CMS Request for Information 2025
Executive Order 14192 Unleashing Prosperity Through
Deregulation of the Medicare Program

Resources
https://www.cms.gov/medicare-regulatory-relief-rfi (responses)
https://www.cms.gov/files/document/unleashing-prosperity-through-deregulation-medicare-program-request-information.pdf
https://www.whitehouse.gov/presidential-actions/2025/01/unleashing-prosperity-through-deregulation/

Quick Links for Where Comments Submitted

Topic 1: Streamline Regulatory Requirements

1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?

Elimination of Qualifying 3-Night Inpatient Hospital Stay for SNF Coverage
NARA recommends CMS eliminate the requirement that Medicare beneficiaries must have a 3-night inpatient hospital stay to qualify for skilled nursing facility (SNF) coverage. This policy no longer aligns with the capabilities of today's healthcare system and impedes timely, appropriate transitions to post-acute care. Flexibilities during the COVID-19 public health emergency demonstrated that waiving the 3-night rule maintained patient safety while enhancing effectiveness of beneficiaries achieving outcomes. Medicare Advantage plans are allowed to waive the 3-day stay requirement. Nearly 60 percent of all Medicare beneficiaries receive coverage through programs that generally waive the three-day requirement. All Medicare beneficiaries should receive comparable care and services, regardless of how they participate in Medicare benefits.

Recent CMS changes to admission criteria for a beneficiary in the hospital have created an increase in beneficiaries classified as receiving care in observation stays. An observation stay is classified as outpatient status and does not qualify beneficiaries for Part A SNF coverage. The care and services of an observation and acute care stay can be indistinguishable especially when a beneficiary remains in observation for three or more days. The HHS OIG has identified the impact of observation status on beneficiaries across

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the country and, in the OIG's 2021 Top Unimplemented Recommendations report, called for ensuring all Medicare beneficiaries have the same access to post-hospital care in a SNF, regardless of how their hospital stays are classified.

The 3-night inpatient stay can lead to unintended consequences: extended hospitalizations purely to meet SNF eligibility criteria, delayed transitions to appropriate care settings, increased risk of hospital-acquired complications, delayed throughput and added strain on already overburdened hospital systems. In contrast, allowing clinical judgment and care coordination to guide SNF admissions promotes patient-centered care, operational efficiency and value-based care. Eliminating this requirement improves hospital capacity to care for others and lowers costs. We encourage CMS to permanently retire the 3-night rule to modernize Medicare policy, support value-based care, and reflect CMS's commitment to improving outcomes, reducing administrative burden, and empowering providers to deliver the right care in the right setting at the right time.

Occupational Therapists as Independent Discipline to Open Home Health Episodes
~~Additionally,~~ NARA encourages CMS to modernize policy and ensure that all rehabilitation therapy providers, including occupational therapists, are granted the authority to open home health episodes. Under current Medicare regulations, occupational therapists are only permitted to conduct the initial assessment visit and complete the comprehensive assessment when occupational therapy services are included in the plan of care in conjunction with either physical therapy or speech-language pathology, and only in cases where skilled nursing services are not part of the initial plan. This limitation restricts timely access to care, increases costs of care and may delay the initiation of appropriate services for patients who would most benefit from an occupational therapy-led assessment.

NARA believes occupational therapy should be recognized as a qualifying discipline to open home health episodes independently. Occupational therapists possess the necessary skills and training to evaluate a patient's functional status, safety, and ability to perform activities of daily living within the context of their home environment. In many cases, particularly with patients recovering from surgery, experiencing functional decline, or managing chronic conditions, occupational therapy is the most appropriate and effective discipline to conduct the initial assessment and guide the development of an individualized plan of care, as they can do in every other care setting.

Expanding the ability of occupational therapists to initiate home health episodes would promote timely and patient-centered care, reduce delays in service delivery, and ensure that patients receive the right interventions from the most appropriate provider from the outset. Therefore, NARA urges CMS to revise current regulations to allow occupational therapists to open home health cases independently when clinically appropriate. This change would align regulatory policy with modern interdisciplinary care practices and better serve the needs of Medicare beneficiaries.

Reimbursement for Graduate-Level Therapists in Clinical Rotations

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~~Additionally,~~ NARA believes physical therapy, occupational therapy, and speech-language pathology students who have completed their undergraduate coursework and are in clinical rotations as part of an accredited graduate-level clinical education program should be eligible to provide services under Medicare Part B when under direct supervision of a licensed and credentialed therapist, and that these services should be reimbursable. Clinical rotations are an essential component of professional preparation for all rehabilitation therapy disciplines, and allowing students to participate in care delivery under appropriate supervision ensures continuity of high-quality patient care while supporting the development of the future healthcare workforce. A student in the Doctor of Physical Therapy (DPT) program is required to complete a minimum of 30 weeks of full-time clinical education. A student in the Master of Occupational Therapy (MOT) program is required to complete a minimum of 24 weeks of full time level II fieldwork. A student in the Masters of Speech-Language Pathology must complete a minimum of 400 clock hours of supervised clinical experience. The intent of these required clinical hours is for the student to have direct hands-on experience under the supervision of a licensed therapist to develop the competencies necessary for entry-level practice.

Currently, Medicare Part B does not allow for reimbursement of services provided by graduate students. This policy creates unnecessary barriers to clinical training, places an undue burden on supervising therapists who are required to essentially duplicate all care provided by students, and limits the capacity of providers to accept and mentor students. These restrictions contribute to clinical site shortages and strain the pipeline of qualified rehabilitation therapy professionals entering the workforce at a time when demand for these services is growing due to an aging population and increased prevalence of chronic conditions.

NARA asserts that with direct supervision, defined as the presence and active involvement of the licensed therapist in the same location, available to intervene as needed, students can safely and effectively contribute to patient care. Permitting reimbursement for these supervised services would incentivize providers to offer more clinical training opportunities, foster a robust and sustainable rehabilitation workforce, and ensure access to timely therapy services for Medicare beneficiaries.

NARA urges CMS to revise current Medicare Part B regulations to allow services furnished by graduate-level students in PT, OT, and SLP programs to be billable when provided under the direct supervision of a licensed therapist. This policy change would modernize Medicare's approach to clinical education and reflect the high standards and structured supervision already embedded in professional training programs.

Therapy CPT Codes Added to Medicare Telehealth Services List Under Category 2
During the COVID-19 Public Health Emergency (PHE), CMS implemented temporary waivers that allowed Medicare beneficiaries to receive physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services via telehealth. This policy change was essential in maintaining continuity of care, improving access, and

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demonstrating that many therapy services can be delivered safely and effectively in a virtual format.

We strongly recommend that CMS adopt this temporary PHE-era policy as a permanent provision by adding the commonly used PT, OT, and SLP CPT codes: 97110, 97112, 97116, 97150, 97161-97164, 97530, 97535, 97537, 97542, 97750, 97755, and 97763 to the Medicare Telehealth Services List under Category 2. This category requires that services delivered via telehealth demonstrate clinical benefit equivalent to in-person care, an evidence standard that therapy services have clearly met during the PHE and beyond.

In February 2021, the Physical Therapy & Rehabilitation Journal published an article that concluded that telehealth in physical therapy could be comparable or better to in-person rehabilitation with certain conditions such as osteoarthritis, low-back pain, hip and knee replacement, and multiple sclerosis and in the context of cardiac and pulmonary rehabilitation. These services were safely and effectively delivered via telehealth platforms since 2020. Telehealth allows therapy services to continue via telehealth removing significant barriers for Medicare beneficiaries in rural or underserved areas, as well as those with mobility, transportation, or caregiving limitations. It reduces indirect costs (transportation, missed work, caregiver time) and supports the CMS value-based care strategy by helping patients remain functional, independent, and less likely to be hospitalized or institutionalized. The widespread adoption of telehealth tools by therapy providers, combined with high satisfaction rates from both patients and clinicians, demonstrates the feasibility and desirability of continuing these services post-PHE.

CMS should formally add therapy-related CPT codes to the Medicare Telehealth Services List under Category 2 to ensure the continuity and sustainability of this proven care modality while maintaining the progress made in expanding access to rehabilitative care and avoid reverting to outdated limitations that restrict beneficiary choice and hinder access to care.

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1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?

Consistence in the Medicare Credentialing Process
Medicare credentialing has become a significant burden for providers causing delays to care, unbillable services, denials and higher costs for beneficiaries for both institutional and professional providers. While the PECOS system has been a significant improvement over the paper version, there are still processing errors with the Medicare Administrative Contractors that create significant operational issues for providers. Recently, our members have shared the following administrative burden issues resulting in delayed processing of their application:

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- Requests to provide vehicle information for mobile/portable services when the expanded information clarifies this is not required for services provided in the home – which was appropriately indicated on the application;
- Request to remove all speech-language pathologists from the application because they cannot be credentialed in an outpatient therapy group. The analyst stated they should use the speech-language pathology group option on the application – which does not exist;
- Requesting ASHA certification for a speech-language pathologist which is not a requirement when the state license information has been provided;
- Requests for documents that were uploaded to the application;
- Site verification representative going to address not on the application;
- Unclear understanding for an initial 855B form if reassigning therapists should be reassigned on the 855B or via the 855I and 855R forms in combination. A licensed therapist is required for the 855B but if the therapist does not have an active 855I then that needs to be completed. The 855I with 855R and 855B are not connected (there is no ability to connect them during the submission process by the provider) in the PECOS system when delivered to the MAC, thus causing processing delays particularly when 2 different analysts are assigned the untethered applications;
- Requests for diplomas and/or college transcripts when the state license has been provided; and
- Showing up to an administrative only stie for a site verification and requesting to see the therapy space, when the application states it is an administrative site only.

The current 30-day timeframe to complete and submit an 855I and 855R provider enrollment application is overly restrictive, particularly in cases where rehabilitation therapists are providing short-term or vacation coverage. Unlike physicians and certain other healthcare professionals, rehabilitation therapy providers including physical therapists, occupational therapists, and speech-language pathologists are not permitted to utilize locum tenens arrangements. This limitation poses significant challenges on access for practices striving to maintain continuity of care while navigating the administrative complexities of onboarding a temporary or new therapist.

Given the complexity of the credentialing process, including detecting an error, the extended timeframe would provide greater flexibility to correct this issue when care has already been delivered in good faith to meet the beneficiary's needs. During the COVID-19 public health emergency, CMS recognized the need for this type of flexibility and temporarily extended the timeframe for submitting credentialing paperwork to 90 days. This policy adjustment was critical in allowing providers to adapt quickly, ensure therapists were credentialed properly, and maintain uninterrupted patient care. The extended window reduced administrative strain and allowed organizations to comply with payer rules without sacrificing service availability without compromising patient safety or the integrity of the Medicare program.

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NARA recommends that CMS consider reinstating and formalizing this more flexible 90-day window for provider enrollment submissions, particularly in situations involving temporary staffing or emergent coverage needs. Doing so would alleviate a significant administrative burden on therapy providers, enhance operational efficiency, and support timely access to care for patients. A more reasonable credentialing timeline would reflect the realities of clinical practice and enable providers to focus on delivering high-quality, patient-centered services rather than navigating avoidable administrative hurdles.

Additionally, NARA is deeply concerned about the extremely excessive processing times associated with the CMS 855A application for institutional providers, particularly rehabilitation agencies. Our members consistently report that these applications take on average 9 to 10 months to be processed and approved. This lengthy delay creates significant administrative and financial burdens for providers seeking to serve Medicare beneficiaries and limits access to care.

A critical issue is that the effective date granted by CMS is not applied retroactively to the requested effective date or even the application submission date. As a result, providers that choose to provide care for beneficiaries in need are unable to bill for services rendered during the months-long processing period, despite being prepared and ready to deliver care in accordance with all applicable Medicare conditions of participation. This policy not only delays access to essential rehabilitation services for patients but also places providers in a precarious financial position.

In order to meet the regulatory requirements for certification as a rehabilitation agency, providers are required to treat a minimum number of Medicare beneficiaries prior to final approval. However, without an effective date that aligns with the start of those services, providers are effectively forced to deliver uncompensated care. This creates a situation where organizations are providing medically necessary services to Medicare beneficiaries often at a loss solely to satisfy compliance requirements, while being prohibited from submitting claims for reimbursement. This has traditionally been a challenge, however, is becoming increasingly difficult with the current workforce and inflationary pressures providers are facing.

This practice is fundamentally unfair and unsustainable, particularly for small or independent rehabilitation providers who may lack the financial reserves to absorb months of unreimbursed care. Moreover, it undermines access to care for patients in need of rehabilitation services, particularly in underserved or rural areas where provider availability is already limited.

NARA strongly urges CMS to revise its policy regarding the 855A application process in two key ways: first, by significantly reducing the processing time for these applications, and second, by allowing retroactive effective dates to either the originally requested effective date or the date the application was received. Implementing these changes would alleviate a critical administrative bottleneck, reduce undo financial hardship for providers during an

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inefficient process, and expand timely access to high-quality rehabilitation services for Medicare beneficiaries.

Development of Meaningful Quality Measures
NARA recommends that CMS focus on developing quality measures that provide meaningful information to patients, caregivers, discharge planners, providers, and payers and adequately distinguish SNFs from one another without creating excessive administrative burden. This should include measures that reflect the beneficiary outcomes that can be achieved through the delivery of physical therapy, occupational therapy, and speech language pathology practitioner's services. We encourage CMS to take into consideration that hospitals are required to collect data related to a beneficiary's social determinants of health (SDOH) and this information could be shared with post-acute care providers, including SNFs, if they were incentivized or mandated to do so. However, since post-acute care providers, including SNFs, were not included in the HITECH interoperability incentives, then under CMS' proposal, they would be burdened with the requirement to collect this data even when discharged from the hospital. Therefore, we recommend that SNFs do not have to collect this information upon admission but rather upon discharge for discharge planning. NARA requests CMS remove any unnecessary administrative burden on SNF practitioners for any quality measure implemented, so that reporting requirements and patient care time can be appropriately balanced.

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1C. Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and other providers?

Eliminate Barriers to Participating in Alternative Payment Models
NARA supports quality outcomes and reimbursement based on these quality outcomes results; however, the Merit-based Incentive Payment System (MIPS) is an administrative and financial burden for rehabilitation therapists. NARA urges CMS to reconsider the application of the MIPS and similar programs to physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs), due to the disproportionate administrative burden, limited number of providers who can participate due to the type of claim form they bill with, and associated costs it imposes on small and mid-sized rehabilitation practices.

Currently, PTs, OTs, and SLPs providing outpatient therapy services under Medicare Part B and bill through rehabilitation agencies, skilled nursing facilities (SNFs), and hospital outpatient departments are unable to participate in MIPS because they bill on the UB-04 Institutional Claim form (CMS 1450). Therapists in a private practice group bill for services under their own NPI on the CMS 1500 form, and as such, can participate in MIPS. Per the MedPAC report on outpatient therapy services payment system in November 2021, 61% of therapy providers spending for Part B services was submitted by providers on the UB-04 form and, as a result, MIPS applies to less than 39% of Part B therapy providers. NARA

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recommends modifying value-based payment programs to be inclusive of all therapy providers regardless of the claim form they bill services with to have the opportunity to provide beneficiary outcome data and share in the opportunity for higher reimbursement.

While the intention of MIPS to improve quality of care and tie reimbursement to performance is commendable, the framework was not designed with the structure or workflows of rehabilitation therapy in mind. The system is complex, burdensome, data-heavy, and requires significant investments in technology, staff training, and reporting infrastructure resources that are often beyond the reach of many therapy practices, particularly those that are independently owned or located in rural or underserved areas.

The administrative workload associated with MIPS is substantial. Practices must dedicate significant resources to data collection, measure tracking, submission requirements, and compliance monitoring. For many private practices, this results in the diversion of clinical staff time or the need to hire dedicated administrative personnel. A study published in *JAMA Health Forum* found that, in 2019, physician practices spent more than 200 staff hours per physician annually on MIPS-related activities, with an average cost of $12,811 per physician . While this study focused on physician practices, the administrative demands are comparable for rehabilitation therapists, who often lack the economies of scale to absorb these costs.

Additionally, the requirement to use MIPS-qualified registries or certified electronic health record (EHR) systems further increases costs. Many therapy practices must pay substantial fees per clinician annually to participate in registries, and those that lack interoperable EHRs may need to purchase new systems or pay for custom integrations that cost several thousand dollars per year. These financial pressures are particularly challenging given that Medicare reimbursement for therapy services has been steadily declining, and MIPS incentives rarely offset the costs of participation.

Another critical concern is that many MIPS quality measures are not relevant or specific to rehabilitation therapy. The current measure set for PTs, OTs, and SLPs remains limited, with few measures capturing meaningful functional outcomes or improvements in quality of life which are core aspects of therapy care. This misalignment not only undermines the purpose of performance measurement but places providers at risk of penalties based on measures that do not reflect the value or complexity of their work.

The inclusion of rehabilitation therapists in MIPS has created a substantial and unsustainable administrative and financial burden on rehabilitation therapy practices. Rather than advancing value-based care in the therapy field, it has diverted resources from patient services, introduced inefficiencies, and placed smaller providers at a significant disadvantage. While we fully support efforts to improve quality, CMS must either ensure adequate funding and reimbursement that reflect the real costs of compliance for all eligible providers or significantly simplify the processes required to participate.

Streamline Additional Documentation Request Process

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NARA strongly urges CMS to streamline and standardize the Additional Documentation Request (ADR) process across all Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and Unified Program Integrity Contractors (UPICs). The current variation in ADR procedures, communication practices, and documentation requirements across regions creates a disproportionate and unnecessary administrative burden for physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs), particularly those in private practice and smaller outpatient clinics.

The lack of a unified ADR protocol across CMS contractors means that therapy providers in different regions are held to inconsistent operational and technical standards. For example:

- In some MAC jurisdictions, providers report being able to submit ADRs electronically through a user-friendly portal with immediate confirmation of receipt, while in other regions, contractors require outdated fax or mailed documentation processes with no tracking or acknowledgment, increasing the likelihood of lost or misdirected submissions.
- UPICs and RACs differ in their expectations for documentation format, the depth of medical necessity justification, and which elements (e.g., progress notes, plan of care, functional outcome measures) must be included even for identical CPT codes.
- Certain MACs impose shorter response windows (e.g., 30 days) with limited flexibility for extensions, while others provide more generous timelines or clearer instructions for responding to large or complex requests.
- Providers in rural and underserved areas, especially in regions served by MACs with more rigid submission methods, face greater challenges in timely and accurate submission due to limited infrastructure (e.g., lack of broadband for online portals, unreliable fax systems), further compounding access issues for Medicare beneficiaries.

This regional inconsistency not only confuses providers but also increases the risk of denied claims based on procedural discrepancies rather than the clinical appropriateness of care. Providers that operate across multiple states may have to train staff on different ADR rules for each MAC jurisdiction, which is inefficient and prone to error. Furthermore, when denials are issued based on technical submission faults rather than substantive documentation issues, providers are forced into lengthy and costly appeals processes that delay payment and strain operational cash flow.

The administrative burden of managing ADRs is not trivial. NARA members report that responding to a single ADR can require 4–8 hours of administrative and clinical staff time, not including time spent tracking submissions or responding to follow-up questions. Practices receiving multiple ADRs in a short period sometimes triggered by automatic edits rather than suspected fraud or overutilization can be overwhelmed, especially if they lack full-time compliance staff or billing departments. This burden directly impacts patient care. When therapists are pulled away from clinical responsibilities to manage ADR-related tasks or when practices hesitate to accept complex Medicare patients due to the overly burden of audits and nonpayment, the quality and accessibility of care suffer.

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NARA urges CMS to take the following actions to address this issue:

1. Standardize ADR request protocols across all CMS contractors, including format, required elements, response timeframes, and acceptable submission methods.
2. Implement a centralized electronic ADR portal accessible to all providers, with receipt tracking and status updates.
3. Require contractors to provide consistent education and support to providers on documentation expectations for therapy services.
4. Monitor and publicly report contractor variability, including rates of technical denials and appeals reversals, to improve accountability and oversight.
5. Place limits on the frequency and volume of ADRs, especially for small practices with a strong history of compliance and no patterns of billing outliers.

Without these changes, the administrative costs and regional inconsistencies in ADR handling will continue to erode provider participation in Medicare, limit access to timely therapy services, and place an undue burden on practices simply trying to comply with complex federal regulations.

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Topic 3: Identification of Duplicative Requirements

3A. Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?

Streamline Credentialing Process and Requirements Across Healthcare Programs
NARA continues to hear from our members about closed networks and excessively lengthy credential/contracting processes with a commercial payer offering a Medicare Advantage plan can take anywhere from 90 – 180 days. This delay causes access challenges for beneficiaries, especially for those without easy transportation and HMO plans who reside in assisted and independent living facilities with a non-credentialed provider onsite. An additional issue with these payers' process is they do not make the effective date of the contract retroactive to the requested effective date or date the application was submitted. So, the beneficiary is forced to wait until the credentialing/contracting process has been completed up to 180 days to access care referred to by their physician. As a comparison, the enrollment process for a Medicare private practice group allows for a retrospective effective date within parameters and typically takes 30 – 45 days.

We request CMS to direct MAOs to process credentialing and contracting applications for Medicare providers timelier and to make the effective dates retroactive in line with CMS's established process. As the number of Medicare beneficiaries enrolled in Medicare Advantage plans continues to grow quickly due to the additional healthcare benefits and financial flexibility; beneficiaries have decreased access due to these credentialing

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timelines, significantly reduced reimbursement compared to Medicare allowable rates, and increased administrative burden. We believe CMS needs to standardize MAO processes and monitor strategies more closely to ensure beneficiaries are receiving timely care and providers are not burdened by unnecessary administrative work when their time is best spent treating beneficiaries.

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3C. How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?

Realistic Implementation Timelines
NARA urges CMS and relevant regulatory bodies to adopt more structured, transparent, and realistic timelines for the implementation of changes to Medicare policies, particularly when such changes require updates to electronic health record (EHR) systems, billing platforms, or other digital infrastructure used by rehabilitation providers. The rehabilitation therapy community including physical, occupational, and speech therapy providers relies heavily on software vendors to manage electronic documentation, claims submission, and regulatory compliance. When CMS releases new rules, such as updates to billing codes, documentation standards, or quality reporting metrics (e.g., MIPS or Home Health Value-Based Purchasing adjustments), these changes often require substantial reconfiguration of provider-facing systems.

Too often, CMS releases final rules with minimal time between the announcement and the required go-live date. In many cases, technology vendors receive full specifications and official guidance only weeks before implementation is expected. This leaves little to no time for:

- Development and configuration of system changes to reflect new regulatory requirements.
- Internal testing and quality assurance to ensure systems work correctly and integrate with existing workflows.
- Provider education and training, which is essential to prevent noncompliance or service disruptions.

This rushed process increases the risk of billing errors, documentation omissions, and compliance failures. It also places undue strain on small and mid-sized practices that lack dedicated IT or compliance departments.

Technology vendors, including EHR developers, practice management system providers, and billing software companies, operate under tight development cycles. Implementing CMS-mandated changes often requires:

- Coding and integrating new features or billing logic.
- Updating interoperability functions (e.g., HL7, FHIR).

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- Conducting usability testing to ensure compliance workflows are accurate and user-friendly.
- Deploying updates across hundreds or thousands of provider clients simultaneously.

Without sufficient lead time typically at least 120 – 180 days from final rule publication, vendors cannot reliably implement, test, and distribute compliant updates, putting both providers and patients at risk.

When regulatory changes take effect before systems are ready, providers may be forced to revert to manual documentation or workaround solutions that are prone to error. This can result in:

- Delayed or denied claims, causing financial hardship for providers.
- Reduced patient access, particularly in rural or underserved areas where small practices may temporarily halt services until systems are operational.
- Increased administrative and financial burden, as staff must interpret and apply changes without technological support or automation.

Misalignment in implementation timelines also creates discrepancies between regions, contractors (MACs), and vendors, making it difficult to ensure equitable application of Medicare policy. To improve alignment and reduce unnecessary burden, NARA recommends that CMS and its contractors adopt the following best practices:

- Establish a minimum 180-day advance notice for any regulation or policy change that requires system configuration or billing updates.
- Provide vendors with detailed implementation specifications (e.g., code sets, logic changes, data reporting formats) at the same time as policy announcements.
- Coordinate rollout schedules across all MACs to ensure national consistency in enforcement and provider expectations.
- Offer optional pilot testing periods for major regulatory updates, so vendors and providers can identify and resolve technical issues before full implementation.
- Include technology readiness assessments in CMS's regulatory planning process to ensure stakeholders are adequately prepared before go-live dates.

CMS’s efforts to modernize and improve Medicare are vital to ensuring high-quality, value-driven care. However, successful implementation depends on thoughtful coordination with the provider and technology communities. Without adequate time and support for configuration and testing, even well-intended policy changes can result in widespread disruption, administrative burden, and compromised patient access. NARA urges CMS to adopt structured, transparent timelines that align regulatory changes with the operational realities of the healthcare technology ecosystem.

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Topic 4: Additional Recommendations

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4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.

Use of Telehealth for Home Health Agencies
NARA remains deeply concerned that CMS continues to exclude home health agencies (HHAs) from the ability to bill for telehealth services, unlike other post-acute care settings where such services are increasingly recognized and reimbursed. This inconsistency represents a missed opportunity to improve access and efficiency through the use of clinically appropriate tools to achieve patient outcomes particularly in rural and underserved areas, where finding and retaining skilled rehabilitation professionals remains a persistent challenge.

Throughout the public health emergency (PHE) and beyond, telehealth has proven to be a vital tool in reaching beneficiaries as a complement to in-person care. In other care settings, telehealth has allowed patients to receive timely interventions, often accelerating their progress toward recovery goals. In the home health context, the continued restriction on reimbursable telehealth services forces agencies to delay or limit care when capacity is challenged, which can increase a beneficiary's length of stay and reduce the overall efficiency and responsiveness of care delivery.

The inability of HHAs to utilize telehealth particularly for physical, occupational, and speech therapy also creates a disparity in care access. Beneficiaries in rural areas, who are referred for therapy by their physicians, may go without services entirely if a providers with capacity cannot be secured. Telehealth could serve as a bridge to care, helping ensure that medically necessary, physician-ordered services are delivered in a timely and clinically appropriate manner.

NARA members report that patients who received therapy via telehealth in other settings during and after the PHE achieved clinical outcomes and expressed high satisfaction with their care. Many patients felt that the quality of care delivered remotely matched their in-person experiences, especially when it came to education, home exercise instruction, fall prevention strategies, and chronic condition management. These types of interventions are particularly well-suited to telehealth because they allow therapists to observe and address functional barriers in the patient's actual home environment.

Incorporating telehealth as a reimbursable modality in the home health benefit would align with CMS's stated goals of reducing unnecessary hospital utilization and improving access to care. Moreover, allowing HHAs to use telehealth when clinically appropriate could reduce costs by preventing functional decline, emergency department visits, hospital admissions, and readmissions. NARA strongly urges CMS to adopt a consistent policy across all post-acute care settings that permits the use of and reimbursement for telehealth services, including within the home health benefit. Expanding this access will help meet beneficiary needs, support providers facing workforce shortages, and ensure more equitable access to therapy services across all geographic regions.

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Consistency in Application of Regulations Amongst CMS Contractors
NARA urges CMS to address persistent inconsistencies in the interpretation and application of regulations by Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), and Unified Program Integrity Contractors (UPICs). These inconsistencies create confusion, increase administrative burden, and place physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) in private practice at increased risk of technical denials, audits, and delayed reimbursements even when delivering medically necessary and compliant care.

Across the country, providers are experiencing inconsistent enforcement of Medicare rules depending on their geographic location and MAC jurisdiction. This includes variations in:

- Local Coverage Determinations and MAC Articles
- Documentation expectations for medical necessity.
- Frequency and scope of ADRs (Additional Documentation Requests).
- Review thresholds and audit triggers.
- Definitions and guidance around functional limitation reporting, therapy thresholds, and KX modifier use.
- Misunderstanding that therapy organizations can enroll in Medicare as an institutional provider (Part A – 855A) and/or professional providers (Part B – 855B).

These inconsistencies cause clinical confusion, risk of errors and put beneficiaries at risk for not receiving the care a beneficiary should receive. The inconsistencies cause unsubstantiated technical denials that are often overturned, pulling providers from patients to focus on denial recovery.

This lack of standardization and education undermines provider confidence in the system, forces practices to expend time and resources to interpret divergent contractor expectations and leads to inequitable access to care for Medicare beneficiaries. For example, a therapy service approved by one MAC may be denied by another for identical documentation. This not only disrupts care continuity but also places smaller or rural practices that often lack legal or compliance support at a greater disadvantage.

In many cases, MAC staff themselves appear to lack a consistent understanding of current CMS policy, particularly when new rules or program updates are released. Providers frequently report receiving conflicting information when calling MAC hotlines or communicating with audit personnel. Inaccurate or incomplete guidance from contractor representatives exacerbates confusion and increases the risk of inadvertent noncompliance.

To address this, CMS must require that MACs receive standardized, timely education and updated training whenever new rules are implemented. This should include:

- Clear interpretive guidance issued by CMS and distributed to all contractors simultaneously.

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- Ongoing training requirements for MAC staff to ensure up-to-date knowledge of evolving policy.
- Publicly available FAQs and webinars for providers that reflect the most current and uniform guidance.

Without such investment in education, providers are left navigating a patchwork of interpretations that can result in denials, appeals, and delayed payment.

Policy and regulatory changes often roll out inconsistently across MAC regions, leading to misalignment in enforcement and provider preparedness. For example, new documentation rules or electronic submission requirements may go into effect on different timelines depending on the MAC creating disparities in compliance expectations and operational challenges for multi-site or multi-state practices.

To improve consistency and transparency, CMS should implement and enforce:

- Unified rollout dates across all MACs for new regulations and policy changes.
- Advance notice of no less than 90 days before enforcement begins, to allow practices time to train staff and adjust workflows.
- Public rollout calendars showing key implementation dates for all contractors, updated regularly and accessible to all providers. Then hold the contactors accountable for these dates.

Standardizing rollout timelines is essential for ensuring fairness and adequate preparation. As it stands, practices must guess when enforcement will begin or interpret conflicting guidance issued by different contractor regions.

CMS has a responsibility to ensure its regulations are applied fairly, consistently, and transparently across the country. The current decentralized, inconsistent approach leads to confusion, increased administrative burden, and reduced access to care for Medicare beneficiaries especially from smaller rehabilitation practices. NARA strongly urges CMS to establish clear expectations, uniform implementation standards, robust MAC education, and consistent rollout timelines to promote regulatory equity and provider compliance.

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