarios of patients outside the MMTA clinical groupings that present strong cases for palliative care service needs.

There are also issues with the HCPCS codes available to home health agencies to bill in the bundle for telephonic services of social workers (such as the HCPCS G0155, REV 0569 in hospice). Additionally, there is a lack of coding for the delivery of a nurse focused maintenance program which would be essential to offer for palliative care patients. Currently, there are HCPCS codes for therapy-based maintenance programs (G0159, G0160, G0161) but, as was required by the *Jimmo v. Sebelius* settlement, maintenance extends to not only therapy but nursing supports.

To address these issues and encourage more palliative care services in home health, LeadingAge makes the following recommendations:

- Enhance the payment structure for palliative care patients to incentivize greater coordination between the certifying clinicians as well as incentivize use of more disciplines from the home health benefit.
    - If CMS develops a Part B billing model for palliative care which separates the palliative care assessment from the palliative care billing, a certifying clinician could bill for the assessment and formally establish through that assessment the palliative nature of the home health orders. Especially in more rural areas community-based palliative care might be difficult to obtain but a certifying clinician with palliative training could establish a home health plan of care with palliative goals supported through the home health interdisciplinary team and offer additional benefits including spiritual care through the Part B billing available to the clinician.
    - Additionally, if a Part B billing structure is created for palliative care, CMS should consider how to layer home health with Part B palliative care to ensure components of palliative care like spiritual care could be offered to home health beneficiaries via the certifying plan of care.
    - Due to the restrictive payments, social work and home health aide services are deeply underutilized in home health writ large and clearly would have beneficial impacts on this segment of the home health population. Additional support through increased payment could better support these services. As we note in this letter, there has been a downward trend in utilization in aide and social work services in home health, especially since the implementation of PDGM. We believe additional funding to ensure adequate support for these services would have to come through Congress.
- Nursing services are most common which can support the physical needs of palliative care patients such as medication adherence and evaluation.
- More clearly established coding for nursing-based maintenance programs and coding for social work education of families and social work telephonic based outreach are also needed.

Quality Barriers and Solutions for Home Health Palliative Care

Quality reporting creates even more disincentives to support palliative care patients due to the exclusive focus on improvement in function. Despite the *Jimmo* settlement, nearly all home health quality measures focus on the improvement of function for patients. This diminishes the real ability of home health agencies to support maintenance of function and support of symptom management, which may not improve functioning but is essential for quality of life. For many palliative care patients at the beginning of their serious illness trajectory, this maintenance is far more important than improvement and is a truer metric of the quality of care they receive.

To address these issues and encourage more palliative care services in home health, LeadingAge makes the following recommendations:

- Create a distinction for patients in home health who receive rehabilitative services vs. maintenance/palliative services.
- This distinction would be established by the certifying clinician on their orders for home health.
- CMS should add an item to the OASIS indicating which type of home health service is being delivered (rehabilitative, maintenance, or palliative) based on the certifying clinician's orders or assessments and adjust which OASIS items need to be responded to and how quality measures would be calculated from the responses.
- While not endorsed by the Consensus Building Entity, CMS already has measure specifications for stabilization built into OASIS.[9]

Examples of Palliative Care Patients Served by Home Health

In order to support CMS's efforts to better define the palliative care population in home health, we offer the following patient examples which are outside of the MMTA category but meet the eligibility requirements for homebound and skilled-need requirements and require palliative-based supports rather than rehabilitative supports. As CMS considers updates to the Medicare Benefit Policy Manual we hope that these types of patients can be included.

Patient A: A 78-year-old patient with end-stage heart failure and a non-healing Stage 4 sacral pressure ulcer receives home health under the Wound/Skin grouping. Skilled nursing provides complex dressing changes and pain management to prevent infection and control symptoms. The Medicare Administrative Contractor (MAC) may deny claims, arguing that dressing changes are maintenance care that a family caregiver can perform, overlooking the clinical complexity of managing a deteriorating palliative wound and breakthrough pain.

Patient Profile

- **Condition:** Stage 4 sacral pressure ulcer, end-stage heart failure, severe chronic pain.
- **Grouping:** Wound/Skin Management.
- **Goal:** Palliation, symptom control, and wound stabilization rather than healing or functional recovery.

Patient B: A 74-year-old patient with an advanced, progressive ischemic stroke (recurrent) and vascular dementia maps to the Neuro/Stroke Rehabilitation clinical grouping.

The patient is receiving skilled physical and speech therapy under a skilled maintenance program alongside nursing for palliative symptom management. Because the patient has reached a plateau and is in slow neurological decline, a Medicare Administrative Contractor (MAC) looking through a traditional restorative lens sees a high denial risk. Lack of restorative progress, and the expectation that a caregiver could be trained to provide custodial support (vs a skilled need) would be typical.

[9] Centers for Medicare & Medicaid Services. (n.d.). *Home health outcome measures table: OASIS-E 2025* [Data table]. https://www.cms.gov/files/document/home-health-outcome-measures-table-oasis-e2025.pdf

Patient Profile

- **Primary Diagnosis (ICD-10):** I69.398 (Other sequelae of cerebral infarction) paired with F01.511 (Vascular dementia with behavioral disturbance).
- **PDGM Grouping:** Neuro/Stroke Rehabilitation.
- **Clinical Picture:** Severe left-sided hemiplegia, profound dysphagia, neurogenic bowel/bladder, and aphasia. The patient is bedbound and requires maximum assistance for all transfers.
- **Care Plan Focus:** Palliative maintenance therapy. This includes establishing a safe positioning routine to prevent aspiration, physical therapy to prevent debilitating joint contractures, and nursing to manage neurogenic pain and terminal agitation.

We recommend CMS issue the following guidance for MACs in addition to an illustrative example in the Medicare Benefit Policy Manual:

- CMS should provide clear guidance to the MACs that denials should not be based on any standard of decline, i.e. with how quickly a patient declines or how slowly they decline. By the nature of the benefit, home health is time limited and does not adequately account for the full trajectory of an individual's decline.
- CMS should provide clear guidance to the MACs that training and support for family caregivers to provide palliative care including dressing changes and complex symptom management supports are grounds for home health service.

Home Health Quality Reporting Program (HH QRP)

LeadingAge strongly supports CMS's efforts to better align the HH QRP program with the Expanded Home Health Value Based Purchasing (HHVBP) model as well as creating more consistency between the reporting standards for the calendar year payment updates and the Annual Payment Updates (APU). Additionally, we provide considerations for future measures that look at advance care planning and the role of home health agencies in the process.

Proposal To Revise HH QRP Data Submission Deadlines Beginning with the CY 2027 HH QRP

In the CY2026 Home Health Proposed Rule, CMS solicited feedback on reducing the OASIS assessment data submission deadline from 4.5 months to 45 days. Generally, commenters were supportive of the change including LeadingAge who recommended 60 days instead of 45 days to align with the expectations of the current Conditions of Participation. Generally, LeadingAge supported the change which would shorten the amount of time it takes for quality measure data to be posted publicly on Care Compare. We did note concerns that a 60-day timeline may be more appropriate for home health due to the reporting requirements of OASIS. In this rule, CMS provides

additional detail on the proposed 45-day timeline which better explains the purpose of aligning to this standard instead of the 60-day standard due to aligning the reporting with calendar quarters.

LeadingAge supports CMS's proposal to reduce the OASIS assessment data submission deadline from 4.5 months to 45 days.

Proposal To Revise the OASIS & HHCAHPS Annual Payment Update Reporting Timeframe and Regulation Text Related to Reconsiderations

The current OASIS and HHCAHPS annual payment update (APU) reporting timeframe differs from that used by other major CMS payment updates. Notably, the expanded HHVBP Model annual payment adjustment and the HH PPS updates are both based on a calendar year timeline. To improve alignment between HH payment policies and OASIS QRP reporting requirements, CMS is proposing to revise the OASIS and HHCAHPS APU data reporting timeframe to reflect a January 1 through December 31 reporting timeframe, or the calendar year. CMS believes this update would provide clarity to HH payment updates and facilitate the alignment of the HH pay-for-reporting policies with other HH payment policies.

As stated above, LeadingAge supports CMS's work to align the data submission expectations of the program with the calendar year nature of the rule instead of a federal fiscal year. To that end, LeadingAge supports revisions to both the OASIS and HHCAHPS Annual Payment Update Reporting Timeframes as well as the corresponding regulatory text revisions to implement the changes.

HQRP Measure Concepts Under Consideration for Future Years—Request for Information (RFI)

CMS requested feedback on the importance, relevance, appropriateness, and applicability of the quality measure concepts related to advance care planning in home health. In part, this comes from CMS's efforts during the Measures Under Consideration process to include a measure in the HH QRP that would look at the percentage of patients 18 and older with one inpatient encounter who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the electronic health record. This was tied to a record being available at the time of hospital discharge despite being proposed for the home health setting.

While LeadingAge agrees with CMS that in post-acute care (PAC) settings, where patients recover from acute illness, injury, or major procedures, their needs and goals may evolve as their condition changes, we do not necessarily agree that holding PAC providers accountable to a measure of documenting advance care planning is effective. We agree that patient priorities can shift over the course of recovery, especially if the recovery is difficult and not meeting the expectations of the patient or certifying clinician. We agree that regular reassessment and transparent communication

are essential to maintaining person-centered care, however, high-quality advance care planning is essential to achieve goal-concordant care. **While LeadingAge strongly supports advance care planning with Medicare beneficiaries in other settings, due to the continuing decrease in visits and the intermittent and temporary nature of home health services, lack of evidence-based advance care planning interventions in home health, and current clear regulatory barriers, LeadingAge does not believe it is either appropriate, relevant, or applicable to develop advance care planning measures for home health agencies.**

CMS was clear that evidence-based outcomes are prioritized in determining which aspects of advance care planning are appropriate for home health. In our review of the existing, limited research on advance care planning in home health, there is limited research on the most common conditions seen by home health agencies, including cardiovascular and pulmonary disease and in general more research is needed on the role home health agencies play in these discussions.[10] Many of the studies had very limited sample size, often restricted to a single agency, and while some of the goal conflicts between family members was mitigated by a home health agency's intervention in the planning conversation, there were no statistically significant differences found in perceptions of collaboration and readiness for advanced care planning in the population.[11]

When we discussed this effort with our members, all members shared that they comply with the requirements of 42 CFR 489.102(a) to provide written information about patient rights with regards to advance care planning, requirements to document in the medical record if the patient has an advance directive and having written policies and procedures regarding advance directives. Additionally, the regulations clearly state:

> *(i) In the case of a home health agency, in advance of the individual coming under the care of the agency. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided*.

This seems to imply that home health agencies should not engage in advance care planning while providing care to the patient. While many of our members shared they attempt to address changing needs of patients and communicate those needs to the referring/certifying clinician, they have limited time with patients and in many cases do not have long term relationships with patients like other providers would. Many members felt like additional education to support staff to have an effective advance care planning conversation would be welcome; however, one study from the UK found limited evidence for the effectiveness of advanced care training for care home workers and despite the call for additional research few studies exist.[12]

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[10] Bigger, S., & Haddad, L. (2019). Advance Care Planning in Home Health: A Review of the Literature. *Journal of Hospice & Palliative Nursing*, *21*(6), 518–523. https://doi.org/10.1097/NJH.0000000000000591

[11] Tay, D. L., Ellington, L., Towsley, G. L., Supiano, K., & Berg, C. A. (2020). Evaluation of a collaborative advance care planning intervention among older adult home health patients and their caregivers. *Journal of Palliative Medicine, 23*(9), 1214–1222. https://doi.org/10.1089/jpm.2019.0521

[12] Gleeson, A., Noble, S., & Mann, M. (2021). Advance care planning for home health staff: A systematic review. *BMJ Supportive & Palliative Care, 11*(2), 209–216. https://doi.org/10.1136/bmjspcare-2018-001680

The Expanded Home Health Value Based Purchasing

LeadingAge appreciates CMS's update on the Expanded HHVBP program in this year's rule. In particular, we are grateful CMS took our recommendations from CY2026 and did not make any changes to the HHVBP program this calendar year. Since the implementation of the program there have been multiple changes in the measurement baselines and quality measures, continually moving the goalposts for home health agencies. We are eager to have a year with no changes to measures, baselines or otherwise to work with members to improve their performance.

We also appreciate CMS bringing to the attention of the HHVBP Technical Expert Panel (TEP) changes recommended by LeadingAge to scoring rules associated with accurate data submission.[13] [14] CMS confirmed LeadingAge's findings that 14% of the highest performing HHVBP agencies (those receiving a +5% adjustment) also received an annual payment adjustment penalty of 2% for missing their quality reporting expectations and the majority were in Los Angeles, CA. We are grateful to the TEP for understanding our concerns and seeing CMS's proposals to address the issue as "intuitive and long overdue." The TEP did request CMS conduct further analysis of the potential impacts to providers and we hope CMS will propose changes to this particular scoring rule in future rulemaking cycles to preserve the integrity of the Expanded HHVBP model.

While CMS did not propose any changes to the Expanded HHVBP model, we wish to convey our previous recommendation on the program specifically, expanding the number of cohorts. 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.

Our initial recommendation to CMS was to consider redefining cohort sizes based on average daily census or OASIS episodes during the baseline year. And while we still believe this is a valid redevelopment, the calculations necessary to redefine cohorts by patient size could be more cumbersome for CMS as well as agencies. However, if CMS were to define a third cohort to be large-volume agencies with less than 40 returned surveys in the baseline year which would prevent the calculation of CAHPS measures, this would create a more equitable distribution of cohorts and allow each to be compared based on available data. Currently, large-volume cohort agencies

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[13] Abt Global. (2026). *2025 Technical Expert Panel meeting: Home Health Quality Reporting Program and Expanded Home Health Value-Based Purchasing Model summary report*. Centers for Medicare & Medicaid Services.
https://www.cms.gov/priorities/innovation/files/hhvbp-tep-summary-report.pdf
[14] LeadingAge. (n.d.). *LeadingAge expresses concerns on Medicare home health benefit, HHVBP*.
https://leadingage.org/leadingage-expresses-concerns-on-medicare-home-health-benefit-hhvbp/

without 40 returned surveys are not assessed a score for CAHPS measures. In LeadingAge's analysis of the CY2024 performance data, we found that, of the top 10 percent of large-volume achieving agencies (those receiving some percentage increase) 85% had "No or insufficient data available" for CAHPS scores to be included in their calculations. We argue this provides agencies who do not obtain enough returned surveys an advantage over those agencies with 40 or more completed returned surveys as those agencies with CAHPS scores have more data to be compared against their achievement and improvement thresholds.

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-volume cohort struggle to get 40 returned surveys despite their compliance with HH QRP requirements. **We request CMS evaluate the creation of a third cohort which would bifurcate the current large-volume cohort into two: one cohort would include HHAs who had sufficient data to calculate CAHPS measures during the baseline year and a second cohort which did not have sufficient data to calculate CAHPS measures during the baseline year.**

Provider Enrollment

General Comments on Enrollment Proposals

LeadingAge fundamentally supports CMS's efforts to protect the Medicare Trust Fund and Medicare beneficiaries from fraud, waste, and abuse. Enrollment policies are critical to prevent unqualified and potentially fraudulent individuals and entities from inappropriately billing the Medicare program and harming beneficiaries through subpar care delivery. The authorities currently conveyed to CMS allow for the denial and removal of these individuals and entities who engage in fraudulent or abusive behaviors.

We wish to make abundantly clear that LeadingAge has consistently supported the administration's targeted actions against fraud and has encouraged CMS's efforts to detect, prevent, and deter fraud, waste, and abuse in the Medicare program as evidenced by our numerous letters regarding our concerns.[15] **We are not opposed to stronger fraud enforcement**. Rather, we believe that CMS should continue to target bad actors without creating a provider-enrollment regime in which broad discretion, undefined standards, third-party conduct, or simple technical compliance failures can produce disproportionate consequences for legitimate providers.

Our central concern is that the proposed rule significantly expands CMS's enrollment denial, revocation, reporting, and related enforcement authorities while simultaneously removing or failing to establish objective standards and procedural safeguards. The result could be severe and lasting enrollment consequences for legitimate providers based on technical errors, conduct of third parties and staff outside their control, or broadly defined associations rather than intentional or egregious misconduct.

In addition to the concerns with the broad scope of these proposals which may put quality providers at risk of revocation or denial, we believe CMS has failed to acknowledge the impact of these proposed changes, provide adequate justifications, and afford the public a meaningful opportunity to comment.

To begin, we are deeply concerned that the regulatory impact analysis offered in the proposed rule does not appropriately consider the unintended cascading consequences across Medicare enrollments, Medicare participation, and beneficiary access. Many of the proposals in Section V.C. are blunt and administratively burdensome approaches to program integrity that do not adequately target high-risk providers and instead impose new compliance burdens on all providers regardless of their risk. These enrollment proposals appear to be contrary to CMS's commitment to reducing

[15] LeadingAge. (2023, January 13). *Hospice program integrity ideas: Hospice industry consensus*. https://leadingage.org/wp-content/uploads/2023/01/Hospice-Program-Integrity-Ideas_Hospice-Industry-Consensus-Final-1.13.23-.pdf, LeadingAge. (2026, January 6). *Home health member network resource*. https://leadingage.org/wp-content/uploads/2026/01/Home-Health-Member-Network-Resource-January-6-2026.pdf, LeadingAge. (n.d.). *LeadingAge joins in coalition recommendations to CMS on fighting fraud*. https://leadingage.org/resources/leadingage-joins-in-coalition-recommendations-to-cms-on-fighting-fraud/

regulatory burdens enumerated in CMS's previous requests for information which sought to identify an eliminate outdated or unnecessary regulation, and initiating a pending rulemaking on Cutting Administrative Requirements for Excellence in Patient Care (CMS-3484).

Additionally, unlike in previous rules on provider enrollment, very little analysis was conducted regarding impact on Medicare providers or Medicare beneficiaries. For example, CMS's proposal not only to remove the 5-year look back period for affiliations but also expand the scope of entities and individuals covered under the definitions of "managing employee" and "affiliation" would significantly increase the administrative and reporting burdens for providers. Yet the Regulatory Impact Analysis is devoid of any reference to costs to providers resulting from these new requirements.

We request CMS conduct a comprehensive and realistic regulatory impact analysis for each component of this rule before finalizing any proposals.

Additionally, we do not believe there has been an appropriate public notice and opportunity for comment. The sections on provider enrollment were buried in a proposed rule, that traditionally concerns a specific provider setting, making it less likely that members of the public who may engage on Medicare-wide enrollment issues would understand the consequences of this rule to non-home health agencies. This is also inconsistent with previous enrollment proposals which were standalone revisions to the rules governing Medicare.[16]

By incorporating these proposals into the CY2027 Home Health Proposed Rule, providers who have no association with home health or do not typically track policy developments within that provider payment or quality program may have limited knowledge and awareness that this rule carries substantial changes to provider enrollment for ***all*** Medicare providers. **LeadingAge urges CMS to withdraw its proposal and reissue these cross-cutting provider enrollment reforms in a separate rulemaking rather than embedding them in provider-type-specific payment rules.**

Requests for Clarifications

In our review of the rule, we identified several questions that were not appropriately answered by the information and we request clarification.

1. If the enrollment provisions of this rule were to move forward, what is the proposed implementation timeline? Is it the same timeline as the rest of the rule's provisions regarding the CY2027 Home Health Payment Updates? Or would these new requirements

[16] *Medicare program; requirements for establishing and maintaining Medicare billing privileges*, 68 Fed. Reg. 22064 (April 25, 2003). *Medicare, Medicaid, and Children's Health Insurance Programs; program integrity enhancements to the provider enrollment process*, 84 Fed. Reg. 47794 (September 10, 2019). https://www.federalregister.gov/documents/2019/09/10/2019-19208/medicare-medicaid-and-childrens-health-insurance-programs-program-integrity-enhancements-to-the Since 2003, CMS has issued standalone regulations that set forth standards for provider enrollment with Medicare Program; Requirements for Establishing and Maintaining Medicare Billing Privileges (68 FR 22064). Most recently in 2019, CMS issued the final Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process.

take effect during the revalidation of a currently enrolled provider or on the submission of an enrollment application to the Medicare program for a new provider?
If these provisions were to be finalized as proposed, we ask that CMS allow all providers, whether they are currently enrolled or submitting new applications, at least one year to comply with the requirements of the rule. Especially with regard to gathering and submitting information to CMS regarding managing employees and affiliations, long standing enrollees like our mission driven, nonprofit members need adequate time to conduct thorough research on previous affiliations which could go back decades. This will also provide CMS time to develop clear guidance regarding affiliations and ensure MACs and the PECOS system are prepared for the onslaught of new information.

2. In addition to representing home health, hospice, and skilled nursing providers enrolled in the Medicare program, LeadingAge also represents Programs of All-Inclusive Care for the Elderly (PACE). Do these provisions impact PACE programs?
We urge CMS not to directly apply these provisions to PACE programs due to the sheer volumes of contracts these relatively small providers must maintain. Additionally, PACE organizations have their own regulatory program integrity oversight through their three-way contracts with Medicaid and Medicare programs. Because of the need for information on employees and related parties, PACE programs will be asked for significant additional information from their contracted parties during the contracting process. Additionally, PACE programs are uniquely reliant and obligated to maintain significant contractual relationships to fulfill their regulatory requirements. These new requirements could create significant liabilities in network contracts, particularly in areas with very limited medical specialists.

3. How is CMS preparing to implement the collection and storage of these additional reporting requirements? Does CMS have a plan to standardize information across different MACs?
LeadingAge is deeply concerned about the capacity of the PECOS system, MACs, and CMS staff to process and make sense of the volume of information this proposed rule will create. During the implementation of the updated 855A addendum requiring skilled nursing facilities to disclose significant additional information on ownership, management, and related parties during revalidation, many of our members raised concerns that MACs did not have clear instructions from CMS on what information met the requirements, or clear processes for confirming receipt. Additionally, many found that PECOS had limitations on the characters in certain fields that prevented proper disclosure. All these issues need to be addressed prior to 2 million enrolled providers updating their enrollment documentation. CMS must issue clear guidance prior to implementing any of these proposals. The guidance must be consistent and easy to follow for all Medicare enrolled providers and MACs.

Modifications of Current Revocation and New Revocation Provisions

Abuse of Billing Privileges 424.535(a)(8)(ii)

CMS proposes to remove all the factors under section 424.535(a)(8)(ii) that CMS could consider in determining whether the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements to allow CMS the maximum flexibility to address possible scenarios without rigid constraints. CMS believes the existing factors established for revocation based on abuse of billing privileges often constrain their ability to effectively address all scenarios. LeadingAge fundamentally disagrees with CMS's proposal on several grounds.

First, CMS believes the requirement to consider "Percentage of Claims Denied" is problematic since non-compliant billing often occurs notwithstanding a low percentage of denied claims. While we understand CMS's concern that there may be inappropriate claims that do not get denied, we do not believe that "a simple finding that several of the provider's claims do not meet Medicare requirements" is a valid enough reason for revocation from the Medicare program and potential bar on reentry up to 10 years. A few claims out of thousands being incorrect should be addressed by the Medicare Administrative Contractor (MAC) through a Targeted Probe and Educate (TPE) process. Medicare billing is complicated, and providers who make a good faith effort to respond to their MAC's TPE requests should not be placed in a position of potential revocation without the opportunity to correct minor errors that show up on occasional billing. By removing the criteria to consider the "percentage of submitted claims that were denied during the period under consideration" providers have no clear understanding of their risk in having one claim denied vs. 1% of similar claims rejected. It is unrealistic to expect all Medicare providers to have a perfect claims approval rate. Without clear guidelines on how CMS will assess denial rates, that is, in essence, the risk being placed on providers. Any rejected claims could lead to revocation.

Second, we are concerned that CMS's removal of the factors under § 424.535(a)(8)(ii) would make it easier for CMS to revoke enrollment for other types of non-compliant claims such as rejected claims. We note that § 424.535(a)(8)(ii)(C) specifically addresses "the type of billing non-compliance *and* the specific facts surrounding said non-compliance" which could include rejected claims - but not necessarily all of them. For example, hospice agencies currently are experiencing increased claims rejections, not due to their own non-compliance, but rather a claims edit required by CMS of the MACs which has not been appropriately implemented and requires MACs to manually edit rejections.[17] Therefore, rejected claims are not necessarily indicative of a lack of compliance from providers. Yet it appears that under the proposed changes, which do not provide for any limitations on CMS' determination of a provider's pattern or practice of failing to meet Medicare requirements, CMS would have grounds to revoke provider enrollments based on claims

[17] National Government Services. (n.d.). Production alert details [Medicare claims alert]. https://www.ngsmedicare.com/web/ngs/production-alert-details?alertid=15875831&lob=93618&state=97162&rgion=93624

rejections that were beyond the provider's control. That is an inappropriate and dangerous expansion of CMS's authority.

Finally, CMS states it must have the maximum flexibility to address all possible § 424.535(a)(8)(ii) scenarios without the rigid constraints of the existing factors.

Therefore, LeadingAge recommends the following changes to alleviate CMS' concerns with the rigidity of the existing factors:

- **CMS should retain the existing objective regulatory factors but expand the percentage of claims considered to include claims which were denied, rejected, or otherwise non-compliant to capture the extended universe of claims issues.**
- **CMS should also establish standards that consider the frequency, nature, and severity of the noncompliance to distinguish between technical coding errors and deliberate fraud. This should include interventions from Fiscal Intermediaries to educate the provider and supplier on correct billing practices.**

We believe that the original safeguards established in regulations preserve CMS's ability to address genuine abusive billing while the additional recommendations work to establish standards of targeted program integrity rather than a sanction for ordinary claims compliance errors which could waste valuable resources.

False or Misleading Information § 424.535(a)(4) and § 424.530(a)(4)

CMS proposes to amend section § 424.535(a)(4) and § 424.530(a)(4) to allow revocations or denials based on the submission of false or misleading information on or in association with any CMS or Medicare enrollment-related form including forms for enrollment, revalidation, reactivation, voluntary termination of enrollment or EFT data etc. LeadingAge does not inherently disagree with CMS's proposal.

However, in its efforts to remove fraudulent providers, CMS should ensure that enforcement tools are proportionate and risk-based and offer due-diligence protections for good-faith error and compliance. Many of the proposed expansions of CMS authority, including this authority to revoke or deny based on false and misleading information, do not distinguish the intent behind the provider's conduct. A recurring concern is that the proposed authorities do not adequately distinguish fraud or intentional misconduct from clerical mistakes, documentation deficiencies, technical enrollment problems, conflicting CMS/MAC guidance, or circumstances beyond a provider's control.

This matters because enrollment revocation is an extraordinarily consequential remedy. Providers should not face essentially the same sanction for inadvertent noncompliance as actors engaged in intentional fraud. CMS should establish materiality and, where appropriate, knowledge/intent standards and reserve denial or revocation for significant program-integrity risks rather than routine compliance errors.

LeadingAge Recommends:

- **CMS revise proposed changes at § 424.535(a)(4) and § 424.530(a)(4) to require that provider revocations and denials based on the submission of false or misleading information involve a showing of intent to mislead or a pattern of inaccurate submissions, rather than isolated, inadvertent errors.**

Extension of Revocations § 424.535(i)

CMS proposes to expand its authority under § 424.535(i) such that they could also revoke ***any*** of a provider's other enrollments if the provider's triggering enrollment is denied for any reason under § 424.530(a). LeadingAge is particularly concerned with this expansion of authority for revocation especially when CMS makes these additional revocations automatic. It is one thing to trigger an investigation based on credible concerns that a related entity was denied entry to the Medicare program based on submitting false or misleading information, but entirely another to establish blanket revocation of provider enrollments based on one denial. Additionally, we do not believe that CMS's example provides the appropriate rationale for establishing this expanded authority.

CMS provides a single example of how this authority would be helpful to automatically revoke a provider's other enrollments but does not discuss how widespread this potential situation may be. The example focuses on a denial of enrollment on the grounds of having a false storefront and submitting misleading information in an enrollment. CMS does not explain why additional investigations into the provider's other enrollments would not be conducted because of the denial or why further investigation would not result in revocation for other grounds. CMS currently has the authority to review any provider's enrollments at any time if they believe there is the potential for waste, fraud, and abuse. It is not clear why, given the deficiencies of the failed provider application, CMS could not investigate the provider's other enrollments for similar deficiencies before taking further action. Based on the example a false storefront is cause for revocation under § 424.535(a)(5)(i) and submitting misleading information is a cause for revocation under § 424.535(a)(4).

Of most concern, is CMS' failure to limit this expansion of cross-enrollment revocations to denials based on fraud, material misrepresentation, or beneficiary safety. If this proposal were to move forward, and a hospice or home health application were denied due to the existence of the current 6-month moratorium, CMS could legitimately revoke all the provider's other enrollments unrelated to home health or hospice regardless of any intent to defraud the Medicare program. As written, there are no guardrails to prevent the utilization of the authority against providers who have a moratorium in place but are compliant providers.

Many of the proposals in this rule expand the circumstances in which CMS can deny, revoke, retroactively revoke, preclude, or bar reapplication without providing a meaningful opportunity to the provider to correct the underlying problem or relationships. Providers should generally have an opportunity to correct inaccurate information, cure technical deficiencies, remove or disassociate from a problematic individual, explain disputed information, or rebut CMS's alleged connection

between conduct and the provider before losing enrollment. The concern becomes particularly serious where CMS could extend a problem involving one enrollment to other enrollments and other federal health programs such as Medicaid.

LeadingAge Recommends:

- **CMS revise proposed changes at § 424.535(i) to require a separate, individualized finding of a material program-integrity risk in order to revoke an additional enrollment, together with notice and an opportunity to rebut the alleged connection.**

High-Risk Enrollments (§ 424.535(a)(24))

CMS is proposing a new authority to revoke a provider's or supplier's enrollment if it deems the enrollment as presenting a "high risk of fraud, waste, or abuse" due to the provider's or supplier's location within a "limited geographic area" that has an "excessive number of providers and suppliers."

LeadingAge is deeply concerned about the lack of guardrails to establish "limited geographic area" or "excessive number" when implementing this new authority and, more explicitly, that revocations could take place even if there was no evidence of fraud, waste and abuse. This proposal is too broad and too vague for providers to mitigate their exposure to risk.

Many of our members are located in medical office buildings to be close to referral partner organizations. Home health and hospice agencies that are near geriatric or oncology practices, not for nefarious purposes, but to better coordinate care of shared patients. Additionally, many LeadingAge members are large Continuing Care Retirement Communities with multiple Medicare provider types in a small geographic area of a campus. Without any clear standards in place, these campuses which are attempting to serve the entire continuum of needs for their residents from skilled nursing, to outpatient therapy, to hospice and home health services could be penalized just for serving their community.

This proposal offers substantial discretion without clear standards for when an area constitutes a program-integrity risk. We understand CMS's concern given the examples of fraudulent home health and hospice organizations congregating in the same limited geographic area with other providers who may refer to them. But those entities had clear signs of other program integrity concerns that could be addressed with other revocation remedies including, submission of false and misleading information, nonoperational store fronts, and clear affiliations that pose an undue risk.

CMS would essentially be codifying an arbitrary and capricious standard, as it has neither established, nor defined with any certainty, how an excessive number of providers and suppliers within a limited geographic area would necessarily present a high risk of fraud, waste, or abuse. Additionally, Section 1866(b)(2) of the Social Security Act gives the Secretary authority to terminate provider agreements after determining that the provider has failed to comply substantially with provisions of the agreement. However, it is difficult, if not impossible, for providers to even know

whether they are doing anything that would result in CMS invoking this provision. A provider itself would not necessarily know whether it is located in a limited geographic area with an excessive number of providers or suppliers. It would not have any notice of how CMS would consider these variables as "presenting" a high risk of fraud, waste, or abuse. Without even requiring a finding of wrongdoing or any type of collusion among the providers, CMS' revocation authority under this proposal leaves providers vulnerable to losing their Medicare enrollment without any way of mitigating potential risks.

LeadingAge recommends that CMS rescind this proposal.

Retroactive Revocations

CMS proposes to make all revocation reasons retroactive to the date of noncompliance rather than the 30-day standard after CMS issues the revocation notice. Under the proposal, nearly all revocation reasons will have a specific date of noncompliance with the given revocation reason and CMS will have the authority to recoup any payments distributed to the provider during the period of noncompliance.

LeadingAge opposes this proposal. We understand CMS's rationale for making all revocation retroactive to the date of noncompliance but as with other sections of this rule, we are deeply concerned that CMS provides no distinction between intentional deception and clerical errors. For example, a provider who misses a deadline for the reporting of a new address could face the same retroactive revocation consequences as a provider who has severely harmed a patient. Applying a retroactive revocation across all revocation reasons will create a disproportionate and punitive structure that may force providers to voluntarily opt-out of providing Medicare services due to the sheer risk of recoupment for minor infractions.

It is also questionable whether this proposal would be consistent with the Medicare statute under Section 1866(b)(2) of the Social Security Act, which states:

> The Secretary may refuse to enter into an agreement under this section or, **upon such reasonable notice to the provider** and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary-…has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder…"

We believe that CMS's proposal to make all revocations retroactive to the point of noncompliance does not conform with the explicit requirement of "reasonable notice to the provider." If CMS retroactively revokes Medicare coverage during a timeframe that is at any point before this final rule takes effect, CMS cannot claim that reasonable notice was given to the provider. We do not believe a provider had "reasonable notice" that the services that were performed five years ago, when the rule was not even in effect - would not be covered by Medicare due to a policy change in the future and a reason for noncompliance that was not identified until after the rule took effect.

LeadingAge recommends that CMS rescind this proposal.

Claim Submission After Revocation

CMS is proposing to change the timeframe for revoked providers to submit all claims for items and services furnished before the date of the revocation letter. CMS proposes reducing the timeframe from 60 days to 15 days. In addition to this substantially shortened timeline, with the substantial changes to retrospective revocation dates, CMS is proposing to clarify that while revocation is effective as of the date listed under the reason for revocation, the timeframe for submitting all claims is within 15 calendar days of the date of the revocation letter.

LeadingAge understands CMS's concerns that the current final claims timeline of 60 days for revoked providers remains a substantial period of time to submit additional false claims, however, most of our provider settings have a 30 day billing timeframe which coincides with MDS and OASIS submission timelines which determine the final payment for a stay or episode. Members cannot submit legitimate claims in 15 days and continue to comply with other CMS regulations and claims-processing guidance.

Additionally, reducing the timeframe to 15 days does not account for other regulations within the same regulatory framework which allow providers additional remedy timelines to avoid revocation altogether. Specifically, 424.535(e) allows providers time to submit proof that it has terminated its business relationship with any party with adverse activities within 15 days of the revocation notice. Requiring a 15-day final claims submission does not account for this additional reversal of revocation.

LeadingAge Recommends:

- **CMS retain a post-revocation claims submission period of 60 days for all providers allowing for complete and legitimate claims to be submitted following the Medicare Claims Processing Manual, and provider-specific reporting requirements that impact payment determinations such as the Patient-Driven Groupings Model or Patient Driven Payment Model. This would also allow providers time to submit proof of terminated relationships which lead to the revocation.**
- **CMS should expand reasons for reversal of revocation under § 424.535(e) to include <u>all</u> revocation grounds related to managing employees or affiliations. The regulations currently state that a revocation can be reversed "if the provider or supplier terminates and submits proof that it has terminated its business relationship with that individual or organization within 15 days of the revocation notification." The regulation currently limits the ability to reverse the revocation to sanction, exclusion, debarment, or felony. LeadingAge believes this should be applicable to any revocation grounds related to a third party.**
- **If CMS were to move forward with the proposal to reduce the timeframe to 15 days, it is imperative that guidance be incorporated into claims processing on how the deadline will apply to payment systems that require assessment data or other processing prerequisites to determine service pricing.**

Modification to Current Denial Reasons and New Denial Reasons

Debt § 424.530(a)(6), Payment Suspension § 424.530(a)(7), and Other Program Terminations/Suspensions § 424.530(a)(14)

CMS proposes to expand the scope of individuals and relationships subject to three denial reasons: 424.530(a)(6) Medicare debts, 424.530(a)(7) payment suspensions, and 424.530(a)(14) other program terminations/suspensions. These changes seek to expand Medicare debt to include managing employees, managing organizations, and individuals and entities with any other form of business or financial relationship with the provider. For payment suspensions, the changes would include individuals and entities with any form of business relationship with the provider or supplier. Finally, program terminations/suspensions would expand to include a provider's owners, managing employees and managing organizations. We have significant concerns about the expansion of this authority and the potential impact to compliant providers.

First, we want to recognize CMS's goal for implementing these changes is to remove individuals and entities from the Medicare program which may have significant influence on a provider and their conduct in the Medicare program. While that is a sound principle, in practice it is much more complicated. Many providers have hundreds of vendors and employees that are actively engaged in the day-to-day activities of the organization, typically with no more outsized influence than the next vendor or employee. In some instances a managing employee may be the individual managing the grounds of the nursing home or a vendor which cleans linens. These relationships, while important may have little to no impact on the provider's Medicare operations.

Expanding Medicare debt and payment suspensions to cover managing employees or individuals with any form of business with the provider could inadvertently put a provider's enrollment at risk despite their efforts to conduct thorough due diligence. To our knowledge, there is no database of individuals or organizations with Medicare debts that have yet to be paid. In some instances, a former managing employee of a Medicare provider which was revoked for unpaid debts may not even know their former employer was revoked for debt, let alone have the ability to repay those debts and avoid future employment concerns. This has the potential to effectively "blacklist" certain managing employees from working in Medicare provider settings simply because they have the inability to pay back debts beyond their means.

Additionally, the administrative burdens and complexities that would result from having to now look at the Medicare liabilities of a larger pool of people and vendors, for Medicare debt, payment suspensions, and terminations would be excessive and is not adequately accounted for in the rule's regulatory impact analysis. Debt from a managing employee or a historical acquisition of another entity could now jeopardize the new enrollment of a Medicare provider who had no control over this original debt. We would agree that providers have a responsibility to conduct due diligence in establishing partnerships and hiring employees. But this carries with it a good-faith standard that is not present in the current policy revision.

- **CMS must establish good-faith standards for provider screening to allow providers to demonstrate the process they went through to evaluate business partners and managing employees and avoid being held responsible for disclosures the provider was unable to identify, and in some cases, the third party itself may not be aware of themselves.**
- **CMS must define and limit the scope of "individuals and entities with any other form of business or financial relationship with the provider" to include only those entities which have a direct influence over the provider's operations, management, or Medicare billing.**
- **CMS should expand reasons for reversal of a denial under § 424.530(c) to include <u>all</u> denial grounds related to managing employees or affiliations. The regulations currently state that a denial can be reversed "if the provider or supplier terminates and submits proof that it has terminated its business relationship with that individual or organization within 30 days of the denial notification." The regulation currently limits the ability to reverse the denial to sanction, exclusion, debarment, or felony. LeadingAge believes this should be applicable to any denial grounds related to a third party.**

Same Suite (§ 424.530(a)(19))

CMS proposes a new denial ground based on the provider having its practice location in the same suite or office as another provider whose Medicare enrollment has been revoked or denied.

Similar to our concerns with CMS' proposal to establish a High-Risk Enrollments revocation, we are concerned that this denial reason does not appropriately address the nature of healthcare sector presently, where providers are co-located for efficiency and better care coordination. While this denial reason does establish that a provider located at the same suite would have to be revoked or denied, it does not address the relationship between the providers or a time limit on how old the revocation is. The lack of clear guardrails for application of the denial reason makes it extremely likely that providers acting in good faith, could be inadvertently revoked or denied by Medicare.

If, for example, a physician practice had previously been located in an office suite and was revoked for inappropriate prescribing, and then a hospice organization leases the same space, that hospice organization could be revoked despite not having any affiliation with the previous tenants. In the past, LeadingAge has recommended to CMS additional scrutiny on hospices co-locating at the address.[18] However, that was intended as an oversight mechanism to further investigate these providers for fraudulent activities rather than a blanket reason for revocation or denial of enrollment.

[18] LeadingAge. (n.d.). *LeadingAge joins in coalition recommendations to CMS on fighting fraud*. https://leadingage.org/resources/leadingage-joins-in-coalition-recommendations-to-cms-on-fighting-fraud/

CMS's claims that discretion will be used when applying this denial reason does not alleviate any of our member concerns. The proposal allows too much authority with absolutely no guardrails.

LeadingAge Recommends

- **Require in a subparagraph how CMS is expected to clearly demonstrate a substantive nexus, such as common ownership, referral relationship, management, or operational control, between the enrolling provider and the revoked or denied provider, rather than relying exclusively on the physical address on enrollment information.**
- **Allow the new enrolling providers to offer clear evidence that there is no existing or former relationship with the denied or revoked provider. Limit this requirement only to the initial enrollment not to subsequent revalidations.**

Hospice Medical Directors and Administrators (§ 424.530(a)(20))

CMS proposes a new denial authority for hospice enrollment if: 1) the enrolling hospice's medical director is the medical director of multiple other hospices, or practices at such a distance (for example, in a different state) from the enrolling hospice that the medical director cannot realistically perform all medical director functions; 2) If the enrolling hospice's administrator is the administrator of multiple other hospices or located at such a distance from the enrolling hospice that the administrator cannot realistically perform all required administrator functions; or 3) The hospice's medical director does not have an active physician medical license in the state in which they are practicing.

LeadingAge has previously supported and encouraged CMS to further investigate providers with staff working at multiple hospices. Since 2023, LeadingAge has offered recommendations to the administration to curb the rise of fraudulent hospice providers in Medicare including creating "red flag" criteria for the certification program to trigger additional investigation before certification or revalidation of a hospice program whose administrator oversees multiple hospices.[19] Most recently, in December 2025, LeadingAge recommended requiring hospices disclose any managing employees (e.g., Medical Director, Administrator) that are employed or contracted with another Medicare-certified entity.[20]

The key words in our recommendations were "investigate" and "disclose." We never argued that a hospice program should be denied enrollment simply for having employees working at multiple hospices. While we understand CMS's concerns regarding this practice and that it led to significant fraud in several areas of the country, LeadingAge represents many rural hospice providers that rely on medical directors that serve multiple hospices because qualified physicians, and in some

[19] LeadingAge. (2023, January 13). *Hospice program integrity ideas: Hospice industry consensus*. https://leadingage.org/wp-content/uploads/2023/01/Hospice-Program-Integrity-Ideas_Hospice-Industry-Consensus-Final-1.13.23-.pdf

[20] LeadingAge. (2026, January 6). *Home health member network resource*. https://leadingage.org/wp-content/uploads/2026/01/Home-Health-Member-Network-Resource-January-6-2026.pdf

instances administrators, are few and far between in rural areas. We have significant concerns that implementing a standard such as this for denials of enrollment, which can trigger reviews of managing employee enrollments, especially enrolled physicians, could create a chilling effect for physicians to consider acting as a hospice medical director at all. We have already seen concerning commentary regarding Medicare's crackdown on hospice affiliations and the threat they represent to physicians, medical groups, skilled nursing facilities and other providers.[21] Placing a specific denial reason for hospice medical directors and administrators as part of this subpart could lead to physicians distancing themselves from hospice providers due to the risks of affiliations.

Again, LeadingAge supports additional scrutiny and disclosure of key personnel working at multiple agencies. However, we do not believe 42 CFR part 424, subpart P is the appropriate place to address specific hospice program integrity issues. Enrollment regulations are explicitly broad to cover all Medicare providers. These types of compliance and disclosure requirements are best suited for the individual providers' conditions of participation.

LeadingAge Recommends

- **CMS rescind this proposal and instead convene stakeholders in the hospice and physician community to better understand the needs of rural hospices and how to develop compliance facing Conditions of Participation that address key personnel working at multiple providers.**

Misuse of Identity § 424.530(a)(21)

CMS proposes to add a denial reason for situations involving prospective enrollees using compromised identities. This is similar to the current Misuse of Billing Number revocation reason.

LeadingAge supports this new reason for denial.

Reapplication Bar (§ 424.530(f))

The current regulation only restricts the reapplication bar for up to 10 years to providers who submitted false or misleading information on their application. CMS proposes to allow – but not require – the reapplication bar to apply to any denial reason. CMS also proposes to remove the factors which determine the length of the bar as they are specifically tailored to denials based on false information and because a single set of factors would not adequately capture all the considerations which go into the reasons for denial. CMS is not proposing to require a reapplication bar on every denial.

LeadingAge understands and supports CMS's intent in the proposal to prevent fraudulent actors from entering the Medicare program once identified through the enrollment process, especially as the current limited scope of the reapplication bar is only for false and misleading information. CMS

[21] Bloomberg Tax. (n.d.). *Medicare crackdown on hospice affiliations threatening providers*. https://news.bloombergtax.com/business-and-practice/medicare-crackdown-on-hospice-affiliations-threatening-providers

clearly states that the bar is discretionary and that "less serious" offenses may not require a bar. However, without clear criteria, this could be left up to interpretation and a provider could be barred from reapplying for up to ten years.

LeadingAge Recommends

- **CMS should establish criteria for determining the reapplication bar timeline as well as provide a definition for what is considered "less serious denial situations."**
- **CMS should add a paragraph excluding providers who are denied enrollment under 424.350(a)(1) based on a provider's failure to respond timely to a revalidation request or other request for information. This is consistent with the reenrollment bar under 424.353(a)(1).**

Changes in Majority Ownership (CIMOS)

CMS proposes new reasons for denial and revocation at § 424.530(a)(22) and 424.535(a)(25), respectively, if CMS determines that the HHA, hospice, or DMEPOS supplier failed to comply with the provisions and requirements of the 36-month rule related to the Change in Majority Ownership (CIMOS).

In our comments to the CY2024 Home Health Proposed Rule, LeadingAge supported the proposal to extend the "36-month rule" to hospice so as to require that when a hospice undergoes a CIMO by sale within 36 months after the effective date of its initial enrollment or within 36 months following the hospice's most recent CIMO, the provider agreement and Medicare billing privileges will not convey. We also supported CMS mirroring the same exceptions for hospice that apply to home health.

We are disappointed to see CMS confirm what we have heard anecdotally in the sector about providers' attempts to circumvent the rule through not reporting changes in ownership and very clear ownership by management agreements. We continue to believe the 36-month rule helps to prevent fraud, waste, and abuse by preventing quick sales of newly certified home health, hospice, and DME providers and instead requiring the original owners to actually demonstrate a desire to serve Medicare beneficiaries in the first three years. Misrepresenting ownership through unreported changes or practical ownership through management does not show good intent on the part of the original owners/operators and must be discouraged.

To ensure proper enforcement of this rule, we support CMS's adding a denial and revocation reason for change in majority ownership non-compliance.

Temporary Moratoria (§ 424.570)

CMS proposes to update the regulatory information on temporary moratoria to clarify: (1) that the date the moratorium is imposed is the moratorium's effective date, which is the date on which the moratorium notice was filed for public inspection at the Office of the Federal Register (OFR), (2) add hospice and DME to the parenthetical citation at 424.570(a)(1)(iii)(C) regarding the 36-month rule

considerations for moratoria, (3) add a new section outlining what qualifies as a "new" provider including initial enrollments, CIMO, enrollment from revoked providers, reactivation applications, enrollments for voluntary terminations.

LeadingAge understands CMS's concerns regarding individuals taking advantage of a delay in posting to gain access to the Medicare program. However, we strongly disagree with CMS's change in regulation which would make a moratorium's effective date the date of public inspection and not the date of publication in the Federal Register. CMS overestimates the quickness – and more importantly – the quality of an enrollment application any provider would submit to "beat the deadline". Quality providers take multiple months or even years to complete their applications and show their qualifications to surveyors. Any provider who does not go through the appropriate process and rushes an application is likely to be denied on the grounds CMS has already established and now intends to strengthen through these regulations.

We also have concerns about the inclusion of reactivation application under proposed 424.570(a)(1)(i)'s definition of "new" Medicare application types. While CMS states that "the only material differences between a revoked and a deactivated provider are that the former is subject to a reenrollment bar and a potentially more exhaustive reentry process (for instance, undergoing a state survey or accreditation)," we disagree with CMS's assessment. The remedies for deactivation and revocation are very different, and revocation comes with a bar on reenrollment based on the severity of the revocation reason. We would argue that CMS's current regulations at 424.540(b) permit--but do not require--a new application as part of the reactivation process. The language states:

> (2) Notwithstanding paragraph (b)(1) of this section, CMS ***may***, for any reason, require a deactivated provider or supplier to, as a prerequisite for reactivating its billing privileges, submit a complete Form CMS-855 application.

In contrast, a new enrollment application and applicable documentation are required for reenrollment after revocation per 424.353(d)(1). CMS's proposal that deactivated providers are "new" despite not being required to submit new applicable enrollment applications at the time of reactivation aligns neither with the longstanding interpretation provided in CMS's existing regulations, nor with Section 1866(j)(7) of the Social Security Act, which contains no reference to reactivated providers when addressing the applicability of a moratorium on new providers.

LeadingAge Recommends that CMS:

- **Retain the current standard of publication in the Federal Register as the initiation date of the moratorium.**
- **Remove reactivation applications under the definition of "new" application types under § 424.570(a)**

Hospice Reactivations (§ 424.540(b)(3))

CMS proposes adding hospices to a requirement for deactivated providers – currently just home health agencies – to obtain an initial state survey/accreditation before being reactivated.

While we do not consider a reactivated provider to be equivalent to a "new" provider, we do believe that the program integrity struggles faced by the hospice field in the last several years dictates a closer examination of compliance after a deactivation for any reason.

Therefore, LeadingAge supports CMS's proposal to require deactivated hospice agencies to complete an initial survey to be reactivated.

Definition of "Operational" and "Signage"

CMS is proposing to clarify and expand the definition of an "operational" provider or supplier to establish what constitutes a functioning provider capable of providing services to Medicare beneficiaries. CMS is also proposing to update the definition of signage to mirror what is required for DMEPOS providers with some exceptions.

In previous comments, LeadingAge has applauded CMS's expansion and enhancement of site visits, which put more federal presence on the ground in high-risk areas and created meaningful accountability at the point of enrollment and afterwards.[22] Increased boots-on-the-ground oversight is one of the most effective deterrents to fraudulent enrollment, and we've encouraged CMS to continue and expand these efforts in high-risk markets for home health and hospice.

On-site visits are a critical component of initial enrollment and revalidation, but transparency is key. We have also heard complaints about the site visitors themselves. During both the recent off-cycle revalidation process for SNFs and site visit project for hospices in 2023, members told us that the contractor behavior made them suspicious of the process. They did not show identification, they did not come with documentation or language that made the hospice agencies or nursing homes feel comfortable letting the contractor into the office or nursing home. They could not clearly state why they were on site, but made threats like "if you do not let me take pictures, if you don't let me in, you will lose your Medicare funding." While CMS did ultimately improve their transparency, we want to be sure that any future site visit contractors are clear as to their identities and purpose through better training, documentation and oversight to the contractors charged with the visits.

We believe that this change to the operational definition is a step in the right direction as it more clearly defines for these contractors what they are explicitly looking for. Some of our provider members have also experienced difficulties being approved for Medicare enrollment due to a misinterpretation of the regulation by the site visit contractor. LeadingAge had to intervene on behalf of the member who waited over a year to know why they were denied for enrollment for being "nonoperational" when there were clear indications that their new location was operational.

[22] LeadingAge. (2026, January 6). *Home health member network resource*. https://leadingage.org/wp-content/uploads/2026/01/Home-Health-Member-Network-Resource-January-6-2026.pdf

However, we do believe CMS should further enhance the "Operational" definition by including the same exceptions as provided in the "Signage" definition. This is particularly important for organizations like home health and hospices who do not operate like a facility-based setting and may not have qualified staff at the office or adequate equipment due to the simple reason they treat patients almost exclusively at the patient's residence. Among the exceptions listed in the proposed "Signage" definition, there are the following considerations which could impact many providers who do not treat patients at their office locations:

- The provider shares office space with another provider (for example, physicians in a group practice sharing a common suite, though the group itself must have signage).
- The provider treats patients in the patients' homes.
- The provider treats patients in the provider's home and only uses the provider's address for administrative purposes.
- The provider performs telehealth services from home.

LeadingAge Recommends

- **Adding language to the definition of "Operational" to mirror the exceptions outlined in the proposed definition of "Signage" which would allow Medicare enrolling and enrolled entities which serve patients in their homes to avoid unintended consequences of a denial or revocation under 424.530(a)(5) and 424.535(a)(5) respectively.**

Retention and Furnishing of Documentation (§ 424.516)

CMS proposes to add new § 424.516(f)(3) clarifying that all documentation required to be retained and furnished under § 424.516(f) must be accurate, complete, and compliant with all CMS requirements. Because 424.535(a)(10) provides that noncompliance with the documentation or CMS access requirements specified in 424.516(f) may constitute a ground for revocation, this change could lead to significant consequences for providers that may have minor errors in their documentation.

As we've stated previously in these comments, in its efforts to remove fraudulent providers, CMS should ensure that enforcement tools are proportionate and risk-based. We understand CMS's concerns with the documentation reviews that identify missing information and inaccurate records however, expanding this definition to cover all Medicare providers when only hospice errors were cited in the proposal is inappropriate. It is not unusual for physicians, hospitals, and skilled nursing providers to have an occasional clerical error on the date of a service or a missing signature. These types of errors should not be grounds for termination, for any provider type – hospice or otherwise, from the Medicare program.

Again, this expanded authority does not adequately distinguish fraud or intentional misconduct from clerical mistakes, documentation deficiencies, technical enrollment problems, conflicting CMS/MAC guidance, or circumstances beyond a provider's control. For example, there could be a

simple miscommunication in the hospice where a nurse practitioner who was conducting the face-to-face recertification accidentally signed off after the certification was signed despite talking to the medical director. There was not intention of defrauding Medicare, rather a clerical and timing error between the NP and the physician. Another example is the impact of inclement weather on all hospice operations. This could delay the proper signature, throw off the timing of certifications due to limited HER access. In these situations, providers do the best they can and clearly document the disruptions. While there are some flexibilities for submission of quality data in the event of disaster, there are very few remedies for other documentation or claims processing. These situations are best supported and corrected through TPE through the MAC, not through revocations. Systemic organization wide documentation failures could indicate true intent to manipulate the Medicare program, but one-off clerical errors should not result in revocations.

LeadingAge Recommends:

- **Revise proposed changes at § 424.516(f) to include language that provides that if mistakes are unintentional and can be proven as such, the provider would not be at risk of revocation under § 424.535(a)(10).**

Managing Employees (§ 424.502)

CMS proposes to change the definition of managing employee to include: medical directors (not merely those at SNFs and hospices), clinical directors, departmental heads (for example, a hospital's chief of cardiology), supervising physicians, nursing directors, alternate administrators, and all other clinical personnel who exercise operational or managerial control. CMS clearly states that these types of employees have always been required in the disclosures on a provider's Medicare enrollment application as managing employees sometime have as much or more influence over a provider's daily operations as an owner.

LeadingAge has consistently supported and made recommendations to CMS to explicitly require reporting of these staff members. In 2023, we recommended CMS require hospice agencies to include administrators and medical directors in their Medicare application or revalidation.[23] In the CY2024 Home Health Proposed Rule, LeadingAge supported the proposals to revise the managing employee definition in § 424.502 by adding hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.[24]

We have also recommended that CMS: conduct regular reviews of PECOS enrollments to check the credentials of key provider personnel; determine a threshold for the number of providers a managing employee can be associated with before it triggers mandatory audits through PPEO;[25] and require providers disclosure of any managing employees(e.g., Medical Director, Administrator)

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[23] LeadingAge. (2023, January 13). *Hospice program integrity ideas: Hospice industry consensus*. https://leadingage.org/wp-content/uploads/2023/01/Hospice-Program-Integrity-Ideas_Hospice-Industry-Consensus-Final-1.13.23-.pdf

[24] LeadingAge. (2023). *Comments on the CY 2024 Home Health Prospective Payment System proposed rule*. https://leadingage.org/wp-content/uploads/2023/08/LeadingAgeHHCommentsFINAL2023.pdf

[25] LeadingAge. (2026, March). *LeadingAge CRUSH final*. https://leadingage.org/wp-content/uploads/2026/03/LeadingAgeCRUSHFinal.pdf

that are employed or contracted with another Medicare-certified entity.[26] However, we have also recommended that, CMS should also clarify the "managing employee" definition with the MACs and State Survey Agencies for consistent application of this requirement.[27]

We share this to illustrate that we are in no way opposed to holding managing employees accountable for actions that could lead to waste, fraud and abuse of the Medicare program and significant patient harm. **We are concerned, however, that CMS' proposed definition of "managing employee" fails to define a specific threshold for which an individual's level of influence over the day-to-day operations creates an obligation to disclose that individual on enrollment documents.** Without clearly defined standards and measurable criteria for "influence over a provider's daily operations," organizations could be reporting hundreds of individuals across the organization which would create a significant burden, especially with having to keep up with any turnover or staffing changes. This expansion also put providers at greater risk of enrollment consequences related to a newly reported individual's "managing employee" status. As part of this rule, CMS is proposing to expand certain revocation and denial reasons to include managing employees. Given the sheer breadth of possible employees covered under the expanded definition, this could open a provider to more scrutiny based on their current employees' previous employment and any adverse actions during that time such as establishment of debt. These changes may also force providers to conduct retroactive reviews of employees who previously filled these roles, in order to amend existing provider enrollment applications or complete revalidation requirements, an effort that is not adequately captured in the regulatory impact analysis.

Additionally, as mentioned above and reiterated in our discussion of "Affiliations", LeadingAge is deeply concerned about the capacity of the PECOS system, MACs, and CMS staff to process and make sense of the volume of information this portion of the proposed rule will create. CMS requires that providers report updates to managing employees within 30 days and that enrollment documentation should be updated with a change-of-information application when this occurs before a revalidation. With nearly all 2 million providers needing to make at least some additions or corrections to their enrollment documentation, we are concerned that the systems in place may not be able to handle this volume and that could lead to delays in providers receiving confirmation that their information was submitted and accepted, in turn leaving them open to potential grounds for revocations under 424.535(a)(9).

- **CMS must establish good-faith standards for providers to disclose "managing employee" at § 424.502. As CMS stated, the proposed bulleted categories do not establish any minimum threshold for reporting meaning that some managing employees could be missed in disclosures despite a provider acting in good faith and conducting due diligence to determine what to disclose.**
- **Limit the "managing employee" definition at § 424.502 for purposes of the enrollment-related consequences discussed in the Proposed Rule, including revocation, denial, and affiliation disclosures to individuals who exercise direct supervisory control over**

[26] LeadingAge. (2026, January 6). *Home health member network resource*. https://leadingage.org/wp-content/uploads/2026/01/Home-Health-Member-Network-Resource-January-6-2026.pdf
[27] LeadingAge. (2026, January 6). *Home health member network resource*. https://leadingage.org/wp-content/uploads/2026/01/Home-Health-Member-Network-Resource-January-6-2026.pdf

Medicare Debt (§ 424.530(a)(6)), Payment Suspension (§ 424.530(a)(7)), and Program Terminations/Suspensions (§ 424.530(a)(14)).

Affiliations (§ 424.502)

CMS proposes the following revisions to the affiliation provisions:

- Removing the 5-year lookback period. Affiliations would have to be reported regardless of how long ago it occurred or ended.
- Expanding the affiliation definition to include:
    - An interest in which individuals or entities - or any of their "owning or managing employees or organizations"- exercise control or conduct day-to-day operations of another organization.
    - Any marketing, business, fulfillment, financial, managerial, or beneficiary relationship.

In addition, to this expanded definition and removal of the lookback period, several enrollment denial and revocation reasons are proposed to expand to affiliates, as we discussed above (424.530(a)(6) Medicare debts and 424.530(a)(7) payment suspensions). If finalized, CMS' proposal would include an expanded list of affiliations for the lifetime of the provider's enrollment AND that affiliate's owning or managing employees or organizations. Providers could be revoked or denied if an affiliate at any point were revoked or denied enrollment for:

- Unpaid Medicare debt
- Conviction for misdemeanor sexual assault or financial misconduct (Proposed)
- Terminated or suspended from another Federal health care program
- Felony
- Payment suspensions
- Previous civil judgement under the False Claims Act

LeadingAge believes the proposed definitional changes to "affiliations" and expanded revocation and denial reasons based on affiliations may create significant burdens to providers in regard to risk mitigation.

First, we are deeply concerned that removing the 5-year lookback period will create an unmanageable compliance and reporting burden for providers. Many of our nonprofit, mission-driven members have been enrolled in Medicare for decades. It is infeasible to ask an organization for multiple decades of affiliations, including managing employees of former or current entities exercising operational or managerial control over the day-to-day operations of a provider. There could be hundreds of individuals that would need to be tracked down for even the smallest provider in our membership. The expanded definition is far too burdensome for providers.

In the previous enrollment rules, CMS estimated an Information Collection Requirement (ICR) cost burden projection of $937,500 for enrolling and revalidating providers and suppliers to simply track down the current required affiliation information spanning 5 years and more limited affiliations than

outlined in the proposed rule.[28] Despite nearly a $1 million ICR estimate associated with implementation of the affiliation disclosure requirements established in 2019, CMS states in this proposed rule that "We do not believe that any of our proposed provider enrollment regulatory revisions would impose an information collection burden on interested parties." Specific to disclosures of affiliation CMS solicits comments as to whether additional ICR burden would ensue. **LeadingAge believes it is imperative that CMS provide clear ICR burden estimates for a rule which may require providers to identify information for multiple decades worth of affiliations.**

Second, the growing complexity of the healthcare system necessitates contracting with different vendors to meet compliance expectations, secure marketing support, and procure the best products at the best price, etc. Additionally, many organizations have affiliated to build stronger relationships and more integrated care. Without clear direction from CMS, providers are left to decide which marketing, business, fulfillment, financial, managerial, or beneficiary relationships are necessary to report to CMS.

Finally, we reiterate our concerns about the capacity of the PECOS system, MACs, and CMS staff to process and make sense of the volume of information that just this portion of the proposed rule, in addition to the managing employee portion, will create. Unlike the managing employee requirements, which focus on current employees, these affiliations are not time-based, and information on former managing employees could take significantly longer to identify, if they can be identified at all.

We believe there must be a meaningful nexus between an affiliated party's conduct and the enrolled provider for that relationship to play any role in determining whether the provider's enrollment should be denied or revoked. For example, CMS should consider whether the provider knew or reasonably could have known about an affiliated party's problematic conduct and whether that affiliated party actually creates a current material program-integrity risk. A provider should not lose Medicare enrollment solely because an affiliated party has an adverse event in its history without an individualized finding of risk attributable to the provider.

- **Retain the current 5-year lookback period for § 424.519 which is a reasonable temporal limitation on affiliation disclosure requirements and adopt a safe harbor for providers that make good-faith efforts to identify and disclose relevant information.**
- **Establish reasonable due-diligence standards for denials or revocations based on affiliated party conduct—not strict organizational liability for conduct or information providers could not reasonably discover or control.**
- **Update MAC contracts to include defined timelines for review and approval or denial of CMS855A changes.**
- **Establish a materiality threshold and a good-faith standard for purposes of the expanded Medicare enrollment denial provisions related to Medicare debt, payment**

[28] *Medicare, Medicaid, and Children's Health Insurance Programs; program integrity enhancements to the provider enrollment process*, 84 Fed. Reg. 47794, 47845 (September 10, 2019). https://www.federalregister.gov/d/2019-19208/p-965

suspensions, and affiliated party relationships, and limit the scope of a qualifying "business or financial relationship" to only those relationships involving material influence over a provider's operations and/or Medicare billing for the purposes of Medicare Debt (§ 424.530(a)(6)), Payment Suspension (§ 424.530(a)(7)), and Program Terminations/Suspensions (§ 424.530(a)(14)).

Conclusion

In sum, LeadingAge appreciates the opportunity to provide comments on the CY2027 home health payment update, as well as provider feedback on the requests of information on the development of a home health specific wage index and the role of advance care planning in home health.

We wish to make abundantly clear that LeadingAge does not oppose stronger fraud enforcement. We fully support the authorities currently conveyed to CMS that allow for the denial and removal of individuals and entities who engage in fraudulent or abusive behaviors. However, we believe that CMS should target bad actors without creating a provider-enrollment regime in which broad discretion, undefined standards, third-party conduct, or technical compliance failures can produce disproportionate consequences for legitimate providers. The consequences of these excessive and burdensome proposals may produce disproportionate consequences for legitimate providers and lead to an exodus of providers from the Medicare program, significantly impacting access for Medicare beneficiaries. We urge CMS to consider the concerns that we have raised in this letter and appreciate the opportunity to comment on the CY2027 Home Health Proposed Rule.

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,

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About LeadingAge: *We represent more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with our state partners representing members active in 50 states, the District of Columbia, and Puerto Rico, 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, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care. 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.*