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FILED ELECTRONICALLY

Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1827-P
Mail Stop C4-26-05
PO Box 8016
Baltimore, MD 21244-8016

Submitted electronically at http://www.regulations.gov

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

Dear Administrator Oz:

The National Association of Rehabilitation Providers and Agencies (NARA) represents over 100 member organizations collectively employing 90,000+ physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) delivering care to Medicare beneficiaries nationwide. NARA members provide therapy services across the continuum of care, including outpatient clinics, skilled nursing facilities (SNFs), assisted living facilities (ALFs), retirement communities, hospitals (inpatient and outpatient), and in beneficiaries' homes. As a member-driven organization, NARA advances best practices and business success for rehabilitation providers through education, advocacy, and support. Our diverse membership offers unique insight into the impact of Medicare payment and quality programs, particularly those under the Home Health Prospective Payment System. We appreciate the opportunity to submit the following comments on the proposed rule.

Payment Reductions
While we appreciate the inclusion of a market basket update, we are deeply concerned that the combined impact of the permanent -4.059% prospective adjustment and the -5.0% temporary reduction to recoup alleged overpayments from 2020–2024 resulting in a net

6.4% decrease in reimbursement is neither sustainable nor justified. This would mark the third consecutive year of proposed cuts, placing additional strain on home health providers and jeopardizing their ability to meet the needs of an aging population with increasingly complex care requirements.

NARA strongly opposes these cuts based on behavioral assumption adjustments. CMS's repeated application of aggressive reductions disproportionately penalizes providers and directly threatens beneficiary access to care. The implications of these reductions are far-reaching:

- According to the U.S. Census Bureau, the number of Americans aged 65 and older increased by over 20 million from 2000 to 2020, and is projected to reach 77 million by 2034, surpassing the number of children under 18 for the first time[1].
- Between 2020 and 2024, 50% of U.S. counties lost access to home health agencies, illustrating the growing fragility of the provider network[2].
- A U.S. News & World Report survey found that more than 90% of adults over 65 prefer to age in place, placing even greater demand on the availability and sustainability of home-based care[3].

Despite these clear indicators of growing demand, CMS continues to impose year-over-year reductions that have already destabilized the home health infrastructure, particularly in rural and underserved areas. Providers are already being forced to reduce service areas, limit admissions, or close entirely due to inadequate reimbursement[4]. If CMS continues to implement reduction, the home health infrastructure will continue to decay. Furthermore, workforce shortages and inflation are compounding these pressures:

- The cost to hire and deploy clinicians—including wages, travel expenses, and training—continues to outpace CMS's market basket updates[5].
- Rising fuel prices and medical supply costs further increase the expense of providing in-home care, none of which are adequately addressed in CMS's proposed methodology[6].

Insufficient reimbursement threatens the ability of older adults to remain safely in their homes, undermining public preference, economic efficiency, and CMS's commitment to care in the least restrictive setting. Finally, NARA continues to strongly urge CMS to conduct

[1] U.S. Census Bureau, *An Aging Nation*, 2023, https://www.census.gov/library/publications/2023/demo/p25-1144.html
[2] Alliance for Home Care, *Access Deterioration Report*, 2024, https://www.ahhqi.org
[3] U.S. News & World Report, *Aging in Place Survey*, 2023, https://www.usnews.com/news/health-news/articles/2023-06-14/survey-older-americans-want-to-age-at-home
[4] Partnership for Quality Home Healthcare, *Industry Impact Briefing*, 2025, https://pqhh.org
[5] MedPAC, *Report to Congress: Medicare Payment Policy*, March 2025, https://www.medpac.gov
[6] Bureau of Labor Statistics, *Producer Price Index*, 2024, https://www.bls.gov/ppi

a more nuanced analysis of provider behavior by examining provider-level data with patient functional impairment levels, ICD-10 coding, and comorbidity coding. CMS' data demonstrates home health patients have higher levels of functional impairment and more comorbidities than it estimated in the development of PDGM; therefore, applying a uniform "behavioral adjustment" across all providers fails to account for legitimate variations in care delivery that may result from shifts in patient acuity, complexity, or evolving clinical best practices.

This broad-based adjustment unfairly assumes inappropriate or excessive utilization, failing to distinguish between providers who have responsibly adapted to care for an increasingly medically complex and aging population and those for whom such assumptions may apply. The methodology used to account for behavioral changes does not assess whether these shifts have influenced patient experience or outcomes. As a result, high-performing agencies, particularly those delivering evidence-based, patient-centered care to high-need or underserved populations are at risk of being penalized.

A more equitable and evidence-driven methodology would involve analyzing claims and outcomes data to assess whether observed changes in visit utilization or service intensity correlate with patients' clinical characteristics, including their admission status, medical complexity, and functional status at admission and discharge to account for other variables in payment. This would enable CMS to distinguish between behavioral changes driven by potentially inappropriate coding practices and those driven by legitimate clinical need or regulatory evolution (e.g., shift toward value-based models, increasing use of telehealth, or interdisciplinary care teams).

Disparity in CMS Payment Updates to Medicare Advantage Organizations and Home Health Providers

NARA remains deeply concerned about the growing disparity between the year-over-year reimbursement increases awarded to Medicare Advantage (MA) plans, while finalizing policies that deeply cut HHA payments. MA plans have received annual payment rate increases from CMS totaling over 15% from 2023 through 2025. During the same period, home health agencies have faced consecutive reductions in Medicare reimbursement, with permanent and temporary cuts compounding year over year in 2023, 2024, and 2025. These cuts have significantly strained providers' ability to meet the needs of an aging and increasingly medically complex patient population. While the MA plans are receiving increases, the additional funding has not been translated into increased reimbursement for providers. Instead, MA plans continue to pay below traditional Medicare rates while adding administrative burdens such as prior authorizations, improper denials, and payment delays further jeopardizing access to care for beneficiaries.

HHAs and therapy providers are faced with year over year declining payments and escalating administrative burdens levied by these very MA plans even though they are being paid more

Commented [ES1]: Would we not want to urge provider-level analysis with ICD-10 coding, comorbidity coding too?

Commented [ES2]: To Account for other variables in payment.

Commented [ES3]: Consider this for more direct attention.

Commented [ES4]: Can we add here the payment reductions HHAs have gotten from 2023 to 2025?

So we are essentially putting in place 2 arguments:
1- you give them more and
2- they are keeping the extra $$.

by CMS to administer the benefits. Specifically, HHAs contracting with MA plans continue to be paid at rates that are frequently below traditional Medicare fee-for-service rates. Despite the increased funding to MA plans, these additional dollars are not translating into equitable or timely payments for the providers who deliver care on the ground. This is causing many providers to exit contracts with MA plans resulting in yet another access to care problem for beneficiaries.

This imbalance is compounded by the significant administrative burden imposed by MA plans, including:

- High rates of prior authorization requirements, often for services like physical therapy, occupational therapy, and speech-language pathology, that are commonly approved under traditional Medicare.
- Inaccurate and inappropriate claim denials, which force providers into lengthy and resource-intensive processes, delaying payment, increasing overhead costs, and ultimately threatening access to care for beneficiaries.
- Lack of transparency and consistency in medical necessity criteria, plan-specific policies, and authorization workflows.

These operational challenges are not theoretical. A 2023 HHS Office of Inspector General (OIG) report found that 13% of prior authorization denials by Medicare Advantage plans were for services that met Medicare coverage rules, and 18% of payment denials were for claims that would have been approved under fee-for-service. The current structure places providers at financial risk while allowing MA plans to profit from increased capitated payments. These plans continue to report high gross margins year after year. In 2023[7], MA plans generated average gross margins of $1,982 per enrollee approximately double those in other insurance markets. According to analysis from Kaiser Family Foundation, these elevated gross margins per enrollee have been consistent since 2018[8]. Recently, Humana exited This persistent financial advantage stands in stark contrast to shrinking provider payments, further straining access to care. While insurance groups may be scaling back the extras included in the MA plans, they are still boasting increases in their earnings[9], while providers struggle to continue providing valuable services to Medicare beneficiaries[10].

Commented [ES5]: Do we want to include citations to YOY profit margins of the MA organizations (Humana, Aetna, etc)?

[7] https://www.kff.org/medicare/health-insurer-financial-performance/
[8] https://www.kff.org/affordable-care-act/medicare-advantage-insurers-report-much-higher-gross-margins-per-enrollee-than-insurers-in-other-markets/
[9] https://www.wsj.com/health/healthcare/the-medicare-pullback-is-here-e6ab37da?gaa_at=eafs&gaa_n=ASWzDAiiOp7q0M2zOGaiwaRrfn_bjb_h0PNGpdyWyzSqFP_FQuNVGaYXbQkzNtcZKH8%3D&gaa_ts=68b0519b&gaa_sig=3wyQ7nSCm6OVeR3oNgPbbcHVwzwhwMXr1EkET9CAlzsTohlYWEU9xs6zLkZ1kUuZ1LFmoEmlz951w9nfrTC2_Q%3D%3D
[10] https://www.healthleadersmedia.com/ceo/disadvantage-medicare-advantage-providers-forced-fight-back

In early 2023[11], Humana announced its decision to exit the employer-based commercial group insurance market including fully insured, self-funded, and federal employee health benefit plans to concentrate its resources on higher-growth, government-supported segments such as Medicare Advantage. With this announcement, Humana's share rose by 1.3%. This move aligns with the understanding that Medicare Advantage plans typically deliver stronger margins than commercial offerings. Humana has continued with this strategy through 2025. In effect, CMS is delivering increased funding to intermediaries while the providers responsible for direct beneficiary care face lower reimbursement, higher operational costs, and increased barriers to delivering timely services.

This misalignment is especially troubling as over half of all Medicare beneficiaries are now enrolled in MA, and that number continues to grow. We need CMS to enforce accountability standards for these MAOs. Without policy reforms that ensure MA plans offer providers fair reimbursement rates and reduce unnecessary administrative burden, the imbalance will continue to undermine provider sustainability and patient access particularly in rural and underserved communities.

NARA urges CMS to adopt policies that hold MA plans to the same standards of payment adequacy, access, and efficiency expected of traditional Medicare, and to ensure that future reimbursement increases are tied to downstream improvements in provider payments and care delivery not just plan profitability.

Clarifying Misconceptions About Home Health Agency Margins

While CMS and MedPAC often cite data suggesting that Medicare margins for HHAs are high, this portrayal is misleading and fails to reflect the full financial realities facing providers across the broader healthcare landscape. The assumption that HHAs consistently operate with high profit margins fails to account for critical factors affecting long-term sustainability, including the ripple effect of Medicare rates on other payers and the significant administrative burden posed by managed care.

The margins reported by MedPAC are based solely on fee-for-service (FFS) Medicare reimbursement, which accounts for a shrinking portion of the patient population. According to MedPAC's March 2024 Report to Congress[12], Medicare FFS accounted for only 36% of home health episodes in 2022, with the remaining 64% covered under Medicare Advantage (MA), Medicaid, and commercial plans, all of which pay substantially less than FFS Medicare. In fact, the aforementioned report supports the correlation between other payers such as Medicare Advantage and Medicaid are underpaying home health agencies when compared to traditional Medicare. When Medicare reduces reimbursement rates, other

Commented [ES6]: Is this our correlation? If not - can we cite?

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[11] https://www.reuters.com/business/humana-exit-employer-group-insurance-business-2023-02-23/
[12] MedPAC March 2024 Report to Congress, Chapter 9 – Home Health Services https://www.medpac.gov/document/march-2024-report-to-the-congress-medicare-payment-policy/

payers including Medicare Advantage, Medicaid, and commercial insurers often follow suit with additional cuts, further compounding financial strain on providers.

Home health agencies must comply with vastly different and often more complex rules under Medicare Advantage and Medicaid plans, including:

- Prior authorization for most services;
- Onerous and variable documentation requirements;
- Increased audit activity;
- Frequent claim denials and appeals.

According to a national survey by Premier, Inc. in 2025[13], claims adjudication cost increased from 2022 to 2023 by 23% and 70% of all denials were ultimately overturned and paid after more than 1 round of appeal and review. These burdens increase staffing needs for both clinical and non-clinical roles and divert resources away from patient care, all without corresponding reimbursement increases. There is no penalty levied against payers for these excessive denials that create that create significant financial burdens for providers.

Despite representing a smaller share of total episodes, Medicare FFS rates effectively set the benchmark for the rest of the market. Cuts to the Medicare home health payment system result in downward pressure on rates from other payers, worsening financial strain across the board. As such, reductions in Medicare reimbursement compound existing underpayments from MA and Medicaid, threatening access to care and provider viability, particularly in rural and underserved areas.

The perception of "high margins" in the home health sector is based on an incomplete view of the financial environment in which HHAs operate. When accounting for the broader payer mix and administrative challenges, most agencies face unsustainable margins or net losses, particularly as they serve more Medicare Advantage and Medicaid beneficiaries. We urge CMS to consider the full context of provider finances and to maintain adequate, stable reimbursement through the Medicare program to support access, workforce sustainability, and long-term viability of home-based care.

Proposed Recalibration of PDGM Case-Mix Weights

We acknowledge CMS's continued efforts to annually recalibrate the Patient-Driven Groupings Model (PDGM) using the most current data available. Specifically, the proposed recalibration of case-mix weights, functional impairment thresholds, comorbidity subgroups, and Low-Utilization Payment Adjustment (LUPA) visit thresholds based on CY 2024 claims data is consistent with the agency's stated methodology.

[13] https://premierinc.com/newsroom/policy/claims-adjudication-costs-providers-257-billion-18-billion-is-potentially-unnecessary-expense

However, we remain concerned that the year-over-year changes to the underlying PDGM algorithm create significant instability for home health providers. Each recalibration cycle introduces shifts that materially affect reimbursement rates, patient grouping, and clinical and operational planning, making it increasingly difficult to assess performance, forecast financial impact, or implement sustainable care delivery strategies.

In particular, the annual fluctuation of key variables, such as case-mix weight distributions and functional impairment scoring thresholds, disrupts providers' ability to track outcomes, compare historical performance, and understand trends over time. These changes result in a moving target that diminishes the transparency and predictability of the payment system while also contradicting the original reason for PDGM which was to match resource use to patient characteristics.

Commented [ES8]: Should we also point out that it appears to contradict the original reason for the PDGM - to match resource use to patient characteristics.

How can resource use based on patient characteristics change year over year without cost inputs to back it up? Just saying functional levels should be divided into 3 pieces of pie - does not mean the patient changed…it means they decided to pay less for the exact same patient in December 2024 versus January 2025.

Additionally, while we appreciate the technical documentation accompanying the proposed rule, we urge CMS to enhance transparency around the modeling process used to generate these recalibrations, including the statistical rationale and potential provider-level impacts. Providers would benefit from multi-year comparative tables and impact simulations that allow for meaningful longitudinal analysis and financial planning. Given these concerns, we respectfully request that CMS:

- Clearly delineate which aspects of the PDGM algorithm are structurally revised versus recalibrated based on claims data;
- Provide multi-year comparative analysis of case-mix weight shifts and functional thresholds;
- Limit recalibrations to material changes in patient acuity or utilization trends;
- And offer greater opportunity for stakeholder engagement prior to finalizing major methodological changes.

Ensuring a more consistent and transparent approach to PDGM recalibration is essential to supporting high-quality care delivery, operational stability, and long-term value-based transformation in the home health sector.

Face-to-Face Encounter Clarifications
We support CMS's proposal that confirms a certifying physician or allowed non-physician practitioner (NPP) does not need to personally perform the face-to-face (F2F) encounter. This clarification appropriately aligns Medicare's F2F regulatory language with the statutory flexibilities established under the CARES Act and recognizes the collaborative nature of modern team-based care. It reduces unnecessary administrative burden while maintaining appropriate clinical oversight and accountability in the certification process. Allowing the certifying provider to rely on documentation from another clinician within the same practice:

- Ensures continued focus on patient-centered care,

- Promotes operational efficiency, particularly in high-volume or multi-specialty practices,
- And reduces delays in initiating timely home health services, particularly for patients transitioning from acute or post-acute settings.

We commend CMS for this proposal and urge the agency to finalize this policy as written in the final rule. Codifying this flexibility will improve clarity, align policy with statutory intent, and support broader efforts to streamline care coordination without compromising documentation integrity.

Home Health Value Based Purchasing Updates

NARA commends CMS for its proposal to adopt new OASIS-based functional measures that assess a patient's ability to complete self-care activities such as bathing and dressing. We support the inclusion of these measures as they reflect meaningful, patient-centered outcomes that are highly relevant to both home health providers and the beneficiaries we serve. These activities of daily living (ADLs) are foundational indicators of a patient's functional status, safety, and independence in the home. The ability to perform these tasks without assistance is not only essential to maintaining dignity and quality of life, but also closely correlated with reduced risk of hospitalization, falls, and institutionalization. For home health providers, these measures:

- Align with clinical goals of promoting safe, functional independence;
- Reinforce the value of interdisciplinary rehabilitation services, including physical, occupational, and speech therapy;
- And provide actionable data to monitor patient progress and guide care planning.

Importantly, these measures also help demonstrate the value of home-based care by capturing outcomes that matter to patients, families, and caregivers. As CMS and stakeholders continue to move toward value-based care models, ensuring that the quality reporting framework captures functional improvements is essential. We appreciate CMS's efforts to refine and expand measures reflecting real-world functional outcomes. We urge the agency to finalize the proposal to include these new OASIS-based self-care items and to continue engaging providers in the development and implementation of patient-centered, clinically meaningful quality measures.

NARA respectfully requests that CMS establish a clear timeline to remove the M Items from Value-Based Purchasing (VBP) and transition fully to Section GG. Continuing to rely on functional M Items while also reporting Section GG only prolongs the inevitable and will amplify the disruption when M Items are eventually eliminated for mobility and self-care measures. This dual reporting structure undermines the integrity and comparability of the data while imposing duplicative documentation burdens on providers. Moving decisively

Commented [SL9]: Do we want to request a timeline to remove the M Items from VBP and move entirely to section GG? I understand the TEP recommened the M items due to the deep data already established, but continually falling back to the functional M items will only increase the pain later when we move out of M for mobiity and self care entirely and go to section GG. (my two cents)

Commented [ES10R9]: I agree. It also negative affects the integrity of the data and is double burden

and transparently to Section GG will ensure alignment, reduce administrative strain, and enhance the accuracy of functional outcome reporting.

Concern with Proposed Measure Removal Factor 9: Feasibility of Implementation
NARA respectfully opposes CMS's proposal to add and codify Measure Removal Factor 9 at § 484.358, which would allow the agency to remove a quality measure from the Home Health Quality Reporting Program (HH QRP) if "it is not feasible to implement the measure specifications." While we appreciate CMS's intent to ensure practicality in measure selection and maintenance, we believe this proposed criterion is overly vague and potentially redundant given the existing removal factors, which already allow CMS to eliminate measures that are burdensome, duplicative, or have data collection or reliability issues. Codifying a broadly worded "feasibility" factor raises several concerns:

- Lack of specificity may lead to inconsistent application or misinterpretation by stakeholders.
- It could allow for premature or non-transparent removal of clinically meaningful measures, especially those that capture important but complex domains such as functional status, care coordination, or patient engagement.
- CMS already has adequate authority under existing factors (e.g., measures that are "no longer meaningful," "more burdensome than beneficial," or "have implementation issues") to address feasibility concerns.

Rather than codify a new and ambiguous removal factor, we urge CMS to:

- Clarify how "feasibility" would be objectively assessed and distinguished from existing removal factors;
- Ensure stakeholder engagement in any decision to remove a measure under this criterion;
- And maintain a strong commitment to preserving patient-centered, functional, and outcome-based quality measures that reflect the value of home-based care.

In its current form, Factor 9 is unnecessary and risks undermining transparency and consistency in the HH QRP measure lifecycle. We respectfully request that CMS reconsider this proposal and instead reinforce its commitment to clear, evidence-based, and stakeholder-informed quality measurement.

RFI: HH QRP Measure Concepts Under Consideration for Future Years
NARA appreciates CMS's consideration of future measure concepts related to interoperability, well-being, nutrition, and delirium. While CMS has made significant investments to advance interoperability, progress within the post-acute care sector remains limited. The lack of seamless data exchange continues to create inefficiencies and administrative burdens for providers. Improved interoperability, particularly access to

standardized data on SDOH and other patient characteristics has the potential to streamline care coordination and enhance patient outcomes across the continuum.

NARA strongly encourages CMS to prioritize the expansion of interoperability infrastructure in post-acute settings and to identify sustainable funding mechanisms to support implementation. Achieving full interoperability across all care settings is essential to reducing administrative burden and ensuring high-quality, efficient care for Medicare beneficiaries.

NARA members strongly support CMS's commitment to advancing whole-person, person-centered care as outlined in the CMS Strategic Plan. We believe promoting the well-being of beneficiaries receiving home health services must involve an integrated approach that encompasses physical, mental, and social health. Evidence, including a 2018 study published in the *Journal of Physics*[14], demonstrates that loss of muscle mass and strength contributes to frailty a condition often exacerbated by malnutrition. Incorporating nutrition as a formal quality measure would align with CMS's efforts to improve health outcomes and reduce disparities by addressing root causes of physical decline in older adults. Home health agencies are uniquely positioned to assess and address nutritional challenges in the home environment, making this an appropriate and feasible setting for quality measurement. We encourage CMS to prioritize the development and adoption of nutrition-related measures that are evidence-based, risk-adjusted, and aligned with patient goals of care.

Investing in proactive approaches to well-being and nutrition for older adults directly supports the Five M's of Geriatric Care: Medications, Mind, Mobility, Multi-complexity, and what Matters Most, with strong evidence to back their impact. For example, nutritional interventions can decrease hospital readmission rates by 27% and support medication effectiveness by addressing malnutrition, a key driver of poor medication outcomes.[15] Cognitive engagement through physical activity and proper nutrition has been associated with a 35% lower risk of cognitive decline,[16] supporting Mind and well-being. For older adults with multiple chronic conditions, comprehensive lifestyle interventions including diet and physical activity have been shown to reduce emergency department visits and improve functional outcomes.[17] In fact, structured physical activity programs have been shown to reduce falls by up to 30%, a critical factor in preserving Mobility and preventing costly injuries

[14] https://iopscience.iop.org/article/10.1088/1742-6596/1073/4/042032/pdf
[15] Saghafi-Asl, M., et al. (2021). *Malnutrition and hospital readmission: A systematic review and meta-analysis*. Clinical Nutrition ESPEN. https://doi.org/10.1016/j.clnesp.2021.01.003
[16] Ngandu, T., et al. (2015). *A 2-year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER)*. The Lancet. https://doi.org/10.1016/S0140-6736(15)60461-5
[17] Centers for Medicare & Medicaid Services (CMS). (2021). *Chronic Care Management Report to Congress*. https://www.cms.gov

and hospitalizations.[18] Most importantly, these programs reflect what Matters Most to older adults: independence, functional ability, and quality of life core outcomes consistently prioritized in person-centered care models.[19] Embedding these interventions in CMS initiatives, including through the Value-Based Purchasing Program, would drive measurable improvements in outcomes while advancing the goals of equitable, value-based care.

Malnutrition and poor nutritional status are critical yet often under-recognized drivers of physical deterioration, hospital readmissions, and loss of independence in the Medicare home health population. Early identification and targeted intervention for nutritional risk are essential components of preventive care and chronic disease management core pillars of CMS's person-centered, value-based care transformation. Incorporating a nutrition-focused quality measure would:

- Support timely screening and intervention to mitigate frailty, weight loss, and muscle wasting, which are major contributors to functional decline;
- Enhance care coordination by prompting engagement from interdisciplinary team members, including nurses, therapists, and dietitians;
- Advance equity by identifying social determinants of health such as food insecurity, which disproportionately affect underserved populations;
- And provide actionable data to reduce disparities and strengthen outcomes related to recovery, independence, and quality of life.

NARA appreciates CMS's continued commitment to holistic, equitable, and preventive approaches in the home health setting, and we urge the agency to move forward with incorporating nutrition into the HH QRP framework.

Telehealth In Home Health Setting

NARA continues to urge CMS to modernize its policies and allow the use of telehealth services to count as a visit in the home health setting like it has in most other settings. Telehealth greatly expands access to care for Medicare beneficiaries, particularly those in rural and underserved communities by enabling remote monitoring, virtual check-ins, and therapy sessions. Telehealth supports continuity of care, reduces avoidable hospitalizations, and enhances patient engagement. Integrating telehealth into home health does not replace in-person visits but rather augments care delivery, allowing agencies to respond more quickly to changes in condition and tailor interventions to patient needs. Ultimately, permitting telehealth within home health aligns with CMS' goals of improving

[18] Sherrington, C., et al. (2020). *Exercise for preventing falls in older people living in the community*. British Journal of Sports Medicine. https://doi.org/10.1136/bjsports-2019-101512

[19] Institute for Healthcare Improvement. (2020). *Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults*. https://www.ihi.org

health equity, promoting person-centered care, and ensuring that beneficiaries receive the right care, at the right time, in the right place.

NARA members have found their patients receiving telehealth services in other settings have expressed satisfaction and appreciation of the ability to participate in care remotely during the PHE and post-PHE. In addition, most patients have reported that their needs were met through telehealth in a similar way to their in-person care experience. Therapy interventions delivered through an electronic or digital medium have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions or readmissions. Education and home exercise programs, including those focused on falls prevention and chronic pain, function particularly well with telehealth because the therapist can evaluate and treat the patient within the real-life context of the home environment. NARA sees the opportunity to recognize all these benefits in the home health setting if telehealth is expanded.

Concerns Regarding Retroactive Revocation Authority in Medicare Provider Enrollment
NARA acknowledges CMS's ongoing efforts to strengthen Medicare program integrity and reduce fraud, waste, and abuse. However, we have concerns regarding the proposal to expand the number of grounds under which CMS may revoke a provider's enrollment retroactively. While we support actions that target bad actors and uphold program integrity, we urge CMS to provide greater clarity regarding:

- The specific circumstances under which retroactive revocation would be applied;
- The maximum look-back period for such revocations;
- And most critically, the availability and scope of a timely and fair appeal process for affected providers.

Retroactive revocation poses significant risks for compliant providers who may be inadvertently swept into enforcement actions due to clerical, administrative, or good-faith errors especially in cases where operational standards have evolved or where CMS's own guidance may have been unclear. Without well-defined parameters and procedural safeguards, this policy could be introduced:

- Financial instability due to retroactive payment recoupments,
- Disruption of patient care, particularly in underserved areas,
- And a chilling effect on provider participation in Medicare, especially among small or rural organizations.

We strongly urge CMS to:

- Clearly define the types of violations that would trigger retroactive revocation;

- Specify the timeframe within which CMS may apply such action (e.g., 12 or 24 months);
- And ensure that all revocation decisions are subject to a transparent appeals and reconsideration process consistent with principles of due process.

While we share CMS's commitment to program integrity, we caution against broad or undefined retroactive enforcement authority that may inadvertently penalize legitimate providers and jeopardize patient access to care.

Concern Regarding OASIS Requirement for Medicare Part B Outpatient Therapy Patients Treated by HHAs

NARA is significantly alarmed by the July 2025 CMS Quarterly OASIS Q&As issued on July 2, 2025[20], stating that OASIS assessments are required for patients receiving outpatient Medicare Part B therapy services in the home when those services are furnished by a home health agency (HHA). This interpretation seems contradictory to the delineation of the skilled home health services delivered under Medicare Part A benefit and those delivered through the outpatient (Medicare B) benefit. This represents a significant and abrupt departure from long-standing practice without a formal analysis of the impact on provider burden. It imposes an unnecessary and unjust burden on both home health providers and patients. NARA is also concerned that it will significantly reduce access to ongoing therapy services for patients who may not have transportation to an outpatient clinic. We strongly urge CMS to revise the July 2025 CMS Quarterly OASIS Q&A to reflect that the collection of OASIS data is only required for patients receiving care for services provided under Part A.

The OASIS was designed to support care planning, quality measurement, and payment for more complex patients receiving services under the home health benefit (Medicare Part A) Applying the OASIS requirement to outpatient services provided by a home health agency is:

- Misaligned with the intent and scope of OASIS, which does not reflect the clinical attributes of patients receiving outpatient therapy or regulatory framework of outpatient therapy;
- Operationally burdensome and duplicative, adding significant documentation requirements without any corresponding value for patient care or quality reporting. In fact, including this information in the HH agencies QRP or VBP measures would create significant and undue 'noise,' potentially skewing CMS' and the public's interpretation of the measures on Care Compare ;
- And while HHAs are increasingly looking to value-based arrangements to meet the needs of their patients, it disadvantages those HHA's expanding their services by providing outpatient therapy services. compared to all other providers delivering the same level of therapy service, in the same setting.

[20] https://qtso.cms.gov/system/files/qtso/CMS_OAI_Qtr_2_2025_QAs_July_2025_final%20508.pdf

We urge CMS to rescind or revise this interpretation immediately and issue clear guidance that OASIS assessments are not required for patients receiving outpatient Medicare Part B therapy in the home, regardless of the service provider. Maintaining consistency across provider types and aligning regulatory requirements with the intent of the benefit category is essential to ensuring equitable, efficient, and patient-centered care.

Conclusion

NARA is deeply concerned that the CY 2026 Home Health Proposed Rule continues a troubling pattern of inadequate reimbursement, broad-brush policy assumptions, and escalating administrative burdens that collectively undermine the financial stability and operational capacity of home health providers. The proposed permanent and temporary payment reductions are based on generalized behavioral assumptions that fail to reflect the real-world variability in provider practice patterns, patient acuity, and geographic challenges. Moreover, the continued recalibration of the PDGM model combined with expanding reporting requirements and prior authorization pressures from downstream payers imposes unnecessary administrative strain that diverts resources from patient care. In this value-based healthcare environment, more beneficiaries are utilizing home health services in place of higher cost levels of care. This is an appropriate and purposeful trend that reduces overall spending and allows patients to remain in and receive care in their home environment. HAs are dependent on CMS to create policies and payment structures that adequately reflect the resources required to provide this level of high quality care in the home in today's environment. As Medicare sets the tone for the broader reimbursement environment, these cuts trigger a ripple effect, prompting further reductions by Medicare Advantage and commercial payers, exacerbating access issues for vulnerable populations and threatening the sustainability of high-quality, home-based care.

We thank you for the opportunity to provide comments related to this proposed rule. Should you have any questions concerning these comments, please contact Christie Covington, NARA Executive Director at christie.covington@naranet.org.

Respectfully submitted,

Chris Carlin, OTR/L, MBA
President of the Board, National Association of Rehabilitation Providers &Agencies