DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 414, 422, 423, 424, 484, and 498

[CMS–1844–P]

RIN 0938–AV80

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

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would set forth routine updates to the Medicare home health payment rates in accordance with existing statutory and regulatory requirements. In addition, this proposed rule discusses the behavior adjustment and proposes a temporary behavior adjustment and proposes to recalibrate the case-mix weights and update the functional impairment levels; comorbidity subgroups; and low-utilization payment adjustment (LUPA) thresholds for CY 2027. Additionally, this proposed rule discusses the provision of home health palliative care services and includes a request for information (RFI) on a home health specific wage index. This rule would also propose changes to the Home Health Quality Reporting Program (HH QRP) and summarizes potential initiatives to improve alignment between the HH QRP and expanded Home Health Value Based Purchasing (HHVBP) Model. Lastly, the rule would—clarify the application of the DMEPOS face-to-face encounter requirements for the replacement of DMEPOS items; make changes to the provider and supplier enrollment requirements; make changes regarding DME benefit expansion for infusion pumps and drugs; and discuss collection of information requirement changes regarding the DMEPOS Competitive Bidding Program (CBP) country of origin.

DATES: To be assured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. EDT on August 31, 2026.

ADDRESSES: In commenting, please refer to file code CMS–1844–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may (and we encourage you to) submit electronic comments on this regulation to *https://www.regulations.gov/docket/CMS-2026-XXXX.* Follow the instructions under the ''submit a comment'' tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1844–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1844–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

For general information about the Home Health Prospective Payment System (HH PPS), send your inquiry via email to *HomeHealthPolicy@cms.hhs.gov.*

For information about the Home Health Quality Reporting Program (HH QRP), send your inquiry via email to *homehealthqualityquestions@cms.hhs.gov.*

For more information about the expanded Home Health Value-Based Purchasing (HHVBP) Model, please visit the Expanded HHVBP Model web page at *https://www.cms.gov/priorities/innovation/innovation-models/expanded-home-health-value-based-purchasing-model* or send your inquiry via email to *HHVBPquestions@cms.hhs.gov.*

Nancy Allert (410) 786–4317, Jennifer Phillips (410) 786–1023, Olufemi Shodeke (410) 786–1649, Misty Whitaker (410) 786–4975, for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Encounter Requirements for Identical Replacement Items. Frank Whelan (410) 786–1302, for Medicare provider and supplier enrollment and DMEPOS accreditation.

For more information about the DME Benefit Expansion for Infusion Pumps and Drugs, send your inquiry via email to *DMEPOS@cms.hhs.gov.*

Austin Gutowski, (410) 786–1643, for DME Competitive Bidding Program—Country of Origin.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov/.* Follow the search instructions on that website to view public comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a plain language summary of this rule may be found at *https://www.regulations.gov/.*

I. Executive Summary

A. Purpose and Legal Authority

1. Home Health Prospective Payment System (HH PPS)

As required under section 1895(b) of the Social Security Act (the Act), this proposed rule would update the CY 2027 Medicare payment rates for home health agencies (HHAs). In this proposed rule, we include an analysis of home health utilization, as well as analysis of the difference between assumed versus actual behavior change on estimated aggregate expenditures for home health payments as a result of the change in the unit of payment to 30 days and the implementation of the Patient Driven Groupings Model (PDGM) case-mix adjustment methodology. This proposed rule also discusses the permanent adjustments applied in previous years and proposes a temporary adjustment to the CY 2027 home health base payment rate. In addition, this rule proposes to recalibrate the PDGM case-mix weights and to update the low-utilization payment adjustment (LUPA) thresholds, functional impairment levels, and comorbidity adjustment subgroups under sections 1895(b)(4)(A)(i) and (b)(4)(B) of the Act for 30-day periods of care in CY 2027. This proposed rule proposes to update the CY 2027 fixed-dollar loss (FDL) ratio for outlier payments (so that outlier payments as a percentage of estimated total payments are projected not to exceed 2.5 percent,

as required by section 1895(b)(5)(A) of the Act).

Additionally, this rule discusses provision of palliative care services under the Medicare home health benefit and includes a request for information (RFI) regarding the construction of a home health specific wage index.

2. Home Health (HH) Quality Reporting Program (QRP)

In accordance with the statutory authority at section 1895(b)(3)(B)(v) of the Act, we are proposing updated quality reporting policies. First, we summarize potential initiatives to improve alignment between the HH QRP and expanded HHVBP Model. We also propose to revise the HH QRP data submission deadlines beginning with the CY 2027 HH QRP. We also propose to revise the HH QRP OASIS and HHCAHPS Annual Payment Update (APU) reporting timeframe to report a calendar year of data (January 1 through December 31). We propose some revisions to regulatory text in support of rule proposals and to improve digital transfer of information during the reconsiderations process. Finally, we are soliciting public comments on one Request for Information (RFI) on future measure concepts for the HH QRP.

3. Expanded Home Health Value-Based Purchasing (HHVBP) Model

We are not proposing any expanded HHVBP Model-specific policy changes in this proposed rule. We have included a brief summary of the Model with context relevant to potential alignment between the HH QRP and the expanded HHVBP Model.

4. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Encounter Requirements for Identical Replacement Items

We propose clarifying the application of the DMEPOS face-to-face encounter requirements, as outlined in 42 CFR 410.38, and the related documentation necessary to support the replacement of DMEPOS items. We do not believe it necessary to require an additional in-depth beneficiary examination to ''gather[ ] subjective and objective information associated with diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered'' for replacement items. Such information should be recorded when the beneficiary is initially assessed and receives the item, and the practitioner should only write replacement orders for beneficiaries with ongoing medical need for the item(s). Therefore, we propose that an additional face-to-face encounter within the 6 months preceding an order/prescription for replacement of a DMEPOS item will not be required per 42 CFR 410.38. We clarify that for purposes of 42 CFR 410.38(d)(2), a ''replacement'' refers to the provision of an item that replaces an item falling under the same Healthcare Common Procedure Coding System (HCPCS) code; it does not include those situations involving the provision of a different item, for example, because of a change in medical condition.

5. Provider Enrollment and DMEPOS Accreditation

Consistent with section 1866(j) of the Act, we are proposing a number of Medicare provider enrollment provisions to strengthen and clarify certain aspects of the provider enrollment process. These include but are not limited to: (1) adding grounds for denying or revoking a provider's or supplier's Medicare enrollment; and (2) expanding the reasons for which CMS can apply a retroactive effective date for provider and supplier revocations. These changes are necessary to help ensure that payments are made only to qualified providers and suppliers, which we believe would assist in protecting the Trust Funds and Medicare beneficiaries.

We are also proposing several minor revisions to our DMEPOS accreditation provisions in § 424.58, such as clarifying certain timeframes by which DMEPOS accreditation organizations must report data to CMS. We believe these revisions would help improve the efficiency of the DMEPOS accreditation process.

6. Durable Medical Equipment (DME) Benefit Expansion for Infusion Pumps and Drugs

In section V.C. of this proposed rule, we propose to make changes to the Medicare Part B definition of DME at 42 CFR 414.202 to implement amendments made to the definition of DME at section 1861(n) of the Act by section 6222(a) of the Consolidated Appropriations Act, 2026 (CAA, 2026), expanding the scope of the benefit for DME to include certain external infusion pumps and associated home infusion drugs or other associated supplies. The legal authority for this proposed rule is provided by section 1861(n) of the Act, as amended by section 6222(a) of the CAA, 2026, and section 1871 of the Act.

7. DMEPOS Competitive Bidding Program—Country of Origin

We discuss requesting to revise the DMEPOS Competitive Bidding Program (CBP) information collection under Office of Management and Budget (OMB) Control Number 0938–1408 (CMS–10744) to require DMEPOS CBP contract suppliers to report the country of origin for the lead items furnished during the contract's period of performance. This information will allow beneficiaries and interested parties to learn where the DMEPOS item originated, if interested.

B. Summary of the Provisions of This Proposed Rule

1. Home Health Prospective Payment System (HH PPS)

In section II.B.1. of this proposed rule, we provide monitoring and data analysis on the PDGM utilization.

In section II.C.1. of this proposed rule, we discuss the permanent behavior adjustment and propose a temporary adjustment to the base payment rate under the HH PPS.

In section II.D. of this proposed rule, we propose to recalibrate the CY 2027 PDGM case-mix weights and to update the low-utilization payment adjustment (LUPA) thresholds, functional impairment levels, and comorbidity adjustment subgroups.

In section II.E. of this proposed rule, we propose to update the home health wage index. We also propose to update the CY 2027 national, standardized 30-day period payment rates and the CY 2027 national per-visit payment amounts by the home health payment update percentage. Additionally, this rule proposes the CY 2027 fixed dollar loss (FDL) ratio to ensure that aggregate outlier payments are projected not to exceed 2.5 percent of the total aggregate payments, as required by section 1895(b)(5)(A) of the Act.

In section II.F. of this proposed rule, we discuss the provision of palliative care services under the Medicare home health benefit.

In section II.G. of this proposed rule, we include a request for information (RFI) on the construction of a home health specific wage index.

2. Home Health Quality Reporting Program (HH QRP)

In section III.D. of this proposed rule, we summarize potential initiatives to improve alignment between the HH QRP and expanded HHVBP Model.

In section III.E. of this proposed rule, we are proposing to revise the HH QRP data submission deadlines beginning with the CY 2027 HH QRP.

We are also proposing to revise the HH QRP OASIS and HHCAHPS Annual Payment Update (APU) reporting timeframe to report a calendar year of data (January 1 through December 31). Additionally, we propose some

revisions to regulatory text in support of rule proposals or to improve digital transfer of information during the reconsiderations process.

In section III.F. of this proposed rule, we are soliciting public comments on one Request for Information (RFI) on future measure concepts for the HH QRP.

3. Expanded Home Health Value Based Purchasing (HHVBP) Model

In section IV. of this proposed rule, we summarize the expanded HHVBP Model. We are not proposing any expanded HHVBP Model-specific changes in this proposed rule. We have included a brief summary of the Model with context relevant to potential alignment between the HH QRP and expanded HHVBP Model.

4. DMEPOS Requirements for Identical Replacement Items

In section V.A. of this proposed rule, we would clarify that while an order would continue to be required for replacement of DMEPOS items, a new face-to-face encounter would not need to occur to support payment for these DMEPOS items.

5. Provider Enrollment and DMEPOS Accreditation

We are proposing a number of Medicare provider enrollment provisions to strengthen and clarify certain aspects of the provider enrollment process. These include, but are not limited to, the following:

- Adding grounds for denying or revoking a provider's or supplier's Medicare enrollment.
- Expanding the reasons for which CMS can apply a retroactive effective date for provider and supplier revocations.
- CMS can currently impose a reapplication bar of up to 10 years if the provider or supplier is denied enrollment for submitting false or misleading information on or with their enrollment application. (This means they cannot reapply to Medicare for up to 10 years.) We propose to expand this to permit a reapplication bar regardless of the denial reason.

We believe these revisions would help keep unqualified providers and suppliers out of the Medicare program, which, in turn would prevent improper Medicare payments to such parties.

We also propose several minor changes to our DMEPOS accreditation provisions in § 424.58, such as proposing a timeframe by which an accrediting organization must report suspected fraud, waste, or abuse to CMS. We believe these changes would help improve the DMEPOS accreditation program's efficiency.

6. DME Benefit Expansion for Infusion Pumps and Drugs

In section V.C. of this proposed rule, we propose to revise the definition of DME at 42 CFR 414.202 to implement section 6222(a) of the CAA, 2026 by providing that certain external infusion pumps, associated home infusion drugs, or other associated supplies are treated as meeting the ''appropriate for use in the home'' requirement when specified statutory criteria are satisfied.

7. DMEPOS Competitive Bidding Program—Country of Origin

In section VI. of this proposed rule, we discuss our request to revise the collection currently approved under OMB Control Number 0938–1408 (CMS–10744) to collect from DMEPOS CBP contract suppliers the country of origin for the lead items furnished during the DMEPOS CBP contract's period of performance.

As done historically with the product information reported on Form C by a DMEPOS CBP contract supplier, the reported country of origin information would be populated in the Medicare Supplier Directory for the contract supplier during the contract period of performance.

C. Summary of the Regulatory Impact Analysis

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TABLE 1: SUMMARY OF ECONOMIC COSTS AND TRANSFERS, BY PROPOSED PROVISION

Provision Description	Costs and Cost Savings	Transfers	Other Notes
CY 2027 HH PPS Payment Rate Update		The overall economic impact related to the proposed changes in payments under the HH PPS for CY 2027 is estimated to be $420 million (2.4 percent). The $420 million increase in estimated payments for CY 2027 reflects the effects of the CY 2027 proposed home health payment update percentage of 2.1. percent ($370 million increase), and an estimated 0.3 percent increase that reflects the effects of an updated FDL ($50 million increase).	To ensure that home health payments are consistent with statutory payment authority for CY 2027.
HH QRP	There are no anticipated changes to burden related to the HH QRP proposals.		
Expanded HHVBP Model		The overall economic impact of the expanded HHVBP Model for CYs 2023 through 2027 is an estimated $3.376 billion in total savings to FFS Medicare from a reduction in unnecessary hospitalizations and SNF usage as a result of greater quality improvements in the HH industry. As for payments to HHAs, there are no aggregate increases or decreases expected to be applied to HHAs competing in the expanded HHVBP Model.	
DMEPOS Requirements for Identical Replacement Items			The fiscal impact of this proposed clarification cannot be estimated as it only identifies whether a face-to-face encounter is required for payment for replacement of DMEPOS items.
Provider Enrollment and DMEPOS Accreditation	We project an annual cost of approximately $1.4 million to conduct the State surveys or accreditations for reactivating hospices.	We estimate an annual transfer from Medicare providers and suppliers to the federal government of approximately $82 million. This would stem from our expansion of the grounds for which we can retroactively revoke providers and suppliers.	
DME Benefit Expansion for Infusion Pumps and Drugs		The expansion is estimated to result in net savings to Medicare of approximately $800,000 per year.	Beneficiaries may be able to choose to receive additional drugs via home infusion that are currently only available in an outpatient healthcare setting.
Country of Origin	We anticipate a minimal financial impact for DMEPOS contract suppliers as we believe they will be familiar with the DMEPOS they provide and should be able to identify the country of origin based on the markings on the product or by obtaining documentation from the manufacturer. The estimated burden estimates for DMEPOS contract suppliers are included in the COI section. Details about this proposed update to Form C will be shared before the required reporting period in CMS's request to revise to OMB Information Collection Request Control No. 0938-1408 (CMS-10744), which will occur closer to when Round 2028 is implemented. Because Form C is a contracting form, it will only be needed once a new round begins.		

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II. Home Health Prospective Payment System

A. Overview of the Home Health Prospective Payment System

1. Statutory Background

Section 1895(b)(1) of the Act requires the Secretary to establish a Home Health Prospective Payment System (HH PPS) for all costs of home health services paid under Medicare. Section 1895(b)(2)(A) of the Act requires that, in defining a prospective payment amount, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services. In accordance with the statute, as amended by the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), we issued a final rule which appeared in the July 3, 2000, **Federal Register** (65 FR 41128) to implement the HH PPS legislation.

Section 5201(c) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted February 8, 2006) added new section 1895(b)(3)(B)(v) to the Act, requiring home health agencies (HHAs) to submit data for purposes of measuring health care quality, and linking the quality data submission to the annual applicable home health payment update percentage increase. This data submission requirement is applicable for CY 2007 and each subsequent year. Pursuant to section 1895(b)(3)(B)(v)(I) of the Act, if an HHA does not submit quality data, the home health market basket percentage increase is reduced by 2 percentage

points. In the November 9, 2006, **Federal Register** (71 FR 65935), we issued a final rule to implement the pay-for-reporting requirement of the DRA, which was codified at § 484.225(h) and (i) in accordance with the statute. The pay-for-reporting requirement was implemented on January 1, 2007.

Section 51001(a)(1)(B) of the Bipartisan Budget Act of 2018 (BBA of 2018) (Pub. L. 115–123) amended section 1895(b) of the Act to require a change to the home health unit of payment to 30-day periods beginning January 1, 2020. Section 51001(a)(2)(A) of the BBA of 2018 added a new subclause (iv) under section 1895(b)(3)(A) of the Act, requiring the Secretary to calculate a standard prospective payment amount (or amounts) for 30-day units of service furnished that end during the 12-month period beginning January 1, 2020, in a budget neutral manner, such that estimated aggregate expenditures under the HH PPS during CY 2020 are equal to the estimated aggregate expenditures that otherwise would have been made under the HH PPS during CY 2020 in the absence of the change to a 30-day unit of service. Section 1895(b)(3)(A)(iv) of the Act requires that the calculation of the standard prospective payment amount (or amounts) for CY 2020 be made before the application of the annual update to the standard prospective payment amount as required by section 1895(b)(3)(B) of the Act.

Additionally, section 1895(b)(3)(A)(iv) of the Act requires that in calculating the standard prospective payment amount (or amounts), the Secretary must make assumptions about behavior changes that could occur as a result of the implementation of the 30-day unit of service under section 1895(b)(2)(B) of the Act and case-mix adjustment factors established under section 1895(b)(4)(B) of the Act. Section 1895(b)(3)(A)(iv) of the Act further requires the Secretary to provide a description of the behavior assumptions made in notice and comment rulemaking. CMS finalized these behavior assumptions in the CY 2019 HH PPS final rule with comment period (83 FR 56461).

Section 51001(a)(2)(B) of the BBA of 2018 also added a new subparagraph (D) to section 1895(b)(3) of the Act. Section 1895(b)(3)(D)(i) of the Act requires the Secretary annually to determine the impact of differences between assumed behavior changes, as described in section 1895(b)(3)(A)(iv) of the Act, and actual behavior changes on estimated aggregate expenditures under the HH PPS with respect to years beginning with 2020 and ending with 2026. Section 1895(b)(3)(D)(ii) of the Act requires the Secretary, at a time and in a manner determined appropriate, through notice and comment rulemaking, to provide for one or more permanent increases or decreases to the standard prospective payment amount (or amounts) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures, as determined under section 1895(b)(3)(D)(i) of the Act. Additionally, section 1895(b)(3)(D)(iii) of the Act requires the Secretary, at a time and in a manner determined appropriate, through notice and comment rulemaking, to provide for one or more temporary increases or decreases to the payment amount for a unit of home health services for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures, as determined under section 1895(b)(3)(D)(i) of the Act. Such a temporary increase or decrease shall apply only with respect to the year for which such temporary increase or decrease is made, and the Secretary shall not take into account such a temporary increase or decrease in computing the payment amount for a unit of home health services for a subsequent year. Finally, section 51001(a)(3) of the BBA of 2018 amends section 1895(b)(4)(B) of the Act by adding a new clause (ii) to require the Secretary to eliminate the use of therapy thresholds in the case-mix system for CY 2020 and subsequent years.

Division FF, section 4136 of the Consolidated Appropriations Act, 2023 (CAA, 2023) (Pub. L. 117–328) amended section 1834(s)(3)(A) of the Act to require that, beginning with 2024, the separate payment for furnishing negative pressure wound therapy (NPWT) be for just the device and not for nursing and therapy services. Payments for nursing and therapy services are to be included as part of payments under the HH PPS. The separate payment for 2024 was required to be equal to the supply price used to determine the relative value for the service under the Medicare Physician Fee Schedule (as of January 1, 2022) for the applicable disposable device updated by the percentage increase in the Consumer Price Index for All Urban Consumers (CPI–U). The separate payment for 2025 and each subsequent year is to be the payment amount for the previous year updated by the percentage increase in the CPI–U (United States city average) for the 12-month period ending in June of the previous year reduced by the productivity adjustment as described in section 1886(b)(3)(B)(xi)(II) of the Act for such year. The CAA, 2023 also added section 1834(s)(4) of the Act to require that beginning with 2024, as part of submitting claims for the separate payment, the Secretary shall accept, and process claims submitted using the type of bill that is most commonly used by home health agencies to bill services under a home health plan of care.

2. Current System for Payment of Home Health Services

For home health periods of care beginning on or after January 1, 2020, Medicare makes payment under the HH PPS on the basis of a national, standardized 30-day period payment rate that is adjusted for case-mix and area wage differences in accordance with section 51001(a)(1)(B) of the BBA of 2018. The national, standardized 30-day period payment rate includes payment for the six home health disciplines (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services). Payment for non-routine supplies (NRS) is also part of the national, standardized 30-day period rate. Durable medical equipment (DME) provided as a home health service, as defined in section 1861(m)(5) of the Act, is paid the fee schedule amount or is paid through the competitive bidding program and such payment is not included in the national, standardized 30-day period payment amount. Additionally, the 30-day period payment rate does not include payment for certain injectable osteoporosis drugs and disposable negative pressure wound therapy (dNPWT) devices, but such drugs and devices must be billed by the HHA while a patient is under a home health plan of care, as the law requires separate consolidated billing of certain osteoporosis drugs and dNPWT devices.

To better align payment with patient care needs and to better ensure that clinically complex and ill beneficiaries have adequate access to home health care, in the CY 2019 HH PPS final rule with comment period (83 FR 56406), we finalized case-mix methodology refinements, including the removal of therapy thresholds, through the Patient-Driven Groupings Model (PDGM) for home health periods of care beginning on or after January 1, 2020. The PDGM did not change eligibility or coverage criteria for Medicare home health services, and if the individual meets the criteria for home health services as described at 42 CFR 409.42, the individual can receive Medicare home health services, including therapy services. For more information about the

role of therapy services under the PDGM, we refer readers to the Medicare Learning Network (MLN) Matters article SE20005 available at *https://www.cms.gov/regulations-and-guidance guidancetransmittals2020-transmittals/se20005.* To adjust for case-mix for 30-day periods of care beginning on and after January 1, 2020, the HH PPS uses a 432-category case-mix classification system to assign patients to a home health resource group (HHRG) using patient characteristics and other clinical information from Medicare claims and the Outcome and Assessment Information Set (OASIS) instrument. These 432 HHRGs represent the different payment groups based on five main case-mix categories under the PDGM, as shown in figure B1. Each HHRG has an associated case-mix weight that is used in calculating the payment for a 30-day period of care. For periods of care with visits less than the low-utilization payment adjustment (LUPA) threshold for the HHRG, Medicare pays national per-visit rates based on the discipline(s) providing the services. Medicare also adjusts the national standardized 30-day period payment rate for certain intervening events that are subject to a partial payment adjustment. For certain cases that exceed a specific cost threshold, an outlier adjustment may also be available.

Under this case-mix methodology, case-mix weights are generated for each of the different PDGM payment groups by regressing resource use for each of the five categories (admission source, timing, clinical grouping, functional impairment level, and comorbidity adjustment) using a fixed effects model. A detailed description of each of the case-mix variables under the PDGM have been described previously, and we refer readers to the CY 2021 HH PPS final rule (85 FR 70303 through 70305) for further information.

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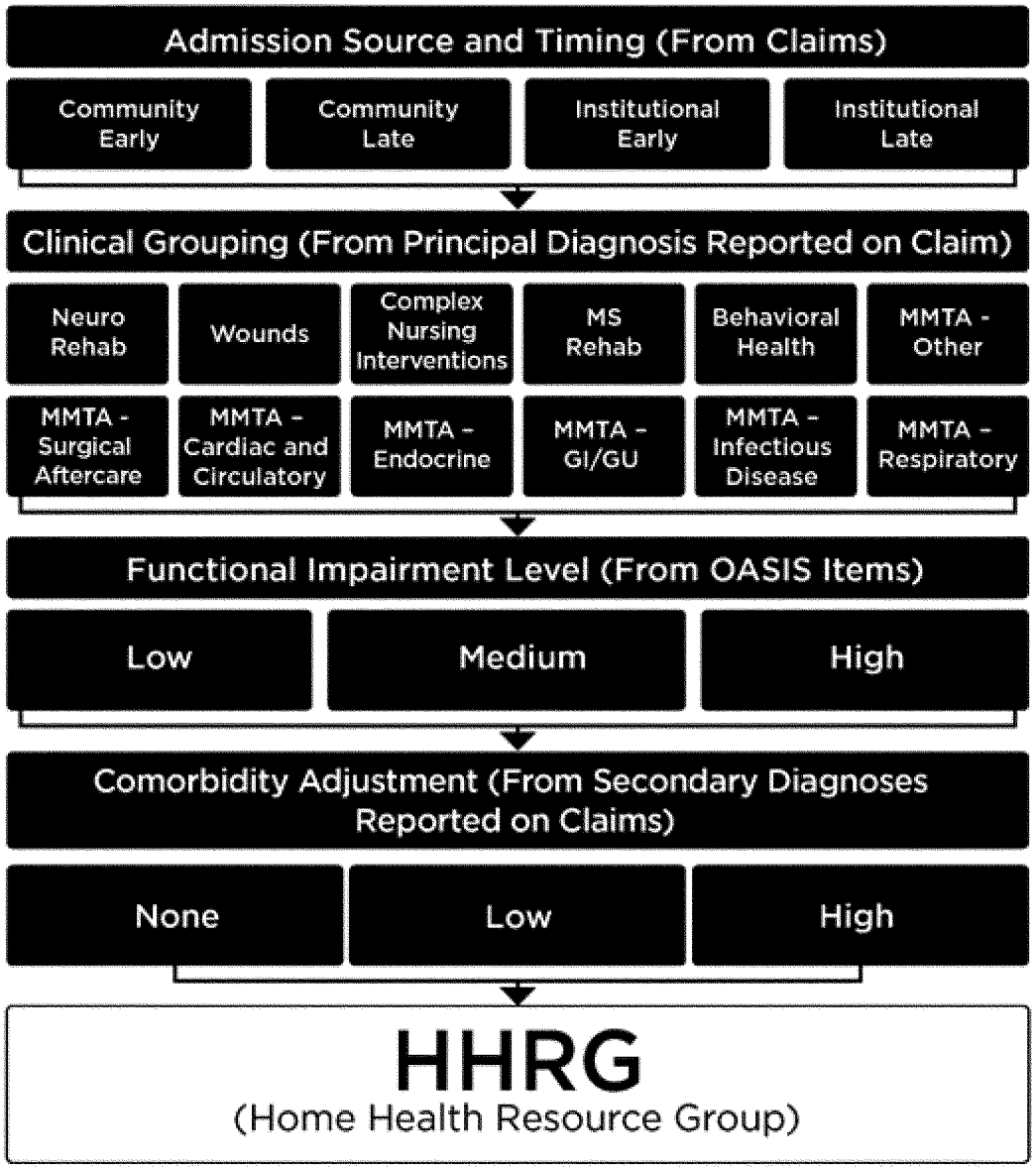
FIGURE 1: CASE-MIX VARIABLES IN THE PDGM



Notes: MMTA (Medication Management, Teaching and Assessment), MS (Musculoskeletal), GI (Gastrointestinal tract), GU (Genitourinary system)

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B. Monitoring the Effects of the Implementation of the PDGM

1. Routine PDGM Monitoring

CMS routinely analyzes Medicare home health benefit utilization, including but not limited to, overall total 30-day periods of care and average periods of care per HHA user; distribution of the type of visits in a 30-day period of care; the percentage of periods that receive the LUPA; estimated costs for 30-day period of care; the percentage of 30-day periods of care by clinical group, comorbidity adjustment, admission source, timing, and functional impairment level; the proportion of 30-day periods of care with and without any therapy visits, nursing visits, and/or aide/social worker visits; and number of home health visits using telecommunications technology and remote patient monitoring. For the monitoring included in this rule, we examine simulated data for CYs 2018 and 2019 and actual data for CYs 2020, 2021, 2022, 2023, 2024, and 2025 for 30-day periods of care. We refer readers to the CY 2022 HH PPS final rule (*86 FR 35881*) for discussion about simulated data for CYs 2018 and 2019.

(a) Utilization

Table 2 shows the overall utilization of home health services. This data indicates the average number of 30-day periods of care per unique HHA beneficiary was higher in CY 2025 compared to CYs 2021, 2022, and 2023. The data also indicates that overall, the number of 30-day periods of care decreased between CY 2018 and CY

2025. Table 3 shows the average utilization of visits per 30-day period of care by home health discipline. Table 4 shows the proportion of 30-day periods of care that are LUPAs and the average number of visits per discipline of those LUPA 30-day periods of care over time. The data show a decreasing trend in the average number of visits per 30-day period and average number of visits per discipline for LUPA 30-day periods of care between CY 2018 and CY 2025.

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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.

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.

TABLE 4: THE PROPORTION OF 30-DAY PERIODS OF CARE THAT ARE LUPAs AND THE AVERAGE NUMBER OF VISITS BY HOME HEALTH DISCIPLINE FOR LUPA HOME HEALTH PERIODS, CYs 2018-2025

	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Total LUPA % of Overall 30-day Periods	6.70%	6.80%	8.7%	7.9%	7.8%	6.9%	6.9%	6.6%
Discipline (Average # visits for LUPA home health periods)								
Skilled Nursing	1.15	1.14	1.19	1.12	1.08	0.99	0.99	0.98
Physical Therapy	0.43	0.46	0.53	0.55	0.60	0.51	0.52	0.52
Occupational Therapy	0.07	0.07	0.08	0.08	0.09	0.07	0.08	0.08
Speech Therapy	0.02	0.02	0.02	0.02	0.02	0.02	0.02	0.02
Home Health Aide	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Social Worker	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
Total (all disciplines)	1.69	1.71	1.84	1.79	1.81	1.61	1.63	1.62

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.

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(b) Analysis of 2024 Cost Report Data for 30-Day Periods of Care

In the CY 2026 HH PPS proposed rule (90 FR 29120), we provided a summary of analysis on FY 2023 HHA cost report data, as this was the most recent and complete cost report data at the time of rulemaking, and CY 2024 claims to estimate 30-day period of care costs. Our analysis showed that the CY 2024 national, standardized 30-day period payment rate of $2,038.13, was approximately 32 percent more than the estimated CY 2024 estimated 30-day period cost of $1,548.39.

Using this same process in this proposed rule to compare home health payment to costs, we examined 2024 HHA Medicare cost reports (CMS Form 1728–20, OMB No. 0938–0222), as this is the most recent and complete cost report data at the time of rulemaking. We also examined CY 2025 home health claims to estimate 30-day period of care costs. We excluded LUPAs and partial payment adjustments when calculating the average number of visits. We used the 2024 average NRS costs per visit, which was $4.89. To update the estimated 30-day period of care costs, we begin with the 2024 average costs per visit with NRS for each discipline and multiply that amount by the CY 2025 home health payment update percentage of 2.7 percent (or a home health payment update factor of 1.027). We then multiplied that amount for each discipline by the 2025 average number of visits by discipline to determine the 2025 estimated 30-day period costs. Table 5 shows the estimated average costs for 30-day periods of care by discipline with NRS and the total 30-day period of care costs with NRS for CY 2025.

TABLE 5: ESTIMATED AVERAGE COSTS FOR 30-DAY PERIODS OF CARE IN CY 2025

Discipline	2024 Average Cost per Visit	2025 Average Number of Visits	2025 Market Basket Update	2025 Estimated 30-Day Period Costs
Skilled Nursing	$186.76	4.02	1.027	$771.05
Physical Therapy	$180.76	2.88	1.027	$534.64
Occupational Therapy	$178.53	0.76	1.027	$139.35
Speech Pathology	$210.08	0.13	1.027	$28.05
Medical Social Services	$311.88	0.04	1.027	$12.81
Home Health Aide	$114.27	0.40	1.027	$46.94
Total				$1,532.84

Source: 2024 Medicare cost report data obtained in January 2026. Home health visit information came from 30-day periods with a through date in CY 2025 (Obtained from the CCW VRDC on January 15, 2026).
Note: The average number of visits in CY 2025 excludes LUPAs and PEPs.

The CY 2025 national standardized 30-day period payment rate was $2,057.35, which is approximately 34 percent more than the CY 2025 estimated 30-day period cost of $1,532.84. Moreover, as shown in table 3 in this proposed rule, HHAs have reduced visits under PDGM in CY 2025.

(c) Clinical Groupings and Comorbidities

Each 30-day period of care is grouped into one of 12 clinical groups, which describes the primary reason for which a patient is receiving home health services under the Medicare home health benefit. The clinical grouping is based on the principal diagnosis reported on the home health claim. Table 6 shows the distribution of the 12 clinical groups over time.

TABLE 6: DISTRIBUTION OF 30-DAY PERIODS OF CARE BY THE 12 PDGM CLINICAL GROUPS, CYs 2018-2025

Clinical Grouping	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Behavioral Health	1.7%	1.5%	2.3%	2.4%	2.3%	2.2%	2.1%	2.2%
Complex Nursing	2.6%	2.5%	3.5%	3.3%	3.2%	3.1%	3.1%	3.1%
MMTA – Cardiac	16.5%	16.1%	18.9%	18.5%	17.9%	17.5%	17.1%	16.8%
MMTA – Endocrine	17.3%	17.4%	7.2%	6.9%	6.8%	7.0%	7.1%	7.3%
MMTA – GI/GU	2.2%	2.3%	4.7%	4.7%	4.9%	5.0%	5.2%	5.2%
MMTA – Infectious	2.9%	2.7%	4.8%	4.6%	4.6%	4.7%	4.8%	4.8%
MMTA – Other	4.7%	4.7%	3.1%	3.6%	3.5%	3.7%	3.8%	3.9%
MMTA – Respiratory	4.3%	4.1%	7.8%	8.0%	7.8%	7.2%	7.0%	6.6%
MMTA – Surgical Aftercare	1.8%	1.8%	3.6%	3.4%	3.4%	3.5%	3.5%	3.5%
MS Rehab	17.1%	17.3%	19.4%	19.8%	20.8%	21.2%	21.4%	21.5%
Neuro Rehab	14.4%	14.5%	10.5%	10.9%	11.0%	10.9%	10.8%	10.8%
Wound	14.5%	15.1%	14.2%	13.9%	13.7%	14.0%	14.1%	14.2%

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.

Thirty-day periods of care receive a comorbidity adjustment category based on certain secondary diagnoses reported on home health claims. These diagnoses are based on a home health specific list of clinically and statistically significant secondary diagnosis subgroups with similar resource use. We refer readers to section II.D. of this proposed rule and

the CY 2020 HH PPS final rule with comment period (*84 FR 60493*) for further information on the comorbidity adjustment categories. Home health 30-day periods of care can receive a low or a high comorbidity adjustment, or no comorbidity adjustment. Table 7 shows the distribution of 30-day periods of care by comorbidity adjustment category for all 30-day periods.

TABLE 7: DISTRIBUTION OF 30-DAY PERIODS OF CARE BY COMORBIDITY ADJUSTMENT CATEGORY FOR 30-DAY PERIODS, CYs 2018-2025

Comorbidity Adjustment	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
None	55.6%	52.0%	49.1%	49.6%	37.3%	30.7%	29.1%	24.1%
Low	35.3%	38.0%	36.9%	36.8%	47.8%	52.6%	55.4%	58.3%
High	9.2%	10.0%	14.0%	13.5%	14.9%	16.7%	15.4%	17.6%

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: The average case mix weight for each clinical group includes all 30-day periods regardless of other adjustments (for example admission source, timing, comorbidities, etc.). 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

(d) Admission Source and Timing

Each 30-day period of care is classified into one of two admission source categories—community or institutional, depending on what healthcare setting was utilized in the 14 days prior to receiving home health care. Thirty-day periods of care for beneficiaries with any inpatient acute care hospitalizations, inpatient psychiatric facility (IPF) stays, skilled nursing facility (SNF) stays, inpatient rehabilitation facility (IRF) stays, or long-term care hospital (LTCH) stays within 14-days prior to a home health admission are designated as institutional admissions. The institutional admission source category also includes patients that had an acute care hospital stay during a previous 30-day period of care and within 14 days prior to the subsequent, contiguous 30-day period of care and for which the patient was not discharged from home health and readmitted. All other 30-day periods of care would be designated as community admissions.

Thirty-day periods of care are classified as ''early'' or ''late'' depending on when they occur within a sequence of 30-day periods of care. The first 30-day period of care is classified as early and all subsequent 30-day periods of care in the sequence (second or later) are classified as late. A subsequent 30-day period of care would not be considered early unless there is a gap of more than 60 days between the end of one previous period of care and the start of another. Information regarding the timing of a 30-day period of care comes from Medicare home health claims data and not the OASIS assessment to determine if a 30-day period of care is ''early'' or ''late''. Table 8 shows the distribution of 30-day periods of care by admission source and period timing.

TABLE 8: DISTRIBUTION OF 30-DAY PERIODS OF CARE BY ADMISSION SOURCE AND PERIOD TIMING, CYs 2018-2025

Admission Source	Period Timing	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Community	Early	13.5%	13.8%	12.4%	11.6%	11.7%	11.6%	11.5%	11.6%
Community	Late	61.1%	60.9%	61.8%	63.7%	63.1%	63.1%	63.5%	64.2%
Institutional	Early	18.6%	18.4%	20.0%	18.6%	19.2%	19.3%	18.8%	18.3%
Institutional	Late	6.8%	6.9%	5.8%	6.1%	6.0%	6.1%	6.1%	6.0%

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.

(e) Functional Impairment Level

Each 30-day period of care is placed into one of three functional impairment levels (low, medium, or high) based on responses to certain OASIS functional items associated with grooming, bathing, dressing, ambulating, transferring, and risk for hospitalization. The specific OASIS items that are used for the functional impairment level are found in table 7 in the CY 2020 HH PPS final rule with comment period (*84 FR 60490*). Responses to these OASIS items are grouped together into response categories with similar resource use and each response category has associated points. A more detailed description as to how these response categories were established can be found in the technical report, ''Overview of the Home Health Groupings Model'' posted on the HHA web page [1]. The sum of these points results in a functional impairment score used to group 30-day periods of care into a functional impairment level with similar resource use. The scores associated with the functional impairment levels vary by clinical group to account for differences in resource utilization. A patient's functional impairment level remains the same for the first and second 30-day periods of care unless there is a significant change in condition that warrants an ''other follow-up'' assessment prior to the second 30-day period of care. For each 30-day period of care, the Medicare claims processing system looks for occurrence code 50 on the claim to correspond to the M0090 date of the applicable assessment. Table 9 shows the distribution of 30-day periods by functional impairment level.

TABLE 9: DISTRIBUTION OF 30-DAY PERIODS OF CARE BY FUNCTIONAL IMPAIRMENT LEVEL, CYs 2018-2025

Functional Impairment Level	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Low	33.9%	31.9%	25.7%	23.3%	28.1%	29.8%	30.4%	29.3%
Medium	34.9%	35.5%	32.7%	32.6%	33.1%	31.8%	31.8%	32.7%
High	31.2%	32.6%	41.7%	44.2%	38.8%	38.4%	37.8%	38.0%

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.

[1] *https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health/home-health-patient-driven-groupings-model.*

(f) Therapy and Non-Therapy Visits

Beginning in CY 2020, section 1895(b)(4)(B)(ii) of the Act eliminated the use of therapy thresholds in calculating payments for CY 2020 and subsequent years. Prior to implementation of the PDGM, HHAs could receive an adjustment to payment based on the number of therapy visits provided during a 60-day episode of care. We examined the proportion of actual 30-day periods of care with and without therapy visits. To be covered as skilled therapy, the services must require the skills of a qualified therapist (that is, PT, OT, or SLP) or qualified therapist assistant and must be reasonable and necessary for the treatment of the patient's illness or injury. As shown in table 4, we monitor the number of visits per 30-day period of care by each home health discipline. Any 30-day period of care can include both therapy and non-therapy visits. If any 30-day period of care consisted of only visits for PT, OT, or SLP, then this 30-day period of care is considered ''therapy only''. If any 30-day period of care consisted of only visits for skilled nursing, home health aide, or social worker, then this 30-day period of care is considered ''no therapy''. If any 30-day period of care consisted of at least one therapy visit and one non-therapy visit, then this 30-day period of care is considered ''therapy + non-therapy''. Table10 shows the proportion of 30-day periods of care with only therapy visits, at least one therapy visit and one non-therapy visit, and no therapy visits. Figure 2 shows the proportion of 30-day periods of care by the number of therapy visits (excluding zero) provided during 30-day periods of care.

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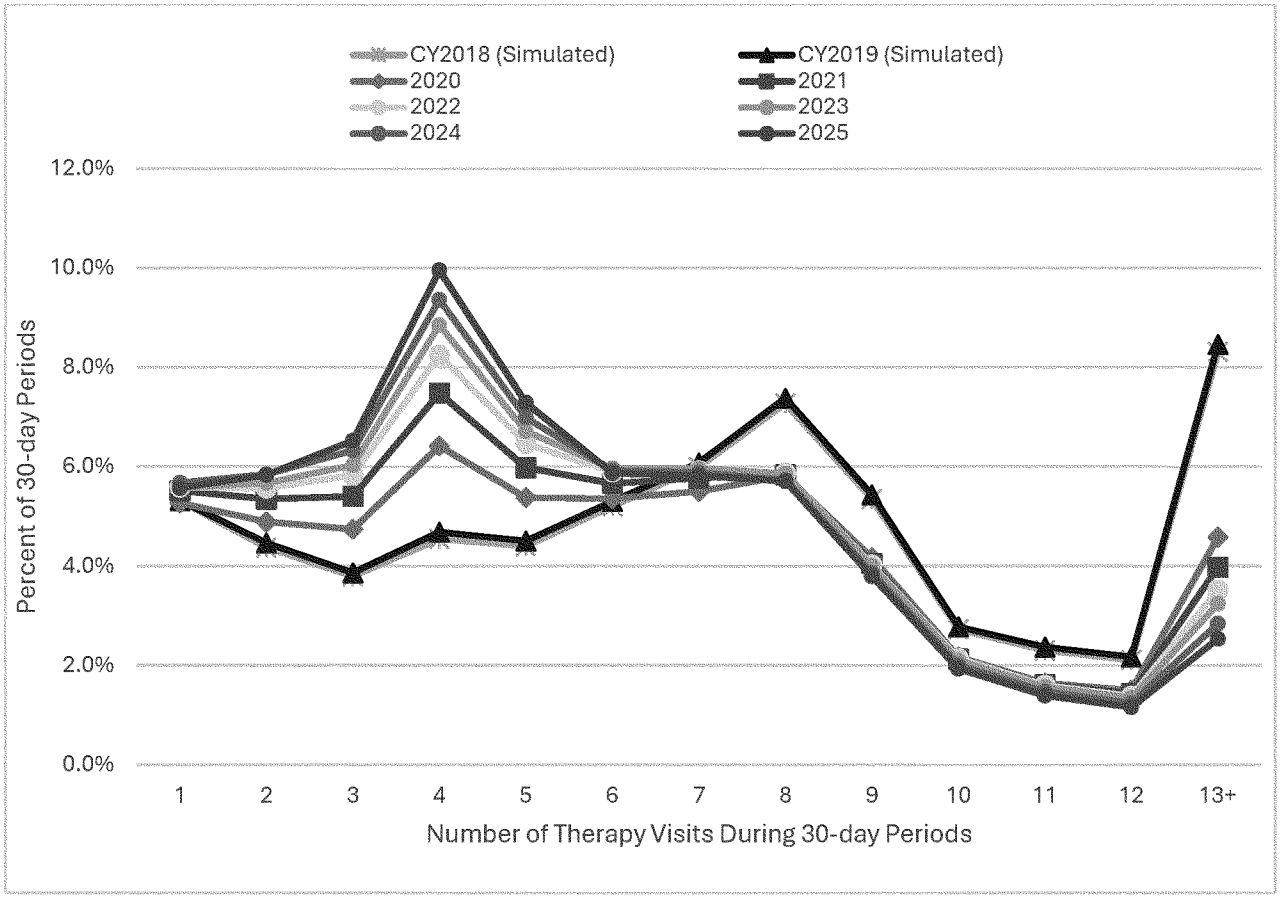
TABLE 10: PROPORTION OF 30-DAY PERIODS OF CARE WITH ONLY THERAPY, AT LEAST ONE THERAPY VISIT + NON-THERAPY VISIT, AND NO THERAPY VISITS FOR CYs 2018-2025

30-day Period Visit Type	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Therapy Only	13.5%	14.4%	15.2%	17.7%	19.3%	20.0%	20.4%	20.9%
Therapy + Non-Therapy	48.2%	48.4%	42.2%	42.5%	42.7%	42.8%	42.7%	42.4%
No Therapy	38.3%	37.2%	42.6%	39.8%	38.0%	37.2%	36.9%	36.6%
Total 30-day periods	**9,336,898**	**8,744,171**	8,423,688	9,269,971	8,593,266	8,319,064	8,275,089	7,719,986

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.

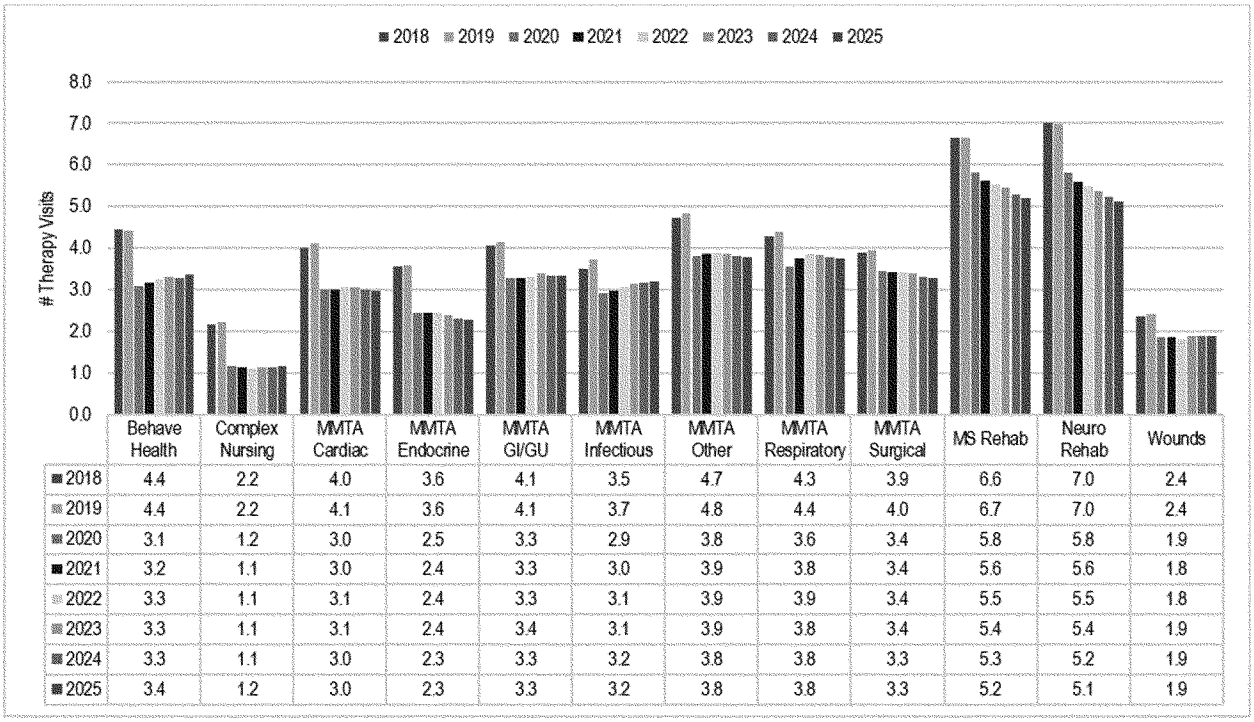
FIGURE 2: PROPORTION OF 30-DAY PERIODS BY THE NUMBER OF THERAPY VISITS DURING 30-DAY PERIODS, CYs 2018-2025



Source: CY 2018 and CY 2019 simulated PDGM data with behavioral assumptions came from the Home Health LDS. CY 2020 PDGM data was accessed from the CCW VRDC on July 12, 2021. CY 2021 PDGM data accessed from the CCW VRDC on July 14, 2022. CY 2022 PDGM data was accessed from the CCW VRDC on July 13, 2023. CY 2023 PDGM 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.

Both figures 2 and 3 indicate there have been changes in the distribution of both therapy and non-therapy visits in CY 2025 compared to CY 2024. For example, the proportion of 30-day periods with one through five therapy visits during a 30-day period increased in CY 2025 compared to prior years. However, when comparing therapy utilization from before the PDGM (CYs 2018 and 2019) to after the implementation of the PDGM (CYs 2020–2025), we also see stabilization in overall therapy visits across all clinical groups, as shown in figure 3.

FIGURE 3: AVERAGE THERAPY VISITS PER 30-DAY PERIOD BY CLINICAL GROUP, CYs 2018-2025



	Behave Health	Complex Nursing	MMTA Cardiac	MMTA Endocrine	MMTA GI/GU	MMTA Infectious	MMTA Other	MMTA Respiratory	MMTA Surgical	MS Rehab	Neuro Rehab	Wounds
2018	4.4	2.2	4.0	3.6	4.1	3.5	4.7	4.3	3.9	6.6	7.0	2.4
2019	4.4	2.2	4.1	3.6	4.1	3.7	4.8	4.4	4.0	6.7	7.0	2.4
2020	3.1	1.2	3.0	2.5	3.3	2.9	3.8	3.6	3.4	5.8	5.8	1.9
2021	3.2	1.1	3.0	2.4	3.3	3.0	3.9	3.8	3.4	5.6	5.6	1.8
2022	3.3	1.1	3.1	2.4	3.3	3.1	3.9	3.9	3.4	5.5	5.5	1.8
2023	3.3	1.1	3.1	2.4	3.4	3.1	3.9	3.8	3.4	5.4	5.4	1.9
2024	3.3	1.1	3.0	2.3	3.3	3.2	3.8	3.8	3.3	5.3	5.2	1.9
2025	3.4	1.2	3.0	2.3	3.3	3.2	3.8	3.8	3.3	5.2	5.1	1.9

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.

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We also examined the proportion of 30-day periods of care with and without skilled nursing, social work, or home health aide visits. Table 11 shows the number of 30-day periods of care with only skilled nursing visits, at least one skilled nursing visit and one other visit type (therapy or non-therapy), and no skilled nursing visits. Table 12 shows the number of 30-day periods of care with and without home health aide or social worker visits.

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TABLE 11: PROPORTION OF 30-DAY PERIODS OF CARE WITH ONLY SKILLED NURSING, SKILLED NURSING + OTHER VISIT TYPE, AND NO SKILLED NURSING VISITS FOR CYs 2018-2025

30-day Period Visit Type	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Skilled Nursing Only	33.8%	33.1%	38.5%	36.2%	34.7%	34.1%	34.0%	33.9%
Skilled Nursing + Other	51.6%	51.5%	45.3%	45.0%	45.0%	44.8%	44.6%	44.2%
No Skilled Nursing	14.7%	15.5%	16.2%	18.8%	20.4%	21.1%	21.4%	21.9%
Total 30-day periods	9,336,898	8,744,171	8,423,688	9,269,971	8,593,266	8,319,064	8,275,089	7,719,986

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.

TABLE 12: PROPORTION OF 30-DAY PERIODS OF CARE WITH AND WITHOUT HOME HEALTH AIDE AND/OR SOCIAL WORKER VISITS FOR CYs 2018-2025

30-day Period Visit Type	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Any HH aide and/or social worker	16.6%	15.9%	13.2%	12.2%	11.3%	10.9%	10.3%	9.8%
No HH aide and/or social worker	83.4%	84.1%	86.8%	87.8%	88.7%	89.1%	89.7%	90.2%
Total 30-day periods	9,336,898	8,744,171	8,423,688	9,269,971	8,593,266	8,319,064	8,275,089	7,719,986

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.

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(g) Home Health Services Using Telecommunications Technology

As discussed in the CY 2023 final rule (*87 FR 66858*), we began collecting data on the use of telecommunications technology used during a home health period using three G-codes reported on home health claims. Collecting data on services furnished via telecommunications technology on claims allows CMS to analyze the characteristics of patients using services provided remotely. The monitoring illustrates which services are most frequently furnished via telecommunication technology and generally how long remote patient monitoring is utilized.

We began collecting this information from HHAs on a voluntary basis on January 1, 2023, and have required this information to be reported on claims starting on July 1, 2023 (*87 FR 66858*). The three G-codes help identify when home health services are furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system

(G0320); synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications systems (G0321); and the collection of physiologic data digitally stored and/or transmitted by the patient to the HHA, that is, remote patient monitoring (G0322). We capture the usage and length of remote patient monitoring using the start date of the remote patient monitoring and the number of days of monitoring indicated on the claim. We also looked at the disciplines most often providing remote patient monitoring. We examined the utilization of telecommunications technology devices during a home health period and remote patient monitoring by looking at home health claims that included the three G-codes. Tables 13 and 14 show that the use of telecommunications services and remote patient monitoring reported on CY 2025 home health claims have declined from prior year's monitoring (90 FR 29126 and 29127) and are mainly associated with skilled nursing.

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TABLE 13: TELEHEALTH VISITS RECORDED ON HOME HEALTH CLAIMS (CYs 2024 and 2025)

Calendar Year (CY)	Claims with at Least 1 Telehealth Visit	Number of Telehealth Visits	Unique Beneficiaries with at Least 1 Telehealth Visit	Unique Providers with at Least 1 Telehealth Visit
CY 2024				
Skilled Nursing	139,730	284,854	96,535	1,087
PT	26,363	43,189	20,950	566
OT	5,422	8,805	4,303	325
SLP	1,470	2,312	1,045	166
Aide	1	1	1	1
MSS	4,675	5,337	4,137	285
CY 2025				
Skilled Nursing	71,451	139,100	49,824	996
PT	11,564	18,003	9,209	473
OT	2,348	3,485	2,071	217
SLP	617	878	479	104
Aide	0	0	0	0
MSS	2,733	2,931	2,553	260

Source: CY 2024 data was accessed from the CCW VRDC on March 13, 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).

TABLE 14: REMOTE PATIENT MONITORING DAYS RECORDED ON HOME HEALTH CLAIMS (CYs 2024 and 2025)

Calendar Year (CY)	Claims with at Least 1 Day of Remote Patient Monitoring	Number of Remote Patient Monitoring Days	Unique Beneficiaries with at Least 1 Day of Remote Patient Monitoring	Unique Providers with at Least 1 Day of Remote Patient Monitoring
CY 2024				
Skilled Nursing	38,513	679,102	20,786	455
PT	694	11,266	535	108
OT	76	1,253	68	26
SLP	124	2,143	79	14
Aide	29	596	23	13
MSS	176	4,148	117	7
CY 2025				
Skilled Nursing	31,057	543,296	16,277	381
PT	503	7,771	389	96
OT	102	1,724	92	33
SLP	114	1,994	66	11
Aide	14	257	13	5
MSS	214	4,074	131	6

Source: CY 2024 data was accessed from the CCW VRDC on March 13, 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).

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C. Proposed CY 2027 Payment Adjustments Under the HH PPS

1. Proposed Behavior Adjustments Under the HH PPS

a. Background

As discussed in section II.A.1. of this proposed rule, starting in CY 2020, the Secretary was required by section 1895(b)(2)(B) of the Act to change the unit of payment under the HH PPS from a 60-day episode of care to a 30-day period of care. CMS was also required to make assumptions about behavior changes that could occur as a result of the implementation of the 30-day unit of payment and the case-mix adjustment factors that eliminated the use of therapy thresholds. In the CY 2019 HH PPS final rule with comment period (83 FR 56455), we finalized three behavior change assumptions which were also described in the CY 2022 and 2023 HH PPS rules (86 FR 35890, 87 FR 37614, and 87 FR 66795 through 66796). In the CY 2020 HH PPS final rule with comment period (84 FR 60519), we included these behavior change assumptions in the calculation of the 30-day budget neutral payment amount for CY 2020, finalizing a negative 4.36 percent behavior change assumption adjustment (''assumed behaviors''). We did not propose any changes for CYs 2021 and 2022 related to the behavior change assumptions finalized in the CY 2019 HH PPS final rule with comment period, or to the negative 4.36 percent behavior change assumption adjustment, finalized in the CY 2020 HH PPS final rule with comment period.

In the CY 2023 HH PPS final rule (87 FR 66796), we stated that we had concluded, based on our annual monitoring at that time, that the three expected behavior changes did in fact occur as a result of the implementation of the PDGM and that other behaviors, such as changes in the provision of therapy and changes in functional impairment levels, had also occurred. We also reminded readers that in the CY 2020 HH PPS final rule with comment period (84 FR 60513), we stated we interpret actual behavior changes to encompass behavior changes that were previously outlined as assumed by CMS, and other behavior changes not identified at the time we established the budget-neutral 30-day payment rate for CY 2020. In the CY 2023 HH PPS final rule (87 FR 66796), we provided supporting evidence that indicated the number of therapy visits declined in CYs 2020 and 2021, as well as a slight decline in therapy visits beginning in CY 2019 after the finalization of the removal of therapy thresholds, but prior to implementation of the PDGM. In section II.B.1. of the CY 2025 HH PPS proposed rule (89 FR 55318), our analysis continued to show the actual 30-day periods are similar overall to the simulated 30-day periods as well as a continued decline in therapy visits, indicating that HHAs changed their behavior to reduce therapy visits. Although the analysis demonstrates evidence of individual behavior changes (for example, in the volume of visits for

LUPAs, therapy sessions, etc.), we use the entirety of the behaviors to calculate estimated aggregate expenditures. The law instructs us to ensure that estimated aggregate expenditures under the PDGM are equal to the estimated aggregate expenditures that otherwise would have been made under the prior system.

Section 4142(a) of the CAA, 2023 required CMS to present, to the extent practicable, a description of the actual behavior changes occurring under the HH PPS from CYs 2020 through 2026. This subsection of the CAA, 2023 also required CMS to provide datasets underlying the simulated 60-day episodes and discuss and provide time for stakeholders to provide input on and ask questions about the payment rate development for CY 2023. CMS complied with these requirements by posting online both the supplemental limited data set (LDS) and descriptive files and the description of actual behavior changes that affected CY 2023 payment rate development. Additionally, on March 29, 2023, CMS conducted a webinar entitled ''Medicare Home Health Prospective Payment System (HH PPS) Calendar Year (CY) 2023 Behavior Change Recap, 60-Day Episode Construction Overview, and Payment Rate Development.'' The webinar was open to the public and discussed the actual behavior changes that occurred upon implementation of the PDGM; our approach used to construct simulated 60-day episodes using 30-day periods; payment rate development for CY 2023; and information on the supplemental data files containing information on the simulated 60-day episodes and actual 30-day periods used in calculating the permanent adjustment to the payment rate. Materials from the webinar, including the presentation and the CY 2023 descriptive statistics from the supplemental LDS files containing information on the number of simulated 60-day episodes and actual 30-day periods in CY 2021 that were used to construct the permanent adjustment to the payment rate, as well as information such as the number of episodes and periods by case-mix group, case-mix weights, and simulated payments, can be found on the Home Health Patient-Driven Groupings Model web page at *https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health/home-health-patient-driven-groupings-model.*

b. Method to Annually Determine the Impact of Differences Between Assumed Behavior Changes and Actual Behavior Changes on Estimated Aggregate Expenditures

In the CY 2023 HH PPS final rule (87 FR 66804), we finalized the methodology to evaluate the impact of the differences between assumed and actual behavior changes on estimated aggregate expenditures. In the CY 2024 HH PPS final rule (88 FR 77687 through 77688), we provided an overview of the methodology with detailed instructions for each step.

Under the prior 153-group system (and the first three years for assessments associated with the PDGM completed prior to CY 2023), HHAs submitted the Outcome and Assessment Information Set (OASIS) instrument version D. However, OMB approved an updated version of the OASIS instrument, OASIS–E under OMB control number 0938–1279,[2] on November 30, 2022, effective January 1, 2023. Therefore, in the CY 2025 HH PPS final rule (89 FR 88364), we finalized two additional methodological assumptions related to mapping and imputation of OASIS–D responses from OASIS–E. We refer readers to the CY 2024 and CY 2025 HH PPS final rules for further information about the methodology.

c. Calculating Permanent and Temporary Payment Adjustments

To adjust the base payment rate based on increases or decreases in estimated aggregate expenditures that result from differences between assumed behavior changes and actual behavior changes for 2020 through 2026, we calculate one or more permanent prospective adjustments by calculating the percent change between the actual 30-day base payment rate and the recalculated 30-day base payment rate. This percent change is converted into an adjustment factor and applied in the annual rate update process.

To account for increases or decreases in estimated aggregate expenditures that result from differences between assumed behavior changes and actual behavior changes from 2020 through 2026, we calculate one or more temporary prospective adjustments by calculating the dollar amount difference between the estimated aggregate expenditures from all 30-day periods using the recalculated 30-day base payment rate, and the aggregate expenditures for all 30-day periods using the actual 30-day base payment rate for each of those years once data is available (87 FR 66804). In other words, when determining the dollar amount of aggregate expenditures in prior years that we must offset in future years, we use the full dataset of actual 30-day periods using both the actual and recalculated 30-day base payment rates to ensure that the utilization and distribution of claims are the same. In accordance with section 1895(b)(3)(D)(iii) of the Act, each temporary adjustment is applied prospectively but, as its name suggests, only with respect to the year for which such temporary increase or decrease is made. Therefore, after we determine the dollar amount we plan to reconcile in a given year, we calculate a temporary adjustment factor to be applied to the base payment rate for that year. The temporary adjustment factor is based on an estimated number of 30-day periods in the next year using historical data trends, and as applicable, controls for any permanent adjustment factor, case-mix weight recalibration neutrality factor, wage index budget neutrality factor, and the home health payment update. The temporary adjustment factor is applied last since the adjustment applies only to the respective year. That is, the temporary adjustment is not permanently fixed into future base payment rates. We refer readers to the CY 2024 HH PPS final rule (88 FR 77689 through 77694) for analysis of CYs 2020 through 2022 claims, the CY 2025 HH PPS final rule (89 FR 88366 through 88369) for analysis of CY 2023 claims, and the CY 2026 HH PPS final rule (90 FR 55365 through 55367) for analysis of CY 2024 claims.

d. CY 2025 Preliminary Claims Results

We stated in the CY 2026 HH PPS final rule (90 FR 55365) that we were exercising our authority expressly delegated under the statute to apply permanent adjustments ''at a time and in a manner appropriate'' not to apply any permanent adjustment for CY 2026 based on CY 2023 or 2024 data, as these years may contain data with behaviors attributable to factors beyond the implementation of the PDGM and a 30-day unit of payment. However, we also noted we will continue to annually analyze the data through CY 2026 claims, as required by law, to determine if any additional permanent adjustments would need to be made based on the impact of assumed versus actual behavior change on estimated aggregate expenditures resulting from the implementation of the PDGM and the 30-day unit of payment. While the law requires us to continue to evaluate the need for any additional permanent

[2] The current expiration date for this information collection request is December 31, 2027.

adjustments in future rulemaking, we reiterate that any additional permanent adjustment(s) would need to be related to actual behavior change resulting only from the implementation of the PDGM and the change in the unit of payment as required by law. Therefore, we will continue to compare estimated aggregate expenditures under the PDGM and the 153-group payment system, using the most recent complete home health claims data available at the time of rulemaking, as required by section 1895(b)(3)(D)(i) of the Act. While the CY 2025 analysis presented in this proposed rule uses the most complete data available at the time, it is considered preliminary and, as more data become available from the latter half of CY 2025, we will update our analysis in the final rule. The CY 2027 HH PPS final rule would use the complete CY 2025 data to determine any permanent and temporary adjustments needed to the CY 2027 payment rate. However, while the claims data and the permanent and temporary adjustments results would be considered complete for CY 2027, any adjustments to future payment rates may be subject to additional considerations such as permanent adjustments taken in previous years.

The claims data used in rulemaking is released in the HH PPS LDS file twice each year, one with the proposed and one with the final rule. Accordingly, the HH PPS LDS file released with this proposed rule includes two files: the actual CY 2025 30-day periods and the CY 2025 simulated 60-day episodes.

We remind readers that a data use agreement (DUA) is required to purchase the CY 2027 proposed HH PPS LDS file using the CMS–R–0235A form under OMB control number 0938–0734. Access would be granted for both the 30-day periods and the simulated 60-day episodes under one DUA. Visit the HH PPS LDS web page for more information.[3] In addition, the proposed CY 2027 Home Health Descriptive Statistics from the LDS Files spreadsheet is available on the HH PPS Regulations and Notices web page,[4] does not require a DUA, and is available at no cost to interested parties. The spreadsheet contains information on the number of simulated 60-day episodes and actual 30-day periods in CY 2025 that were used to determine the adjustments. The spreadsheet also provides information such as the number of episodes and periods by case-mix group, case-mix weights, and simulated payments.

e. Applying the Methodology to CY 2025 Data To Determine the CY 2027 Permanent and Temporary Adjustments

To comply with Section 1895(b)(3)(D)(ii) of the Act, we are required to annually analyze data from CY 2020 through CY 2026 and show the calculations to illustrate how the aggregate expenditures differ from actual and assumed behavior changes. We also continue to analyze differences in aggregate expenditures and calculate what the budget neutral rate would be to understand how the budget neutral rate differs from the actual finalized payment rate for CY 2025. We then determine whether the difference between the budget neutral rate and actual finalized payment rate can be directly attributed to behavior from PDGM implementation as discussed in CY 2026 final rule.

Using the methodology finalized in the CY 2023 HH PPS final rule to apply for all the years in which an adjustment is appropriate, we continue to use actual CY 2025 30-day periods to determine what the proposed permanent and temporary payment adjustments should be to offset for such increases or decreases in estimated aggregate expenditures as a result of the impact of differences between assumed behavior changes and actual behavior changes. We provide tables 15 and 16 to illustrate the same information displayed in prior rules to show the permanent adjustment that would need to be applied if the comparison of the aggregate expenditures were a result of behavior change due to the implementation of the PDGM. However, similar to what was finalized in the CY 2026 HH PPS final rule (90 FR 55364 through 55365), we believe any behavior changes reflected in preliminary CY 2025 claims for this CY 2027 proposed rule are not directly attributable to the PDGM but other confounding factors that began in CY 2023 (that is, continued recalibration of case-mix weights, a change to the OASIS–E, and previous reductions to the home health payment rate). The permanent adjustment calculated will be illustrative as part of our analysis of CY 2025 claims; however, we are not proposing to apply a permanent adjustment to the CY 2027 payment rate, as discussed previously. We show table 17 as another illustrative example showing a calculated permanent adjustment, using CY 2025 aggregate expenditures if we were to determine that the behavior changes that occurred could be directly attributed to the implementation of the PDGM.

Using the preliminary CY 2025 dataset, we began with 8,228,904 30-day periods of care and dropped 444,897 30-day periods of care that had a claim occurrence code 50 date after October 31, 2025. We also excluded 847,700 30-day periods of care that had a claim occurrence code 50 date before January 1, 2025, to ensure the 30-day period will not be part of a simulated 60-day episode that began in CY 2026. Applying the additional exclusions and assumptions as described in the finalized methodology (87 FR 66804), an additional 60,233 30-day periods were excluded.

The Company believes the proposed Observer provisions in the amended By-Laws are consistent with the Act because the Observer position will provide a means for individuals who are employed by, or otherwise affiliated with, an Exchange Member but may not be able, or willing, to serve as a Board member for one reason or another, to now be able to serve the Company in an advisory role and provide such valuable expertise and knowledge to help the Company carry out its business.

Using the preliminary dataset for CY 2025 (6,557,369 actual 30-day periods which made up the 3,860,954 simulated 60-day episodes) we determined the estimated aggregate expenditures using the finalized CY 2025 HH PPS payment rate were lower than the actual estimated aggregate expenditures under the PDGM HH PPS. As shown in table 15, aggregate expenditures under the PDGM were higher than if the 153-group payment system were still in place in CY 2025 and therefore, we determined the CY 2025 30-day base payment rate should have been $1,953.60 based on actual behavior changes.

We determined that for CYs 2020 through CY 2022 a total of −9.480 percent permanent adjustment was needed (after accounting for the −3.925 percent applied to the CY 2023 payment rate, the −2.890 percent applied to the CY 2024 payment rate, and the −1.975 percent applied to the CY 2025 payment rate). The CY 2026 permanent adjustment was calculated using the permanent adjustments already applied to CYs 2023, 2024, and 2025 finalized payment rates and to reach the payment rate reduction needed for CYs 2020 through 2022.

In order to determine behavior changes only applicable to CY 2025, we simulated what the CY 2025 base payment rate would have been if the −1.023 percent adjustment that we determined using CY 2024 claims had been implemented and to compare

[3] *https://www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/home_health_pps_lds.*

[4] *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.*

PDGM claims with 153-group priced claims using 60-day simulated episodes.

To do so, we started with the budget neutral CY 2024 base payment of $1,914.73 generated by CY 2024 simulated 60-day episodes (as published in the CY 2026 HH PPS final rule (90 FR 55366)) and applied the CY 2025 case-mix weights recalibration neutrality factor (1.0039), the CY 2025 wage index budget neutrality factor (0.9988), the CY 2024 labor-related share budget neutrality factor (1.0), and the CY 2025 home health payment update factor (1.027). We determined the CY 2025 base payment rate for assumed behavior would have been $1,971.73.

For the CY 2025 annual permanent adjustment, we calculated the percent change between the two payment rates for only CY 2025. For the CY 2025 annual temporary adjustment we calculated the difference in aggregate expenditures in dollars for all CY 2025 PDGM 30-day claims using the two payment rates. This difference is shown as the retrospective dollar amount we would need to offset payment using one or more temporary adjustments in future years. Our results for the CY 2025 annual (single year) permanent and temporary adjustment calculations using CY 2025 preliminary claims data are shown in table 15.

TABLE 15: ILLUSTRATIVE CY 2025 PERMANENT AND TEMPORARY ADJUSTMENT CALCULATIONS WHEN COMPARING PDGM CLAIMS USING SIMULATED 60-DAY EPISODES

	Budget-neutral 30-day Payment Rate with Assumed Behavior Changes	Budget-neutral 30-day Payment Rate with Actual Behavior Changes	CY 2025 Only Adjustment
Base Payment Rate	$1,971.73*	$1,953.60	**Permanent** -0.919%
Aggregate Expenditures	$16,644,686,086.56**	$15,898,581,794.94	**Temporary** -$746,104,291.62

Source: CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed from the CCW on March 12, 2026.

*The $1,971.73 (shown in table 15) is equal to the recalculated budget neutral 30-day base payment rate of $1,914.73 for CY 2024 multiplied by the CY 2025 recalibration factor (1.0039), CY 2025 wage index budget neutrality factor (0.9988), CY 2025 labor-related share budget neutrality factor (1.0), and the CY 2025 home health payment update factor (1.027).

** The estimated aggregate expenditures for assumed behavior ($16.6 billion), uses the budget neutral CY 2025 payment rate of $2,057.35 as finalized in the CY 2025 HH PPS final rule (89 FR 88424).

As shown in table 15, we illustrate that a permanent prospective adjustment of −0.919 percent to the CY 2027 30-day payment rate (assuming all adjustments from prior years were applied) for CY 2025 would be required to offset for such increases in estimated aggregate expenditures. Again, table 15 is illustrative because we are continuing to limit the calculation of the permanent adjustments to only include data from CYs 2020 through 2022 as finalized in the CY 2026 HH PPS final rule (90 FR 55365 through 55367) and the calculated permanent adjustment does not include implemented permanent adjustments from prior years. We reiterate that any additional permanent adjustment(s) must be determined to be related to actual behavior change resulting only from the implementation of the PDGM and the change in the unit of payment as required by law.

f. CY 2027 Permanent Adjustment and Proposed Temporary Adjustment Calculations

In the preceding section we describe how we analyzed CY 2025 preliminary claims data to determine the effects of actual behavior change on estimated aggregate expenditures. Again, that illustrative analysis included simulations that assumed the full permanent adjustments were already taken. We note that CMS implemented a payment adjustment of −1.975 percent for the CY 2025 payment rate, rather than the −3.95 percent we calculated (89 FR 88373), so the calculations set forth later in this section reflect the remaining adjustments that still needed to be recognized.

Therefore, the calculation in this section includes any of the remaining adjustments not applied in previous years (that is, CYs 2020 through 2024 claims data), as well as the adjustment needed to account for CY 2025 claims. In calculating the full permanent adjustment needed to the CY 2027 30-day payment rate, we compare estimated aggregate expenditures under the PDGM and the prior system. Unlike the annual adjustments described in table 15, we do not assume we made the full adjustment from prior years. This section will also include calculation of a permanent adjustment using the actual CY 2025 payment rate and the budget neutral rate for CY 2025 using the method discussed in the CY 2026 final rule.

As discussed in section II.C.1.d. of this proposed rule, using the preliminary dataset for CY 2025 (6,557,369 actual 30-day periods which made up the 3,860,954 simulated 60-day episodes) we determined the CY 2025 30-day base payment rate should have been $1,953.60 based on actual behavior. We then compared the repriced 30-day base payment rate based

on actual behavior to the CY 2025 30-day base payment rate of $2,057.35 we paid based on assumed behaviors. The percent change, as summarized in table 16, between the actual CY 2025 base payment rate of $2,057.35 (based on assumed behaviors) and the CY 2025 recalculated base payment rate of $1,953.60 (based on actual behaviors) illustrates the total permanent adjustment that would reflect CY 2020 through CY 2025 claims. We conduct this calculation to satisfy the requirements described in section 1895(b)(3)(D)(ii) of the Act to illustrate what the permanent adjustment would be. We consider table 16 illustrative because we are proposing to limit the calculation of the permanent adjustments to only include data from CYs 2020 through 2022 as finalized in the CY 2026 final rule (90 FR 55365 through 55367).

TABLE 16: ILLUSTRATIVE TOTAL PERMANENT ADJUSTMENT FOR CYs 2020 THROUGH 2025 CLAIMS

Actual CY 2025 Base Payment Rate (Assumed Behavior)	Recalculated CY 2025 Base Payment Rate (Actual Behavior)	Total Permanent Prospective Adjustment
$2,057.35	$1,953.60	-5.043%*

Source: CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed on the CCW on March 12, 2026.

*This is the total permanent adjustment based on CY 2025 data which includes the previous permanent adjustment of -1.975% applied. However, as described later, we recognize that for CY 2027 we must also account for adjustment made in CY 2026.

As shown in table 16, a permanent prospective adjustment of −5.043 percent to the CY 2027 30-day payment rate would be required to offset for such increases in estimated aggregate expenditures. To illustrate this calculation:

$$\frac{(\$1{,}953.60 - \$2{,}057.35)}{\$2{,}057.35} = -5.043\ \%$$

As we stated in the CY 2026 HH PPS final rule (90 FR 55357), applying a −1.975 percent (half of the proposed −3.95 percent) permanent adjustment to the CY 2025 30-day payment rate would not adjust the rate fully to account for differences in behavior changes on estimated aggregate expenditures in CYs 2020, 2021, 2022, and 2023. Using CY 2025 claims data, as shown in table 16, a permanent prospective adjustment of −5.043 percent to the CY 2027 30-day payment rate would offset for increases in estimated aggregate expenditures for CYs 2020 through 2025. We note that adjustment factors are multiplied in this payment system, and individual numbers (that is, percentages) cannot be added or subtracted together to determine the final adjustment. Therefore, we cannot determine the illustrative CY 2027 permanent adjustment, which would include estimated aggregate expenditures in CY 2025, by simply subtracting the −1.975 percent applied in CY 2025 and the −1.023 percent applied in CY 2026 from the total permanent adjustment of −5.043 percent as shown in table 16.

Instead, we account for the permanent adjustment applied in prior years when we calculate the CY 2027 permanent adjustment by solving the following equation To illustrate this calculation we used the following approach.

$$x = 1 - \left(\frac{1-0.05043}{1-0.01023}\right)$$

$$x = 1 - 0.95938$$

$$x = 0.04062 \text{ (that is, } 4.062 \text{ percent)}$$

We note that the −4.062 percent is calculated as a permanent adjustment for CY 2027 illustrating what we would need if we were to offset the difference in aggregate expenditures between CY 2025 claims priced under the PDGM and the 153-group system and adjusting for the permanent adjustments applied in prior years.

We continue to apply the methodology finalized in the CY 2026 HH PPS final rule to determine what the permanent adjustment for CY 2025 claims would be even though we stopped comparing claims priced under PDGM and 153-group after CY 2022 claims for the purposes of applying a permanent adjustment in this proposed rule. As displayed in table 17, we calculate the permanent adjustment for CY 2025 by determining the percent change between the actual CY 2025 30-day payment rate ($2,057.35) and the budget neutral rate for CY 2025

($2,036.29). The budget neutral rate for CY 2025 is the finalized CY 2024 budget neutral rate discussed in CY 2026 final rule ($1,977.43) multiplied by the CY 2025 case-mix weights recalibration neutrality factor (1.0039), the CY 2025 wage index budget neutrality factor (0.9988), and the CY 2025 home health payment update factor (1.027).

TABLE 17: ILLUSTRATIVE CY 2025 PERMANENT AND PROPOSED TEMPORARY ADJUSTMENT CALCULATIONS

	CY 2025 Nationalized Standardized 30-day Period Payment	CY 2025 Budget Neutral Payment Rate	CY 2025 Only Adjustment
Base Payment Rate	$2,057.35*	$2,036.29	**Permanent** -1.024%
Aggregate Expenditures	$16,644,686,086.56 **	$16,492,320,912.40	**Temporary** -$152,365,174.16

Source: CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed from the CCW on March 12, 2026.
* The $2,057.35 corresponds to the actual CY2025 payment rate. ** The estimated aggregate expenditures for assumed behavior ($16.6 billion), uses the actual CY 2025 payment rate of $2,057.35 as finalized in the CY 2025 HH PPS final rule.

In section II.C.1.d of this proposed rule, we discussed various trends that are part of monitoring changes related to the PDGM using analysis of CY 2025 claims. The data continues to show minimal changes that could be attributed to the PDGM implementation after CY 2022 by a large proportion of home health providers. We also continue to acknowledge the difficulty in attributing any behavior change occurring from CYs 2023 through 2025 directly to the PDGM implementation and its effects on expenditures from the other changes occurring in those years. As discussed in the CY 2026 HH PPS final rule, CMS introduced several policy changes that make isolating the effect of implementing a permanent adjustment, with claims data from CYs 2023 through 2025, for the PDGM difficult. These changes include recalibration of case-mix weights and LUPA visit thresholds finalized in the CY 2023, 2024, 2025, and 2026 final rules; reassignment of certain ICD–10–CM codes related to the PDGM clinical groups and comorbidity groups in the CY 2023 HH PPS final rule; finalized permanent adjustments in the CY 2023, 2024, and 2025 HH PPS final rules; the introduction of OASIS–E in 2023 and finalized mapping of OASIS–E to OASIS–D in the CY 2025 HH PPS final rule for calculating functional points for functional impairment levels during repricing; and the expanded HHVBP Model. For these reasons, we maintain that limiting the application of the permanent adjustment to analysis of data from CYs 2020 through 2022 continues to be the most accurate application of the law. However, as required by law, we will continue to analyze data through CY 2026 claims to determine if any additional permanent adjustments are needed to account for the impact of assumed versus actual behavior change related to the implementation of the PDGM and the change to a 30-day unit of payment on estimated aggregate expenditures. As a result, we propose to not apply a permanent adjustment to the CY 2027 payment rate.

The dollar amount that needs to be collected through the temporary adjustment increased when examining home health claims from CY 2025 because those claims were paid using the actual 30-day payment rate ($2,057.35) instead of the calculated budget neutral payment rate for CY 2025 ($2,036.29). That is, had the payment rate in CY 2025 been $2,036.29, there would not be an increase in what needs to be collected through the temporary adjustment when examining home health claims from CY 2025. Because the 30-day payment rate was not budget neutral until the CY 2026 payment rate with the application of the −1.023 percent permanent adjustment, the temporary adjustment continued to accrue.

As described previously in this proposed rule, to account for such increases or decreases in estimated aggregate expenditures as a result of the impact of differences between assumed behavior changes and actual behavior changes in any given year from CY 2020 to CY 2026, we calculate the temporary prospective adjustment by calculating the dollar amount difference between the estimated aggregate expenditures from all 30-day periods using the recalculated 30-day base payment rate, and the aggregate expenditures for all 30-day periods using the actual 30-day base payment rate for that year. In other words, when determining the temporary retrospective dollar amount, we used the full dataset of actual 30-day periods using both the actual and recalculated 30-day base payment rates to ensure that the utilization and distribution of claims are the same. We refer readers to the CY 2024 HH PPS final rule (88 FR 77689 through 77694) for analysis of CYs 2020 through 2022 claims, the CY 2026 HH PPS final rule (90 FR 55366 through 55367) for analysis of CY 2023 and 2024 claims, and section II.C.1.d. of this proposed rule for the analysis of CY 2025 claims. Table 18 provides a summary of the temporary adjustment dollar amount for CYs 2020 through 2026.

TABLE 18: SUMMARY OF TEMPORARY ADJUSTMENTS DOLLAR AMOUNTS FOR CYs 2020 – 2026

Claims Analysis Year	Dollar Amount
CY 2020	-$873,073,121
CY 2021	-$1,211,002,953
CY 2022	-$1,405,447,290
CY 2023	- $836,208,180
CY 2024	- $430,435,218
CY 2025 – This proposed rule	-$152,365,174
CY 2026	TBD
Total (through CY 2025)	-$4,908,531,936

Source: CY 2020 Home Health Claims Data, Periods that begin and end in CY 2020 accessed from the CCW on July 12, 2021. CY 2021 Home Health Claims Data, Periods that end in CY 2021 accessed from the CCW on July 15, 2022. CY 2022 Home Health Claims Data, Periods that end in CY 2022 accessed from the CCW on July 15, 2023. CY 2023 Home Health Claims Data, Periods that end in CY 2023 accessed from the CCW on July 11, 2024. CY 2024 Home Health Claims Data, Periods that end in CY 2024 accessed from the CCW on July 11, 2025. CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed from the CCW on March 12, 2026.
Note: The anticipated temporary adjustments of approximately $4.9 billion (through CY 2025) will require temporary adjustment(s) to the base payment rate to offset for such increases in estimated aggregate expenditures. The dollar amount will be converted to a factor when implemented in future rulemaking.

Therefore, we exercise our authority under section 1895(b)(3)(D)(iii) of the Act to apply ''one or more'' temporary adjustments to continue recoupment of the retrospective overpayments for CYs 2020 through 2025. Specifically, we propose to implement a 3.0 percent reduction in CY 2027, that is equivalent to a 0.9700 temporary adjustment factor, to the CY 2027 national, standardized payment rate. Using historical trends, we estimated 7,680,775 30-day periods would occur in CY 2027. Using this estimated utilization, a 3.0 percent reduction to the CY 2027 30-day payment rate would begin to collect approximately $500 million of the total temporary adjustment dollar amount, equating to about 10 percent of the total $4.9 billion shown in table 18. In doing so; however, we would need to account for the remaining temporary adjustment dollar amount for CYs 2020 through 2026, plus any possible adjustments for CY 2027 and 2028, in future years. It is important to note that the estimated $500 million dollar amount anticipated to be collected by the implementation of the temporary adjustment factor is based on an estimate of the number of 30-day periods that would occur in CY 2027. It may not reflect the actual dollar amount to be collected if the actual number of 30-day periods and other utilization trends in CY 2027 differ from what was estimated. In other words, CMS will calculate the actual amount collected from the temporary adjustment in CY 2027 and credit it to the overall cumulative temporary dollar amount.

In accordance with section 1895(b)(3)(D)(iii) of the Act, the temporary adjustment is to be applied on a prospective basis and shall apply only with respect to the year for which such temporary increase or decrease is made. This means we would not include the −3.0 percent temporary adjustment applied for CY 2027 when calculating the CY 2028 base payment rates. However, to continue recoupment of the retrospective overpayments, we may propose additional temporary adjustments in future rulemaking and are not proposing that the −3.0 percent temporary adjustment would be applied each year after CY 2027. Rather, we will continue to analyze the data each year through CY 2026 claims as required by law, and in a time and manner deemed appropriate, we will propose one or more temporary adjustments to account for retrospective overpayments. We also note the $4.9 billion does not account for any monies recouped in CY 2026, as we do not have this dollar amount at the time of this CY 2027 rulemaking. In future rulemaking, we will show the remaining balance, accounting for the previous recoupment amount; however, there will be a lag. We refer readers to section II.E.3.b. for the CY 2027 base payment rates with and without the temporary adjustment.

We solicit comments on the proposals to not apply a permanent adjustment and to apply the −3.0 percent temporary adjustment to the CY 2027 home health base payment rate.

D. Proposed CY 2027 Home Health Low Utilization Payment Adjustment (LUPA) Thresholds, Functional Impairment Levels, Comorbidity Sub-Groups, and Case-Mix Weights

1. Proposed CY 2027 PDGM LUPA Thresholds

Under the HH PPS, LUPAs are paid when a certain numerical minimum visit threshold for a payment group during a 30-day period of care is not met. In the CY 2019 HH PPS final rule with comment period (83 FR 56492), we finalized a policy setting the LUPA thresholds at the 10th percentile of visits or two visits, whichever is higher, for each payment group. This means the LUPA threshold for each 30-day period of care varies depending on the PDGM payment group to which it is assigned. If the LUPA threshold for the payment group is met under the PDGM, the 30-day period of care would be paid the full 30-day period case-mix adjusted payment amount (subject to any partial payment adjustment or outlier adjustments). If a 30-day period of care does not meet the PDGM LUPA visit threshold, then payment would be made using the per-visit payment amounts as described in section II.E.3.c. of this proposed rule. For example, if the LUPA visit threshold is four, and a 30-day period of care has four or more visits,

it is paid the full 30-day period payment amount; if the period of care has three or fewer visits, payment is made using the per-visit payment amounts.

In the CY 2019 HH PPS final rule with comment period (83 FR 56492), we finalized our policy that the LUPA thresholds for each PDGM payment group will be reevaluated every year based on the most current utilization data available at the time of rulemaking. However, as CY 2020 was the first year of the new case-mix adjustment methodology, we stated in the CY 2021 HH PPS final rule (85 FR 70305, 70306) that we would maintain the LUPA thresholds that were finalized and shown in table 18 of the CY 2020 HH PPS final rule with comment period (84 FR 60522) for CY 2021 payment purposes. We stated that at that time, we did not have sufficient CY 2020 data to reevaluate the LUPA thresholds for CY 2021.

In the CY 2022 HH PPS final rule with comment period (86 FR 62249), we finalized the proposal to recalibrate the PDGM case-mix weights, functional impairment levels, and comorbidity subgroups while maintaining the LUPA thresholds for CY 2022. We stated that because there are several factors that contribute to how the case-mix weight is set for a particular case-mix group (such as the number of visits, length of visits, types of disciplines providing visits, and non-routine supplies) and the case-mix weight is derived by comparing the average resource use for the case-mix group relative to the average resource use across all groups, we believe the COVID–19 public health emergency (PHE) will have impacted utilization within all case-mix groups similarly. Therefore, the impact of any reduction in resource use caused by the PHE on the calculation of the case-mix weight will be minimized since the impact will be accounted for both in the numerator and denominator of the formula used to calculate the case-mix weight. However, in contrast, 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 will 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 18 in the CY 2020 HH PPS final rule with comment period (84 FR 60522) for CY 2022 payment purposes.

For CY 2024, we proposed to update the LUPA thresholds using CY 2022 Medicare home health claims (as of March 17, 2023) linked to OASIS assessment data. We believed that CY 2022 data would be more indicative of visit patterns in CY 2024 rather than continuing to use the LUPA thresholds derived from the CY 2018 pre-PDGM data. Therefore, we finalized a policy to update the LUPA thresholds for CY 2024 using data from CY 2022.

For CY 2027, we are proposing to update the LUPA thresholds using CY 2025 home health claims utilization data (as of March 15, 2026), in accordance with our policy to annually recalibrate the case-mix weights and update the LUPA thresholds, functional impairment levels, and comorbidity subgroups. After reviewing the CY 2025 home health claims utilization data, we determined that LUPA visit patterns in 2025 were similar to visits in 2024 and a total of 18 case-mix groups have a decline in their LUPA threshold of a single visit and two case-mix groups have their LUPA threshold increase by a single visit. The proposed LUPA thresholds for the CY 2027 PDGM payment groups with the corresponding Health Insurance Prospective Payment System (HIPPS) codes and the case-mix weights are listed in table 24.

We are soliciting public comments on the proposed updates to the LUPA thresholds for CY 2027. The proposed LUPA thresholds will be updated based on more complete CY 2025 claims data in the final rule.

2. Proposed CY 2027 Functional Impairment Levels

Under the PDGM, the functional impairment level is determined by responses to certain OASIS items associated with activities of daily living and risk of hospitalization; that is, responses to OASIS items M1800–M1860 and M1033. A home health period of care receives points based on each of the responses associated with these functional OASIS items, which are then converted into a table of points corresponding to increased resource use. The sum of all these points results in a functional impairment score which is used to group home health periods into a functional level with similar resource use. That is, the higher the points, the more the response is associated with increased resource use, or increased impairment. The three functional impairment levels of low, medium, and high were designed so that approximately one-third of home health periods from each clinical group falls within each level. This means home health periods in the low impairment level have responses for the functional OASIS items that are associated with the lowest resource use, on average. Home health periods in the high impairment level have responses for the functional OASIS items that are associated with the highest resource use on average.

For CY 2027, we are proposing to use CY 2025 claims data to update the functional points and functional impairment levels by clinical group. The CY 2018 HH PPS proposed rule (82 FR 35320) and the technical report from December 2016, posted on the Home Health PPS Archive web page, located at *https://www.cms.gov/medicare/home-health-pps/home-health-pps-archive,* provides a more detailed explanation as to the construction of the functional impairment levels using the OASIS items. We are proposing to use the same methodology previously finalized to update the functional impairment levels for CY 2027. The proposed updated OASIS functional points table and the table of functional impairment levels by clinical group for CY 2027 are listed in tables 19 and 20, respectively.

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TABLE 19: PROPOSED OASIS POINTS TABLE FOR CY 2027

	Responses	CY 2027 Proposed Points	Percent of Periods with this Response Category*
M1800: Grooming	0 or 1	**0**	**21.4%**
	2 or 3	**3**	**78.6%**
M1810: Current Ability to Dress Upper Body	0 or 1	**0**	**15.9%**
	2 or 3	**5**	**84.1%**
M1820: Current Ability to Dress Lower Body	0 or 1	**0**	**7.7%**
	2	**4**	**63.5%**
	3	**11**	**28.8%**
M1830: Bathing	0 or 1	**0**	**2.0%**
	2	**2**	**8.6%**
	3 or 4	**8**	**48.0%**
	5 or 6	**16**	**41.4%**
M1840: Toilet Transferring	0 or 1	**0**	**58.3%**
	2, 3 or 4	**6**	**41.7%**
M1850: Transferring	0	**0**	**1.0%**
	1	**3**	**16.4%**
	2, 3, 4 or 5	**5**	**82.7%**
M1860: Ambulation/Locomotion	0 or 1	**0**	**2.7%**
	2	**4**	**13.3%**
	3	**0**	**66.3%**
	4, 5 or 6	**19**	**17.7%**
M1033: Risk of Hospitalization	Three or fewer items marked (Excluding responses 8, 9 or 10)	**0**	**52.9%**
	Four or more items marked (Excluding responses 8, 9 or 10)	**11**	**47.1%**

Source: Percent of periods in 2025 with this response category using CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed from the CCW on March 15, 2026.

Note: *For item M1860, the point values for response 2 is worth more than the point values for response 3. There may be times in which the resource use for certain OASIS items associated with functional impairment will result in a seemingly inverse relationship to the response reported. However, this is the result of the direct association between the responses reported on the OASIS items and actual resource use. For item M1033, responses 8, 9, and 10 represent "currently reports exhaustion", "other risk(s) not listed in 1-8", and "none of the above", respectively.*

TABLE 20: PROPOSED THRESHOLDS FOR FUNCTIONAL LEVELS BY CLINICAL GROUP, FOR CY 2027

Clinical Group	Level of Impairment	CY 2027 Points
MMTA - Other	Low	**0-30**
	Medium	**31-42**
	High	**43+**
Behavioral Health	Low	**0-31**
	Medium	**32-44**
	High	**45+**
Complex Nursing Interventions	Low	**0-31**
	Medium	**32-55**
	High	**56+**
Musculoskeletal Rehabilitation	Low	**0-31**
	Medium	**32-44**
	High	**45+**
Neuro Rehabilitation	Low	**0-33**
	Medium	**34-50**
	High	**51+**
Wound	Low	**0-32**
	Medium	**33-50**
	High	**51+**
MMTA - Surgical Aftercare	Low	**0-30**
	Medium	**31-42**
	High	**43+**
MMTA - Cardiac and Circulatory	Low	**0-29**
	Medium	**30-42**
	High	**43+**
MMTA - Endocrine	Low	**0-27**
	Medium	**28-42**
	High	**43+**
MMTA - Gastrointestinal tract and Genitourinary system	Low	**0-33**
	Medium	**34-46**
	High	**47+**
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases	Low	**0-31**
	Medium	**32-44**
	High	**45+**
MMTA - Respiratory	Low	**0-32**
	Medium	**33-44**
	High	**45+**

Source: CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed from the CCW on March 15, 2026.

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We are soliciting public comments on the proposed updates to the functional points and the functional impairment levels by clinical group.

3. Proposed CY 2027 Comorbidity Subgroups

Thirty-day periods of care are assigned to a comorbidity adjustment category based on the presence of certain secondary diagnoses reported on home health claims. These diagnoses are based on a home-health specific list of clinically and statistically significant secondary diagnosis subgroups with similar resource use, meaning the diagnoses have at least as high as the median resource use and are reported in more than 0.1 percent of 30-day periods of care. Home health 30-day periods of care can receive a comorbidity

adjustment under the following circumstances:

- *High comorbidity adjustment:* There are two or more secondary diagnoses on the home health-specific comorbidity subgroup interaction list that are associated with higher resource use when both are reported together compared to when they are reported separately. That is, the two diagnoses may interact with one another, resulting in higher resource use.
- *Low comorbidity adjustment:* There is a reported secondary diagnosis on the home health-specific comorbidity subgroup list that is associated with higher resource use.
- *No comorbidity adjustment:* There is no secondary diagnosis or there is a secondary diagnosis that does not meet the criteria for a low or high comorbidity adjustment.

In the CY 2019 HH PPS final rule with comment period (83 FR 56406), we stated that we will continue to examine the relationship of reported comorbidities on resource utilization and make the appropriate payment refinements to help ensure that payment is in alignment with the actual costs of providing care. For CY 2027, we are proposing to use the same methodology used to establish the comorbidity subgroups to update the comorbidity subgroups using CY 2025 home health data with linked OASIS data (as of March 15, 2026).

For CY 2027, we are proposing to update the comorbidity subgroups to include 21 low comorbidity adjustment subgroups and 100 high comorbidity adjustment interaction subgroups. The proposed CY 2027 low comorbidity adjustment subgroups and the high comorbidity adjustment interaction subgroups including those diagnoses within each of these comorbidity adjustments are shown in tables 21 and 22. The proposed CY 2027 low comorbidity adjustment subgroups and the high comorbidity adjustment interaction subgroups including those diagnoses within each of these comorbidity adjustments will also be posted on the HHA Center web page at *https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/home-health-agency-center.*

We invite comments on the proposed updates to the low comorbidity adjustment subgroups and the high comorbidity adjustment interactions for CY 2027.

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TABLE 21: PROPOSED LOW COMORBIDITY ADJUSTMENT SUBGROUPS FOR CY 2027

Low Comorbidity Subgroup	Description
Renal 3	Other disorders of the kidney and ureter, excluding chronic kidney disease and ESRD
Endocrine 3	Type 1, Type 2, and Other Specified Diabetes
Circulatory 7	Atherosclerosis, includes Peripheral Vascular Disease, Aortic Aneurysms and Hypotension
Circulatory 2	Hemolytic, Aplastic, and Other Anemias
Gastrointestinal 2	Intestinal Obstruction and Ileus
Heart 10	Dysrhythmias, includes Atrial Fibrillation and Atrial Flutter
Heart 5	Atherosclerotic Heart Disease with Angina
Heart 11	Heart Failure
Neurological 10	Diabetes with neuropathy
Neoplasms 18	Secondary Neoplasms of Urinary and Reproductive Systems, Skin, Brain, and Bone
Endocrine 4	Other Combined Immunodeficiencies and Malnutrition, includes graft-versus-host-disease
Neoplasms 2	Malignant Neoplasms of Digestive Organs, includes Gastrointestinal Cancers
Neoplasms 17	Secondary neoplasms of respiratory and GI systems.
Circulatory 9	Other Venous Embolism and Thrombosis
Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae
Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
Circulatory 10	Varicose Veins and Lymphedema
Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
Skin 4	Stages Two-Four and unstageable pressure ulcers by site

Source: CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed on the CCW March 15, 2026.

TABLE 22: PROPOSED HIGH COMORBIDITY ADJUSTMENT INTERACTIONS FOR CY 2027

Comorbidity Subgroup Interaction	Comorbidity Group	Description	Comorbidity Group	Description
1	Behavioral 2	Mood Disorders, includes Depression and Bipolar Disorder	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
2	Behavioral 2	Mood Disorders, includes Depression and Bipolar Disorder	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
3	Behavioral 2	Mood Disorders, includes Depression and Bipolar Disorder	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
4	Behavioral 2	Mood Disorders, includes Depression and Bipolar Disorder	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
5	Behavioral 4	Psychotic, major depressive, and dissociative disorders, includes unspecified dementia, eating disorder and intellectual disabilities	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
6	Behavioral 4	Psychotic, major depressive, and dissociative disorders, includes unspecified dementia, eating disorder and intellectual disabilities	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
7	Behavioral 5	Phobias, Other Anxiety and Obsessive Compulsive Disorders	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae
8	Behavioral 5	Phobias, Other Anxiety and Obsessive Compulsive Disorders	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
9	Behavioral 5	Phobias, Other Anxiety and Obsessive Compulsive Disorders	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
10	Behavioral 5	Phobias, Other Anxiety and Obsessive Compulsive Disorders	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
11	Behavioral 5	Phobias, Other Anxiety and Obsessive Compulsive Disorders	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
12	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Circulatory 1	Nutritional, Enzymatic, and Other Heredity Anemias
13	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Circulatory 7	Atherosclerosis, includes Peripheral Vascular Disease, Aortic Aneurysms and Hypotension
14	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Circulatory 9	Other Venous Embolism and Thrombosis
15	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Heart 11	Heart Failure
16	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Infectious 1	C-diff, MRSA, E-coli

Comorbidity Subgroup Interaction	Comorbidity Group	Description	Comorbidity Group	Description
17	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Neurological 10	Diabetes with neuropathy
18	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Neurological 11	Disease of the Macula and Blindness/Low Vision
19	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Renal 3	Other disorders of the kidney and ureter, excluding chronic kidney disease and ESRD
20	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
21	Cerebral 4	Sequelae of Cerebrovascular Diseases, includes Cerebral Atherosclerosis and Stroke Sequelae	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
22	Circulatory 1	Nutritional, Enzymatic, and Other Heredity Anemias	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
23	Circulatory 1	Nutritional, Enzymatic, and Other Heredity Anemias	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
24	Circulatory 10	Varicose Veins and Lymphedema	Endocrine 1	Hypothyroidism
25	Circulatory 10	Varicose Veins and Lymphedema	Endocrine 4	Other Combined Immunodeficiencies and Malnutrition, includes graft-versus-host-disease
26	Circulatory 10	Varicose Veins and Lymphedema	Heart 10	Dysrhythmias, includes Atrial Fibrillation and Atrial Flutter
27	Circulatory 10	Varicose Veins and Lymphedema	Heart 12	Other Heart Diseases
28	Circulatory 10	Varicose Veins and Lymphedema	Heart 8	Other Pulmonary Heart Diseases
29	Circulatory 10	Varicose Veins and Lymphedema	Infectious 1	C-diff, MRSA, E-coli
30	Circulatory 10	Varicose Veins and Lymphedema	Musculoskeletal 2	Rheumatoid Arthritis
31	Circulatory 10	Varicose Veins and Lymphedema	Neurological 12	Nondiabetic neuropathy
32	Circulatory 10	Varicose Veins and Lymphedema	Renal 1	Chronic kidney disease and ESRD
33	Circulatory 10	Varicose Veins and Lymphedema	Renal 3	Other disorders of the kidney and ureter, excluding chronic kidney disease and ESRD
34	Circulatory 10	Varicose Veins and Lymphedema	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
35	Circulatory 10	Varicose Veins and Lymphedema	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
36	Circulatory 2	Hemolytic, Aplastic, and Other Anemias	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
37	Circulatory 2	Hemolytic, Aplastic, and Other Anemias	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
38	Circulatory 4	Hypertensive Chronic Kidney Disease	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers

Comorbidity Subgroup Interaction	Comorbidity Group	Description	Comorbidity Group	Description
39	Circulatory 4	Hypertensive Chronic Kidney Disease	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
40	Circulatory 7	Atherosclerosis, includes Peripheral Vascular Disease, Aortic Aneurysms and Hypotension	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
41	Circulatory 7	Atherosclerosis, includes Peripheral Vascular Disease, Aortic Aneurysms and Hypotension	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
42	Circulatory 7	Atherosclerosis, includes Peripheral Vascular Disease, Aortic Aneurysms and Hypotension	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
43	Circulatory 7	Atherosclerosis, includes Peripheral Vascular Disease, Aortic Aneurysms and Hypotension	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
44	Circulatory 9	Other Venous Embolism and Thrombosis	Endocrine 3	Type 1, Type 2, and Other Specified Diabetes
45	Circulatory 9	Other Venous Embolism and Thrombosis	Endocrine 4	Other Combined Immunodeficiencies and Malnutrition, includes graft-versus-host-disease
46	Circulatory 9	Other Venous Embolism and Thrombosis	Heart 11	Heart Failure
47	Circulatory 9	Other Venous Embolism and Thrombosis	Musculoskeletal 4	Lumbar Spinal Stenosis
48	Circulatory 9	Other Venous Embolism and Thrombosis	Respiratory 4	Bronchitis, Emphysema, and Interstitial Lung Disease
49	Circulatory 9	Other Venous Embolism and Thrombosis	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
50	Endocrine 1	Hypothyroidism	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
51	Endocrine 1	Hypothyroidism	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
52	Endocrine 3	Type 1, Type 2, and Other Specified Diabetes	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
53	Endocrine 3	Type 1, Type 2, and Other Specified Diabetes	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
54	Endocrine 3	Type 1, Type 2, and Other Specified Diabetes	Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
55	Endocrine 3	Type 1, Type 2, and Other Specified Diabetes	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
56	Endocrine 3	Type 1, Type 2, and Other Specified Diabetes	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
57	Endocrine 4	Other Combined Immunodeficiencies and Malnutrition, includes graft-versus-host-disease	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
58	Endocrine 4	Other Combined Immunodeficiencies and Malnutrition, includes graft-versus-host-disease	Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
59	Endocrine 4	Other Combined Immunodeficiencies and Malnutrition, includes graft-versus-host-disease	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers

Comorbidity Subgroup Interaction	Comorbidity Group	Description	Comorbidity Group	Description
60	Endocrine 5	Obesity, and Disorders of Metabolism and Fluid Balance	Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
61	Endocrine 5	Obesity, and Disorders of Metabolism and Fluid Balance	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
62	Gastrointestinal 4	Alcoholic Liver Disease, Chronic Hepatitis, Fibrosis and Cirrhosis of the Liver	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
63	Heart 10	Dysrhythmias, includes Atrial Fibrillation and Atrial Flutter	Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
64	Heart 11	Heart Failure	Neoplasms 18	Secondary Neoplasms of Urinary and Reproductive Systems, Skin, Brain, and Bone
65	Heart 11	Heart Failure	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
66	Heart 11	Heart Failure	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
67	Heart 11	Heart Failure	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
68	Heart 12	Other Heart Diseases	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
69	Heart 7	Chronic Ischemic Heart Disease	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
70	Heart 8	Other Pulmonary Heart Diseases	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
71	Heart 9	Valve Disorders	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
72	Infectious 1	C-diff, MRSA, E-coli	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia
73	Infectious 1	C-diff, MRSA, E-coli	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
74	Musculoskeletal 3	Joint Pain	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
75	Musculoskeletal 3	Joint Pain	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
76	Musculoskeletal 4	Lumbar Spinal Stenosis	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
77	Musculoskeletal 4	Lumbar Spinal Stenosis	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
78	Neurological 10	Diabetes with neuropathy	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
79	Neurological 10	Diabetes with neuropathy	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia

Comorbidity Subgroup Interaction	Comorbidity Group	Description	Comorbidity Group	Description
80	Neurological 12	Nondiabetic neuropathy	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease
81	Neurological 12	Nondiabetic neuropathy	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
82	Neurological 4	Alzheimer's disease and related dementias	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
83	Neurological 4	Alzheimer's disease and related dementias	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
84	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease	Renal 1	Chronic kidney disease and ESRD
85	Neurological 5	Spinal Muscular Atrophy, Systemic atrophy and Motor Neuron Disease	Respiratory 9	Respiratory Failure and Atelectasis
86	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia	Neurological 8	Epilepsy
87	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia	Renal 3	Other disorders of the kidney and ureter, excluding chronic kidney disease and ESRD
88	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia	Respiratory 5	Chronic Obstructive Pulmonary Disease, and Asthma, and Bronchiectasis
89	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia	Respiratory 9	Respiratory Failure and Atelectasis
90	Neurological 7	Paraplegia, Hemiplegia and Quadriplegia	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
91	Neurological 8	Epilepsy	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
92	Renal 1	Chronic kidney disease and ESRD	Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
93	Renal 3	Other disorders of the kidney and ureter, excluding chronic kidney disease and ESRD	Respiratory 10	2019 Novel Coronavirus
94	Renal 3	Other disorders of the kidney and ureter, excluding chronic kidney disease and ESRD	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
95	Respiratory 5	Chronic Obstructive Pulmonary Disease, and Asthma, and Bronchiectasis	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers
96	Respiratory 5	Chronic Obstructive Pulmonary Disease, and Asthma, and Bronchiectasis	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
97	Respiratory 9	Respiratory Failure and Atelectasis	Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis
98	Respiratory 9	Respiratory Failure and Atelectasis	Skin 4	Stages Two-Four and unstageable pressure ulcers by site
99	Skin 1	Cutaneous Abscess, Cellulitis, and Lymphangitis	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers

Comorbidity Subgroup Interaction	Comorbidity Group	Description	Comorbidity Group	Description
100	Skin 3	Diseases of arteries, arterioles and capillaries with ulceration and non-pressure chronic ulcers	Skin 4	Stages Two-Four and unstageable pressure ulcers by site

Source: CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed from the CCW on March 15, 2026.

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4. Proposed CY 2027 PDGM Case-Mix Weights

As finalized in the CY 2019 HH PPS final rule with comment period (83 FR 56502), the PDGM places patients into meaningful payment categories based on patient and other characteristics, such as timing, admission source, clinical grouping using the reported principal diagnosis, functional impairment level, and comorbid conditions. The PDGM case-mix methodology results in 432 unique case-mix groups called home health resource groups (HHRGs). We also finalized a policy in the CY 2019 HH PPS final rule with comment period (83 FR 56515) to annually recalibrate the PDGM case-mix weights using a fixed effects model with the most recent and complete utilization data available at the time of annual rulemaking. Annual recalibration of the PDGM case-mix weights ensures that the case-mix weights reflect, as accurately as possible, current home health resource use and changes in utilization patterns. To generate the proposed recalibrated CY 2027 case-mix weights, we used CY 2025 home health claims data with linked OASIS data (as of March 15, 2026). These data are the most current and complete data available at the time of rulemaking. We believe that recalibrating the case-mix weights using data from CY 2025 would be reflective of PDGM utilization and patient resource use for CY 2027. The proposed recalibrated case-mix weights will be updated in the final rule based on more complete CY 2025 claims data.

The claims data provide visit-level data and data on whether non-routine supplies (NRS) were provided during the period and the total charges of NRS. We determine the case-mix weight for each of the 432 different PDGM payment groups by regressing resource use on a series of indicator variables for each of the categories using a fixed effects model as described in the following steps:

Step 1: Estimate a regression model to assign a functional impairment level to each 30-day period. The regression model estimates the relationship between a 30-day period's resource use and the functional status and risk of hospitalization items included in the PDGM, which are obtained from certain OASIS items. We refer readers to table 19 for further information on the OASIS items used for the functional impairment level under the PDGM. We measure resource use with the cost-per-minute + NRS approach that uses information from 2023 home health cost reports. We use 2023 home health cost report data because it is the most complete cost report data available at the time of rulemaking. Other variables in the regression model include the 30-day period's admission source, clinical group, and 30-day period timing. We also include home health agency level fixed effects in the regression model. After estimating the regression model using 30-day periods, we divide the coefficients that correspond to the functional status and risk of hospitalization items by 10 and round to the nearest whole number. Those rounded numbers are used to compute a functional score for each 30-day period by summing together the rounded numbers for the functional status and risk of hospitalization items that are applicable to each 30-day period. Next, each 30-day period is assigned to a functional impairment level (low, medium, or high) depending on the 30-day period's total functional score. Each clinical group has a separate set of functional thresholds used to assign 30-day periods into a low, medium or high functional impairment level. We set those thresholds so that we assign roughly a third of 30-day periods within each clinical group to each functional impairment level (low, medium, or high).

Step 2: A second regression model estimates the relationship between a 30-day period's resource use and indicator variables for the presence of any of the comorbidities and comorbidity interactions that were originally examined for inclusion in the PDGM. Like the first regression model, this model also includes home health agency level fixed effects and includes control variables for each 30-day period's admission source, clinical group, timing, and functional impairment level. After we estimate the model, we assign comorbidities to the low comorbidity adjustment if any comorbidities have a coefficient that is statistically significant (p-value of 0.05 or less) and which have a coefficient that is larger than the 50th percentile of positive and statistically significant comorbidity coefficients. If two comorbidities in the model and their interaction term have coefficients that sum together to exceed $150 and the interaction term is statistically significant (p-value of 0.05 or less), we assign the two comorbidities together to the high comorbidity adjustment.

Step 3: After Step 2, each 30-day period is assigned to a clinical group, admission source category, episode timing category, functional impairment level, and comorbidity adjustment category. For each combination of those variables (which represent the 432 different payment groups that comprise

the PDGM), we then calculate the 10th percentile of visits across all 30-day periods within a particular payment group. If a 30-day period's number of visits is less than the 10th percentile for their payment group, the 30-day period is classified as a Low Utilization Payment Adjustment (LUPA). If a payment group has a 10th percentile of visits that is less than two, we set the LUPA threshold for that payment group to be equal to two. That means if a 30-day period has one visit, it is classified as a LUPA and if it has two or more visits, it is not classified as a LUPA.

Step 4: Take all non-LUPA 30-day periods and regress resource use on the 30-day period's clinical group, admission source category, episode timing category, functional impairment level, and comorbidity adjustment category. The regression includes fixed effects at the level of the home health agency. After we estimate the model, the model coefficients are used to predict each 30-day period's resource use. To create the case-mix weight for each 30-day period, the predicted resource use is divided by the overall resource use of the 30-day periods used to estimate the regression.

The case-mix weight is then used to adjust the base payment rate to determine each 30-day period's payment. Table 23 shows the coefficients of the payment regression used to generate the weights, and the coefficients divided by average resource use.

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TABLE 23: COEFFICIENT OF PAYMENT REGRESSION AND COEFFICIENT DIVIDED BY AVERAGE RESOURCE USE

Variable	Coefficient	Percentage of 30-Day Periods for this Model	Coefficient Divided by Average Resource Use
Clinical Group and Functional Impairment Level (MMTA - Other - Low is excluded)			
MMTA - Other - Medium Functional	$131.86	1.3%	0.0778
MMTA - Other - High Functional	$297.44	1.3%	0.1754
MMTA - Surgical Aftercare - Low Functional	-$35.65	1.2%	-0.0210
MMTA - Surgical Aftercare - Medium Functional	$141.13	1.2%	0.0832
MMTA - Surgical Aftercare - High Functional	$351.50	1.1%	0.2073
MMTA - Cardiac and Circulatory - Low Functional	-$23.39	5.7%	-0.0138
MMTA - Cardiac and Circulatory - Medium Functional	$128.74	5.9%	0.0759
MMTA - Cardiac and Circulatory - High Functional	$301.32	5.5%	0.1777
MMTA - Endocrine - Low Functional	$464.14	2.5%	0.2737
MMTA - Endocrine - Medium Functional	$546.30	2.6%	0.3221
MMTA - Endocrine - High Functional	$702.01	2.2%	0.4139
MMTA - Gastrointestinal tract and Genitourinary system - Low Functional	-$38.64	1.8%	-0.0228
MMTA - Gastrointestinal tract and Genitourinary system - Medium Functional	$125.17	1.6%	0.0738
MMTA - Gastrointestinal tract and Genitourinary system - High Functional	$295.87	1.7%	0.1745
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases - Low Functional	-$7.22	1.6%	-0.0043
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases - Medium Functional	$144.43	1.7%	0.0852
MMTA - Infectious Disease, Neoplasms, and Blood-Forming Diseases - High Functional	$365.64	1.5%	0.2156
MMTA - Respiratory - Low Functional	-$18.08	2.2%	-0.0107
MMTA - Respiratory - Medium Functional	$146.98	2.3%	0.0867
MMTA - Respiratory - High Functional	$312.02	2.1%	0.1840
Behavioral Health - Low Functional	-$93.73	0.8%	-0.0553
Behavioral Health - Medium Functional	$122.41	0.7%	0.0722
Behavioral Health - High Functional	$249.68	0.7%	0.1472
Complex - Low Functional	-$26.24	0.9%	-0.0155
Complex - Medium Functional	$161.98	0.9%	0.0955
Complex - High Functional	$122.19	0.9%	0.0720
MS Rehab - Low Functional	$53.42	7.7%	0.0315

Variable	Coefficient	Percentage of 30-Day Periods for this Model	Coefficient Divided by Average Resource Use
MS Rehab - Medium Functional	$188.06	7.6%	0.1109
MS Rehab - High Functional	$410.73	6.3%	0.2422
Neuro - Low Functional	$186.14	3.6%	0.1098
Neuro - Medium Functional	$350.55	4.1%	0.2067
Neuro - High Functional	$594.87	3.2%	0.3508
Wound - Low Functional	$620.36	4.8%	0.3658
Wound - Medium Functional	$779.31	4.9%	0.4595
Wound - High Functional	$994.71	4.6%	0.5865
Admission Source with Timing (Community Early is excluded)			
Community - Late	-$551.55	64.4%	-0.3252
Institutional - Early	$364.22	18.2%	0.2148
Institutional - Late	$235.84	6.1%	0.1391
Comorbidity Adjustment (No Comorbidity Adjustment - is excluded)			
Comorbidity Adjustment - Has at least one comorbidity from comorbidity list, no interaction from interaction list	$98.60	59.0%	0.0581
Comorbidity Adjustment - Has at least one interaction from interaction list	$359.15	16.4%	0.2118
Constant	$1,552.31		
Average Resource Use	$1,695.94		
Number of 30-day Periods	7,631,827		
Adjusted R-Squared	0.314		

Source: CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed from the CCW on March 15, 2026.

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The proposed case-mix weights for CY 2027 are listed in table 24 and will also be posted on the HHA Center web page at *https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center* upon display of this proposed rule.

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TABLE 24: CASE-MIX WEIGHTS AND LUPA THRESHOLDS FOR EACH HHRG PAYMENT GROUP

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
1FC11	Behavioral Health - High	Early - Community	0	1.0625	4
1FC21	Behavioral Health - High	Early - Community	1	1.1207	4
1FC31	Behavioral Health - High	Early - Community	2	1.2743	4
2FC11	Behavioral Health - High	Early - Institutional	0	1.2773	3
2FC21	Behavioral Health - High	Early - Institutional	1	1.3354	4
2FC31	Behavioral Health - High	Early - Institutional	2	1.4891	4
3FC11	Behavioral Health - High	Late - Community	0	0.7373	2
3FC21	Behavioral Health - High	Late - Community	1	0.7955	2
3FC31	Behavioral Health - High	Late - Community	2	0.9491	2
4FC11	Behavioral Health - High	Late - Institutional	0	1.2016	3
4FC21	Behavioral Health - High	Late - Institutional	1	1.2597	3
4FC31	Behavioral Health - High	Late - Institutional	2	1.4134	3
1FA11	Behavioral Health - Low	Early - Community	0	0.8600	3
1FA21	Behavioral Health - Low	Early - Community	1	0.9182	3
1FA31	Behavioral Health - Low	Early - Community	2	1.0718	3
2FA11	Behavioral Health - Low	Early - Institutional	0	1.0748	3
2FA21	Behavioral Health - Low	Early - Institutional	1	1.1329	3
2FA31	Behavioral Health - Low	Early - Institutional	2	1.2866	3
3FA11	Behavioral Health - Low	Late - Community	0	0.5348	2
3FA21	Behavioral Health - Low	Late - Community	1	0.5930	2
3FA31	Behavioral Health - Low	Late - Community	2	0.7466	2
4FA11	Behavioral Health - Low	Late - Institutional	0	0.9991	3
4FA21	Behavioral Health - Low	Late - Institutional	1	1.0572	2
4FA31	Behavioral Health - Low	Late - Institutional	2	1.2109	2
1FB11	Behavioral Health - Medium	Early - Community	0	0.9875	4
1FB21	Behavioral Health - Medium	Early - Community	1	1.0456	4
1FB31	Behavioral Health - Medium	Early - Community	2	1.1993	3
2FB11	Behavioral Health - Medium	Early - Institutional	0	1.2022	3
2FB21	Behavioral Health - Medium	Early - Institutional	1	1.2604	4
2FB31	Behavioral Health - Medium	Early - Institutional	2	1.4140	4
3FB11	Behavioral Health - Medium	Late - Community	0	0.6623	2
3FB21	Behavioral Health - Medium	Late - Community	1	0.7204	2
3FB31	Behavioral Health - Medium	Late - Community	2	0.8740	2
4FB11	Behavioral Health - Medium	Late - Institutional	0	1.1265	3
4FB21	Behavioral Health - Medium	Late - Institutional	1	1.1847	3

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
4FB31	Behavioral Health - Medium	Late - Institutional	2	1.3383	3
1DC11	Complex - High	Early - Community	0	0.9874	2
1DC21	Complex - High	Early - Community	1	1.0455	2
1DC31	Complex - High	Early - Community	2	1.1991	2
2DC11	Complex - High	Early - Institutional	0	1.2021	3
2DC21	Complex - High	Early - Institutional	1	1.2603	3
2DC31	Complex - High	Early - Institutional	2	1.4139	3
3DC11	Complex - High	Late - Community	0	0.6621	2
3DC21	Complex - High	Late - Community	1	0.7203	2
3DC31	Complex - High	Late - Community	2	0.8739	2
4DC11	Complex - High	Late - Institutional	0	1.1264	2
4DC21	Complex - High	Late - Institutional	1	1.1846	2
4DC31	Complex - High	Late - Institutional	2	1.3382	2
1DA11	Complex - Low	Early - Community	0	0.8998	2
1DA21	Complex - Low	Early - Community	1	0.9580	2
1DA31	Complex - Low	Early - Community	2	1.1116	2
2DA11	Complex - Low	Early - Institutional	0	1.1146	3
2DA21	Complex - Low	Early - Institutional	1	1.1727	3
2DA31	Complex - Low	Early - Institutional	2	1.3264	3
3DA11	Complex - Low	Late - Community	0	0.5746	2
3DA21	Complex - Low	Late - Community	1	0.6328	2
3DA31	Complex - Low	Late - Community	2	0.7864	2
4DA11	Complex - Low	Late - Institutional	0	1.0389	3
4DA21	Complex - Low	Late - Institutional	1	1.0970	2
4DA31	Complex - Low	Late - Institutional	2	1.2507	2
1DB11	Complex - Medium	Early - Community	0	1.0108	2
1DB21	Complex - Medium	Early - Community	1	1.0690	2
1DB31	Complex - Medium	Early - Community	2	1.2226	2
2DB11	Complex - Medium	Early - Institutional	0	1.2256	3
2DB21	Complex - Medium	Early - Institutional	1	1.2837	3
2DB31	Complex - Medium	Early - Institutional	2	1.4373	3
3DB11	Complex - Medium	Late - Community	0	0.6856	2
3DB21	Complex - Medium	Late - Community	1	0.7437	2
3DB31	Complex - Medium	Late - Community	2	0.8974	2
4DB11	Complex - Medium	Late - Institutional	0	1.1499	3
4DB21	Complex - Medium	Late - Institutional	1	1.2080	3
4DB31	Complex - Medium	Late - Institutional	2	1.3616	3
1HC11	MMTA - Cardiac - High	Early - Community	0	1.0930	4
1HC21	MMTA - Cardiac - High	Early - Community	1	1.1511	4

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
1HC31	MMTA - Cardiac - High	Early - Community	2	1.3047	3
2HC11	MMTA - Cardiac - High	Early - Institutional	0	1.3077	4
2HC21	MMTA - Cardiac - High	Early - Institutional	1	1.3659	4
2HC31	MMTA - Cardiac - High	Early - Institutional	2	1.5195	4
3HC11	MMTA - Cardiac - High	Late - Community	0	0.7678	2
3HC21	MMTA - Cardiac - High	Late - Community	1	0.8259	2
3HC31	MMTA - Cardiac - High	Late - Community	2	0.9795	3
4HC11	MMTA - Cardiac - High	Late - Institutional	0	1.2320	3
4HC21	MMTA - Cardiac - High	Late - Institutional	1	1.2902	3
4HC31	MMTA - Cardiac - High	Late - Institutional	2	1.4438	3
1HA11	MMTA - Cardiac - Low	Early - Community	0	0.9015	4
1HA21	MMTA - Cardiac - Low	Early - Community	1	0.9597	3
1HA31	MMTA - Cardiac - Low	Early - Community	2	1.1133	4
2HA11	MMTA - Cardiac - Low	Early - Institutional	0	1.1163	3
2HA21	MMTA - Cardiac - Low	Early - Institutional	1	1.1744	3
2HA31	MMTA - Cardiac - Low	Early - Institutional	2	1.3280	4
3HA11	MMTA - Cardiac - Low	Late - Community	0	0.5763	3
3HA21	MMTA - Cardiac - Low	Late - Community	1	0.6344	2
3HA31	MMTA - Cardiac - Low	Late - Community	2	0.7881	2
4HA11	MMTA - Cardiac - Low	Late - Institutional	0	1.0406	3
4HA21	MMTA - Cardiac - Low	Late - Institutional	1	1.0987	3
4HA31	MMTA - Cardiac - Low	Late - Institutional	2	1.2523	3
1HB11	MMTA - Cardiac - Medium	Early - Community	0	0.9912	4
1HB21	MMTA - Cardiac - Medium	Early - Community	1	1.0494	4
1HB31	MMTA - Cardiac - Medium	Early - Community	2	1.2030	3
2HB11	MMTA - Cardiac - Medium	Early - Institutional	0	1.2060	4
2HB21	MMTA - Cardiac - Medium	Early - Institutional	1	1.2641	4
2HB31	MMTA - Cardiac - Medium	Early - Institutional	2	1.4177	4
3HB11	MMTA - Cardiac - Medium	Late - Community	0	0.6660	2
3HB21	MMTA - Cardiac - Medium	Late - Community	1	0.7241	2
3HB31	MMTA - Cardiac - Medium	Late - Community	2	0.8778	2
4HB11	MMTA - Cardiac - Medium	Late - Institutional	0	1.1303	3
4HB21	MMTA - Cardiac - Medium	Late - Institutional	1	1.1884	3
4HB31	MMTA - Cardiac - Medium	Late - Institutional	2	1.3420	3
1IC11	MMTA - Endocrine - High	Early - Community	0	1.3292	4
1IC21	MMTA - Endocrine - High	Early - Community	1	1.3874	4
1IC31	MMTA - Endocrine - High	Early - Community	2	1.5410	4
2IC11	MMTA - Endocrine - High	Early - Institutional	0	1.5440	4
2IC21	MMTA - Endocrine - High	Early - Institutional	1	1.6021	4

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
2IC31	MMTA - Endocrine - High	Early - Institutional	2	1.7558	4
3IC11	MMTA - Endocrine - High	Late - Community	0	1.0040	3
3IC21	MMTA - Endocrine - High	Late - Community	1	1.0622	3
3IC31	MMTA - Endocrine - High	Late - Community	2	1.2158	3
4IC11	MMTA - Endocrine - High	Late - Institutional	0	1.4683	4
4IC21	MMTA - Endocrine - High	Late - Institutional	1	1.5264	4
4IC31	MMTA - Endocrine - High	Late - Institutional	2	1.6801	4
1IA11	MMTA - Endocrine - Low	Early - Community	0	1.1890	4
1IA21	MMTA - Endocrine - Low	Early - Community	1	1.2471	4
1IA31	MMTA - Endocrine - Low	Early - Community	2	1.4008	4
2IA11	MMTA - Endocrine - Low	Early - Institutional	0	1.4037	4
2IA21	MMTA - Endocrine - Low	Early - Institutional	1	1.4619	4
2IA31	MMTA - Endocrine - Low	Early - Institutional	2	1.6155	4
3IA11	MMTA - Endocrine - Low	Late - Community	0	0.8638	3
3IA21	MMTA - Endocrine - Low	Late - Community	1	0.9219	3
3IA31	MMTA - Endocrine - Low	Late - Community	2	1.0755	3
4IA11	MMTA - Endocrine - Low	Late - Institutional	0	1.3280	4
4IA21	MMTA - Endocrine - Low	Late - Institutional	1	1.3862	3
4IA31	MMTA - Endocrine - Low	Late - Institutional	2	1.5398	3
1IB11	MMTA - Endocrine - Medium	Early - Community	0	1.2374	5
1IB21	MMTA - Endocrine - Medium	Early - Community	1	1.2956	4
1IB31	MMTA - Endocrine - Medium	Early - Community	2	1.4492	4
2IB11	MMTA - Endocrine - Medium	Early - Institutional	0	1.4522	4
2IB21	MMTA - Endocrine - Medium	Early - Institutional	1	1.5103	4
2IB31	MMTA - Endocrine - Medium	Early - Institutional	2	1.6640	4
3IB11	MMTA - Endocrine - Medium	Late - Community	0	0.9122	3
3IB21	MMTA - Endocrine - Medium	Late - Community	1	0.9704	3
3IB31	MMTA - Endocrine - Medium	Late - Community	2	1.1240	3
4IB11	MMTA - Endocrine - Medium	Late - Institutional	0	1.3765	4
4IB21	MMTA - Endocrine - Medium	Late - Institutional	1	1.4346	4
4IB31	MMTA - Endocrine - Medium	Late - Institutional	2	1.5883	4
1JC11	MMTA - GI/GU - High	Early - Community	0	1.0898	3
1JC21	MMTA - GI/GU - High	Early - Community	1	1.1479	2
1JC31	MMTA - GI/GU - High	Early - Community	2	1.3015	2
2JC11	MMTA - GI/GU - High	Early - Institutional	0	1.3045	4
2JC21	MMTA - GI/GU - High	Early - Institutional	1	1.3627	3
2JC31	MMTA - GI/GU - High	Early - Institutional	2	1.5163	3
3JC11	MMTA - GI/GU - High	Late - Community	0	0.7646	2
3JC21	MMTA - GI/GU - High	Late - Community	1	0.8227	2

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
3JC31	MMTA - GI/GU - High	Late - Community	2	0.9763	2
4JC11	MMTA - GI/GU - High	Late - Institutional	0	1.2288	3
4JC21	MMTA - GI/GU - High	Late - Institutional	1	1.2870	3
4JC31	MMTA - GI/GU - High	Late - Institutional	2	1.4406	3
1JA11	MMTA - GI/GU - Low	Early - Community	0	0.8925	3
1JA21	MMTA - GI/GU - Low	Early - Community	1	0.9507	2
1JA31	MMTA - GI/GU - Low	Early - Community	2	1.1043	2
2JA11	MMTA - GI/GU - Low	Early - Institutional	0	1.1073	3
2JA21	MMTA - GI/GU - Low	Early - Institutional	1	1.1654	3
2JA31	MMTA - GI/GU - Low	Early - Institutional	2	1.3191	3
3JA11	MMTA - GI/GU - Low	Late - Community	0	0.5673	2
3JA21	MMTA - GI/GU - Low	Late - Community	1	0.6254	2
3JA31	MMTA - GI/GU - Low	Late - Community	2	0.7791	2
4JA11	MMTA - GI/GU - Low	Late - Institutional	0	1.0316	3
4JA21	MMTA - GI/GU - Low	Late - Institutional	1	1.0897	3
4JA31	MMTA - GI/GU - Low	Late - Institutional	2	1.2434	3
1JB11	MMTA - GI/GU - Medium	Early - Community	0	0.9891	3
1JB21	MMTA - GI/GU - Medium	Early - Community	1	1.0473	3
1JB31	MMTA - GI/GU - Medium	Early - Community	2	1.2009	3
2JB11	MMTA - GI/GU - Medium	Early - Institutional	0	1.2039	3
2JB21	MMTA - GI/GU - Medium	Early - Institutional	1	1.2620	3
2JB31	MMTA - GI/GU - Medium	Early - Institutional	2	1.4156	3
3JB11	MMTA - GI/GU - Medium	Late - Community	0	0.6639	2
3JB21	MMTA - GI/GU - Medium	Late - Community	1	0.7220	2
3JB31	MMTA - GI/GU - Medium	Late - Community	2	0.8757	2
4JB11	MMTA - GI/GU - Medium	Late - Institutional	0	1.1282	3
4JB21	MMTA - GI/GU - Medium	Late - Institutional	1	1.1863	3
4JB31	MMTA - GI/GU - Medium	Late - Institutional	2	1.3399	3
1KC11	MMTA - Infectious - High	Early - Community	0	1.1309	2
1KC21	MMTA - Infectious - High	Early - Community	1	1.1890	2
1KC31	MMTA - Infectious - High	Early - Community	2	1.3427	2
2KC11	MMTA - Infectious - High	Early - Institutional	0	1.3457	3
2KC21	MMTA - Infectious - High	Early - Institutional	1	1.4038	3
2KC31	MMTA - Infectious - High	Early - Institutional	2	1.5574	3
3KC11	MMTA - Infectious - High	Late - Community	0	0.8057	2
3KC21	MMTA - Infectious - High	Late - Community	1	0.8638	2
3KC31	MMTA - Infectious - High	Late - Community	2	1.0175	2
4KC11	MMTA - Infectious - High	Late - Institutional	0	1.2700	3
4KC21	MMTA - Infectious - High	Late - Institutional	1	1.3281	3

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
4KC31	MMTA - Infectious - High	Late - Institutional	2	1.4817	3
1KA11	MMTA - Infectious - Low	Early - Community	0	0.9111	2
1KA21	MMTA - Infectious - Low	Early - Community	1	0.9692	2
1KA31	MMTA - Infectious - Low	Early - Community	2	1.1228	2
2KA11	MMTA - Infectious - Low	Early - Institutional	0	1.1258	3
2KA21	MMTA - Infectious - Low	Early - Institutional	1	1.1840	3
2KA31	MMTA - Infectious - Low	Early - Institutional	2	1.3376	3
3KA11	MMTA - Infectious - Low	Late - Community	0	0.5858	2
3KA21	MMTA - Infectious - Low	Late - Community	1	0.6440	2
3KA31	MMTA - Infectious - Low	Late - Community	2	0.7976	2
4KA11	MMTA - Infectious - Low	Late - Institutional	0	1.0501	3
4KA21	MMTA - Infectious - Low	Late - Institutional	1	1.1083	3
4KA31	MMTA - Infectious - Low	Late - Institutional	2	1.2619	3
1KB11	MMTA - Infectious - Medium	Early - Community	0	1.0005	3
1KB21	MMTA - Infectious - Medium	Early - Community	1	1.0586	2
1KB31	MMTA - Infectious - Medium	Early - Community	2	1.2122	2
2KB11	MMTA - Infectious - Medium	Early - Institutional	0	1.2152	3
2KB21	MMTA - Infectious - Medium	Early - Institutional	1	1.2734	3
2KB31	MMTA - Infectious - Medium	Early - Institutional	2	1.4270	3
3KB11	MMTA - Infectious - Medium	Late - Community	0	0.6753	2
3KB21	MMTA - Infectious - Medium	Late - Community	1	0.7334	2
3KB31	MMTA - Infectious - Medium	Late - Community	2	0.8870	2
4KB11	MMTA - Infectious - Medium	Late - Institutional	0	1.1395	3
4KB21	MMTA - Infectious - Medium	Late - Institutional	1	1.1977	3
4KB31	MMTA - Infectious - Medium	Late - Institutional	2	1.3513	3
1AC11	MMTA - Other - High	Early - Community	0	1.0907	4
1AC21	MMTA - Other - High	Early - Community	1	1.1488	4
1AC31	MMTA - Other - High	Early - Community	2	1.3025	3
2AC11	MMTA - Other - High	Early - Institutional	0	1.3054	4
2AC21	MMTA - Other - High	Early - Institutional	1	1.3636	4
2AC31	MMTA - Other - High	Early - Institutional	2	1.5172	4
3AC11	MMTA - Other - High	Late - Community	0	0.7655	2
3AC21	MMTA - Other - High	Late - Community	1	0.8236	2
3AC31	MMTA - Other - High	Late - Community	2	0.9772	2
4AC11	MMTA - Other - High	Late - Institutional	0	1.2298	3
4AC21	MMTA - Other - High	Late - Institutional	1	1.2879	3
4AC31	MMTA - Other - High	Late - Institutional	2	1.4415	3
1AA11	MMTA - Other - Low	Early - Community	0	0.9153	3
1AA21	MMTA - Other - Low	Early - Community	1	0.9734	3

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
1AA31	MMTA - Other - Low	Early - Community	2	1.1271	3
2AA11	MMTA - Other - Low	Early - Institutional	0	1.1301	3
2AA21	MMTA - Other - Low	Early - Institutional	1	1.1882	3
2AA31	MMTA - Other - Low	Early - Institutional	2	1.3418	4
3AA11	MMTA - Other - Low	Late - Community	0	0.5901	2
3AA21	MMTA - Other - Low	Late - Community	1	0.6482	2
3AA31	MMTA - Other - Low	Late - Community	2	0.8019	2
4AA11	MMTA - Other - Low	Late - Institutional	0	1.0544	3
4AA21	MMTA - Other - Low	Late - Institutional	1	1.1125	3
4AA31	MMTA - Other - Low	Late - Institutional	2	1.2661	3
1AB11	MMTA - Other - Medium	Early - Community	0	0.9931	4
1AB21	MMTA - Other - Medium	Early - Community	1	1.0512	4
1AB31	MMTA - Other - Medium	Early - Community	2	1.2048	4
2AB11	MMTA - Other - Medium	Early - Institutional	0	1.2078	4
2AB21	MMTA - Other - Medium	Early - Institutional	1	1.2660	4
2AB31	MMTA - Other - Medium	Early - Institutional	2	1.4196	4
3AB11	MMTA - Other - Medium	Late - Community	0	0.6678	2
3AB21	MMTA - Other - Medium	Late - Community	1	0.7260	2
3AB31	MMTA - Other - Medium	Late - Community	2	0.8796	2
4AB11	MMTA - Other - Medium	Late - Institutional	0	1.1321	3
4AB21	MMTA - Other - Medium	Late - Institutional	1	1.1903	3
4AB31	MMTA - Other - Medium	Late - Institutional	2	1.3439	4
1LC11	MMTA - Respiratory - High	Early - Community	0	1.0993	3
1LC21	MMTA - Respiratory - High	Early - Community	1	1.1574	3
1LC31	MMTA - Respiratory - High	Early - Community	2	1.3111	3
2LC11	MMTA - Respiratory - High	Early - Institutional	0	1.3140	4
2LC21	MMTA - Respiratory - High	Early - Institutional	1	1.3722	3
2LC31	MMTA - Respiratory - High	Early - Institutional	2	1.5258	4
3LC11	MMTA - Respiratory - High	Late - Community	0	0.7741	2
3LC21	MMTA - Respiratory - High	Late - Community	1	0.8322	2
3LC31	MMTA - Respiratory - High	Late - Community	2	0.9858	2
4LC11	MMTA - Respiratory - High	Late - Institutional	0	1.2383	3.5
4LC21	MMTA - Respiratory - High	Late - Institutional	1	1.2965	3
4LC31	MMTA - Respiratory - High	Late - Institutional	2	1.4501	3
1LA11	MMTA - Respiratory - Low	Early - Community	0	0.9046	3
1LA21	MMTA - Respiratory - Low	Early - Community	1	0.9628	2
1LA31	MMTA - Respiratory - Low	Early - Community	2	1.1164	2
2LA11	MMTA - Respiratory - Low	Early - Institutional	0	1.1194	3
2LA21	MMTA - Respiratory - Low	Early - Institutional	1	1.1775	3

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
2LA31	MMTA - Respiratory - Low	Early - Institutional	2	1.3312	4
3LA11	MMTA - Respiratory - Low	Late - Community	0	0.5794	2
3LA21	MMTA - Respiratory - Low	Late - Community	1	0.6376	2
3LA31	MMTA - Respiratory - Low	Late - Community	2	0.7912	2
4LA11	MMTA - Respiratory - Low	Late - Institutional	0	1.0437	3
4LA21	MMTA - Respiratory - Low	Late - Institutional	1	1.1018	3
4LA31	MMTA - Respiratory - Low	Late - Institutional	2	1.2555	3
1LB11	MMTA - Respiratory - Medium	Early - Community	0	1.0020	3
1LB21	MMTA - Respiratory - Medium	Early - Community	1	1.0601	3
1LB31	MMTA - Respiratory - Medium	Early - Community	2	1.2137	3
2LB11	MMTA - Respiratory - Medium	Early - Institutional	0	1.2167	4
2LB21	MMTA - Respiratory - Medium	Early - Institutional	1	1.2749	4
2LB31	MMTA - Respiratory - Medium	Early - Institutional	2	1.4285	4
3LB11	MMTA - Respiratory - Medium	Late - Community	0	0.6768	2
3LB21	MMTA - Respiratory - Medium	Late - Community	1	0.7349	2
3LB31	MMTA - Respiratory - Medium	Late - Community	2	0.8885	2
4LB11	MMTA - Respiratory - Medium	Late - Institutional	0	1.1410	3
4LB21	MMTA - Respiratory - Medium	Late - Institutional	1	1.1992	3
4LB31	MMTA - Respiratory - Medium	Late - Institutional	2	1.3528	3
1GC11	MMTA - Surgical Aftercare - High	Early - Community	0	1.1226	3
1GC21	MMTA - Surgical Aftercare - High	Early - Community	1	1.1807	2
1GC31	MMTA - Surgical Aftercare - High	Early - Community	2	1.3343	2
2GC11	MMTA - Surgical Aftercare - High	Early - Institutional	0	1.3373	4
2GC21	MMTA - Surgical Aftercare - High	Early - Institutional	1	1.3955	4
2GC31	MMTA - Surgical Aftercare - High	Early - Institutional	2	1.5491	4
3GC11	MMTA - Surgical Aftercare - High	Late - Community	0	0.7974	2
3GC21	MMTA - Surgical Aftercare - High	Late - Community	1	0.8555	2
3GC31	MMTA - Surgical Aftercare - High	Late - Community	2	1.0091	2
4GC11	MMTA - Surgical Aftercare - High	Late - Institutional	0	1.2616	3
4GC21	MMTA - Surgical Aftercare - High	Late - Institutional	1	1.3198	3
4GC31	MMTA - Surgical Aftercare - High	Late - Institutional	2	1.4734	4
1GA11	MMTA - Surgical Aftercare - Low	Early - Community	0	0.8943	2
1GA21	MMTA - Surgical Aftercare - Low	Early - Community	1	0.9524	2
1GA31	MMTA - Surgical Aftercare - Low	Early - Community	2	1.1061	2
2GA11	MMTA - Surgical Aftercare - Low	Early - Institutional	0	1.1090	3
2GA21	MMTA - Surgical Aftercare - Low	Early - Institutional	1	1.1672	3
2GA31	MMTA - Surgical Aftercare - Low	Early - Institutional	2	1.3208	4
3GA11	MMTA - Surgical Aftercare - Low	Late - Community	0	0.5691	2
3GA21	MMTA - Surgical Aftercare - Low	Late - Community	1	0.6272	2

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
3GA31	MMTA - Surgical Aftercare - Low	Late - Community	2	0.7808	2
4GA11	MMTA - Surgical Aftercare - Low	Late - Institutional	0	1.0333	3
4GA21	MMTA - Surgical Aftercare - Low	Late - Institutional	1	1.0915	3
4GA31	MMTA - Surgical Aftercare - Low	Late - Institutional	2	1.2451	3
1GB11	MMTA - Surgical Aftercare - Medium	Early - Community	0	0.9985	3
1GB21	MMTA - Surgical Aftercare - Medium	Early - Community	1	1.0567	2
1GB31	MMTA - Surgical Aftercare - Medium	Early - Community	2	1.2103	2
2GB11	MMTA - Surgical Aftercare - Medium	Early - Institutional	0	1.2133	3
2GB21	MMTA - Surgical Aftercare - Medium	Early - Institutional	1	1.2714	4
2GB31	MMTA - Surgical Aftercare - Medium	Early - Institutional	2	1.4251	4
3GB11	MMTA - Surgical Aftercare - Medium	Late - Community	0	0.6733	2
3GB21	MMTA - Surgical Aftercare - Medium	Late - Community	1	0.7314	2
3GB31	MMTA - Surgical Aftercare - Medium	Late - Community	2	0.8851	2
4GB11	MMTA - Surgical Aftercare - Medium	Late - Institutional	0	1.1376	3
4GB21	MMTA - Surgical Aftercare - Medium	Late - Institutional	1	1.1957	3
4GB31	MMTA - Surgical Aftercare - Medium	Late - Institutional	2	1.3494	4
1EC11	MS Rehab - High	Early - Community	0	1.1575	5
1EC21	MS Rehab - High	Early - Community	1	1.2156	4
1EC31	MS Rehab - High	Early - Community	2	1.3693	4
2EC11	MS Rehab - High	Early - Institutional	0	1.3722	5
2EC21	MS Rehab - High	Early - Institutional	1	1.4304	5
2EC31	MS Rehab - High	Early - Institutional	2	1.5840	5
3EC11	MS Rehab - High	Late - Community	0	0.8323	2
3EC21	MS Rehab - High	Late - Community	1	0.8904	2
3EC31	MS Rehab - High	Late - Community	2	1.0440	3
4EC11	MS Rehab - High	Late - Institutional	0	1.2966	4
4EC21	MS Rehab - High	Late - Institutional	1	1.3547	4
4EC31	MS Rehab - High	Late - Institutional	2	1.5083	4
1EA11	MS Rehab - Low	Early - Community	0	0.9468	4
1EA21	MS Rehab - Low	Early - Community	1	1.0049	4
1EA31	MS Rehab - Low	Early - Community	2	1.1586	4
2EA11	MS Rehab - Low	Early - Institutional	0	1.1616	4
2EA21	MS Rehab - Low	Early - Institutional	1	1.2197	5
2EA31	MS Rehab - Low	Early - Institutional	2	1.3733	5
3EA11	MS Rehab - Low	Late - Community	0	0.6216	2
3EA21	MS Rehab - Low	Late - Community	1	0.6797	2
3EA31	MS Rehab - Low	Late - Community	2	0.8334	2
4EA11	MS Rehab - Low	Late - Institutional	0	1.0859	4
4EA21	MS Rehab - Low	Late - Institutional	1	1.1440	4

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
4EA31	MS Rehab - Low	Late - Institutional	2	1.2976	4
1EB11	MS Rehab - Medium	Early - Community	0	1.0262	5
1EB21	MS Rehab - Medium	Early - Community	1	1.0843	4
1EB31	MS Rehab - Medium	Early - Community	2	1.2380	4
2EB11	MS Rehab - Medium	Early - Institutional	0	1.2410	5
2EB21	MS Rehab - Medium	Early - Institutional	1	1.2991	5
2EB31	MS Rehab - Medium	Early - Institutional	2	1.4527	5
3EB11	MS Rehab - Medium	Late - Community	0	0.7010	2
3EB21	MS Rehab - Medium	Late - Community	1	0.7591	2
3EB31	MS Rehab - Medium	Late - Community	2	0.9128	2
4EB11	MS Rehab - Medium	Late - Institutional	0	1.1653	4
4EB21	MS Rehab - Medium	Late - Institutional	1	1.2234	4
4EB31	MS Rehab - Medium	Late - Institutional	2	1.3770	4
1BC11	Neuro - High	Early - Community	0	1.2661	4
1BC21	Neuro - High	Early - Community	1	1.3242	4
1BC31	Neuro - High	Early - Community	2	1.4778	4
2BC11	Neuro - High	Early - Institutional	0	1.4808	5
2BC21	Neuro - High	Early - Institutional	1	1.5390	4
2BC31	Neuro - High	Early - Institutional	2	1.6926	4
3BC11	Neuro - High	Late - Community	0	0.9409	2
3BC21	Neuro - High	Late - Community	1	0.9990	3
3BC31	Neuro - High	Late - Community	2	1.1526	3
4BC11	Neuro - High	Late - Institutional	0	1.4051	4
4BC21	Neuro - High	Late - Institutional	1	1.4633	4
4BC31	Neuro - High	Late - Institutional	2	1.6169	4
1BA11	Neuro - Low	Early - Community	0	1.0251	4
1BA21	Neuro - Low	Early - Community	1	1.0832	4
1BA31	Neuro - Low	Early - Community	2	1.2368	4
2BA11	Neuro - Low	Early - Institutional	0	1.2398	4
2BA21	Neuro - Low	Early - Institutional	1	1.2980	4
2BA31	Neuro - Low	Early - Institutional	2	1.4516	4
3BA11	Neuro - Low	Late - Community	0	0.6999	2
3BA21	Neuro - Low	Late - Community	1	0.7580	2
3BA31	Neuro - Low	Late - Community	2	0.9116	2
4BA11	Neuro - Low	Late - Institutional	0	1.1641	3
4BA21	Neuro - Low	Late - Institutional	1	1.2223	3
4BA31	Neuro - Low	Late - Institutional	2	1.3759	4
1BB11	Neuro - Medium	Early - Community	0	1.1220	4
1BB21	Neuro - Medium	Early - Community	1	1.1801	4

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
1BB31	Neuro - Medium	Early - Community	2	1.3338	4
2BB11	Neuro - Medium	Early - Institutional	0	1.3368	4
2BB21	Neuro - Medium	Early - Institutional	1	1.3949	4
2BB31	Neuro - Medium	Early - Institutional	2	1.5485	4
3BB11	Neuro - Medium	Late - Community	0	0.7968	2
3BB21	Neuro - Medium	Late - Community	1	0.8549	2
3BB31	Neuro - Medium	Late - Community	2	1.0086	2
4BB11	Neuro - Medium	Late - Institutional	0	1.2611	4
4BB21	Neuro - Medium	Late - Institutional	1	1.3192	4
4BB31	Neuro - Medium	Late - Institutional	2	1.4728	4
1CC11	Wound - High	Early - Community	0	1.5018	4
1CC21	Wound - High	Early - Community	1	1.5600	4
1CC31	Wound - High	Early - Community	2	1.7136	4
2CC11	Wound - High	Early - Institutional	0	1.7166	5
2CC21	Wound - High	Early - Institutional	1	1.7747	4
2CC31	Wound - High	Early - Institutional	2	1.9284	4
3CC11	Wound - High	Late - Community	0	1.1766	3
3CC21	Wound - High	Late - Community	1	1.2348	3
3CC31	Wound - High	Late - Community	2	1.3884	3
4CC11	Wound - High	Late - Institutional	0	1.6409	4
4CC21	Wound - High	Late - Institutional	1	1.6990	4
4CC31	Wound - High	Late - Institutional	2	1.8527	4
1CA11	Wound - Low	Early - Community	0	1.2811	4
1CA21	Wound - Low	Early - Community	1	1.3392	4
1CA31	Wound - Low	Early - Community	2	1.4929	4
2CA11	Wound - Low	Early - Institutional	0	1.4959	4
2CA21	Wound - Low	Early - Institutional	1	1.5540	4
2CA31	Wound - Low	Early - Institutional	2	1.7076	4
3CA11	Wound - Low	Late - Community	0	0.9559	2
3CA21	Wound - Low	Late - Community	1	1.0140	3
3CA31	Wound - Low	Late - Community	2	1.1677	3
4CA11	Wound - Low	Late - Institutional	0	1.4202	4
4CA21	Wound - Low	Late - Institutional	1	1.4783	4
4CA31	Wound - Low	Late - Institutional	2	1.6319	4
1CB11	Wound - Medium	Early - Community	0	1.3748	4
1CB21	Wound - Medium	Early - Community	1	1.4330	4
1CB31	Wound - Medium	Early - Community	2	1.5866	4
2CB11	Wound - Medium	Early - Institutional	0	1.5896	4
2CB21	Wound - Medium	Early - Institutional	1	1.6477	4

HIPPS	Clinical Group and Functional Level	Admission Source and Timing	Comorbidity Adjustment (0 = none, 1 = single comorbidity, 2 = interaction)	Recalibrated Weight for 2027	LUPA Visit Threshold (LUPAs have fewer visits than the threshold)
2CB31	Wound - Medium	Early - Institutional	2	1.8013	4
3CB11	Wound - Medium	Late - Community	0	1.0496	3
3CB21	Wound - Medium	Late - Community	1	1.1077	3
3CB31	Wound - Medium	Late - Community	2	1.2614	3
4CB11	Wound - Medium	Late - Institutional	0	1.5139	4
4CB21	Wound - Medium	Late - Institutional	1	1.5720	4
4CB31	Wound - Medium	Late - Institutional	2	1.7257	4

Source: CY 2025 Home Health Claims Data, Periods that end in CY 2025 accessed from the CCW on March 15, 2026.

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Changes to the PDGM case-mix weights are implemented in a budget neutral manner by multiplying the CY 2027 national standardized 30-day

period payment rate by a case-mix budget neutrality factor. Typically, the case-mix weight recalibration neutrality factor is also calculated using the most recent, complete home health claims data available. For CY 2027, we would continue the practice of using the most recent complete home health claims data at the time of rulemaking, which is currently CY 2025 data. The case-mix budget neutrality factor is calculated as the ratio of 30-day base payment rates such that total payments when the CY 2027 PDGM case-mix weights (developed using CY 2025 home health claims data) are applied to CY 2025 utilization (claims) data are equal to total payments when CY 2026 PDGM case-mix weights (developed using CY 2024 home health claims data) are applied to CY 2025 utilization data. This produces a case-mix budget neutrality factor for CY 2027 of 1.0045.

We invite public comments on the CY 2027 proposed case-mix weights and proposed case-mix weight budget neutrality factor.

E. Proposed CY 2027 Home Health Payment Rate Updates

1. Proposed CY 2027 Home Health Market Basket Update for HHAs

Section 1895(b)(3)(B) of the Act requires that the standard prospective payment amounts for home health be increased by a factor equal to the applicable home health market basket update for those HHAs that submit quality data as required by the Secretary. In the CY 2024 HH PPS final rule (88 FR 77726), we finalized a rebasing of the home health market basket to reflect 2021 cost report data. We also finalized a policy for CY 2024 and subsequent years that the labor-related share is 74.9 percent, and the non-labor-related share is 25.1 percent. A detailed description of how we rebased the home health market basket and labor-related share is available in the CY 2024 HH PPS final rule (88 FR 77726 through 77742).

In the CY 2015 HH PPS final rule (79 FR 38384), we finalized our methodology for calculating and applying the productivity adjustment. As we explained in that rule, section 1895(b)(3)(B)(vi) of the Act, requires that, in CY 2015 (and in subsequent calendar years, except CY 2018 (under section 411(c) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114–10, enacted April 16, 2015)), the market basket percentage under the HH PPS as described in section 1895(b)(3)(B) of the Act be annually adjusted by changes in economy-wide productivity. Section 1886(b)(3)(B)(xi)(II) of the Act defines the productivity adjustment as equal to the 10-year moving average of change in annual economy-wide private nonfarm business multifactor productivity (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, calendar year, cost reporting period, or other annual period). The Bureau of Labor Statistics (BLS) publishes the official measures of productivity for the United States economy. The productivity measure referenced in section 1886(b)(3)(B)(xi)(II) of the Act is published by BLS as private nonfarm business total factor productivity (TFP) (previously referred to as multifactor productivity).[5] We refer readers to *https://www.bls.gov/productivity* for the BLS historical published TFP data. A complete description of IHS Global Inc.'s (IGI) TFP projection methodology is available on the CMS website at *https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-research-and-information.*

The proposed home health update percentage for CY 2027 is based on the estimated home health market basket percentage increase, specified at section 1895(b)(3)(B)(iii) of the Act of 3.1 percent (based on IHS Global Inc.'s first quarter 2026 forecast with historical data through fourth quarter 2025). The estimated CY 2027 proposed home health market basket percentage increase of 3.1 percent would then be reduced by a productivity adjustment, in accordance with section 1895(b)(3)(B)(vi) of the Act. Based on IGI's first quarter 2026 forecast, the proposed productivity adjustment is currently estimated to be 1.0 percentage point for CY 2027. Therefore, the proposed productivity-adjusted CY 2027 home health market basket update is 2.1 percent (3.1 percent market basket percentage increase, reduced by a 1.0 percentage point productivity adjustment). Furthermore, we are proposing that if more recent data become available (for example, a more recent estimate of the market basket percentage increase and/or productivity adjustment), we would use such data, if appropriate, to determine the CY 2027 market basket percentage increase and productivity adjustment in the final rule.

Section 1895(b)(3)(B)(v) of the Act requires that the home health percentage update be decreased by 2 percentage points for those HHAs that do not submit quality data as required by the Secretary. For HHAs that do not submit the required quality data for CY 2027, the proposed home health payment update percentage is 0.1 percent (2.1 percent minus 2 percentage points).

We invite public comments on the proposed CY 2027 home health market basket percentage increase and productivity adjustment.

2. Proposed CY 2027 Home Health Wage Index

a. Background

Sections 1895(b)(4)(A)(ii) and (b)(4)(C) of the Act require the Secretary to provide appropriate adjustments to the proportion of the payment amount under the HH PPS that account for area wage differences, using adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services. Since the inception of the HH PPS, we have used inpatient hospital wage data in developing a wage index to be applied to home health payments. We are proposing to continue this practice for CY 2027, as it is our belief that, in the absence of home health-specific wage data that accounts for area differences, using inpatient hospital wage data, including any changes made by the Office of Management and Budget (OMB) to Metropolitan Statistical Area (MSA) definitions, is appropriate and reasonable for the HH PPS.

In general, OMB issues major revisions to statistical areas every 10 years, based on the results of the decennial census. However, OMB occasionally issues minor updates and revisions to statistical areas in the years between the decennial censuses. On April 10, 2018, OMB issued OMB Bulletin No. 18–03, which superseded the August 15, 2017, OMB Bulletin No. 17–01. On September 14, 2018, OMB issued OMB Bulletin No. 18–04 which superseded the April 10, 2018, OMB Bulletin No. 18–03. These bulletins established revised delineations for Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and provided guidance on the use of the delineations of these statistical areas. A copy of OMB Bulletin No. 18–04 may be obtained at *https://www.whitehouse.gov/wp-content/uploads/2018/09/Bulletin-18-04.pdf.* In the CY 2021 HH PPS final rule (85 FR 70298), we finalized our proposal to adopt the revised OMB delineations with a 5 percent cap on wage index decreases in CY 2021.

[5] *https://www.bls.gov/productivity/notices/2021/mfp-to-tfp-term-change.htm.*

On July 21, 2023, OMB issued Bulletin No. 23–01, which updates and supersedes OMB Bulletin No. 20–01, issued on March 6, 2020. OMB Bulletin No. 23–01 establishes revised delineations for the MSAs, Micropolitan Statistical Areas, Combined Statistical Areas, and Metropolitan Divisions, collectively referred to as Core Based Statistical Areas (CBSAs). A copy of OMB Bulletin No. 23–01 is available online at *https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf.*

According to OMB, the delineations from OMB Bulletin 23–01 reflect the 2020 Standards for Delineating Core Based Statistical Areas (CBSAs) (the ''2020 Standards''), which appeared in the **Federal Register** (86 FR 37770 through 37778) on July 16, 2021, and application of those standards to Census Bureau population and journey-to-work data (for example, 2020 Decennial Census, American Community Survey, and Census Population Estimates Program data). The OMB ''2020 Standards'' define a ''Metropolitan Statistical Area'' as being associated with at least one Urban Area that has a population of at least 50,000 and a ''Micropolitan Statistical Area'' as being associated with at least one Urban Area that has a population of at least 10,000, but less than 50,000 (86 FR 37778).

In the CY 2025 HH PPS final rule (89 FR 88354), we finalized our proposal to adopt the revised OMB delineations from OMB Bulletin 23–01 with a 5 percent cap on wage index decreases at the CBSA level as well as at the county level. In that final rule we stated that we believe it is important for the HH PPS wage index to use the latest OMB delineations available in order to maintain a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. We also stated that we believe using the most current OMB delineations will increase the integrity of the HH PPS wage index by creating a more accurate representation of geographic variation in wage levels. In conjunction with our implementation of the revised labor market delineations beginning in CY 2025, and consistent with the treatment of Micropolitan Statistical Areas under the Inpatient Prospective Payment System (IPPS), we also finalized continuing to treat Micropolitan Statistical Areas as ''rural'' and including Micropolitan Statistical Areas in the calculation of each state's statewide rural wage index. Therefore, the HH PPS statewide rural wage index is determined using IPPS hospital data from hospitals located in Micropolitan Statistical Areas and the HH PPS wage index for each CBSA is determined using IPPS hospital data from hospitals located in Metropolitan Statistical Areas.

b. Five Percent Cap on Wage Index Decreases

In the CY 2023 HH PPS final rule (87 FR 66851 through 66853), we finalized a policy that the CY HH PPS wage index will include a permanent 5 percent cap on wage index decreases for CY 2023 and each subsequent year. Specifically, we finalized, for CY 2023 and subsequent years, the application of a permanent 5 percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. That is, we finalized a policy requiring that a geographic area's wage index for CY 2023 will not be less than 95 percent of its final wage index for CY 2022, regardless of whether the geographic area is part of an updated CBSA, and that for subsequent years, a geographic area's wage index will not be less than 95 percent of its wage index calculated in the prior CY.

Previously this methodology was applied to all counties that make up a CBSA or statewide rural area. However, in the CY 2025 HH PPS final rule (89 FR 88418 through 88421), because of the adoption of the revised OMB delineations from OMB Bulletin 23–01, we finalized a policy applying this methodology to individual counties. Specifically, we finalized a policy applying the 5 percent cap to counties that moved from a CBSA or statewide rural area with a higher wage index value into a new CBSA or statewide rural area with a lower wage index value, so that the county's CY 2025 wage index would not be less than 95 percent of the county's CY 2024 wage index value under the old delineation despite moving into a new delineation with a lower wage index.

Due to the way that we proposed calculating the 5 percent cap for counties that experienced an OMB designation change, some CBSAs and statewide rural areas could have had more than one wage index value. Specifically, some counties that changed OMB designations had a wage index value that was different than the wage index value assigned to the other constituent counties that made up that CBSA or statewide rural area that they moved into after the application of the 5 percent cap. However, for home health claims processing, each CBSA or statewide rural area can have only one wage index value assigned to that CBSA or statewide rural area. Therefore, we finalized a policy, beginning in CY 2025, that counties that have a different wage index value than the CBSA or rural area into which they are designated after the application of the 5 percent cap will use a wage index transition code. These special codes are five digits in length and begin with ''50'' and the remaining digits are unique for that code. The 50XXX wage index transition codes are used only in specific counties; counties located in CBSAs and rural areas that do not correspond to a different transition wage index value will still use the CBSA number.

We also finalized a policy applying the 5 percent cap to these specific counties that correspond to a different wage index value due to a delineation change until the county's new wage index is more than 95 percent of the wage index from the previous calendar year. In order to capture the correct wage index value, an HHA will continue to use the assigned 50XXX transition code on home health claims for services in these counties until the county's wage index value calculated for that calendar year using the new OMB delineations is not less than 95 percent of the county's capped wage index from the previous calendar year.

For CY 2027, the 5 percent cap on wage index decreases will continue to be calculated at the county level as well as the CBSA and statewide rural area level. While some counties that required a transition code for CY 2025 and CY 2026 will continue to use the same transition code for CY 2027, other counties that required a transition code in CY 2025 and CY 2026 will no longer require a transition code in CY 2027. The counties that will no longer require a transition code beginning in CY 2027 have a CY 2027 wage index value in the CBSA or rural area that the county was redesignated into that is higher than 95 percent of the county's CY 2026 wage index. Therefore, these counties will use the CBSA or rural county code of the area into which they were redesignated based on OMB Bulletin No. 23–01.

The complete list of counties and corresponding transition codes can be found as a separate tab in the calendar year's wage index file located on the CMS website at *https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health-pps/home-health-pps-wage-index.*

c. Proposed CY 2027 HH PPS Wage Index

The appropriate wage index value is applied to the labor portion of the HH PPS rates based on the site of service for the beneficiary (defined in section

1861(m) of the Act as the beneficiary's place of residence). For CY 2027, we are proposing to base the HH PPS wage index on the FY 2027 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2022, and before October 1, 2023 (FY 2023 cost report data). The proposed CY 2027 HH PPS wage index would not take into account any geographic reclassification of hospitals, including those in accordance with sections 1886(d)(8)(B) or 1886(d)(10) of the Act but would include the 5 percent cap on wage index decreases as discussed previously.

There exist some geographic areas where there are no hospitals, and thus, no hospital wage data on which to base the calculation of the HH PPS wage index. To address those geographic areas in which there are no inpatient hospitals, and thus, no hospital wage data on which to base the calculation of the CY 2027 HH PPS wage index, we are proposing to continue to use the same methodology discussed in the CY 2007 HH PPS final rule (71 FR 65884) to address those geographic areas in which there are no inpatient hospitals.

For urban areas without inpatient hospitals, we use the average wage index of all urban areas within the State as a reasonable proxy for the wage index for that CBSA. For CY 2027, the only urban area without inpatient hospital wage data is Hinesville, GA (CBSA 25980). Using the average wage index of all urban areas in Georgia as a proxy, we are proposing the CY 2027 wage index value for Hinesville, GA, would be 0.8797.

For rural areas that do not have inpatient hospitals, we use the average wage index from all contiguous Core Based Statistical Areas (CBSAs) as a reasonable proxy. The term ''contiguous'' means sharing a border (72 FR 49859). In the CY 2025 HH PPS final rule (89 FR 88422), we finalized a policy that rural North Dakota would become a rural area without a hospital from which hospital wage data can be derived. Therefore, in order to calculate the wage index for rural area 99935, North Dakota, we finalized using as a proxy, the average pre-floor, pre-reclassified hospital wage data from the contiguous CBSAs: CBSA 13900-Bismark, ND, CBSA 22020-Fargo, ND–MN, CBSA 24220-Grand Forks, ND–MN, and CBSA 33500, Minot, ND. Using this methodology, we are proposing that the CY 2027 HH PPS wage index for rural North Dakota would be 0.8210.

Previously, the only rural area without a hospital from which hospital wage data could be derived was rural Puerto Rico. However, for rural Puerto Rico, we did not apply this methodology due to the distinct economic circumstances that exist there (for example, due to the proximity of almost all of Puerto Rico's various urban and non-urban areas to one another, this methodology would produce a wage index for rural Puerto Rico that is higher than that in half of its urban areas). Instead, we used the most recent wage index previously available for that area, which was 0.4047. Beginning in CY 2025, due to the adoption of the revised OMB delineations, there is now a hospital in rural Puerto Rico from which hospital wage data can be derived. Therefore, we finalized a policy that the wage index for rural Puerto Rico would now be based on the hospital wage data for the area instead of the previously available wage index of 0.4047.

The unadjusted CY 2027 proposed wage index for rural Puerto Rico is 0.2577. However, because 0.2577 is more than a 5 percent decline in the CY 2026 wage index, we are proposing that the CY 2027 5 percent cap adjusted wage index for rural Puerto Rico be set equal to 95 percent of the CY 2026 wage index of 0.3653, which would result in a proposed wage index value of 0.3470.

Additionally, due to the adoption of the revised OMB delineations in the CY 2025 HH PPS final rule, Delaware, which was previously an all-urban state, now has one rural area with a hospital from which hospital wage data can be derived. As such, we are proposing that the CY 2026 wage index for rural Delaware would be 0.9590.

Finally, the Northern Mariana Islands and American Samoa are rural areas with no hospital data from which a wage index can be calculated. In the CY 2026 HH PPS Wage Index and Rate Update final rule (90 FR 55405), using our established methodology for rural areas with no hospitals, we finalized that for CY 2026 and subsequent years, HHAs that provide services in the Northern Mariana Islands and American Samoa would use CBSA 99965 (Guam) and receive the wage index assigned to CBSA 99965 (Guam) of 0.9611. While we appreciate that the islands of the Pacific Rim are not actually contiguous, we believe that same principle applies here, and that Guam is a reasonable proxy for American Samoa and the Northern Mariana Islands. We believe that CBSA 99965 (Guam) represents a reasonable proxy because the islands are located within the Pacific Rim and share a common status as United States Territories.

The proposed HH PPS wage index file applicable for CY 2027 (January 1, 2027, through December 31, 2027) is available on the CMS website at *https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/home-health-agency-center.*

3. Proposed CY 2027 Home Health Payment Update

a. Background

The HH PPS has been in effect since October 1, 2000. As set forth in the July 3, 2000, HH PPS final rule (65 FR 41128), the base unit of payment under the HH PPS was a national, standardized 60-day episode payment rate. As finalized in the CY 2019 HH PPS final rule with comment period (83 FR 56406), and as described in the CY 2020 HH PPS final rule with comment period (84 FR 60478), the unit of home health payment changed from a 60-day episode to a 30-day period effective for those 30-day periods beginning on or after January 1, 2020.

As set forth in § 484.220, we adjust the national, standardized prospective payment rates by a case-mix relative weight and a wage index value based on the site of service for the beneficiary. To provide appropriate adjustments to the proportion of the payment amount under the HH PPS to account for area wage differences, we apply the appropriate wage index value to the labor portion of the HH PPS rates. In the CY 2024 HH PPS final rule (88 FR 77676), we finalized the rebasing of the home health market basket to reflect 2021 Medicare cost report data. We also finalized a policy that, for CY 2024 and subsequent years, the labor-related share is 74.9 percent, and the non-labor-related share is 25.1 percent. The following are the steps we take to compute the case-mix and wage-adjusted 30-day period payment amount for CY 2027:

- Multiply the national, standardized 30-day period rate by the patient's applicable case-mix weight.
- Divide the case-mix adjusted amount into a labor (74.9 percent) and a non-labor portion (25.1 percent).
- Multiply the labor portion by the applicable wage index based on the site of service of the beneficiary.
- Add the wage-adjusted portion to the non-labor portion, yielding the case-mix and wage adjusted 30-day period payment amount, subject to any additional applicable adjustments.

We provide annual updates of the HH PPS rate in accordance with section 1895(b)(3)(B) of the Act. Section 484.225 sets forth the specific annual percentage update methodology. In accordance with section 1895(b)(3)(B)(v) of the Act and § 484.225(i), for an HHA that does not submit home health quality data, as specified by the Secretary, the

unadjusted national prospective 30-day period rate is equal to the rate for the previous calendar year increased by the applicable home health payment update percentage, minus two percentage points. Any reduction of the percentage change will apply only to the calendar year involved and will not be considered in computing the prospective payment amount for a subsequent calendar year.

The final claim that the HHA submits for payment determines the total payment amount for the period and whether we make an applicable adjustment to the 30-day case-mix and wage-adjusted payment amount. The end date of the 30-day period, as reported on the claim, determines which calendar year rates Medicare would use to pay the claim.

We may adjust a 30-day case-mix and wage-adjusted payment based on the information submitted on the claim to reflect the following:

- A LUPA is provided on a per-visit basis as set forth in §§ 484.205(d)(1) and 484.230.
- A partial payment adjustment as set forth in §§ 484.205(d)(2) and 484.235.
- An outlier payment as set forth in §§ 484.205(d)(3) and 484.240.

b. Proposed CY 2027 National, Standardized 30-Day Period Payment Amount

Section 1895(b)(3)(A)(i) of the Act requires that the standard prospective payment rate and other applicable amounts be standardized in a manner that eliminates the effects of variations in relative case-mix and area wage adjustments among different home health agencies in a budget-neutral manner. To determine the CY 2027 national, standardized 30-day period payment rate, we would continue our practice of using the most recent, complete utilization data at the time of rulemaking; that is, we are using CY 2025 claims data for CY 2027 payment rate updates.

As discussed in section II.C.1. of the CY 2026 HH PPS final rule (90 FR 55406), we finalized the implementation of a temporary 3.0 percent reduction to the CY 2026 base payment rate that was equivalent to a final temporary adjustment factor of 0.97000. Per section 1895(b)(3)(D)(iii) of the Act, a temporary adjustment is to be applied for the applicable year and not included when computing a payment rate for a subsequent year. In other words, the temporary adjustment factor for CY 2026 will not be included in the starting payment rate for CY 2027. Therefore, we calculated the CY 2026 national, standardized 30-day period payment with and without the temporary adjustment factor.

To calculate the CY 2027 national, standardized 30-day period payment amount, we begin with the actual CY 2026 national standardized 30-day period payment amount (with the temporary adjustment factor included) and apply an adjustment factor of 1.03093 (which is equal to 1 divided by the CY 2026 temporary adjustment factor of 0.97000) to remove the temporary adjustment factor as shown in table 25.

Table 25: CY 2026 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT (WITHOUT TEMPORARY ADJUSTMENT)

CY 2026 National Standardized 30-Day Period Payment (With Temporary Adjustment)	Removing CY 2026 Temporary Adjustment Factor	CY 2026 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)
$2,038.22	1.03093	$2,101.26

We apply a case-mix weights recalibration budget neutrality factor, a wage index budget neutrality factor, the home health payment update percentage, and a temporary adjustment factor to update the CY 2027 payment rate. As discussed previously, to ensure the changes to the PDGM case-mix weights are implemented in a budget neutral manner, we apply a case-mix weight budget neutrality factor to the CY 2027 national, standardized 30-day period payment rate. The proposed case-mix weight budget neutrality factor for CY 2027 is 1.0045.

Additionally, we apply a wage index budget neutrality factor to ensure that wage index updates and revisions are implemented in a budget neutral manner. To calculate the wage index budget neutrality factor, we first determine the payment rate needed for non-LUPA 30-day periods using the CY 2027 wage index (with the 5 percent cap) so those total payments are equivalent to the total payments for non-LUPA 30-day periods using the CY 2026 wage index (with the 5 percent cap) and the CY 2026 national standardized 30-day period payment rate adjusted by the case-mix weights recalibration neutrality factor. Then, by dividing the payment rate for non-LUPA 30-day periods using the CY 2027 wage index with the 5 percent cap on wage index decreases) by the payment rate for non-LUPA 30-day periods using the CY 2026 wage index (with the 5 percent cap on wage index decreases), we obtain a wage index budget neutrality factor of 1.0009. We then apply the wage index budget neutrality factor of 1.0009 to the 30-day period payment rate.

Next, we update the 30-day period payment rate by the proposed CY 2027 home health payment update percentage of 2.1 percent. As discussed in section II.C.1. of this proposed rule, we are also proposing to apply the temporary 3.0 percent reduction to the CY 2027 base payment rate. The proposed temporary adjustment factor is 0.97000. As discussed previously, per section 1895(b)(3)(D)(iii) of the Act, the temporary adjustment is to be applied for the applicable year and not included when computing a payment rate for a subsequent year. In other words, the temporary adjustment factor for CY 2027 should not be included in the starting payment rate for CY 2028. Therefore, we have calculated the CY

2027 national, standardized 30-day period payment with and without the temporary adjustment factor. The CY 2027 national standardized 30-day period payment rate without a temporary adjustment is only for illustrative purposes. The actual CY 2027 national standardized 30-day period payment rate includes the proposed temporary adjustment and is calculated in table 26.

TABLE 26: PROPOSED CY 2027 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2026 National Standardized 30-Day Period Payment Without Temporary Adjustment	CY 2027 Case-Mix Weights Recalibration Neutrality Factor	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 Proposed HH Payment Update Factor	CY 2027 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2027 Proposed National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,101.26	1.0045	1.0009	1.021	$2,156.98	0.9700	$2,092.27

The proposed CY 2027 national standardized 30-day period payment rate for an HHA that does not submit the required quality data would be updated by 0.1 percent (the proposed CY 2027 home health payment update percentage of 2.1 percent minus 2 percentage points) and is shown in table 27.

TABLE 27: PROPOSED CY 2027 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA

CY 2026 National Standardized 30-Day Period Payment Without Temporary Adjustment	CY 2027 Case-Mix Weights Recalibration Neutrality Factor	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 HH Payment Update Factor Minus 2 Percentage Points	CY 2027 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2027 National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,101.26	1.0045	1.0009	1.001	$2,114.73	0.970	$2,051.29

c. Proposed CY 2027 National Per-Visit Rates for 30-day Periods of Care

The national per-visit rates are used to pay LUPAs and are also used to compute imputed costs in outlier calculations. The per-visit rates are paid by type of visit or home health discipline. The six home health disciplines are as follows:

- Home health aide (HH aide).
- Medical Social Services (MSS).
- Occupational therapy (OT).
- Physical therapy (PT).
- Skilled nursing (SN).
- Speech-language pathology (SLP).

To calculate the proposed CY 2027 national per-visit rates, we start with the CY 2026 national per-visit rates. Then we apply a wage index budget neutrality factor to ensure budget neutrality for LUPA per-visit payments. We calculate the wage index budget neutrality factor by simulating total payments for LUPA 30-day periods of care using the CY 2027 wage index with the 5 percent cap on wage index decreases and comparing it to simulated total payments for LUPA 30-day periods of care using the CY 2026 wage index with the 5 percent cap. By dividing the total payments for LUPA 30-day periods of care using the CY 2027 wage index by the total payments for LUPA 30-day periods of care using the CY 2026 wage index, we obtain a wage index budget neutrality factor of 0.9997. As a reminder, the wage index budget neutrality factors for the national, standardized 30-day period amount and the national LUPA per-visit rates are not equal because they are calculated differently. The wage index budget neutrality factor for the LUPA per-visit payments is calculated by simulating total payments for LUPA 30-day periods while the 30-day period

budget neutrality factor is calculated by simulating payments for non-LUPA 30-day periods.

The LUPA per-visit rates are not calculated using case-mix weights. Therefore, no case-mix weight budget neutrality factor is needed to ensure budget neutrality for LUPA payments. Additionally, we are not applying the permanent adjustment or the temporary adjustment to the LUPA per-visit payment rates but only to the case-mix adjusted 30-day payment rate. Lastly, the per-visit rates for each discipline are updated by the proposed CY 2027 home health payment update percentage of 2.1 percent. The national per-visit rates are adjusted by the wage index based on the site of service of the beneficiary. The per-visit payments for LUPAs are separate from the LUPA add-on payment amount, which is paid for periods that occur as the only period or initial period in a sequence of adjacent periods. The proposed CY 2027 national per-visit rates for HHAs that submit the required quality data are updated by the proposed CY 2027 home health payment update percentage of 2.1 percent and are shown in table 28.

TABLE 28: PROPOSED CY 2027 NATIONAL PER-VISIT PAYMENT AMOUNTS

HH Discipline	CY 2026 Per-Visit Payment Amount	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 HH Payment Update Factor	CY 2027 Per-Visit Payment Amount
Home Health Aide	$80.12	0.9997	1.021	$81.78
Medical Social Services	$283.64	0.9997	1.021	$289.51
Occupational Therapy	$194.74	0.9997	1.021	$198.77
Physical Therapy	$193.42	0.9997	1.021	$197.42
Skilled Nursing	$176.96	0.9997	1.021	$180.62
Speech-Language Pathology	$210.25	0.9997	1.021	$214.60

The CY 2027 per-visit payment rates for HHAs that do not submit the required quality data would be updated by 0.1 percent, which is the proposed CY 2027 home health payment update percentage of 2.1 percent minus 2 percentage points and are shown in table 29.

TABLE 29: PROPOSED CY 2027 NATIONAL PER-VISIT PAYMENT AMOUNTS FOR HHAS THAT DO NOT SUBMIT THE REQUIRED QUALITY DATA

HH Discipline	CY 2026 Per-Visit Payment Amount	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 HH Payment Update Factor Minus 2 Percentage Points	CY 2027 Per-Visit Payment Amount
Home Health Aide	$80.12	0.9997	1.001	$80.18
Medical Social Services	$283.64	0.9997	1.001	$283.84
Occupational Therapy	$194.74	0.9997	1.001	$194.88
Physical Therapy	$193.42	0.9997	1.001	$193.56
Skilled Nursing	$176.96	0.9997	1.001	$177.08
Speech-Language Pathology	$210.25	0.9997	1.001	$210.40

We are soliciting comments on the proposed CY 2027 30-day home health payment rates and the per-visit payment rates.

d. LUPA Add-On Factors

Prior to the implementation of the 30-day unit of payment, LUPA episodes were eligible for a LUPA add-on payment if the episode of care was the first or only episode in a sequence of adjacent episodes. As described in the CY 2008 HH PPS final rule, the average visit lengths in these initial LUPAs are 16 to 18 percent higher than the average

visit lengths in initial non-LUPA episodes (72 FR 49848). LUPA episodes that occur as the only episode or as an initial episode in a sequence of adjacent episodes are adjusted by applying an additional amount to the LUPA payment before adjusting for area wage differences.

In the CY 2014 HH PPS final rule (78 FR 72305), we changed the methodology for calculating the LUPA add-on amount, whereby we finalized the approach of multiplying the per-visit payment amount for the first skilled nursing (SN), physical therapy (PT), or speech language pathology (SLP) visit in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes by 1 + the proportional increase in minutes for an initial visit over non-initial visits. Specifically, we updated the analysis using 100 percent of LUPA episodes and a 20 percent sample of non-LUPA first episodes from CY 2012 claims data. At that time, we finalized add-on factors: 1.8451 for SN; 1.6700 for PT; and 1.6266 for SLP. In the CY 2019 HH PPS final rule with comment period (83 FR 56440), in addition to finalizing a 30-day unit of payment, we finalized our policy of continuing to multiply the per-visit payment amount for the first SN, PT, or SLP visit in LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care by the appropriate add-on factor (using the already established LUPA add-on factors of 1.8451 for SN, 1.6700 for PT, and 1.6266 for SLP) to determine the LUPA add-on payment amount for 30-day periods of care under the PDGM.

In the CY 2025 HH PPS final rule (89 FR 88426 through 88427), in an effort to enhance the accuracy and relevance of LUPA add-on factors to reflect current healthcare practices and costs, we finalized updates to the LUPA add-on factors for PT, SN, and SLP, which had not been revised since the CY 2014 HH PPS final rule (using CY 2012 claims data). We finalized using the same methodology to establish the LUPA add-on amount as used for CY 2014, using updated claims data.

Specifically, in CY 2025, we updated the LUPA add-on factors by using 100 percent of LUPA periods and a 100 percent sample of non-LUPA first periods from CY 2023 claims data (as of September 11, 2024). Our analysis found that the average excess of minutes for the first visit in LUPA periods that were the only period or an initial LUPA in a sequence of adjacent periods are 29.91 minutes for the first visit if SN, 28.08 minutes for the first visit if PT, and 31.57 minutes for the first visit if SLP. The average minutes for all non-first visits in non-LUPA episodes are 41.54 minutes for SN, 45.11 minutes for PT, and 47.15 minutes for SLP. To determine the LUPA add-on factors for each discipline, we calculated the ratio of the average excess minutes for the first visits in LUPA claims to the average minutes for all non-first visits in non-LUPA claims. We then added one to these ratios to obtain the final add on factors. Therefore, beginning in CY 2025 the final LUPA add on factors for SN, PT, and SLP are 1.7200 for SN; 1.6225 for PT; and 1.6696 for SLP.

Additionally, as outlined in the CY 2025 HH PPS proposed rule (89 FR 55378), in order to implement Division CC, section 115, of the Consolidation Appropriations Act (CAA), 2021, CMS finalized changes to the regulations at § 484.55(a)(2) and (b)(3) that allowed occupational therapists to conduct initial and comprehensive assessments for all Medicare beneficiaries under the home health benefit when the plan of care does not initially include skilled nursing care, but included OT, as well as either PT or SLP (86 FR 62351). This change necessitated the establishment of a LUPA add-on factor for calculating the LUPA add-on payment amount for the first skilled OT visit in LUPA periods that occur as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care. However, at the time of the implementation, we stated in the CY 2022 HH PPS final rule (86 FR 62289), there was not sufficient data regarding the average excess minutes for the first visit in LUPA periods when the initial and comprehensive assessments are conducted by occupational therapists. Therefore, we finalized a policy using the PT LUPA add-on factor as a proxy. We also stated in the CY 2022 final rule that we will use the PT LUPA add-on factor as a proxy until we have CY 2022 data to establish a more accurate OT add-on factor for the LUPA add-on payment amounts (86 FR 62289). Ultimately, we refrained from using CY 2022 data (and instead utilized the PT LUPA add-on factor as a proxy for the OT LUPA add-on factor), as we marked the first year that occupational therapists were permitted to conduct the initial assessment. We wanted to extend our analysis to ensure we had sufficient data to reflect OT time spent conducting initial assessments to establish a discrete OT LUPA add-on factor (86 FR 62240).

In the CY 2025 HH PPS final rule (89 FR 88427), we finalized discontinuing the use of the PT LUPA add-on factor as a proxy and established a definitive LUPA add-on factor for OT. We used the same methodology used to establish the LUPA add-on amount for CY 2014, as described previously for the SN, PT, and SLP add-on factors. Specifically, we updated the analysis using 100 percent of LUPA periods and a 100 percent sample of non-LUPA first periods from CY 2023 claims data. Using updated analysis (as of September 11, 2024), we found that the average excess of minutes for the first OT visit in LUPA periods that were the only period or an initial LUPA in a sequence of adjacent periods is 33.28 minutes for the first visit. The average number of minutes for all non-first visits in non-LUPA periods is 45.98 minutes for OT. To determine the LUPA add-on factor for OT to account for the excess minutes during the first visit in a LUPA period, we finalized calculating the ratio of the average excess minutes for the first visits in LUPA claims to the average minutes for all non-first visits in non-LUPA claims. We then added one to this ratio to obtain the final add on factor of 1.7238 for OT. Therefore, the OT LUPA factor of 1.7238 is used when occupational therapy is the first skilled visit in a LUPA period that occurs as the only period or an initial period in a sequence of adjacent periods.

TABLE 30: LUPA ADD-ON FACTORS

Discipline	LUPA Add-on Factors
SN	1.7200
PT	1.6225
SLP	1.6696
OT	1.7238

4. Payments for High-Cost Outliers Under the HH PPS

a. Background

Section 1895(b)(5) of the Act allows for the provision of an addition or adjustment to the home health payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. Under the HH PPS and the previous unit of payment (that is, 60-day episodes), outlier payments were made for 60-day episodes whose estimated costs exceed a threshold amount for each HHRG. The episode's estimated cost was established as the sum of the national wage-adjusted per-visit payment amounts delivered during the episode. The outlier threshold for each case-mix group or PEP adjustment is defined as the 60-day episode payment or PEP adjustment for that group plus a fixed-dollar loss (FDL) amount. For the purposes of the HH PPS, the FDL amount is calculated by multiplying the home health FDL ratio by a case's wage-adjusted national, standardized 60-day episode payment rate, which yields an FDL dollar amount for the case. The outlier threshold amount is the sum of the wage and case-mix adjusted PPS episode amount and wage-adjusted FDL amount. The outlier payment is defined as a proportion of the wage-adjusted estimated cost that surpasses the wage-adjusted threshold. The proportion of additional costs over the outlier threshold amount paid as outlier payments is referred to as the loss-sharing ratio.

As we noted in the CY 2011 HH PPS final rule (75 FR 70397 through 70399), section 3131(b)(1) of the Affordable Care Act amended section 1895(b)(3)(C) of the Act to require that the Secretary reduce the HH PPS payment rates such that aggregate HH PPS payments were reduced by 5 percent. In addition, section 3131(b)(2) of the Affordable Care Act amended section 1895(b)(5) of the Act by redesignating the existing language as section 1895(b)(5)(A) of the Act and revised the language to state that the total amount of the additional payments or payment adjustments for outlier episodes could not exceed 2.5 percent of the estimated total HH PPS payments for that year. Section 3131(b)(2)(C) of the Affordable Care Act also added section 1895(b)(5)(B) of the Act, which capped outlier payments as a percent of total payments for each HHA for each year at 10 percent.

As such, beginning in CY 2011, we reduced payment rates by 5 percent and targeted up to 2.5 percent of total estimated HH PPS payments to be paid as outliers. To do so, we first returned the 2.5 percent held for the target CY 2010 outlier pool to the national, standardized 60-day episode rates, the national per visit rates, the LUPA add-on payment amount, and the NRS conversion factor for CY 2010. We then reduced the rates by 5 percent as required by section 1895(b)(3)(C) of the Act, as amended by section 3131(b)(1) of the Affordable Care Act. For CY 2011 and subsequent calendar years we targeted up to 2.5 percent of estimated total payments to be paid as outlier payments, and apply a 10-percent agency-level outlier cap.

In the CY 2017 HH PPS proposed and final rules (81 FR 43737 through 43742 and 81 FR 76702), we described our concerns regarding patterns observed in home health outlier episodes. Specifically, we noted the methodology for calculating home health outlier payments may have created a financial incentive for providers to increase the number of visits during an episode of care in order to surpass the outlier threshold and simultaneously created a disincentive for providers to treat medically complex beneficiaries who require fewer but longer visits. Given these concerns, in the CY 2017 HH PPS final rule (81 FR 76702), we finalized changes to the methodology used to calculate outlier payments, using a cost-per-unit approach rather than a cost-per-visit approach. This change in methodology allows for more accurate payment for outlier episodes, accounting for both the number of visits during an episode of care and the length of the visits provided. Using this approach, we now convert the national per-visit rates into per 15-minute unit rates. These per 15-minute unit rates are used to calculate the estimated cost of an episode to determine whether the claim would receive an outlier payment and the amount of payment for an episode of care. In conjunction with our finalized policy to change to a cost-per-unit approach to estimate episode costs and determine whether an outlier episode should receive outlier payments, in the CY 2017 HH PPS final rule we also finalized the implementation of a cap on the amount of time per day that would be counted toward the estimation of an episode's costs for outlier calculation purposes (81 FR 76725). Specifically, we limit the amount of time per day (summed across the six disciplines of care) to 8 hours (32 units) per day when estimating the cost of an episode for outlier calculation purposes.

In the CY 2017 HH PPS final rule (81 FR 76724), we stated that we did not plan to re-estimate the average minutes per visit by discipline every year. Additionally, the per unit rates used to estimate an episode's cost were updated by the home health update percentage each year, meaning we would start with the national per visit amounts for the same calendar year when calculating the cost-per-unit used to determine the cost of an episode of care (81 FR 76727). We would continue to monitor the visit length by discipline as more recent data becomes available and may propose updating the rates as needed in the future.

In the CY 2019 HH PPS final rule with comment period (83 FR 56521), we finalized a policy to maintain the current methodology for payment of high-cost outliers upon implementation of PDGM beginning in CY 2020 and calculated payment for high-cost outliers based upon 30-day period of care. Upon implementation of the PDGM and 30-day unit of payment, we finalized the FDL ratio of 0.56 for 30-day periods of care in CY 2020.

In the CY 2021 HH PPS final rule (85 FR 70322), given that CY 2020 was the first year of the PDGM and the change to a 30-day unit of payment, we finalized maintaining the same FDL ratio of 0.56 in CY 2021 as we did not have sufficient CY 2020 data at the time of CY 2021 rulemaking to propose a change to the FDL ratio for CY 2021. In the CY 2022 HH PPS final rule with comment period (86 FR 62292), we estimated that outlier payments would be approximately 1.8 percent of total HH PPS payments in CY 2022 if we maintained an FDL of 0.56. Therefore, in order to pay up to, but no more than, 2.5 percent of total payments as outlier payments we finalized an FDL of 0.40 for CY 2022. In the CY 2023 HH PPS final rule (87 FR 66875), using CY 2021 claims utilization data, we finalized an FDL of 0.35 in order to pay up to, but no more than, 2.5 percent of the total payment as outlier payments in CY 2023. In the CY 2024 HH PPS final rule (88 FR 77749), using CY 2022 claims utilization data, we finalized an FDL of 0.27 for CY 2024. In the CY 2025 HH PPS final rule (89 FR 88354), using CY 2023 claims data (as of July 11, 2024) we finalized an FDL ratio of 0.35 for CY 2025. In the CY 2026 HH PPS final rule (90 FR 55411), using CY 2024 claims data (as of July 11, 2025) we finalized an FDL ratio of 0.37 for CY 2026.

b. Proposed FDL Ratio for CY 2027

For a given level of outlier payments, there is a trade-off between the values selected for the FDL ratio and the loss-sharing ratio. A high FDL ratio reduces the number of periods that can receive outlier payments but makes it possible to select a higher loss-sharing ratio, and

therefore, increase outlier payments for qualifying outlier periods. Alternatively, a lower FDL ratio means that more periods can qualify for outlier payments, but outlier payments per period must be lower.

The FDL ratio and the loss-sharing ratio are selected so that the estimated total outlier payments do not exceed the 2.5 percent aggregate level (as required by section 1895(b)(5)(A) of the Act). We use a value of 0.80 for the loss-sharing ratio, which we believe preserves incentives for agencies to attempt to provide care efficiently for outlier cases. With a loss-sharing ratio of 0.80, Medicare pays 80 percent of the additional estimated costs that exceed the outlier threshold amount.

Using CY 2025 claims data (as of March 12, 2026) and given the statutory requirement that total outlier payments do not exceed 2.5 percent of the total payments estimated to be made under the HH PPS, we are proposing an FDL ratio of 0.29 for CY 2027. We also propose to update the FDL ratio in the final rule based on more complete CY 2025 claims data.

F. Palliative Care Services as Home Health Services

CMS is seeking to advance its broader goal of promoting access to and utilization of palliative care services, with a particular focus on expanding opportunities for beneficiaries to receive these services under the Medicare home health benefit. As part of this effort, CMS included a Request for Information (RFI) in the FY 2027 Hospice Wage Index and Payment Rate Update proposed rule (91 FR 17359) to solicit public input on potential policy, operational, and payment approaches to strengthen and enhance the delivery of palliative care services outside of the hospice benefit. We were especially interested in hearing more about how Medicare practitioners and post-acute care providers furnish community-based palliative care, well as opportunities for improvement. We stated we believe that, as palliative care is a method of care delivery that is provided throughout the continuum of illness, it can be furnished under various Medicare benefits. We also stated that the home is an ideal environment for individuals to receive palliative care services, as remaining in the home during a serious illness may help alleviate psychological and mental distress and allow for more intimate caregiving to be provided by family members. As such, we believe the Medicare home health benefit can be an important step in the care continuum when a patient needs palliative care, either during episodes of serious illness or near end of life, before choosing hospice care.

In accordance with § 409.42(c), to qualify for Medicare coverage of home health services, a beneficiary must need skilled services as set out at § 409.32. Section 409.32(a) states that ''[t]o be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.'' Under the home health benefit, a beneficiary's unique condition and individual needs should be considered in deciding whether skilled nursing care is reasonable and necessary, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time. There are no expectations that life-prolonging therapies will be avoided or that the patient must be considered terminally ill, and the restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. Further, as discussed in chapter seven of the Medicare Benefit Policy Manual (BPM),[6] it is an allowed practitioner, as defined at *§ 484.2,* who is familiar with the patient who determines whether a skilled service is reasonable and necessary based on the patient's individual care needs and goals, and accepted standards of medical and nursing practice. Therefore, if the beneficiary meets the qualifications for coverage of services as set out at § 409.42, he or she could receive palliative care services under the home health benefit, if ordered by an allowed practitioner.

Often skilled services are determined to be reasonable and necessary when a patient has multiple medications and comorbidities, with resultant functional impairments, that leave them homebound with a need for skilled observation of the patient's condition and medication management. A discussion on palliative care delivery in the home emphasizes the importance of home-based care for patients with multiple morbidities and limited mobility.[7] 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. As discussed in the CY 2019 HH PPS proposed rule (83 FR 32402), health teaching; guidance and counseling; case management, treatments and procedures; and surveillance are integral to the care of most home health patients. Palliative care is defined at § 418.3 to mean ''patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.'' We believe that this definition encompasses all the services provided under the Medicare home health benefit. Additionally, these important interventions are often the primary reason for home health services. Section 1861(m) of the Act requires the 30-day period to include all covered home health services: skilled nursing; home health aide; physical therapy; speech-language pathology; occupational therapy; medical social services, and medical supplies. Skilled nursing services can address advanced symptom management, including specialized care to manage pain, nausea and vomiting, depression and anxiety, and respiratory distress. This may also include medication management to monitor therapeutic and adverse effects and review and adjust medications in coordination with allowed practitioners. Medical social services can help address advance care planning needs (including discussion on transition to hospice) as well as offer referrals for social and emotional support for families and caregivers. Physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs) enhance patient quality of life, comfort, and dignity by maximizing functional independence and managing symptoms. PTs focus on mobility, pain management, and safe transfers, while OTs specialize in adapting activities of daily living (ADLs) and environments to maintain independence for as long as possible. SLPs support safe eating and drinking and help facilitate

[6] *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf.*

[7] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Board on Health Care Services; Roundtable on Quality Care for People with Serious Illness. Models and Strategies to Integrate Palliative Care Principles into Care for People with Serious Illness: Proceedings of a Workshop. Washington (DC): National Academies Press (US); 2017 Oct 24. Proceedings of a Workshop. Available from: *https://www.ncbi.nlm.nih.gov/books/NBK538355/.*

communication and decision making for those patients with deficits.

Like other skilled services, comprehensive home health clinical notes are expected to substantiate the need for palliative care necessitating medication management, teaching, and assessment through documentation of the patient's achievement of care needs and goals as outlined in the plan of care. Accordingly, chapter seven of the BPM includes an example of a patient with malignant melanoma who is terminally ill and requires skilled observation, assessment, teaching, and treatment, and who has not elected hospice care. This example explains that the documentation should describe the goal of the skilled nursing intervention, and at each visit the services provided should support that goal. The skilled nursing care that the patient requires would be covered, notwithstanding that the condition is terminal, because the documentation and description must support that the needed services required the skills of a nurse. A palliative care plan for this type of patient would likely include medication and symptom management, including expected treatment responses for pain, anxiety, constipation, nausea, or dyspnea; education and caregiver training on managing symptoms at home; assessing social risk factors including caregiver burden and emotional and psychosocial distress; and skilled therapy for non-pharmacologic pain management strategies and interventions to maximize functional status and independence.

We plan on adding additional palliative care examples of skilled care to the BPM following the publication of the CY 2027 HH PPS final rule to support our goal of encouraging community-based palliative care services, particularly under the Medicare home health benefit. We solicit comments on any concerns or suggestions regarding reaching this goal.

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

For CY 2027, we are proposing to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the HH PPS wage index. We continue to believe that this is the best available Medicare data to estimate costs per day, in accordance with our longstanding wage index policy at § 412.424(a)(2). The purpose of this comment solicitation is to gain information from the public regarding the appropriateness of alternative data sources consistent with our statutory authority and regulatory requirements. We note that other payment systems have explored and are exploring alternative wage index methodologies under their specific programmatic and statutory circumstances. For example, CMS finalized changes to the ESRD PPS wage index using Bureau of Labor Statistics (BLS) occupation-level wage data in the CY 2025 ESRD PPS final rule (89 FR 89116). While this approach was developed under the specific programmatic and statutory circumstances of the ESRD PPS and may not be directly transferable to the HH PPS, CMS is interested in exploring whether similar methodologies using publicly available wage data could be used to better reflect the geographic variation in labor costs for HHAs. In addition, we note that we are also considering the potential use of alternative data sources in other payment systems, including with respect to hospices (91 FR 17361 through 17363), the Inpatient Rehabilitation Facilities PPS (91 FR 17206 and 17207), and the Skilled Nursing Facilities PPS (91 FR 17692).

Furthermore, in its 2023 Report to the Congress,[8] MedPAC discussed various conceptual approaches to Medicare wage indexes, including the use of county-level wage data from BLS with an occupational mix to construct wage indexes that are more specific to the payment setting. MedPAC has previously written about using all-employer, occupation-level wage data to establish different weights for setting-specific occupational labor mixes as one approach to geographic adjustments.

We are soliciting comments on whether we should consider using alternative data sources to construct an HHA specific wage index for potential use in future years. CMS seeks feedback to understand the potential advantages and limitations of using alternative data sources, such as BLS data and home health Medicare cost reports, as well as other methodologies that stakeholders believe could appropriately reflect the geographic variation in labor costs for HHAs. We also seek feedback on the unique considerations applicable to HHAs that should inform how CMS considers the potential use of alternative data sources.

III. Home Health Quality Reporting Program (HH QRP)

A. Background and Statutory Authority

The HH QRP is authorized by section 1895(b)(3)(B)(v) of the Act. Section 1895(b)(3)(B)(v)(II) of the Act requires that, for 2007 and subsequent years, each home health agency (HHA) submit to the Secretary in a form and manner, and at a time, specified by the Secretary, such data that the Secretary determines are appropriate for the measurement of health care quality. To the extent that an HHA does not submit data in accordance with this clause, the Secretary shall reduce the home health market basket percentage increase applicable to the HHA for such year by 2 percentage points pursuant to section 1895(b)(3)(B)(v)(I) of the Act. As provided at section 1895(b)(3)(B)(vi) of the Act, depending on the market basket percentage increase applicable for a particular year, as further reduced by the productivity adjustment (except in 2018 and 2020) described in section 1886(b)(3)(B)(xi)(II) of the Act, the reduction of that increase by 2 percentage points for failure to comply with the requirements of the HH QRP may result in the home health market basket percentage increase being less than 0.0 percent for a year, and may result in payment rates under the HH PPS for a year being less than payment rates for the preceding year. Section 1890A of the Act requires that the Secretary establish and follow a pre-rulemaking process, in coordination with the consensus-based entity (CBE) with a contract under section 1890 of the Act, to solicit input from certain groups regarding the selection of quality and efficiency measures for the HH QRP. The HH QRP regulations can be found at 42 CFR 484.245 and 484.250.

B. Summary of the Provisions of This Proposed Rule

In accordance with the statutory authority at section 1895(b)(3)(B)(v) of the Act, we are proposing the following policies in this proposed rule:

First, we summarize potential initiatives to improve alignment between the HH QRP and expanded HHVBP Model. We also propose to revise the HH QRP data submission deadlines beginning with the CY 2027 HH QRP. In addition, we are proposing to revise the HH QRP OASIS and HHCAHPs annual payment update (APU) reporting timeframe to report a calendar year of data (January 1 through December 31). We propose some revisions to regulatory text in support of rule proposals and to improve digital transfer of information during the reconsiderations process. Finally, we are soliciting public comments on one Request for Information (RFI) on future measure concepts for the HH QRP.

For a detailed discussion of the considerations we historically use for measure selection for the HH QRP

[8] *https://www.medpac.gov/document/chapter-9-reforming-medicares-wage-index-systems-june-2023-report/.*

quality, resource use, and other measures, we refer readers to the CY 2016 HH PPS final rule (80 FR 68695 through 68696). In the CY 2019 HH PPS final rule with comment period (83 FR 56548 through 56550), we finalized the factors we consider for removing previously adopted HH QRP measures.

C. Quality Measures Currently Adopted for the CY 2026 HH QRP

The HH QRP currently includes 18 measures for the CY 2027 program year. As finalized in the CY 2026 HH PPS final rule, the HH QRP currently uses thirteen OASIS-based measures, four claims-based measures, and a HHCAHPS Survey-based composite measure (see table 31).

D. Opportunities for Potential Alignment Between the HH QRP and the Expanded HHVBP Model

CMS has identified substantial opportunities to better align the HH QRP and the expanded HHVBP Model. While the HH QRP and expanded HHVBP Model share similar goals and measures, differences in measure sets, reporting periods, and performance assessment processes may create unnecessary complexity and administrative burden for HHAs. For example, misalignment between HH QRP APU reporting periods and the expanded HHVBP Model's annual performance period may contribute to confusion. Greater alignment would support more consistent evaluation of HHA quality performance and advance CMS quality priorities. Greater alignment is also consistent with CMS's priority of reducing provider burden and creating efficiencies across CMS programs. Opportunities for potential alignment between the HH QRP and expanded HHVBP Model include the following:

- Increasing alignment in expanded HHVBP Model and HH QRP Quality of Patient Care (QoPC) Star Ratings measure sets.
- Aligning HH QRP and expanded HHVBP Model measure reporting periods.
- Aligning HH QRP APU and expanded HHVBP Model annual payment reporting periods.
- Aligning expanded HHVBP Model Interim Performance and HH QRP QoPC Star Rating Reports.
- Aligning timeframe of appeals/suppression review processes for the expanded HHVBP Model and HH QRP.
- Updating scoring methodology to incorporate HH QRP APU penalties in expanded HHVBP Model payment adjustments and factoring HH QRP Quality Assessments Only (QAO) values into QoPC Star Ratings scoring.

We are not seeking comments on this list of opportunities for potential alignment between the HH QRP and expanded HHVBP Model and is providing this list for general awareness of potential areas of alignment that are being considered.

We convened a Technical Expert Panel (TEP) meeting addressing HH QRP and expanded HHVBP Model alignment in December 2025. Please see the 2025 TEP Summary Report for more information (*www.cms.gov/priorities/innovation/files/hhvbp-tep-summary-report.pdf*).

Table 31 reflects current and expected usage of measures for both the expanded HHVBP Model and the HH QRP.

TABLE 31: QUALITY MEASURE USAGE IN HHVBP AND HHQRP COMPONENTS

OASIS-based Measures				
Discharge Function Score*^	Yes	No	Yes	Yes
Improvement in Bathing**	Yes	Yes	Yes	No
Improvement in Upper Body Dressing**	Yes	No	No	Yes
Improvement in Lower Body Dressing**	Yes	No	No	Yes
Improvement in Bed Transferring	No	Yes	No	No
Improvement in Ambulation/Locomotion	No	Yes	No	No
Improvement in Dyspnea	Yes	Yes	Yes	No
Improvement in Management of Oral Medications	Yes	Yes	Yes	No
Timely Initiation of Care	No	Yes	No	No
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury - HH	No	No	No	Yes
Falls with Major Injury	No	No	No	Yes
Transfer of Health Information to Provider	No	No	No	Yes
Transfer of Health Information to Patient	No	No	No	Yes
Influenza Immunization Received	No	No	No	Yes
Drug Regimen Review	No	No	No	Yes
Claims-based Measures				
Potentially Preventable Hospitalizations (PPH)*	Yes	Yes	Yes	No
Discharge to Community – Post Acute Care (DTC-PAC)* ^	Yes	Yes	Yes	Yes
Medicare Spending per Beneficiary- Post Acute Care (MSPB-PAC) **	Yes	No	No	Yes
Potentially Preventable Readmission	No	No	No	Yes
HHCAHPS Survey-based Measures				
Care of Patients***	Yes	Yes	No	Yes
Communication Between Providers and Patients***	Yes	Yes	No	Yes
Talk About Home Safety****	No	No	No	Yes
Review Medicines****	No	No	No	Yes
Talk About Medicine Side Effects****	No	No	No	Yes
Overall Rating of Care Provided by the Home Health Agency	Yes	Yes	Yes	Yes
Willingness to Recommend the Home Health Agency	Yes	No	No	Yes

^ Measures expected to be added to QoPC Star Ratings in the near future.

* Measure added to HHVBP Model starting with the CY 2025 applicable measure set.

** Measure added to HHVBP Model starting with the CY 2026 applicable measure set.

*** Measure removed from the HHVBP Model starting with the CY 2026 applicable measure set.

****Measure added to HH QRP Non-QoPC CY 2026 measure set to replace the Specific Care Issues measure.

E. Form, Manner, and Timing of Data Submission Under the HH QRP

1. Proposal To Revise HH QRP Data Submission Deadlines Beginning With the CY 2027 HH QRP

a. Background

Section 1899B(f)(1) of the Act also requires the Secretary to provide confidential feedback reports to PAC providers on the performance of such PAC providers for quality, resource use, and other measures required under sections 1899B(c)(1) and (d)(1) of the Act beginning 1 year after the applicable specified application date. Further, section 1899B(g) of the Act requires the Secretary to establish procedures for making available to the public information regarding the performance of individual PAC providers for quality, resource use, and other measures required under sections 1899B(c)(1) and (d)(1) of the Act beginning not later than 2 years after the applicable specified application date. The procedures must ensure, including through a process consistent with the process applied under section 1886(b)(3)(B)(viii)(VII) of the Act for similar purposes, that each PAC provider has the opportunity to review and submit corrections to the data and information that are to be made public for the PAC provider prior to such data being made public.

Although assessment data submission, quarterly performance reports, and public reporting are required by statute, timing of data submission under the HH QRP was not initially specified. Thus, in the CY 2017 HHS PPS final rule (81 FR 76784) we finalized our proposal to comply with the requirements of section 1899B(g) of the Act, that HHAs would have approximately 4.5 months after the reporting quarter to correct any errors of their assessment-based data to calculate the measures. During the time of data submission for a given quarterly reporting period and up until the quarterly submission deadline, HHAs could review and perform corrections to errors in the assessment data used to calculate the measures.

Public reporting of data collected under our quality reporting programs, such as the HH QRP, is designed to provide consumers and their families with the most current information to empower them to make quality-informed decisions about where to receive their care. We have identified that the time between when data on measures is submitted to us and when those data are publicly reported (approximately nine months) may be too long to provide the most accurate and up to date information for the public.

We have received feedback from the provider community and TEPs that the aged data used in publicly reported quality measures diminishes their value to consumers. Furthermore, we have heard from HHAs that the HH QRP measure results they receive prior to public reporting are less useful for their quality improvement efforts due to the aged data and the delay in when they receive these reports.

Currently, the largest contributing factor to the 9-month lag between the end of the data collection period and when measures are publicly reported is the 4.5-month timeframe for data submission. Reducing the data submission timeframe from 4.5 months to the 15th day of the second month after the end of the calendar quarter could reduce this lag by up to 3 months, resulting in more timely public reporting of data for consumers and increasing the value of publicly reported data. Additionally, this timeframe provides HHAs with more recent data in support of their quality improvement activities.

In the CY 2026 HH PPS proposed rule, we included a request for information (RFI) on reducing the OASIS assessment data submission deadline from 4.5 months to 45 days (90 FR 29182). We refer readers to the CY 2026 HH PPS final rule (90 FR 55429 and 55430) for a full summary of the public comments received.

b. Proposal To Revise the HH QRP Assessment Data Submission Deadline

Beginning with the CY 2027 HH QRP, we are proposing that HHAs be required to complete their data submissions and make corrections to their OASIS assessment data where necessary no later than the 15th day of the second month after the end of the calendar quarter. However, if the 15th day of the second month falls on a Friday, weekend, or Federal holiday, the date is delayed until 11:59 p.m. EST on the next business day. We are proposing that HHAs would follow the deadlines presented in Table 32 for the CY 2027 HH QRP. We are also proposing that similar calendar year data submission deadlines would apply to future years' payment determinations.

TABLE 32: PROPOSED DATA COLLECTION TIMEFRAME AND DATA SUBMISSION DEADLINES FOR OASIS ASSESSMENT DATA AFFECTING THE CY 2029 PAYMENT DETERMINATION

Calendar Year (CY) Quarter	Data Collection Timeframe	Final Data Submission Deadlines for CY 2029 Payment Determination*
CY 2027 Quarter 1	January 1–March 31, 2027	May 17, 2027
CY 2027 Quarter 2	April 1–June 30, 2027	August 16, 2027
CY 2027 Quarter 3	July 1–September 30, 2027	November 15, 2027
CY 2027 Quarter 4	October 1–December 31, 2027	February 15, 2028

* Data submission deadlines will follow a similar quarterly schedule for subsequent CYs.

We believe that requiring HHAs to submit OASIS assessment data by the 15th day of the second month after the end of the calendar quarter is reasonable. We conducted an analysis on the potential impact of reducing the timeframe by determining how many assessments are currently being submitted by this deadline, which is approximately within 45 days of the end of the quarter. Using 2024 data, we identified that 99.27 percent of all OASIS assessments were submitted to CMS within a 45-day timeframe. Of the remaining 0.63 percent submitted beyond 45 days, 0.24 percent were submitted after the current 4.5-month data submission deadline and would not be further impacted by a change in the data submission deadline. Therefore, only 0.49 percent of OASIS assessments would be impacted by changing the data submission deadline from 4.5 months to require data submission by the 15th day of the second month after the end of the calendar quarter.

We invite comment on this proposal to require that HHAs complete their data submissions and make corrections to their OASIS assessment data where necessary no later than the 15th day of the second month after the end of the calendar quarter beginning with the CY 2027 HH QRP.

2. Proposal To Revise the OASIS Annual Payment Update Reporting Timeframe

a. Background

HHAs are required to submit OASIS data in a timely manner as outlined under section 1895(b)(3)(B)(v) of the Act, as amended by the Deficit Reduction Act (Pub. L. 109–117). Failure to submit OASIS data in a timely manner with respect to a HH QRP year would result in the reduction of the annual home health market basket percentage increase otherwise applicable to an HHA for the corresponding calendar year by 2 percentage points. This annual payment update (APU) was initiated for the HH QRP on January 1, 2007. The HH QRP APU requirements were finalized in the CY 2007 HH PPS Final Rule (71 FR 44087 through 44088) outlining data collection of 12 months of data beginning July 1, 2005 and running through July 1, 2026. This timeframe allowed a full 12 months of data and provided CMS the time necessary to analyze and make any necessary payment adjustments to the CY 2007 payment rates (71 FR 44087 through 44088). The timing for APU reporting has remained on this data calculation cadence since this update.

The current OASIS 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 APU data reporting timeframe to reflect a January 1 through December 31 reporting timeframe, or the calendar year. We believe 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.

b. Proposal

The proposed revision of the OASIS APU data reporting to a calendar year timeframe would require a transition year in which the current reporting timeframe is moved to the new proposed reporting timeframe. We propose the transition occur with the 2028 APU and further propose that the 6 months data collected from July 1, 2026 through December 31, 2026 would serve as the OASIS APU data reporting timeframe to determine the HH QRP 2028 OASIS APU. We also propose that the 2029 OASIS APU would be the first iteration in which the OASIS APU data reporting timeframe will be based on the calendar year, from January 1, 2027 through December 31, 2027. We would continue this new pattern for each subsequent OASIS APU with effective dates for data reporting of January 1 through December 31. OASIS assessments will be considered complete if they comply with the HH Conditions for Payment (COPs) that apply to the applicable year. Please see table 33 that outlines the current OASIS APU data reporting timeframe, the proposed transition reporting timeframe, and the revised OASIS APU timeframe used for the CY 2029 APU and later.

TABLE 33: PROPOSED DATA REPORTING TIMEFRAMES ASSOCIATED WITH UPCOMING HHQRP OASIS APU

OASIS APU Issued	Data Reporting Timeframe
January 2027	July 1, 2025 – June 30, 2026
January 2028 transition	July 1, 2026 - December 31, 2026
January 2029	January 1, 2027 – December 31, 2027

In the CY 2024 HH PPS final rule, CMS proposed adding the following language to the regulatory text at § 484.245(b)(2)(ii)(A): ''A home health agency must meet or exceed the data submission threshold for each submission year (July 1–June 30) set at 90 percent of all required OASIS or successor instrument records and submitted through the CMS designated data submission systems '' (88 FR 77676). With the proposed change to a calendar year reporting timeframe, CMS proposes to revise the language in § 484.245(b)(2)(ii)(A) that currently states ''(July 1–June 30)'' to state ''(January 1 through December 31)''.

3. Proposal To Revise the HHCAHPS Annual Payment Update Reporting Timeframe

a. Background

HHAs are required to submit quality data in a timely manner as outlined under section 1895(b)(3)(B)(v) of the Act. Failure to submit HHCAHPS data in a timely manner with respect to a HH QRP year could result in the reduction of the annual home health market basket percentage increase otherwise applicable to an HHA for the corresponding calendar year by 2 percentage points. HHCAHPS data inclusion in the HHQRP was finalized with the CY 2010 HH PPS Final Rule (FR 74 58098 through 58104). Adding a HHCAHPS annual payment update (APU) to the current HH QRP requirements was also finalized with the CY 2010 HH PPS Final Rule where CMS finalized the policy that HHCAHPS would be included in the APU reporting for the CY 2012 APU based on 6 months of data from October 2010 to March 2011 (FR 74 58103). In the CY 2011 HH PPS final rule, CMS finalized a policy that HHCAHPS APU calculations would require four quarters of data collection from April 1, 2011 to March 31, 2012 for the CY 2013 HH CAHPS APU (FR 75 70406). The timing for HHCAHPS APU reporting has remained on this cadence since this update.

The current HHCAHPS APU reporting timeframe differs from that used by other annual HH CMS payment updates. The expanded HHVBP Model payment adjustment percentage and the HH PPS updates are both based on a calendar year timeline. The OASIS APU data reporting timeframe is also different from a calendar year timeline and we are also proposing an update to a calendar year timeframe in a previous proposal. To improve alignment between home health payment policies and HH QRP pay-for-reporting requirements, we are proposing to revise the HHCAHPS APU data reporting timeframe to reflect a January 1 through December 31 reporting timeframe, or the calendar year. We believe this update would provide clarity related to HH payment updates and facilitate the alignment of CMS HH pay-for-reporting policies with other HH payment policies.

b. Proposal

The proposed revision of the HHCAHPS APU data reporting to a calendar year timeframe would require a transition year in which the current reporting timeframe was moved to the new proposed reporting timeframe. We propose the transition occur with the 2028 HHCAHPS APU and further propose that the nine months of data collected from April 1, 2026 through December 31, 2026 would serve as the HHCAHPS APU data reporting timeframe to determine the HHQRP 2028 APU. We also propose that the 2029 HHCAHPS APU data reporting timeframe would be the first iteration in which the HHCAHPS APU data reporting timeframe would be for a calendar year, from January 1, 2027 through December 31, 2027. We would continue this new pattern for each subsequent HHCAHPS APU with effective dates for data reporting of January 1 through December 31. HHA OASIS assessments would be considered complete if they complied with the HH CoPs and Conditions for Payment that apply to the applicable year. Please see Table 34 that outlines the HHCAHPS current APU data reporting timeframe, the proposed transition reporting timeframe, and the revised APU timeframe used for the CY 2029 APU and later.

TABLE 34: PROPOSED DATA REPORTING TIMEFRAMES ASSOCIATED WITH UPCOMING HHQRP HHCAHPS APU

HHCAHPS APU Issued	Data Reporting Timeframe
January 2027	April 1, 2025 – March 31, 2026
January 2028 transition	April 1, 2026 - December 31, 2026
January 2029	January 1, 2027 – December 31, 2027

We invite comment on the proposals to revise the OASIS APU and HHCAHPS APU reporting timeframes to a calendar year period beginning with the CY 2027 HH QRP.

4. Proposed Updates to Regulation Text Related to Reconsiderations

In the CY2026 HH PPS final rule, CMS updated regulation text language to codify how a provider may request an extension to file a reconsideration (90 FR 55342). We are proposing to further clarify aspects of the reconsideration process to facilitate more timely, digital transmission of information. Specifically, section 484.245(d)(1)(i) currently states, ''HHAs that do not meet the quality reporting requirements under this section for a program year will receive a letter of noncompliance via the United States Postal Service and the CMS-designated data submission system''. We propose to revise this language to specify that HHAs that do not meet the quality reporting requirements under this section for a program year would receive a notification of noncompliance via the CMS-designated data submission system. Section 484.245(d)(1)(ii) currently states, an HHA may request reconsideration no later than 30 calendar days after the date identified on the letter of non-compliance. We propose to revise this language to state that an HHA may request reconsideration no later than 30 calendar days after the date identified on the notification of non-compliance. Section 484.245(d)(2)(v) currently states, CMS identified reason(s) for non-compliance as stated in the non-compliance letter. We propose to revise this language to state, CMS identified reason(s) for non-compliance as stated in the non-compliance notification.

Section 484.245(d)(4)(i) currently states that CMS notifies the HHA, in writing, of its final decision regarding any reconsideration request through at least one of the following methods:

- CMS designated data submission system.
- The United States Postal Service.
- Email from the CMS Medicare Administrative Contractor (MAC).

We propose to revise this language to state that CMS would notify the HHA of its final decision regarding any reconsideration request through a CMS designated data submission system.

We invite comments on these proposed updates to the regulations text related to the reconsideration process.

F. HH QRP Measure Concepts Under Consideration for Future Years—Request for Information (RFI)

In the CY 2024 HH PPS proposed rule (88 FR 43738 through 43740), we included an RFI on a set of principles for selecting and prioritizing HH QRP measures, identifying measurement gaps, and suitable measures for filling these gaps. We refer readers to the CY 2024 HH PPS final rule (88 FR 77773 through 77774) for a summary of the public comments received in response to the RFI.

We are seeking input on the importance, relevance, appropriateness, and applicability of the quality measure concepts related to advanced care planning. Advance care planning is a continuous process that supports people in understanding and communicating their goals, values, and preferences regarding future medical decisions.[9] The Patient Self Determination Act of 1990 [10] supports this process by requiring healthcare facilities to inform patients of their rights regarding medical decisions, including advance directives and end of life care.[11] 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. Factors such as clinical stability, functional status, therapy tolerance, cognition function, prognosis, and personal preferences can all shift during recovery. Regular reassessment and transparent communication are essential to maintaining person-centered care, while advance care planning facilitates shared decision-making by documenting patient preferences and ensuring goal-concordant care throughout care transitions.[12]

As we review new measure concepts, we would prioritize evidence-based outcome measures that promote person-centered care practices. We are seeking input on the relevant aspects of advanced care planning and measures appropriate for the HH setting.

IV. The Expanded Home Health Value-Based Purchasing (HHVBP) Model

As authorized by section 1115A of the Act and finalized in the CY 2016 HH PPS final rule (80 FR 68624), the Center for Medicare and Medicaid Innovation (Innovation Center) implemented the Home Health Value-Based Purchasing (HHVBP) Model (''original Model'') in nine states on January 1, 2016. The design of the original Model leveraged the successes and lessons learned from other CMS value-based purchasing programs and demonstrations to shift from volume-based payments to a model designed to promote the delivery of higher quality care to Medicare beneficiaries. The specific goals of the original Model were to—

- Provide higher incentives for better quality care with greater efficiency;
- Study new potential quality and efficiency measures for appropriateness in the home health setting; and
- Enhance the current public reporting process.

On January 8, 2021, CMS announced the certification of the HHVBP Model for expansion nationwide, as well as the intent to expand the Model through notice and comment rulemaking.[13] In the CY 2022 HH PPS final rule (86 FR 62292 through 62336), we finalized the decision to expand the HHVBP Model to all Medicare certified HHAs in the 50

[9] McMahan, R.D., Tellez, I., & Sudore, R.L. (2021). Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. Journal of the American Geriatrics Society, 69(1), 234–244. *https://doi.org/10.1111/jgs.16801.*

[10] Public Law 101–508, §§ 4206, 4751.

[11] *https://www.congress.gov/bill/101st-congress/house-bill/4449https://www.congress.gov/bill/101st-congress/house-bill/5835.*

[12] McMahan RD, Tellez I, Sudore RL. Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. J Am Geriatr Soc. 2021 Jan;69(1):234–244. doi: 10.1111/jgs.16801. Epub 2020 Sep 7. PMID: 32894787; PMCID: PMC7856112.

[13] *https://www.cms.gov/newsroom/press-releases/cms-takes-action-improve-home-health-care-seniors-announces-intent-expand-home-health-value-based.*

States, territories, and District of Columbia beginning January 1, 2022. CY 2022 was a pre-implementation year. Payment adjustments under the Model are calculated in the year after each performance year and applied two years following each performance year. Therefore, payment adjustments for the first performance year of CY 2023 were implemented in CY 2025. Our codified policies for the expanded HHVBP Model can be found in our regulations at 42 CFR part 484, subpart F, §§ 484.300 through 484.375. The following description of existing HHVBP performance feedback reports is included for background and to provide context for the discussion of potential alignment between the HH QRP and the expanded HHVBP Model in section III of this proposed rule.

CMS publishes two types of routine performance feedback reports that provide HHAs with information on their measure performance:

- The first report type is the Interim Performance Report (IPR), which is issued quarterly. The information in the IPR reflects calculation of the TPS based on rolling data periods that are updated each quarter. CMS issues two versions of the IPR—a preliminary version and a final version that reflects any changes made as a result of the recalculation request process. The IPRs provide interim performance scores, achievement and improvement points, and TPS.
- The second report is the Annual Performance Report (APR). The APR provides HHAs with information on their measure performance using data from the prior calendar year. Like the IPR, the APR provides feedback to HHAs about performance relative to quality measure achievement thresholds, benchmarks, and improvement thresholds. Additionally, the APR includes the HHA's payment adjustment percentage for the upcoming CY, an explanation of when the adjustment will apply, and how CMS determined the adjustment.

We are not proposing any changes for the expanded HHVBP Model.

For more information on the policies we have adopted previously for the expanded HHVBP Model, we refer readers to the following:

- CY 2022 HH PPS final rule (*86 FR 62240*).
- CY 2023 HH PPS final rule (*87 FR 66790*).
- CY 2024 HH PPS final rule (*88 FR 77676*).
- CY 2025 HH PPS final rule (*89 FR 88354*).
- CY 2026 HH PPS final rule (*90 FR 55342*).

CY 2027 will be the fifth performance year for the expanded HHVBP Model. As finalized in the CY 2026 HH PPS final rule, the expanded HHVBP Model currently uses six OASIS-based measures, three claims-based measures, and two HHCAHPS Survey-based measures (see Table 31 in the HH QRP section (section III.) of this proposed rule). We continue to address the number of measures needed to maximize the number of HHAs in each cohort eligible for a payment adjustment.

CMS has identified substantial opportunities to better align the HH QRP and the expanded HHVBP Model, including measure-set alignment. Table 31 in section III. of this proposed rule reflects current and expected usage of measures for both the expanded HHVBP Model and the HH QRP. For more details on the potential alignment between the HH QRP and expanded HHVBP Model, see section III.D. of this proposed rule.

V. Durable Medical Equipment and Provider Enrollment Provisions

A. Overview

In this section of the proposed rule, we are proposing changes and seeking comment on the following DME and provide enrollment provisions:

- In section V.B. of the proposed rule, we would clarify the application of the DMEPOS face-to-face encounter requirements and the related documentation necessary to support the replacement of DMEPOS items.
- In section V.C. of the proposed rule, we are proposing a number of Medicare provider enrollment provisions to strengthen and clarify certain aspects of the provider enrollment process.
- In section V.D. of the proposed rule, we propose to make changes to the Medicare Part B definition of DME regulations in accordance with the statutory changes implemented via section 6222(a) of the CAA, 2026.
- In section V.E. of the proposed rule, we discuss requesting revisions to the information collection requirements that would require DMEPOS CBP contract suppliers to report the country of origin for the lead items furnished during the contract's period of performance.

B. DMEPOS Encounter Requirements for Identical Replacement Items

1. Background

Section 1834(a)(11)(B)(ii) of the Social Security Act, as amended by section 504 of MACRA and codified in the Code of Federal Regulation (CFR) at 42 CFR 410.38, outlines a condition of payment for certain items of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Specifically, it requires a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) (as these four terms are defined in section 1861 of the Act) to write an order that is communicated to the supplier prior to delivery and document that the physician, PA, practitioner, or specialist has had a face-to-face encounter (including through use of telehealth under section 1834(m) of the Act) with the individual involved, during the 6-month period preceding such written order.

On November 8, 2019 (*84 FR 60648*), we published a process whereby items identified as potential vulnerabilities to the Trust Fund may be placed on the *Master List of DMEPOS Items Potentially Subject to Face-to-Face Encounter and Written Orders Prior to Delivery and/or Prior Authorization Requirements* (''Master List''). We analyze the Master List and select items from the Master List to be placed on the *Required Face-to-Face Encounter and Written Orders Prior to Delivery List* (''Required F2F/WOPD List'') via **Federal Register** notice. The face-to-face encounter requirements outlined in 42 CFR 410.38 are only applicable to items that are selected and placed on the Required F2F/WOPD List via **Federal Register** notice.

For the identified items, the treating practitioner must document and communicate to the DMEPOS supplier that the treating practitioner has had a face-to-face encounter with the beneficiary within the 6 months preceding the date of the written order/prescription. The regulation requires the supporting documentation to include the subjective and objective beneficiary specific information used for diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered.

Separately, in our Medicare Benefit Policy Manual (100–02) (Chapter 15, Section 110.2—Repairs, Maintenance, Replacement, and Delivery), we define replacement as the provision of an identical or nearly identical item. Replacements may occur as a result of loss, theft, or irreparable damage, which may be due to a specific incident or event, or irreparable wear, in consideration of the reasonable useful lifetime of the equipment.

Section 414.210(f) discusses payment for replacement of equipment. As specified at *42 CFR 414.210(f)(1),* the reasonable useful lifetime of durable medical equipment is generally determined through program instructions, or in the absence of

program instructions, may be determined by the Medicare Administrative Contractors and be no less than 5 years. If the item of equipment has been in continuous use by the beneficiary for the equipment's useful lifetime or if the contractor determines that the item is lost, stolen, or irreparably damaged, the beneficiary may elect to obtain a new piece of equipment. Replacement may be paid when the practitioner reaffirms the medical necessity of the item through a new order.

2. Proposed Provisions

The proposed regulatory change would clarify that while an order would continue to be required for replacement DMEPOS items, a new face-to-face encounter would not need to occur to support payment for these DMEPOS items. We further clarify that, for purposes of proposed 42 CFR 410.38(d)(2)(iii), a ''replacement'' refers to the provision of an item that replaces an item falling under the same Healthcare Common Procedure Coding System (HCPCS) code; it does not include those situations involving the provision of a different item, for example, because of a change in medical condition. In other words, for paragraph(d) the replacement would be the same type of item (that is, the same HCPCS code as that originally ordered and rendered) with no change to the type of item ordered and rendered. When an order is written to replace an item falling under the same HCPCS code, requiring a new face-to-face examination to document subjective and objective beneficiary specific information regarding how the DMEPOS item will continue to be used in relation to the beneficiary's clinical condition seems burdensome and redundant. If the item is not a replacement item identified by the same HCPCS code, then a new face-to-face encounter would continue to be required, as described in existing 42 CFR 410.38. This clarification does not eliminate the need for a new order, nor does it supersede or eliminate any other coverage instruction—including those iterated in national or local coverage determinations.

C. Provider Enrollment

1. Background and Applicability

a. Enrollment Process

Section 1866(j)(1)(A) of the Act requires the Secretary to establish a process for the enrollment of providers and suppliers into the Medicare program. The overarching purpose of the enrollment process is to help confirm that providers and suppliers (hereafter collectively ''providers'' unless otherwise noted) seeking to bill Medicare for services and items furnished to Medicare beneficiaries meet all applicable Federal and State requirements to do so. The process is, to an extent, a ''gatekeeper'' that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare. Since 2006, we have undertaken rulemaking efforts to outline our enrollment procedures. These regulations are generally codified in 42 CFR part 424, subpart P (currently §§ 424.500 through 424.575 and hereafter occasionally referenced as subpart P). They address, among other things, requirements that providers must meet to obtain and maintain Medicare billing privileges.

As outlined in § 424.510, one such requirement is that the provider must complete, sign, and submit to its assigned Medicare Administrative Contractor (MAC) the appropriate enrollment form, typically the Form CMS–855 (OMB Control No.: 0938–0685). The Form CMS–855, which can be submitted via paper or electronically through the internet-based Provider Enrollment, Chain, and Ownership System (PECOS) process (SORN: 09–70–0532, PECOS), collects important information about the provider. Such data includes, but is not limited to, general identifying information (for example, legal business name), licensure and certification data, and practice locations. The application is used for a variety of provider enrollment transactions, including all of the following:

- Initial enrollment—The provider is—(1) enrolling in Medicare for the first time; (2) enrolling in another Medicare contractor's jurisdiction; or (3) seeking to enroll in Medicare after having previously been enrolled.
- Change of ownership—The provider is reporting a change in its ownership.
- Revalidation—The provider is revalidating its Medicare enrollment information in accordance with § 424.515. (Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) must revalidate their enrollment every 3 years; all other providers and suppliers must do so every 5 years.)
- Reactivation—The provider is seeking to reactivate its Medicare billing privileges after it was deactivated in accordance with § 424.540.
- Change of information—The provider is reporting a change in its existing enrollment information in accordance with § 424.516.

After receiving the provider's initial enrollment application, CMS or the MAC reviews and confirms the information thereon and determines whether the provider meets all applicable Medicare requirements. We believe this screening process has greatly assisted CMS in executing its responsibility to prevent Medicare fraud, waste, and abuse.

As previously mentioned, over the years we have issued various final rules pertaining to provider enrollment. These rules were intended not only to clarify or strengthen certain components of the enrollment process but also to enable us to take further action against providers: (1) engaging (or potentially engaging) in fraudulent or abusive behavior; (2) presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Funds; or (3) that are otherwise unqualified to furnish Medicare services or items. Consistent with this, and as we discuss in this section V.C. of this proposed rule, we propose several changes to our existing Medicare provider enrollment regulations.

b. Legal Authorities

There are two principal categories of legal authorities for our proposed Medicare provider enrollment provisions:

- Section 1866(j) of the Act furnishes specific authority regarding the enrollment process for providers and suppliers; and
- Sections 1102 and 1871 of the Act provide general authority for the Secretary to prescribe regulations for the efficient administration of the Medicare program.

c. Applicable Provider and Supplier Types

The provisions in section V.C. of this proposed rule apply to all Medicare provider and supplier types except as specifically indicated otherwise. The most prominent proposed provisions that would apply only to certain types of providers or suppliers include the following:

- New § 424.530(a)(20), which would permit denial of a hospice's enrollment application for the reasons specified therein.
- New §§ 424.530(a)(22) and 424.535(a)(25), which would allow denial or revocation of a hospice's, home health agency's, or DMEPOS supplier's enrollment for failing to comply with the change in majority ownership provisions in §§ 424.550(b) or 424.551.

- Revised § 424.540(b)(3)(i), which would require reactivating hospices to undergo a State survey or accreditation prior to reactivation.
- Revisions to our DMEPOS accreditation requirements in § 424.58.

d. Comment Solicitation

We solicit and welcome comments on all of the proposed provider enrollment provisions that follow.

2. Revocations and Denials of Enrollment

Under § 424.535(a), CMS may revoke a Medicare provider's enrollment for any of the reasons specified in that paragraph. These reasons include, for instance, the provider's: (1) failure to adhere to Medicare enrollment requirements; (2) exclusion by the HHS Office of Inspector General (OIG); (3) felony conviction within the previous 10 years; (4) pattern of improper or abusive billing; and (5) termination by another Federal health care program. A revocation helps safeguard the Medicare program, the Trust Funds, and beneficiaries by removing from (and preventing payment to) Medicare providers that have engaged in problematic or otherwise non-compliant behavior. When a provider is revoked, it is generally barred from reenrolling in Medicare for a period of 1 to 10 years. The length of this ''reenrollment bar'' is determined based upon the severity of the basis of the revocation.

CMS also has numerous reasons in § 424.530(a) for which it can deny a provider's enrollment application, some of which duplicate our revocation grounds in § 424.535(a) (for instance, OIG exclusion). The general rationale for a denial is akin to that for a revocation: to protect the Medicare program and its beneficiaries from potentially fraudulent or abusive activity.

We have previously finalized a number of regulations adding or revising revocation and denial reasons in subpart P to address particular program integrity vulnerabilities and types of provider conduct. We have also used rulemaking to refine other revocation and denial policies, such as the effective dates of revocations. With our continuing obligation to establish strong payment safeguards, we believe that changes to our revocation and denial policies in subpart P are needed.

a. Modifications of Current Revocation Provisions

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

Section 424.535(a)(8) permits revocation based on the provider's abuse of billing privileges. Per § 424.535(a)(8)(ii), this includes situations where CMS determines that the provider has a pattern or practice of submitting claims that fail to meet Medicare requirements. In making this determination, CMS considers, as appropriate or applicable, the following factors (outlined in § 424.535(a)(8)(ii)(A) through (D)):

- The percentage of submitted claims that were denied during the period under consideration (paragraph (a)(8)(ii)(A)).
- Whether the provider or supplier has any history of final adverse actions and the nature of any such actions (paragraph (a)(8)(ii)(B)).
- The type of billing non-compliance and the specific facts surrounding said non-compliance (to the extent this can be determined) (paragraph (a)(8)(ii)(C)).
- Any other information regarding the provider or supplier's specific circumstances that CMS deems relevant to its determination (paragraph (a)(8)(ii)(D)).

As we noted in the December 5, 2014, final rule that promulgated § 424.535(a)(8)(ii), a provider ''should be responsible for submitting valid claims at all times and that the provider or supplier's repeated failure to do so poses a risk to the Medicare Trust Funds.'' [14]

We propose the following two revisions to § 424.535(a)(8)(ii):

- Remove all the factors in § 424.535(a)(8)(ii)(A) through (D).
- Remove the second sentence of § 424.535(a)(8)(ii) that reads ''In making this determination, CMS considers, as appropriate or applicable, the following''.

We have seen a wide variety of potential § 424.535(a)(8)(ii) cases over the years. However, our existing factors often constrain our ability to effectively address all these factual scenarios. To illustrate, we note the following:

- Final Adverse Actions—Most aberrant billing we have seen is done by providers with no history of adverse actions (for example, Medicare revocations or OIG exclusions). Yet the adverse action factor in § 424.535(a)(8)(ii) essentially requires us to weigh against a finding of improper billing for such providers. That is, this factor assists non-compliant providers so long as the provider lacks an adverse history, which it often will; this hinders our efforts to invoke § 424.535(a)(8)(ii) against the provider.
- Percentage of Claims Denied—This factor, too, is problematic. Non-compliant billing often occurs notwithstanding a low percentage of denied claims, especially with providers that submit many claims. Similar to the adverse history factor, the claim denial criterion thus makes it more difficult to use § 424.535(a)(8)(ii) even if a pattern of abusive billing exists. Moreover, the factor is limited to claim denials and does not consider other types of non-compliant claims (such as rejected claims). In our view, it is the lack of compliance itself, rather than the type of claim involved, that is pertinent.

In sum—and given our responsibility to protect the Trust Funds and taxpayers from improper billing—we must have the maximum flexibility to address all possible § 424.535(a)(8)(ii) scenarios without the rigid constraints of our existing factors. Even with the ''as appropriate or applicable'' qualifier in the opening paragraph of § 424.535(a)(8)(ii), there could still be an implication that we must consider all the factors in our determinations, which, as indicated, hampers the usefulness of § 424.535(a)(8)(ii).

Despite the proposed removal of the criteria in § 424.535(a)(8)(ii), a ''pattern or practice'' within the meaning of revised § 424.535(a)(8)(ii) might be established, for example, by a simple finding that several of the provider's claims do not meet Medicare requirements. In addition, and similar to what we have stated in past regulations when we have proposed new or revised revocation grounds, we would invoke revised § 424.535(a)(8)(ii) only when legitimately warranted under the facts and circumstances and not as a matter of course. Furthermore, interested parties should not conclude that our proposed example: (1) means we would always revoke in that situation; (2) is the only scenario in which we would revoke; and (3) establishes any kind of minimum threshold for CMS action.

(2) False or Misleading Information (§ 424.535(a)(4))

Section 424.535(a)(4) permits revocation if the provider or supplier certified as ''true'' misleading or false information on the enrollment application to be enrolled or maintain enrollment in the Medicare program. We propose to revise § 424.535(a)(4) to allow revocation based on the submission of false or misleading information on or associated with any CMS or Medicare enrollment-related form (including enrollment-related forms created by and/or submitted to CMS contractors). This would also include false or misleading documentation furnished as part of the completion or submission of the CMS or

[14] ''Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment'' (79 FR 72500).

Medicare enrollment-related form. (The current parenthetical in § 424.535(a)(4) regarding potential penalties would remain.)

This proposed expansion has three main components. One is that § 424.535(a)(4) would include certain documents other than Form CMS–855 or Form CMS–20134 (Medicare Enrollment Application: Medicare Diabetes Prevention Program (MDPP) Suppliers) provider enrollment forms. Providers and suppliers must always submit truthful enrollment and enrollment-related information to CMS and its contractors regardless of the form or document involved. Any false or misleading information could lead to improper payments based on inaccurately submitted data and generate doubts about the provider's/supplier's veracity. Additional documents that would fall within the purview of the proposed revisions to § 424.535(a)(4) include, but are not limited to the following:

- Form CMS–588 (Electronic Funds Transfer (EFT) Authorization Agreement; OMB Control Number 0938–0626), which must be submitted with the enrollment application.
- Documents required to demonstrate compliance with HHA capitalization requirements in § 489.28.
- Opt-out affidavits under 42 CFR part 405, subpart D.
- Letters from a provider demonstrating that a particular provider official qualifies as an authorized or delegated official under § 424.502.
- Any other required or requested enrollment-related documentation.

No less than false/misleading data submitted on the application itself, such information furnished via other documentation could result in a non-compliant provider being inadvertently enrolled in Medicare.

Another component is that the submission need not be intended to gain or maintain Medicare enrollment. For § 424.535(a)(4) purposes, the ultimate aim of the submission—be it to enroll, revalidate enrollment, reactivate enrollment, voluntarily terminate enrollment, report changed EFT data, etc.—is not, in our view, as crucial as the truthfulness of the submission. If we continued to limit § 424.535(a)(4) to ''gain or maintain enrollment'' situations, providers might believe they can submit false information on other enrollment-related documents without concern about possible revocation.

The third component is that the information need not have been certified as ''true'' for § 424.535(a)(4) to apply. The correctness of the information is the salient point and not whether it was certified as ''true.''

We believe that our § 424.535(a)(4) expansion would help ensure that providers furnish truthful and accurate enrollment-related data to Medicare. As with current § 424.535(a)(4), though, we would invoke proposed § 424.535(a)(4) only when justified and necessary under the case's facts.

(3) Extension of Revocation (§ 424.535(i))

Section 424.535(i) states that if a provider's enrollment is revoked under § 424.535(a), CMS may revoke any and all of the provider's other enrollments. This provision is designed to ensure that individuals and entities revoked for inappropriate behavior are not permitted to remain enrolled Medicare—and, hence, potentially able to continue their conduct via their other Medicare enrollments—in any capacity. We propose to expand § 424.535(i) such that we could also revoke a provider's other enrollments if the provider's triggering enrollment is denied under § 424.530(a). Some enrollment denials, in our experience, have been based on conduct as concerning to us as that leading to a revocation. Suppose Supplier X has three separate enrollments. It submits a fourth application for a new supplier site. The application is denied because CMS discovers that—(1) the new site is actually a false storefront; and (2) X furnished misleading information on its application. Although this conduct reflects on Supplier X as a whole, we could not take action against X's other enrollments under existing § 424.535(i), since the fourth enrollment was denied rather than revoked. This is disconcerting because X could repeat this behavior via its three remaining enrollments, hence placing the Trust Funds and Medicare beneficiaries at risk. Under our proposed § 424.535(i) revision, though, we would eliminate this vulnerability, for X's recent denial could result in its other enrollments being revoked.

We emphasize that § 424.535(i) would remain a discretionary authority. A denial would not automatically lead to the revocation of the provider's current enrollments.

(4) Expansion and Reorganization of Retroactive Revocation Grounds (§ 424.535(g))

Section 424.535(g) addresses revocation effective dates. Paragraph (g)(1) states that except as described in paragraphs (g)(2) and (g)(3), a revocation becomes effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider; the revocation is thus prospective. Paragraphs (g)(2)(i) through (xv) list situations where the revocation effective date is retroactive. This generally means that the revocation's effective date is retroactive back to the date on which the provider's non-adherence to Medicare requirements commenced.

The purpose of paragraph (g)(2) is to prevent payments to a provider while it is out of compliance. Assume a provider's medical license is revoked by the state on March 1. CMS learns of this and sends a revocation notice to the provider on March 15. If we applied the prospective ''30 days after mailing'' timeframe in paragraph (g)(1), the provider could bill and be paid for services furnished between March 1 and April 15 while unlicensed, resulting in potentially thousands of dollars in improper Medicare payments. Preventing improper payments is a cornerstone of provider enrollment, and retroactive revocation effective dates are crucial mechanisms for ensuring that taxpayer monies are paid only to compliant providers. As § 424.500 makes clear: ''Providers and suppliers must meet and maintain [part 424, subpart P's] enrollment requirements to bill either the Medicare program or its beneficiaries for Medicare-covered services or supplies.'' This means, by extension, that if said requirements are not met, the provider cannot bill—or, in turn, receive payment—for Medicare services or supplies.

Our concerns about paying non-adherent providers are why we have increased the number of retroactive revocation grounds over the years. In the CY 2026 HH PPS final rule (90 FR 55342), we finalized numerous revisions to § 424.535(g) such that many of our existing revocation reasons are now retroactive.[15] So critical is it to make payments only to qualified providers and to comply with the aforementioned requirement in § 424.500 that we now propose to make the remainder of current prospective revocation grounds retroactive. We also believe that the prospect of a retroactive revocation no matter the § 424.535(a) reason could help spur providers to ensure constant

[15] ''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'', published in the **Federal Register** on December 2, 2025 (90 FR 55342).

compliance with Medicare requirements.

There would be two sets of changes to § 424.535(g). First, we would add new retroactive revocation bases. Second, we would restructure § 424.535(g) to remove current § 424.535(g)(1) (which addresses prospective revocations) and realign the existing retroactive grounds to correspond to the numerical order of our § 424.535(a) revocation reasons. To illustrate, current paragraph (g)(2)(i) (which addresses exclusions and debarments) would become paragraph (g)(1)(ii) to correspond to § 424.535(a)(2), which also addresses exclusions and debarments.

(a) General Non-Compliance, Licensure, and Provider Agreements

CMS may revoke a provider under § 424.535(a)(1) if the provider is not in compliance with the enrollment requirements in Title 42 of the Act or in the enrollment application applicable to its provider type. We propose in new § 424.535(g)(1)(i)(A) that said revocation would be effective on the date the non-compliance began (per CMS' or the CMS contractor's determination). This is consistent with several other current retroactive grounds for which the commencement of non-compliance is the effective date; for said current grounds—as well as proposed § 424.535(g)(1)(i)(A)—the rationale is that payments should not be made to non-adherent providers.

State licensure revocations, suspensions, and surrenders (in lieu of further disciplinary action) are also grounds for revocation. As stated in existing § 424.535(g)(2)(iii) and (v), these revocation effective dates are the dates of the revocation, suspension, or surrender. We propose to consolidate paragraphs (g)(2)(iii) and (v) within new § 424.535(g)(1)(i)(B), retaining their current effective dates.

In addition, current § 424.535(g)(2)(vii) addresses effective dates for revocations based on a provider agreement termination under part 489. We propose to retain these dates and incorporate them into new § 424.535(g)(1)(i)(C).

(b) Exclusions/Debarments, Felony Convictions, False Information, and Non-Operational Status

These revocation grounds are addressed in § 424.535(a)(2), (3), (4), and (5)(i), with their concomitant effective dates outlined in existing § 424.535(g)(2)(i), (ii), (ix), and (iv), respectively. With our proposed reorganization of § 424.535(g), § 424.535(g)(2)(i), (ii), (ix), and (iv) would become new § 424.535(g)(1)(ii), (iii), (iv), and (v)(A), respectively.

(We note that due to our proposed expansion of § 424.535(a)(4) (discussed previously), new § 424.535(g)(1)(iv) would include an additional effective date for paragraph (a)(4) revocations based on the submission of false or misleading data not involving the signature of a provider enrollment application certification statement. Specifically, these other false/misleading communications would trigger a revocation effective date of the date the false/misleading information was submitted.)

(c) Failure To Satisfy Enrollment Requirements

Section 424.535(a)(5)(ii) permits revocation if the provider fails to satisfy any Medicare enrollment requirement. We propose in new § 424.535(g)(1)(v)(B) that a § 424.535(a)(5)(ii) revocation becomes effective on the date the Medicare enrollment requirement was not satisfied. This is somewhat akin to our proposed ''date of non-compliance'' effective date for § 424.535(a)(1), but we would instead use ''not satisfied'' to conform to the use of ''satisfy'' in existing § 424.535(a)(5)(ii).(d) Application Fee Payment.

CMS can revoke a provider's enrollment under § 424.535(a)(6) in any of the following four bulleted instances:

- Under § 424.535(a)(6)(i)(A) and (B)—

++ An institutional provider (as defined in § 424.502) fails to submit with its Medicare revalidation application an application fee or hardship exception request that complies with § 424.514; or

++ The hardship exception is not granted, and the institutional provider fails to submit the applicable application form or application fee within 30 days of being notified of the hardship exception request's denial.

- Under § 424.535(a)(6)(ii)(A)*(1)* and *(2):*

++ CMS is unable to deposit the full application fee amount into a government-owned account; or

++ The funds are unable to be credited to the United States Treasury.

- Under § 424.535(a)(6)(ii)(B), the provider lacks sufficient funds in the account at the banking institution whose name is imprinted on the check or other banking instrument to pay the application fee.

- Under § 424.535(a)(6)(ii)(C), there is any other reason why CMS or its Medicare contractor is unable to deposit the application fee into a government-owned account.

Unlike with most of our other revocation reasons, the variety and types of scenarios in § 424.535(a)(6) make it infeasible to establish a uniform revocation effective date based on provider non-compliance or other definitive point (for example, date on which license or state authority to prescribe drugs was revoked, date of felony conviction, etc.) For this reason, we propose in new § 424.535(g)(1)(vi) that a revocation under § 424.535(a)(6) is effective on the date on which CMS or its contractor determines that the provider or supplier should be revoked under this paragraph; the date, in other words, would be that of the CMS or contractor determination instead of, for instance, the date on which CMS could not deposit the funds. This would still allow for retroactivity because of the provider's non-compliance with § 424.514—that is, its failure to pay a full, depositable fee or have a hardship exception approved. Yet it would be flexible enough to address all the various § 424.535(a)(6) situations.

(e) Misuse of Billing Number

CMS may revoke a provider's enrollment under § 424.535(a)(7) if the provider knowingly sells to or allows another individual or entity to use its billing number. (This excludes providers who enter into a valid reassignment of benefits under § 424.80 or a § 489.18 change of ownership.) Given the seriousness of this conduct—with its significant potential for fraud—we believe that the revocation effective date should be the date on which the conduct resulting in the revocation occurred. This would be included in new § 424.535(g)(1)(vii).

(f) Abuse of Billing Privileges

The effective dates for revocations under § 424.535(a)(8)(i) and (ii) are addressed in § 424.535(a)(8)(iii). So that all revocation effective dates can be found in one paragraph, we propose to move and redesignate § 424.535(a)(8)(iii) as new § 424.535(g)(1)(viii). Paragraph (iii) would be deleted from § 424.535(a)(8).

(g) Reporting Enrollment Data Changes

Section 424.535(a)(9) permits revocation if the provider failed to comply with the change of information reporting requirements in §§ 424.516(d) or (e), 410.33(g)(2), or 424.57(c)(2). These four paragraphs collectively address all Medicare provider and supplier types (except Medicare Diabetes Prevention Programs (MDPPs), which are dealt with in § 424.205)) and all types of enrollment data changes. Current § 424.535(g)(2)(x) partially

addresses the effective date of a § 424.535(a)(9) revocation. For revocations based on the provider's failure to timely report a change of ownership or adverse legal action, or a change, addition, or deletion of a practice location, the effective date under § 424.535(g)(2)(x) is day the after the date by which the provider was required to report the change, addition, or deletion. All other changes are prospective under current § 424.535(g)(1).

We propose in new § 424.535(g)(1)(ix) to make all § 424.535(a)(9) revocations retroactive to the day following the due date for reporting the change. While ownership, adverse legal action, and practice location changes are important (hence their inclusion in existing § 424.535(g)(2)(x)), other data changes are as well. A failure to timely report a new managing employee or corporate officer, for example, could result in CMS unknowingly paying a provider with a high-level official who poses a program integrity risk based on past or current conduct. In addition, if we do not timely learn of a provider's new bank, billing agency, or correspondence address, CMS risks sending funds or information to—or receiving claims from—the wrong entity or individual; this could lead to incorrect payments or the inadvertent release of confidential data. The point is that outdated or erroneous enrollment information of any type—not simply ownership, adverse action, or location data—can threaten the Trust Funds, and any failure to timely report such changes means the provider is non-compliant with enrollment requirements. For these reasons—and because the prospect of a retroactive revocation could encourage providers to timely report all enrollment changes—we believe § 424.535(g)(1)(ix) is warranted.

Although the provider is ultimately responsible for ensuring that its enrollment data is timely updated and always accurate, we welcome stakeholder comment on any administrative difficulties in reporting changes in enrollment information and ideas on how they could be addressed.

(h) Failure To Document or Furnish Documentation

CMS can revoke a provider under § 424.535(a)(10) if the provider fails to comply with the documentation or CMS access requirements in § 424.516(f). In general, § 424.516(f) requires providers (including physicians and eligible professionals) to: (1) retain for 7 years all documents regarding written orders, certifications, referrals, prescriptions and requests for payments for Part A or B services, items, or drugs; and (2) furnish access to that documentation upon CMS or CMS contractor request.

We propose in new § 424.535(g)(1)(x)(A) and (B) that a § 424.535(a)(10) effective date is as follows:

- For revocations based on a failure to retain documentation, the date on which CMS or the CMS contractor found that the provider has not complied with this retention requirement.
- For revocations based on a failure to provide access to that documentation, the day after the date by which the provider was required to give access.

We believe proposed § 424.535(g)(1)(x)(A) soundly balances the need for retroactivity—due to, for instance, the provider's non-compliance and our inability to make payment to non-adherent providers—and the need for a clear effective date. To illustrate, suppose CMS discovered several years after a particular service was ordered or certified that the provider lacks documentation thereof. CMS would have no means of knowing whether the documentation was never kept, discarded after 2 years or 4 years, etc. It is therefore difficult to establish an effective date in this scenario, hence the need to use the proposed—and much more precise—§ 424.535(g)(1)(x)(A) date. Regarding § 424.535(g)(1)(x)(B), the provider's failure to provide the documentation constitutes non-compliance, similar to a provider's failure to timely report changes in information. We thus believe that the day after the due date for furnishing access is an appropriate effective date.

(i) Initial Reserve Operating Funds (IROF)

Under 42 CFR 489.28, HHAs must demonstrate that they have sufficient available funds upon application submission and for the 3-month period following the conveyance of Medicare billing privileges to operate the HHA for this 3-month period. CMS can revoke the HHA under § 424.535(a)(11) if, within 30 days of a CMS or Medicare contractor request, the HHA cannot furnish supporting documentation verifying that it meets the IROF requirement. For the same reasons behind proposed § 424.535(g)(1)(x)(B)—specifically, the provider's non-compliance with § 489.28 based on its failure to demonstrate adequate funds—we propose in new § 424.535(g)(1)(xi) that the § 424.535(a)(11) revocation effective date is the day after the date by which the HHA was required to submit the requested documentation.

(j) Other Program Termination

CMS under § 424.535(a)(12) may revoke a provider's Medicare enrollment if the provider is terminated, revoked, or otherwise barred from participation in a State Medicaid program or any other federal health care program. The effective date of a § 424.535(a)(12) revocation is, consistent with existing § 424.535(g)(2)(vi), the date of the termination, revocation, or bar (from the other program). As part of our previously discussed restructuring of § 424.535(g), we propose to redesignate § 424.535(g)(2)(vi) as new § 424.535(g)(1)(xii); however, we would include the terms ''revocation'' and ''bar'' within the latter to correspond to § 424.535(a)(12). (Current § 424.535(g)(1)(vi) only references terminations.)

(k) Drug Enforcement Administration (DEA) Certificates

Section 424.535(a)(13)(i) and (ii) permit revocation if—

- A physician or other eligible professional's DEA Certificate of Registration to dispense a controlled substance is currently suspended or revoked or is surrendered in response to a show cause order; or
- The applicable licensing or administrative body for any state in which the physician or eligible professional practices suspends or revokes the individual's ability to prescribe one or more drugs.

Existing § 424.535(g)(2)(xi) permits retroactive revocation based on the surrender of the provider's DEA certificate of registration in response to a show cause order. (The revocation effective date is the date the certificate was surrendered.) We propose to include DEA certificate revocations and suspensions within this paragraph, with the date of the revocation or suspension as the effective date. It is the permanent or temporary loss of the certificate itself—rather than the form of loss (for example, revocation or surrender)—that is important for program integrity purposes; it would be illogical for certificate surrenders to be part of paragraph (g)(2)(xi) but not revocations or suspensions. As we stated in the CY 2026 HH PPS final rule that promulgated paragraph (g)(2)(xi), meeting all applicable federal and state requirements is necessary for enrollment.[16] If a provider is prescribing or dispensing drugs while non-compliant, we believe the risk this presents to beneficiaries after the

[16] 90 FR 55342.

certificate loss warrants a revocation back to the date said loss occurred.

Per current § 424.535(g)(2)(xii), the effective date of a revocation based on a State's suspension or revocation of the physician's or practitioner's ability to prescribe one or more drugs is the date of the suspension or revocation. We propose to redesignate this paragraph without change as new paragraph (g)(1)(xiii)(B), with existing (g)(2)(xi) redesignated as new paragraph (g)(1)(xiii)(A). This would better correspond numerically with (a)(13)(i) and (ii).

(l) Improper Prescribing Practices

Section 424.535(a)(14) permits revocation if the physician or practitioner has a pattern or practice of prescribing Medicare-covered drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or fails to meet Medicare requirements. We propose in new § 424.535(g)(1)(xiv) that the effective date of a § 424.535(a)(14) revocation would be the last date of the prescription(s) in question; for instance, if there were three prescriptions dated March 1, March 15, and March 30, the last date—March 30 would be the revocation effective date. This approach mirrors that for § 424.535(a)(8)(ii)'s revocation effective date, which, as noted, is the last date of service on the claims in question.

We have in past enrollment rules expressed our concerns about abusive and improper prescribing. Such conduct could cause serious patient harm (for instance, the prescription of unnecessary but dangerous medications). Applying a prospective effective date to a § 424.535(a)(14) revocation would run counter to our obligation to help protect Medicare beneficiaries; we would essentially be allowing the individual to continue prescribing for at least another 30 days, during which time additional beneficiaries might be placed as risk. We thus believe a retroactive revocation in this circumstance is proper.

(m) False Claims Act (FCA)

Revocation is permissible under § 424.535(a)(15) if the provider (or owner, managing employee or organization, officer, or director thereof) has had an FCA civil judgment against them within the previous 10 years. Considering the seriousness of false claims and the threat this poses to the Medicare program, we believe a retroactive revocation effective date back to the date of the judgment is necessary; this would be reflected in new paragraph (g)(1)(xv). Allowing the provider to remain enrolled for 30 or more days via a prospective effective date could result in the continuation of the provider's behavior, at potentially great cost to the Trust Funds.

(Proposed new § 424.535(g)(1)(xvi) is addressed later in this section V.C. of this proposed rule.)

(n) Debts Referred to Treasury

Section 424.535(a)(17) permits revocation if the provider failed to repay a debt that CMS appropriately referred to the United States Department of Treasury. (Paragraph (a)(17) does not apply if: (1) the debt has been discharged by a bankruptcy court; or (2) the administrative appeals process regarding the debt has not been exhausted or the timeframe for filing the appeal (at the appropriate appeal level) has not expired.)

All providers are responsible for satisfying their financial obligations to Medicare. Consistent with our rationale for the original promulgation of § 424.535(a)(17), we believe that referral to the Department of Treasury may indicate the provider's unwillingness to repay a debt, which raises doubts regarding whether the provider is a reliable participant in the Medicare program.

With the need to protect the Medicare program's financial integrity, we propose in new § 424.535(g)(1)(xvii) that the effective date of § 424.535(a)(17) would be retroactive back to the date on which CMS referred the debt to Treasury. A prospective effective date, in our view, would give the provider more time to incur additional debts that it also might not repay, placing taxpayers at considerable financial risk. We also believe that the prospect of a retroactive revocation under § 424.535(g)(1)(xvii) could spur providers to ensure that it repays all debts before they are sent to Treasury.

(o) Revoked Under Different Name or Identity

CMS under § 424.535(a)(18) may revoke a provider that is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period under § 424.535(c) has not expired. The objective is to prevent situations where a revoked provider changes its identity in order to re-enter Medicare and thus circumvent its existing bar on reenrollment. Such conduct is not only dishonest but also threatens the Medicare program's integrity and beneficiaries, for the provider's activity that generated the prior revocation—such as abusive billing or prescribing, fraudulent behavior, etc.—could be repeated in its subsequent enrollment under the different name.

Accordingly, we believe that a retroactive revocation effective date is proper. This date in new § 424.535(g)(1)(xviii) would be the same as the effective date of the provider's current enrollment. Suppose Provider X was revoked effective February 1. It changes its name to Provider Y and re-enrolls in Medicare effective July 1. CMS becomes aware of the provider's current revocation under the Provider X name on September 1 and revokes Provider Y under § 424.535(a)(18). The revocation effective date would be July 1, the effective date of Y's enrollment. We do not believe Provider Y should effectively be rewarded for its circumvention with a revocation effective date that is later than its enrollment effective date. This is because it should not: (1) have attempted to reenroll under the new name to begin with (since it was prohibited from doing so under the original reenrollment bar); and (2) receive payment stemming from what amounts to an improper subsequent enrollment. We believe the severity of the provider's behavior warrants the earliest feasible retroactive revocation date, which could also deter revoked providers from attempting to maneuver around their re-enrollment bar.

(p) Undue Risk

Per § 424.535(a)(19), CMS may revoke a provider or supplier that has or has had an affiliation under § 424.519 that poses an undue risk of fraud, waste, or abuse to the Medicare program. There are many different scenarios that could fall within § 424.535(a)(19) in terms of, for example, the type, time, and length of the affiliation. As with § 424.535(a)(6), this makes it challenging to establish a uniform retroactive revocation effective date applicable to every factual situation. We hence propose in new § 424.535(g)(1)(xix) that a revocation under § 424.535(a)(19) is effective on the date on which CMS or its contractor determines that the provider or supplier should be revoked under this paragraph. This would still remove the risks posed by a prospective effective date—for instance, the continuation of a problematic affiliation that could threaten the Medicare program for another 30 or more days—while ensuring consistency in the application of § 424.535(a)(19) revocation effective dates.

(q) Billing From Non-Compliant Location

CMS may revoke enrollment under § 424.535(a)(20) if the provider billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements. This provision is partly analogous to § 424.535(a)(5)(i), which addresses non-operational locations; § 424.535(a)(5)(i)'s revocation effective date is the date on which the practice location was no longer operational. Yet it perhaps has more similarities to § 424.535(a)(8)(ii) because it references billing (that is, submission of claims) for services. In light of the previously noted importance of maintaining constant compliance with enrollment requirements, we believe a retroactive effective date for § 424.535(a)(20) aligning with that in § 424.535(a)(8)(ii) is needed. Per new § 424.535(g)(1)(xx), this date would be the earliest date on the claims for the non-compliant location that are triggering the revocation.

(r) Abusive Ordering, Certifying, Referring, or Prescribing

Section 424.535(a)(21) permits revocation if the physician or eligible professional has a pattern or practice of ordering, certifying, referring, or prescribing Part A or B services, items, or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements. As with proposed § 424.535(g)(1)(xiv) regarding § 424.535(a)(14), the seriousness of the conduct described in § 424.535(a)(21) and the threats it can present to Medicare patients and the Trust Funds (for instance, ordering unnecessary tests) warrants a retroactive effective date. This date under proposed § 424.535(g)(1)(xxi) would be the date of the last order, certification, referral, or prescription in the applicable pattern or practice, akin to the proposed § 424.535(a)(14) effective date.

(s) Patient Harm

Revocation under § 424.535(a)(22) is permissible if the physician or other eligible professional has been subject to prior action from a State oversight board, Federal or State health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper conduct that led to patient harm. We believe a retroactive revocation effective date for § 424.535(a)(22) is appropriate due to the need to protect Medicare beneficiaries from potential harm. We propose that this effective date per new § 424.535(g)(1)(xxii) would be the date of the prior action that resulted in the revocation.

(t) Supplier Standard and Condition Violation

Several provider and supplier types have certain standards and conditions they must meet in addition to all other enrollment requirements. These types—and their corresponding standard/condition regulatory sections—include independent diagnostic testing facilities (IDTFs) (§ 410.33(g)), DMEPOS suppliers (§ 424.57(b) and (c)), opioid treatment programs (OTP) (§ 424.67(b) and (e)), home infusion therapy suppliers (§ 424.68(c) and (e)), and MDPPs (§ 424.205(b) and (c)). Except for § 424.57(b) violations, CMS under § 424.535(a)(23) may revoke the provider or supplier for non-compliance with any of the standards or conditions applicable to their provider/supplier type. (Revocation is permissible for § 424.57(b) violations (as well as § 424.57(c) non-compliance) under § 424.57(e)(1).) The current § 424.535(a)(23) revocation effective dates (outlined in § 424.535(g)(2)(xv)(A) through (D), respectively) are as follows:

- For standard or condition violations involving the suspension, revocation, or termination (or surrender in lieu of further disciplinary action) of the provider's Federal or State license, certification, accreditation, or MDPP recognition, the date of the suspension, revocation, termination, or surrender.
- For standard or condition violations involving a non-operational practice location, the date the non-operational status began.
- For OTP standard violations involving a felony conviction of a party described in § 424.67(b)(6)(i), the date of the felony conviction.
- For all standard violations not addressed in existing paragraph (g)(2) (which, as discussed, would be incorporated within revised (g)(1)), the prospective effective date in current paragraph (g)(1) applies if the effective date in existing paragraph (g)(3) (discussed shortly) does not.

We propose to retain the dates in § 424.535(g)(2)(xv)(A) through (C), though we would re-designate them as new § 424.535(g)(1)(xxiii)(A)(*1*) through (*3*). In new § 424.535(g)(1)(xxiii)(B)—and consistent with the foregoing concerns about paying non-compliant providers—we propose that the effective date of all other revocations based on a condition or standard violation would be the date of non-compliance with the condition or standard.

We propose two other organizational changes. First, existing § 424.535(g)(2)(viii) states that the effective date of a revocation based on a lapse in the IDTF's comprehensive liability insurance under § 410.33(g)(6) is the date the insurance lapsed. We are not proposing to include a separate effective date for this revocation in revised § 424.535(g)(1) because we believe it would fall within new § 424.535(g)(1)(xxiii)(B), with the lapse date being the standard violation date. Second, existing § 424.535(g)(2)(xiv) states that the effective date of a revocation based on a DMEPOS supplier's non-compliance with a condition or standard in § 424.57(b) or (c) is the date on which the non-compliance began. This provision would not be included in revised § 424.535(g)(1), for new § 424.535(g)(1)(xxiii) would cover § 424.57(b) or (c) violations.

(u) Extension of Revocation

As already noted, § 424.535(i) states that if a provider's Medicare enrollment is revoked, CMS may revoke any and all of the provider's Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types. The effective date of the revocation(s) of the other enrollment(s) is—per existing § 424.535(g)(2)(xiii)—the effective date of the revocation that triggered the other revocation(s). We propose to retain this effective date provision with two modifications. First, we would redesignate it as § 424.535(g)(2)(xxvi). Second, and consistent with our aforementioned proposed modification of § 424.535(i), the effective date of the other revocation(s) would be the date of the triggering revocation or denial.

(Proposed new § 424.535(g)(1)(xxiv) and (xxv) will be addressed later.)

In conclusion, existing § 424.535(g)(3) states that if the action that resulted in the revocation occurred prior to the effective date of the provider's enrollment, the revocation effective date is the same as the effective date of enrollment. To accommodate our restructuring of § 424.535(g), we propose to re-designate § 424.535(g)(3) as § 424.535(g)(2).

(5) Claim Submissions After Revocation (§ 424.535(h))

Under § 424.535(h)(1)(i) (and excluding HHAs), a revoked provider must—within 60 calendar days after the revocation's effective date—submit all claims for items and services furnished

before the date of the revocation letter. For revoked HHAs, § 424.535(h)(1)(ii) states that claims must be submitted within 60 days after the later of the following: (1) the revocation effective date; and (2) the date that the HHA's last payable episode ends.

This general 60-day post-revocation policy was first established in the CY 2009 Physician Fee Schedule final rule (73 FR 69726), published in the **Federal Register** on November 19, 2008.[17] We noted therein that revoked physicians, non-physician practitioners (NPP), physician and NPP groups, and IDTFs had historically been allowed to continue billing for services furnished prior to revocation for up to 27 months after the revocation's effective date.[18] We explained in that rule that: (1) such a long, post-revocation billing period posed significant risk to the Medicare program; and (2) a 60-day post-revocation timeframe for these five general supplier categories (established in new § 424.535(h)) was necessary to limit the Medicare program's exposure to future vulnerabilities.[19]

Consistent with this theme, we later expanded § 424.535(h) to apply to all provider and supplier types in a December 5, 2014, final rule titled, ''Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment'' (79 FR 72500). In the proposed version of that rule, we:

- Cited the concerns we expressed in the CY 2009 PFS final rule regarding the 27-month period.
- Expressed our view that the longer the post-revocation claim submission timeframe, the more opportunity the provider or supplier would have to submit false claims.
- Noted that under § 424.518(c)(3)(ii), a revoked provider falls within the ''high'' categorical risk level. This heightened risk posed by revoked providers threatened the Trust Funds, hence warranting a much shorter 60-day period for all provider and supplier types.[20]

Despite this reduction to 60 days, we have remained concerned about possible fraudulent, improper, or other non-compliant activity by revoked providers. If a provider engaged in such conduct before the revocation, it may continue it afterwards—and 2 months is still an extensive timeframe in which to do so. Indeed, a revoked provider could submit hundreds of improper claims for hundreds of thousands of dollars during this period. If other providers did the same after their revocations, many millions of Trust Fund dollars would be threatened. With the need to protect taxpayer monies from such parties, we believe that further reducing the submission timeframe could correspondingly lessen the program integrity risk, for providers would have less time to engage in inappropriate billing. For these reasons, we propose to change the 60-day timeframe referenced in § 424.535(h) to 15 days. While we recognize that this would be a substantial time reduction, we believe the risk warrants it.

We propose an additional change to § 424.535(h). In 2014, many of our revocations were prospective, meaning they did not become effective until 30 days after the revocation letter was sent. This made § 424.535(h) easier to operationalize, for the revocation effective date in most cases would be in the future; the provider would have 60 days from the prospective effective date to submit its claims. Now, though, many revocation reasons have retroactive effective dates (and, as discussed previously, we are proposing that all revocation reasons be retroactive). Under existing § 424.535(h), therefore, if a provider had 60 days from the revocation effective date to submit its claims but the effective date was more than 60 days retroactive, the submission period might well have expired before the provider even received the revocation letter. To ensure that the provider actually has an opportunity to submit its claims, we propose to change:

- Section 424.535(h)(1)(i) to state that a revoked provider must—within 15 calendar days of the date of the revocation letter—submit all claims for items and services furnished before the revocation effective date.
- Section 424.535(h)(1)(ii) to state that a revoked HHA must—within 15 calendar days of the date of the revocation letter—submit all claims for items and services furnished before the later of the following:''.

Sections 424.535(h)(1)(i)(A) and (B) and (h)(2) (which references the timely filing requirements of § 424.44) need not be revised.

(6). New Revocation Reasons

We also propose to add several new grounds for revocation in § 424.535(a).

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

We have seen an alarming increase in situations where numerous providers and suppliers—sometimes of the same type—are simultaneously operating within a very small geographic area (for instance, a multi-block sector), the same complex or building, or even the same suite. Examples include: (1) several dozen hospices within a four-block area of Los Angeles County; (2) 18 HHAs within the same building in Columbus, Ohio; (3) at least nine cases in Ohio where at least five HHAs have the same practice location address, with four of these nine situations involving at least nine HHAs in one location; and (4) similar situations with several certified providers of the same type operating out of one building in Michigan, Nevada, North Carolina, and Texas. Los Angeles County has been a particularly serious concern. Per CMS data, the number of HHAs in the county between 2019 and 2023 rose over 45 percent, and at least 1,400 new HHAs have enrolled in the county since 2019. There was no medical need for such an increase, which was entirely out of proportion with any increase in the county's beneficiary population and can be a strong indicator of widespread fraud. Others share our concerns about this, including the Medicare Payment Advisory Commission,[21] members of Congress,[22] and even several national HHA and hospice organizations.[23]

We recognize that many medical facilities and complexes have large numbers of providers and suppliers located therein. To illustrate, a medical center comprising three adjacent buildings may have seven physician practices with different specialties, two laboratories, etc. Also, some areas may have several types of providers and suppliers within a particular neighborhood. The vast preponderance of these situations do not, in and of themselves, necessarily mean that fraud, waste, and abuse exists or that program integrity risks are otherwise present. Yet

[17] ''Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).''

[18] Ibid.

[19] Ibid.

[20] ''Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment'' Proposed Rule'' (78 FR 25013), published in the **Federal Register** on April 29, 2013.

[21] *https://www.medpac.gov/wp-content/uploads/2025/12/Tab-H-HHA-update-Dec-2025.pdf.*

[22] Letter from United States House Representatives Brett Guthrie, John Joyce, M.D., Morgan Griffith, Jason Smith, David Schweikert, and Vern Buchanan to T. March Bell, Inspector General, HHS–OIG, January 9, 2026, *https://energycommerce.house.gov/posts/chairmen-guthrie-joyce-griffith-smith-schweikert-and-buchanan-ask-hhs-oig-about-ongoing-hha-and-hospice-fraud-in-los-angeles-county-1.*

[23] Letter from LeadingAge and the National Alliance for Care at Home Letter to Dr. Mehmet Oz, CMS Administrator, December 22, 2025, *https://allianceforcareathome.org/wp-content/uploads/Final-Alliance-and-LeadingAge-Home-Health-and-Hospice-Program-Integrity-Recommendations.pdf.*

we believe those cases mentioned in the previous paragraph—as well as other situations—can and do. Fraud schemes can indeed involve problematic (or potentially problematic) providers operating in same general vicinity, as shown in the Los Angeles County and Columbus situations. Although having, for example, four organizational providers/suppliers of the same type (such as ambulance companies) in a seven-block area does not automatically signify fraud, waste, and abuse, it does—based on our experience—raise questions as to whether there is a patient need for all these providers or whether other considerations, such as fraud, are involved.

With tens of millions of Medicare dollars at risk in any fraud scheme, our role in safeguarding the Trust Funds requires the ability to take revocation action—if circumstances warrant—to address such situations. This is especially important because we currently lack authority under § 424.535(a) to revoke providers/suppliers based on program integrity threats stemming from an excessive number of enrolled providers/suppliers within a particular area. We accordingly propose in new § 424.535(a)(24) that CMS may 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. We note the following concerning this proposal.

First, the term ''high risk'' for purposes of § 424.535(a)(24) does not mean the provider must be in: (1) the high screening level under § 424.518(c); or (2) a region that has traditionally posed a high risk of fraud, waste, and abuse, such as south Florida. To be sure, § 424.518(c) providers—as well as providers in known program integrity hotspots—pose elevated risks, a matter we may consider in § 424.535(a)(24) determinations. Yet other provider types in other areas can present threats as well. The risk that a particular provider poses based on its proximity to other providers—somewhat more so than the provider type and historic geographic risk—is the main consideration under proposed § 424.535(a)(24).

Second, and in a similar vein, a potential fraud scheme can involve multiple provider and supplier types; for instance, several HHAs, hospices, DMEPOS suppliers, physicians, etc., might be participating in a single operation. A § 424.535(a)(24) revocation therefore would not require the provider in question and the other providers/suppliers in the area to be of the same type.

Third, the terms ''limited geographic area'' or ''excessive number'' in the context of § 424.535(a)(24) will have their ordinary, plain-language meanings. This is due to the many factual situations that could arise and our need for flexibility in addressing them—something that thresholds such as minimum/maximum distance or numbers of providers would obstruct. Moreover, such thresholds would alert potentially problematic providers as to how to circumvent a § 424.535(a)(24) revocation. If, for example, we stated that § 424.535(a)(24) only applies if there are at least X number of providers within a radius of X miles, providers seeking to engage in fraud might enroll immediately outside said radius and/or within an area with fewer providers. This would defeat purpose of § 424.535(a)(24). That said, our primary focus is on providers in smaller areas—common buildings and complexes, city and town blocks, neighborhoods, etc. Although we reserve the right to apply § 424.535(a)(24) to providers in larger areas (especially if there is an abnormally high number of providers therein), the application of § 424.535(a)(24) would typically be more geographically limited.

Fourth, an actual finding of fraud, waste, or abuse by the provider or another provider in the area would not be required for a § 424.535(a)(24) revocation. This is akin to section 1866(j)(5) of the Act (codified in § 424.519), which permits denial or revocation if: (1) the provider has or has had a certain type of affiliation with another provider or supplier; and (2) the affiliation poses an undue risk of fraud, waste, or abuse; no determination of actual fraud, waste, or abuse is needed. Section 424.535(a)(24) revocations would be based on the assessed risk and not whether the provider or nearby providers have actually engaged in fraudulent conduct.

Fifth, while several existing revocation reasons in § 424.535(a) require CMS to consider specified factors in its revocation decisions, we are not proposing the same for § 424.535(a)(24). Consistent with our prior discussion regarding § 424.535(a)(8)(ii), we must be able to address all potential § 424.535(a)(24) scenarios without the rigid restrictions of required criteria and based solely on the unique facts and circumstances of each case.

Sixth, and notwithstanding the foregoing, we emphasize that proposed § 424.535(a)(24) is not designed to revoke good-faith providers who otherwise present no apparent risks even though they might, for example, be in an area with numerous other providers. We especially reiterate our understanding that many physicians and practitioners practice in the same building, complex, or other small area. Providers should not assume they would be revoked under § 424.535(a)(24) merely because they operate near other providers. Section 424.535(a)(24) would only be applied when the circumstances involved and the risk presented truly justify it.

Seventh, some interested parties may detect certain similarities between § 424.535(a)(24) and our authority under section 1866(j)(7) of the Act (codified in § 424.570) to impose a temporary enrollment moratorium. Although we address temporary moratoria in greater detail later in section V.C. of this proposed rule, we state here that a moratorium differs from § 424.535(a)(24) in many ways. The latter, for instance: (1) is a revocation reason rather than a prohibition on new enrollments; and (2) takes into account the provider's proximity to other providers of all types, not simply the number of (or risk posed by) providers of the same type.

(b) Certain Misdemeanor Convictions (§ 424.535(a)(16))

In the CY 2024 PFS proposed rule (88 FR 52262), we proposed in new §§ 424.530(a)(16) and 424.535(a)(16) to deny or revoke enrollment if the provider—or any owner, managing employee or organization, officer, or director thereof—was convicted of a Federal or State misdemeanor within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries. We stated that offenses would include (but not be limited in scope or severity to):

- Fraud or other criminal misconduct involving the provider's participation in a Federal or State health care program or the delivery of services or items thereunder.
- Assault, battery, neglect, or abuse of a patient (including sexual offenses).
- Any other misdemeanor that places the Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.[24]

[24] ''Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program'', published in the **Federal Register** on August 7, 2023.

We outlined in that CY 2024 proposed rule our increasing concern about providers convicted of misdemeanors for conduct that could endanger the Trust Funds and beneficiaries. We stated that our responsibility in overseeing the Medicare program requires that we be able to take protective action in such instances.

We also noted that while some States may designate a particular crime as a misdemeanor while others deem it a felony, this does not lessen the risk that the former can pose to Medicare and its beneficiaries.[25] It is the conduct itself, not its classification under State law, that concerns us. This is particularly true since restricting our revocation authority for criminal convictions to felonies could leave us unable to address situations where a felony charge results in a misdemeanor plea.

As explained in the CY 2024 PFS final rule (88 FR 78818), we received numerous comments on this proposal. One of the commenters' concerns was that the proposal was too broad, potentially encompassing many types of misdemeanors involving comparatively modest conduct.[26] Based on the comments received, we did not finalize the proposal. We stated in the CY 2024 PFS final rule that: (1) we would continue to monitor cases of misdemeanor convictions involving significant misconduct; (2) we might pursue future rulemaking to address them; and (3) many misdemeanors—especially those involving assault, battery, neglect, or abuse of a patient (including sexual offenses)—could involve disturbing activity.[27]

Two particularly disconcerting categories of misdemeanor convictions we have recently seen involve sexual assault and financial misconduct. The former can endanger Medicare beneficiaries while the latter can threaten the Trust Funds—both of which we must safeguard. In line with our aforementioned willingness to pursue future rulemaking if warranted, we propose in § 424.535(a)(16) (currently designated as ''Reserved'') to revoke enrollment if the provider or supplier—or any owner, managing employee or organization, officer, or director thereof—was convicted of a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.

While parts of this proposal duplicate those in the CY 2024 proposed rule (for example, the 10-year period, the applicability to owners, directors, etc.), there is one critical difference: it is much narrower in scope. Whereas the CY 2024 proposal was rather open-ended in terms of potential misdemeanors, the present one is limited to sexual assault and financial misconduct. We believe this would reduce interested parties' possible concerns that proposed § 424.535(a)(16) is too broad. In addition, we stress that: (1) terms such as financial misconduct would be based on their plain meanings; and (2) the misdemeanor convictions described in this paragraph must be detrimental to Medicare's (and Medicare beneficiaries') best interests, meaning that not every such conviction would result in revocation.

(c) Effective Dates of New Revocation Reasons

Consistent with our proposed retroactive effective dates for all revocation reasons, we propose the following effective dates for proposed § 424.535(a)(16) and (24). The § 424.535(a)(16) effective date would be the date of the conviction, which mirrors the effective date for felony conviction revocations under § 424.535(a)(3); this date would be referenced in new § 424.535(g)(1)(xvi). For § 424.535(a)(24), we propose in new § 424.535(g)(1)(xxiv) an effective date that is the date on which CMS or its contractor determines that the provider should be revoked under § 424.535(a)(24). This aligns with our proposed effective date for our other risk-based revocation reason in § 424.535(a)(19) and is based on the difficulty in establishing a concrete date as to when the risk addressed in § 424.535(g)(1)(xxiv) commenced.

(7) Revised and New Denial Reasons (§ 424.530(a))

We also propose a number of revised and new denial reasons in § 424.530(a).

(a) Changes to Existing Denial Reasons

(i) Debt (§ 424.530(a)(6))

Current § 424.530(a)(6)(i) and (ii) permit denial if the enrolling provider or owner (as defined in § 424.502) thereof—

- Has an existing Medicare debt; or
- Was previously the owner of a provider that had a Medicare debt when the latter provider's enrollment was voluntarily terminated, involuntarily terminated, or revoked (and additional criteria in § 424.530(a)(6)(ii)(A) through (C) are met).

We propose to include within the scope of § 424.530(a)(6) managing employees, managing organizations, and individuals and entities with any other form of business or financial relationship with the provider.

Section 424.530(a)(6)(i)'s purpose is to prevent providers (and owners thereof) from enrolling additional locations when they have debts to Medicare via their current enrollments that they have not paid. Indeed, if they have not fulfilled these financial obligations, we cannot be certain they will do so with their new enrollments, hence threatening the Trust Funds. The goal of § 424.530(a)(6)(ii), meanwhile, is to address situations where a party—often via their ownership of a provider—(1) incurs a substantial debt to Medicare; (2) exits the Medicare program, shuts down operations altogether, and attempts to re-enter Medicare through another vehicle or under a new business identity. The party's objective often is to avoid paying the prior debt while incurring additional debts through their ownership of the new provider. Section 424.530(a)(6)(ii) helps prevent this by blocking the new provider's enrollment.

Gaps remain, though. As noted in prior rulemaking efforts, managing employees and managing organizations (as defined in § 424.502) often have as much or more influence over a provider's day-to-day operations as an owner. Yet § 424.530(a)(6) only references the provider itself and its owners. Section 424.530(a)(6) thus cannot prevent enrollment if, for instance, a managing employee or organization of the prior provider ran its daily operations, was responsible for its accumulation of large debts, and now seeks to re-enter Medicare through their ownership of the new provider. Moreover, we have seen instances where parties other than owners and managing employees/organizations were substantially involved with the former provider in some capacity; as examples, this includes: (1) parties that furnished services or provided financing for the prior provider; and (2) closely associated health care providers. The core issue, therefore, is not the precise form or label of the relationship with the former provider—that is, whether it was ownership, financial, etc. It is instead the relationship itself and the party's effort to enroll new locations or reenter Medicare through the new provider.

We emphasize that we do not intend to deny enrollment in all scenarios

[25] Ibid.

[26] ''Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program'', published in the **Federal Register** on November 16, 2023.

[27] Ibid.

involving revised § 424.530(a)(6). Each case would be carefully judged on its own circumstances, and denial would only occur when warranted.

(ii) Payment Suspension (§ 424.530(a)(7))

Denial is permitted under § 424.530(a)(7) if the provider, or any owning or managing employee or organization of the provider, is currently under a Medicare or Medicaid payment suspension (as defined in §§ 405.370 through 405.372 or in § 455.23). For the same reasons behind our proposed addition to § 424.530(a)(6), we propose at § 424.530(a)(7) to include within scope individuals and entities with any form of business or financial relationship with the provider. A payment suspension is a serious matter and, as noted, parties other than owners and managing employees/organizations can have relationships with the provider. In addition, restricting § 424.530(a)(7) to owning/managing individuals and entities could encourage these parties to circumvent application of § 424.530(a)(7) by redefining, changing, or limiting their roles within the provider organization even though they would still influence or deal with the provider in some capacity; that is, they would purposely modify or eliminate their ownership or reduce their role in the organization to, they might believe, fall outside the managing employee/organization definitions. Given both this and our responsibility to protect the Trust Funds against problematic parties, we believe our proposed expansion to § 424.530(a)(7) is a prudent measure.

(iii) Program Terminations/Suspensions (§ 424.530(a)(14))

CMS may deny enrollment under current § 424.530(a)(14)(i) if—

- The provider is currently terminated or suspended (or otherwise barred) from participation in a State Medicaid program or any other Federal health care program; or
- The provider's license is currently revoked or suspended in a State other than that in which the provider is enrolling.

We propose two changes to § 424.530(a)(14)(i). One would include the provider's owners, managing employees, and managing organizations within its purview. This aligns with several other denial reasons—such as existing § 424.530(a)(3) and (a)(7)—that include actions against owners and managing employees/organizations. Similar to these other denial grounds, revised § 424.530(a)(14)(i) would help prevent situations where the owning/managing party's conduct that led to the licensure action or the other program termination/suspension could be repeated with the prospective Medicare provider, especially considering (as noted) the significant influence such parties typically have over a provider's operations. Furthermore, it could keep such parties from entering Medicare via a new provider, hoping to shield themselves from application of § 424.530(a)(14)(i) due to the provision's current limitation to providers.

The other change would expand licenses to include those voluntarily surrendered in lieu of further disciplinary action. We have provisions in §§ 424.530 and 424.535 whose scope includes voluntary surrenders, and we believe the same approach for § 424.530(a)(14)(i) is needed because our overriding concern is the loss of the provider's license rather than the type of loss. Voluntary surrenders in lieu of further disciplinary action, in our view, are as much a threat to the Trust Funds and beneficiaries as revocations and suspensions, since they all involve problematic conduct.

(iv) False or Misleading Data (§ 424.530(a)(4))

Section 424.530(a)(4) allows denial based on the provider's/supplier's submission of false or misleading information on the enrollment application to gain enrollment in the Medicare program. We propose to expand § 424.530(a)(4) in the same manner as with proposed § 424.535(a)(4) and for the same reasons. (The parenthetical concerning OIG referral would be retained in existing § 424.530(a)(4).)

(b) New Denial Reasons

(i) Misdemeanor Convictions (§ 424.530(a)(16))

(A) New § 424.530(a)(16)

We propose to duplicate proposed § 424.535(a)(16) in § 424.530(a)(16) (also presently designated as ''Reserved'') as a new denial ground. The same rationale is involved: the need to protect beneficiaries and the Trust Funds against parties convicted of sexual assault or financial misconduct misdemeanors.

(B) ''Final Adverse Action'' Definition

Section 424.502 defines ''final adverse action'' as any of the following: (1) Medicare revocation; (2) State health care license suspension or revocation; (3) revocation or suspension by an accreditation organization; (4) felony conviction; or (5) exclusion or debarment. Given our proposed denial and revocation reasons based on a misdemeanor conviction for sexual assault or financial misconduct, we propose to add such misdemeanors as new paragraph (6) in the ''final adverse action'' definition. (As with felony convictions in paragraph (4), the 10-year period would be that preceding enrollment, revalidation, or reenrollment.)

(ii) Revocation or Denial in Same Suite (§ 424.530(a)(19))

We propose a new denial ground in § 424.530(a)(19) 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. Sharing a suite or office with a provider who has been deemed non-compliant with Medicare requirements could spur concerns about the newly enrolling provider's own willingness to retain compliance if enrolled. This is particularly true when—in situations we have seen—several providers in the same suite engage (or seek to engage) in a fraud scheme, have their Medicare enrollments revoked or denied, and another provider aims to enroll in that same office. Considering the risks posed by the revoked or denied provider, we maintain that we must have the authority to prevent the new enrollment if circumstances justify it.

Though they might appear similar, § 424.530(a)(19) would differ from proposed § 424.535(a)(24) in that the latter: (a) is a revocation reason and not a denial ground; and (b) is partly based on the number of nearby providers, whereas § 424.530(a)(19) is based on shared suites and offices. Sections 424.530(a)(19) and § 424.535(a)(24) thus complement but do not duplicate each other.

We recognize that, for example, physicians that are part of a group frequently share the same suite. If 10 physicians are in the group and one (Dr. X) has their enrollment revoked, this does not automatically mean that a prospective (and Medicare enrolling) 11th group member will be denied enrollment based on Dr X's revocation. Every situation is different, and CMS will only invoke § 424.530(a)(19) when proper.

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

As previously discussed, we have seen serious program integrity issues involving hospices. Indeed, the Office of Inspector General (OIG) has included hospice care among the services posing

a high risk of fraud.[28] It has also recently stated: ''[T]here are significant problems with the [hospice] program. Our reports and investigations have revealed several concerning issues, including poor—sometimes harmful—quality of care, fraud schemes that involve enrolling beneficiaries without their consent, inappropriate billing practices, limited transparency for patients and their families, a payment system that creates incentives to minimize services, and a rapid growth in the number of new hospices, often to take advantage of these conditions.'' [29] In response to these concerns, CMS in recent years has taken numerous steps to address hospice fraud, waste, and abuse. Some have been directed towards persons who operate, control, or manage the hospice, such as the hospice's individual owners, medical directors, and administrators. These initiatives included, but were not limited to—

- Under § 424.518(c), requiring persons who directly or indirectly own 5 percent or more of a newly enrolling hospice (or a hospice undergoing any ownership change) to submit fingerprints for a criminal background check.
- Requiring hospice medical directors who certify a patient's terminal illness under 418.22(c) to be enrolled in or opted out of Medicare, which enables CMS to screen the medical director.
- Clarifying that hospice medical directors and administrators are ''managing employees'' (as that term is defined in § 424.502) and thus must be reported on the hospice's Form CMS–855A enrollment application (OMB Control No. 0938–0685). This helps ensure that CMS knows the identities of these parties and can vet them for potential issues.

In light of medical directors' and administrators' managing control over hospices, we believe that closer oversight of these individuals was necessary—especially considering: (1) the numerous criminal and False Claims Act cases we have seen involving hospice operators; [30] and (2) reports of physicians falsely certifying patients' terminal status.[31] Despite the aforementioned steps, we continue to have program integrity concerns about hospice operators. We still see instances of false physician certifications, kickbacks to certifying physicians, criminal cases involving administrators, hospices billing Medicare while non-compliant with enrollment requirements, etc. On a more specific level, three problematic issues have arisen.

First, there are individuals who serve as medical director or administrator of numerous hospices. Ensuring (1) quality care to hospice patients, (2) the efficiency of the hospice's operations, (3) compliance with Medicare requirements, and (4) hospice program integrity requires the full attention and oversight of the medical director and administrator. We believe that having these roles at numerous facilities limits the time the individual can spend on each facility's operations and raises questions about the person's commitment to oversight; this, in our view, places hospice beneficiaries and program integrity at risk.

Second, we have seen cases where the medical director or administrator is very far from the physical hospice facility; several instances, in fact, involved the hospice and medical director being on opposite sides of the country (for instance, the medical director is in New York, and the hospice is in California). This, too, generates significant concerns about the individual's oversight of the hospice.

Third, certain hospices have been using medical directors with inactive licenses. Section 418.22(c), as noted, requires the medical director who initially certifies the beneficiary's terminal status to be enrolled in or opted-out of Medicare. However, if the medical director is not certifying Medicare beneficiaries' terminal status—and said physician is neither billing Medicare nor ordering/certifying the services/items outlined in § 424.507—enrollment is not required. CMS therefore might not know whether the medical director's license is active and only learn of the inactive status later. Since the medical director Conditions of Participation (CoPs) at § 418.102 and personnel requirements for physicians § 418.114(b)(1) require hospice medical directors to be physicians (and thus licensed), hospices with medical directors with inactive licenses are not compliant with the CoP Medicare requirements.

To address hospice program integrity and to protect beneficiaries, we thus propose new § 424.530(a)(20). This would permit denial of a hospice's enrollment application if any of the following apply:

- 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 required under 42 CFR part 418.

- 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 administrator functions required under 42 CFR part 418.

- The hospice's medical director does not have an active physician medical license in the state in which they are practicing.

Section 424.530(a)(20) would not: (1) formally prohibit medical directors and administrators from serving at more than one hospice; or (2) change hospice CoPs or other hospice policies in 42 CFR part 418. It would simply help us address situations where the hospice's prospective enrollment raises the program integrity concerns outlined in this section V.C. of this proposed rule.

(iv) Misuse of Identity (§ 424.530(a)(21))

We noted previously that § 424.535(a)(7) permits revocation if the provider knowingly sells to or allows another individual or entity to use its billing number. (This does not include providers or suppliers who enter into a valid § 424.80 reassignment of benefits or a § 489.18 change of ownership.) Yet there is no denial reason that specifically addresses misuse of identifiers. This is problematic given situations we have recently seen where a party (X) steals the identity of another party (Y) (for example, another physician or practitioner) and enrolls Y without Y's knowledge and using Y's credentials and identifiers. X then bills and receives payment from Medicare under Y's name. To address this and other situations involving prospective enrollees using compromised identities,

[28] HHS–OIG Fiscal Year 2025 Report, ''Top Management & Performance Challenges Facing HHS'' (*https://oig.hhs.gov/reports/all/2025/2025-top-management-performance-challenges-facing-hhs/*.)

[29] *https://oig.hhs.gov/reports/featured/hospice/*.

[30] See, for example, the proposed rule titled, ''Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update; HH Quality Reporting Program Requirements; HH Value-Based Purchasing Expanded Model Requirements; Home Intravenous Immune Globulin Items and Services; Hospice Informal Dispute Resolution and Special Focus Program Requirements, Certain Requirements for Durable Medical Equipment Prosthetics and Orthotics Supplies; and Provider and Supplier Enrollment Requirements'' (88 FR 43654), published in the **Federal Register** on July, 10, 2023.

[31] See, for example, the proposed rule titled, ''Medicare Program; FY 2024 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice Quality Reporting Program Requirements, and Hospice Certifying Physician Provider Enrollment Requirements'' (88 FR 20022), published in the **Federal Register** on April 4, 2023.

we propose in new § 424.530(a)(21) that CMS can deny enrollment if the prospective provider or supplier is attempting to enroll under another party's identity.

(8) Reapplication Bar (§ 424.530(f))

Under § 424.530(f), CMS may prohibit a prospective provider from enrolling in Medicare for up to 10 years if its enrollment application is denied because the provider submitted false or misleading information on or with (or omitted information from) its application to gain enrollment in Medicare. The goal is to prevent dishonest providers from submitting false information on their initial application and, after being denied enrollment on this ground under § 424.530(a)(4), simply submitting a new application with correct data.

We believe that restricting § 424.530(f) to instances involving false information limits its potential effectiveness, for there are other § 424.530(a) denial reasons that could involve similarly inappropriate provider behavior. Assume a prospective provider's enrollment is denied because the provider is: (1) unlicensed; (2) OIG excluded or has a recent felony conviction; (3) using a false storefront as its practice location; (4) under a current Medicare and Medicaid payment suspension based on a credible allegation of fraud; (5) terminated from another Federal health care program; or (6) revoked from Medicare and attempting to enroll under a different identity. This casts serious doubt as to the provider's honesty and trustworthiness, since the provider likely knows it cannot enroll but is nonetheless hoping to somehow ''sneak into'' the program; indeed, without a reapplication bar in these and similar situations, the provider might routinely submit more such applications with this nefarious objective in mind.

Accordingly, and to safeguard the Medicare program, we propose to revise the introductory text of § 424.530(f) to allow CMS to impose a reapplication bar for up to 10 years based on any § 424.530(a) denial reason (not merely § 424.530(a)(4)). We also propose to delete factors at § 424.530(f)(2) that CMS currently must consider in determining whether to impose a reapplication bar (and the length thereof) for a denial at § 424.530(a)(4). There are two related reasons for this. First, being tailored exclusively to § 424.530(a)(4) situations, these factors would be inapplicable to other denial grounds. Second, proposing different § 424.530(a)(4) criteria would essentially present the same problem mentioned in the previous sentence—specifically, a single set of § 424.530(f) factors could not possibly apply to all § 424.530(a) denial reasons considering the varying facts of each.

Unlike reenrollment bars under § 424.535(c), reapplication bars are discretionary. CMS need not impose them, and we are not proposing to change this. We recognize that less serious denial situations—such as, but not limited to, failure to pay an application fee—might not warrant a reapplication bar. Our focus is mostly on providers whose conduct raises significant program integrity concerns.

We would retain current § 424.530(f)(1) and (f)(3), which address, respectively, the bar's: (1) applicability to the provider's other names, identities, etc.; and (2) impact on the ordering, referral, certification, or prescription of services, items, or drugs. Paragraph (f)(3), though, would be redesignated as revised paragraph (f)(2).

(9) Changes in Majority Ownership (CIMOs)

We previously mentioned § 424.550(b) and § 424.551, the former pertaining to HHAs and hospices and the latter to DMEPOS suppliers (hereafter collectively ''providers''). Under these provisions, if the provider undergoes a CIMO within 36 months of its initial enrollment—or within 36 months of its most recent CIMO—and no exception applies, the provider's enrollment is terminated. (For HHAs and hospices, moreover, the provider agreement is terminated and does not transfer to the new owner.) The provider under its new majority ownership must enroll as a new provider and undergo a state survey or accreditation. (DMEPOS suppliers must obtain a new accreditation.)

There are two main purposes of this ''36-month rule''. First, it enables CMS to undertake a complete screening and vetting of the provider under its new ownership. This is critical for ensuring that the provider is compliant with all Medicare requirements. Second, it helps prevent ''flipping''. This involves a party enrolling a provider for the sole purpose of quickly selling it to another party without the latter having to newly enroll or undergo a survey/accreditation. This makes the provider more financially attractive to the prospective buyer and, in turn, helps the seller generate more revenue from the sale. In short, the seller's exclusive objective is profit, not patient care. This places beneficiaries at risk and allows parties to enter Medicare without the program safeguard of a survey or accreditation.

We have found the 36-month rule helpful in stemming flipping and facilitating greater scrutiny of new owners. Yet we have also seen provider efforts to circumvent or ignore the rule. These include, but are not limited to:

- Failing to notify CMS of the ownership change—meaning the sale occurs and the buyer assumes ownership under the existing enrollment without enrolling the entity as a new provider with a new survey/accreditation. Only later does CMS learn of the sale.
- Using a management (or similar) agreement in lieu of a formal sales agreement. Here, the management agreement states that: (1) managerial (and effectively all other) authority over the provider is transferred to Party X; and (2) X intends to later purchase the provider. Once the 36-month period expires, the sale occurs. In essence, Party X is purchasing the provider within the 36-month period but under the guise of a ''management agreement''.

Such inappropriate attempts to avoid the 36-month rule undercut the latter's critical aim of protecting beneficiaries and the Trust Funds from unvetted and potentially problematic entities. To deter these efforts, we propose in new §§ 424.530(a)(22) and 424.535(a)(25) that we may deny or revoke enrollment if CMS determines that the HHA, hospice, or DMEPOS supplier failed to comply with the provisions and requirements of, as applicable, §§ 424.550(b) or 424.551. The § 424.535(a)(25) revocation effective date under new § 424.535(g)(1)(xxv) would be the date on which CMS or its contractor determined that the provider should be revoked.

3. Preclusion List (42 CFR 422.2 and 423.100)

Addressed primarily in 42 CFR 422.222 and 423.120, the preclusion list is a compilation of providers and prescribers who are prohibited from receiving payment for furnished, ordered, or prescribed MA items/services and Part D drugs. The list's objective is to effectively bar from the MA and Part D programs various entities and persons that pose program integrity risks. Per the definition of ''preclusion list in §§ 422.2 and 423.100, a party may be placed on the preclusion list if they fall into one of the following three categories:

- Currently revoked under Medicare for a reason other than that in § 424.535(a)(3) (which addresses felony convictions), the reenrollment bar has not expired, and CMS determines that the underlying conduct that led to the

revocation is detrimental to the Medicare program's best interests.

• Engaged in behavior, other than that described in § 424.535(a)(3): (1) for which CMS could have revoked the provider/prescriber to the extent applicable had they been enrolled in Medicare; and (2) that CMS determines is detrimental to the Medicare program's best interests.

• Regardless of whether the provider/prescriber is or was enrolled in Medicare, has been convicted of a felony under Federal or State law within the previous 10 years that CMS deems detrimental to the Medicare program's best interests.

We propose to expand this third category to include felony convictions against the provider/prescriber's owner, managing employee, managing organization, corporate director, or corporate officer. As already stated, these parties typically exercise considerable influence over a provider/prescriber's operations, and a felony conviction against said party greatly concerns us; indeed, this is precisely why §§ 424.530(a)(3) and 424.535(a)(3) permit denial or revocation based on felony convictions against owners, managing employees/organizations, and corporate officers/directors. Our proposed change would not only ensure greater consistency with §§ 424.530(a)(3) and 424.535(a)(3) but also help protect the MA and Part D programs from program integrity risks.

The specific regulatory revisions would be to paragraph (3) of the ''preclusion list'' definitions in §§ 422.2 and 423.100. The language therein stating that the prescriber/provider, ''regardless of whether they are or were enrolled in Medicare, has been convicted of a felony. . . .'' would be changed to the prescriber/provider, ''regardless of whether they are or were enrolled in Medicare—or an owner, managing employee, managing organization, director, or officer (as those terms are defined in § 424.502) thereof—has been convicted of a felony. . . . .''.

4. Temporary Moratoria (§ 424.570)

Pursuant to section 1866(j)(7) of the Act and § 424.570, we imposed several temporary enrollment moratoria between 2013 and 2019, and—as of May 13, 2026—there are national moratoria on the enrollment of new HHAs, hospices, and DMEPOS medical supply companies. All moratoria (including a moratorium extension) are announced via a notice published in the **Federal Register**. Also, under § 424.570(a)(1)(iii)(A) through (C) a temporary moratorium does not apply to any of the following:

• Changes in practice location (except if the location is changing from a location outside the moratorium area to a location inside the moratorium area).

• Changes in provider or supplier information, such as phone number.

• Changes in ownership (except changes in ownership of HHAs that would require an initial enrollment).

Since restarting the moratorium process in 2026 after more than 6 years, we have seen several issues that we believe must be addressed in regulation.

a. Effective Date

Per § 424.570(a)(1)(iv), a temporary moratorium does not apply to any enrollment application received by the Medicare contractor prior to the date the moratorium is imposed. We have received questions from interested parties regarding: (1) when the imposition date is; and (2) whether this is the same as the moratorium's effective date. We accordingly propose to revise § 424.570(a)(1)(iv) as follows:

• Existing § 424.570(a)(1)(iv) would be redesignated as new § 424.570(a)(1)(iv)(A).

• New § 424.570(a)(1)(iv)(B) would state 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).

There are often gaps between when a document (such as a proposed rule) is filed for OFR public inspection and when it is published in the **Federal Register**. If we used the latter as the moratorium's imposition/effective date, the affected providers/suppliers might have several days to submit their initial applications in order to ''beat the deadline.'' This would partly obstruct the moratorium's goal of halting all new enrollments and could lead to a rush of new applicants during this gap, some of whom may present program integrity problems. Using the OFR filing date would prevent this scenario, for the moratorium's imposition would be immediate.

b. Ownership Changes

We propose to change the aforementioned parenthetical in § 424.570(a)(1)(iii)(C) from ''(except changes in ownership of home health agencies that would require an initial enrollment)'' to ''(except changes in ownership that require an initial enrollment, such as, but not limited to, an HHA, hospice, or DMEPOS supplier change in majority ownership under §§ 424.550(b) or 424.551)''. This update would conform to other regulations that address this topic and codify existing CMS policy that—like HHAs—hospices and DMEPOS suppliers that undergo a non-exempt CIMO under §§ 424.550(b) or 424.551 must enroll as a new provider/supplier and are thus subject to the moratorium.

c. Other Applicability

Section 424.570(a)(1)(i) states CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. Stakeholders have asked what qualifies as a ''new'' provider/supplier or practice location under the moratorium. To address these, we propose to outline in new § 424.570(a)(1)(i)(A) through (E) the application types that—solely for purposes of § 424.570(a)—are considered ''new'' and to which a moratorium applies:

- Initial enrollment applications
- Change of ownership applications that require an initial enrollment per § 424.570(a)(1)(iii)(C)
- Enrollment applications from revoked providers/suppliers whose reenrollment bars under § 424.535(c) have expired and are seeking to re-enter the Medicare program
- Reactivation applications
- Enrollment applications from voluntarily terminated providers/suppliers seeking to enroll again in the Medicare program

Initial and change of ownership applications are currently referenced in § 424.570. Revoked providers (proposed § 424.570(a)(1)(i)(C)) are removed from the Medicare program altogether; we have thus always considered their applications to reenroll in Medicare to be new enrollments.

Reactivation involves the provider restoring their active enrollment status and Medicare billing privileges after being deactivated per § 424.540. Deactivation means the provider's billing privileges are stopped but can be restored (or ''reactivated'') upon the submission of information required under § 424.540. Deactivation grounds include, but are not limited to, failure to submit a Medicare claim for 6 consecutive months, failure to timely report a change in enrollment information, non-compliance with enrollment requirements, and a non-operational practice location. Although a deactivated provider is not revoked from Medicare, the provider's: (1) ability to bill the program is halted pending its reactivation; (2) enrollment is effectively

shut down; and (3) participation in Medicare is blocked in a manner akin to a revocation. (In fact, 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)). Furthermore, the bases for both revocations and deactivations typically involve concerning provider behavior. Even if the deactivation was based on non-billing with no nefarious conduct, said conduct could have ensued if, for example, an unscrupulous party attempted to access the provider's billing number during the non-billing period. We hence believe that the significant similarities between deactivations and revocations warrant including reactivations within § 424.570(a)(1)(i).

The same rationale applies to voluntary terminations, which involve a provider departing Medicare on their own volition. The provider is consciously severing their relationship with Medicare. While § 424.540(a)(7) permits CMS to deactivate a voluntarily terminating provider rather than outright terminating it, the provider in either case is essentially no longer in the program. It is considered a new provider should it seek to reenter Medicare. The incorporation of voluntary terminations within § 424.570(a)(1)(i) is therefore proper.

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

We mentioned earlier that hospices (like HHAs) that undergo a non-exempt CIMO within 36 months of their initial enrollment (or within 36 months of their previous CIMO) must initially enroll as a new hospice and have a state survey or accreditation. A new enrollment and survey/accreditation help confirm that the hospice under its new ownership is fully vetted, is committed to furnishing quality care, meets all enrollment requirements and CoPs, and does not pose program integrity risks. The substantial program integrity and quality of care benefits of a state survey/accreditation are why in 2009 we promulgated § 424.540(b)(3)(i), which requires a deactivated HHA to obtain an initial state survey/accreditation before it can be reactivated.

We believe the payment safeguard and patient care protections afforded by § 424.540(b)(3) should be extended to hospices. The previously noted hospice fraud we have seen requires, in our view, much closer scrutiny of reactivating hospices—especially since, as already noted, deactivated hospices are blocked from Medicare. We must ensure that the reentering hospice is compliant with all Medicare requirements. We thus propose to revise § 424.540(b)(3)(i) to include hospices.

6. Opt-Out (42 CFR Part 405, Subpart D)

Section 1802(b)(1) of the Act permits certain physicians and practitioners to opt-out of Medicare. Under opt-out, neither the physician/practitioner nor the beneficiary submits a bill to Medicare for services performed. Instead, the beneficiary pays the physician/practitioner out-of-pocket and neither party is reimbursed by Medicare. A private contract is signed between the physician/practitioner and the beneficiary that states, in essence, that neither can receive payment from Medicare for the services performed. The physician/practitioner must also submit an affidavit to Medicare expressing a decision to opt-out of the program and confirming, as further described in § 405.420, compliance with opt-out requirements. Opt-out periods are for 2 years.

Provisions in 42 CFR part 405, subpart D, govern Medicare opt-out. We are proposing the following two regulatory clarifications, both of which reflect current policy.

First, opt-out periods are automatically renewed pursuant to section 1802(b)(3) of the Act unless the physician/practitioner—consistent with § 405.445(a)—notifies the appropriate MAC not later than 30 days before the end of the 2-year period indicating that the physician/practitioner does not want to extend the affidavit's extension for a subsequent 2-year period. In outlining the types of CMS opt-out determinations that are considered ''initial'' under § 498.3(b) (and thus appealable under 42 CFR part 498), § 405.450(a) includes the individual's failure to ''timely renew opt-out''. Since opt-out is automatically extended absent the occurrence in § 405.445(a), we propose to change the quoted language in § 405.450(a) to ''timely cancel automatic renewal''; a similar change would be made to § 498.3(b)(19), which lists various initial opt-out-related determinations.

Second, § 405.400 defines ''opt-out period'' as meaning, in part—with respect to an affidavit that meets the requirements of § 405.420—a 2-year period beginning on the date the affidavit is signed (as specified by § 405.410(c)(1) or (2)). There are instances where the MAC, in reviewing and processing the physician/practitioner's submitted affidavit, needs and requests additional information or clarification from the physician/practitioner. Interested parties have asked whether—if a new affidavit must be submitted per the MAC's request and it is subsequently approved—the opt-out period begins on the signature date of the second or the first submitted affidavit. In § 405.400, we propose to change the ''opt-out period'' definition that states ''the date the affidavit is signed'' to ''the date the first submitted affidavit is signed.'' This reflects our existing policy on this issue, and it aligns with our assignment of effective dates of Medicare billing privileges for most Medicare suppliers (including physicians/practitioners). Under § 424.520(d)(i) and (ii), this effective date for these suppliers is the later of the following: (1) the date of filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or (2) the date that the provider or supplier first began furnishing services at a new practice location. With § 424.520(d)(i), even if the MAC needs the supplier to submit additional/clarifying information on the submitted enrollment application with a newly signed certification statement, the effective date is generally based on the initially submitted application rather than the date on which the additional data was submitted.

7. Private Equity Companies (PECs) and Real Estate Investment Trusts (REITs)

In a November 17, 2023, final rule published in the **Federal Register** titled, ''Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities; Medicare Providers' and Suppliers' Disclosure of Private Equity Companies and Real Estate Investment Trusts'' (88 FR 80141), we implemented section 1124(c) of the Act. This provision—promulgated in § 424.516(g)—requires SNFs to report detailed information about their ownership, management, and associated parties. The regulation's purpose was to gain further insight into the SNF's operators and affiliates—a vital need given concerns about nursing home quality of care.

We expressed particular concern in the November 17, 2023, final rule about the prevalence of PEC and REIT ownership of SNFs. We cited reports indicating links between such ownership and substandard SNF care, primarily due to these entities' emphasis on maximizing profits.[32] One report stated, ''Our estimates show that private equity (PE) ownership increases the short-term mortality of Medicare

[32] 88 FR 80144.

patients by 10 percent, implying 20,150 lives lost due to PE ownership over our twelve-year sample period. This is accompanied by declines in other measures of patient well-being, such as lower mobility, while taxpayer spending per patient episode increases by 11 percent.'' [33] We hence stated in the November 17, 2023, final rule our intention to revise the Form CMS–855A enrollment application [34] to require all certified providers and certified suppliers (not simply SNFs) that complete said form to identify whether an entity they have disclosed thereon is a PEC or a REIT.[35]

The issue goes well beyond SNFs, though. PECs and REITs are involved in other health care sectors, too, including physician practices. The May 2025 edition of the American Medical Association's (AMA) Journal of Ethics (JOE) noted the continued increase in PEC ownership of providers and suppliers and the concerns associated therewith. The AMA JOE website (via which the May 2025 edition could be accessed) stated that private equity ''aim(s) to maximize profitability while minimizing long-term holdings in such investments. . . . One reason private equity investment in the health sector deserves close ethical attention is that private equity firms are, generally, not interested in managing patient panels, clinician personnel, or making service delivery streams work for patients. Another reason is that influx of private equity investment in health care tends to consolidate markets for health services, undermining competition and driving up costs for patients''.[36] Various articles in the May 2025 edition expounded on this theme. Statements therein included:

- ''Physicians have fiduciary duties to respond with care to patient's clinical needs and vulnerabilities, whereas private equity companies have no such ethical or legal duties to patients and strive to maximize financial returns for their investors.'' [37]
- ''Studies on the impact of PE investment in health care have increased in the last decade, with the preponderance of data suggesting that PE acquisitions are associated with reduced staffing levels and on-hand medical supplies. A 2023 systematic review concluded that PE ownership was associated with increased costs to payers and patients.[38]
- ''Private equity firms' acquisition and management of health service delivery entities, such as specialty physicians' practices, have been associated with increased cost and diminished quality of care.'' [39]
- ''Private equity margin maximization and profit-making strategies focus on acquisition, short-term ownership, and sale of health care entities, including residency program opportunities. PE ownership durations generally have 3 purposes: reduce staff, sell assets, and refinance debt.'' [40]

In light of the foregoing, we believe CMS should ascertain the prevalence of PEC and REIT involvement with Medicare Part B suppliers no less than with Part A providers such as SNFs. This is a Medicare-wide issue. Consequently—and like our approach in the November 17, 2023, final rule—we announce our intention to revise the following provider enrollment applications to require all suppliers completing these forms to identify whether any organizations disclosed thereon are PECs or REITs:

- Form CMS–855B (Medicare Enrollment Application—Clinics/Group Practices and Certain Other Suppliers; OMB Control No. 0938–1377).
- Form CMS–855S (Medicare Enrollment Application—Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers; OMB Control No. 0938–1056).
- Form CMS–20134 (Medicare Diabetes Prevention Program (MDPP) Suppliers).

We note that we are relying upon sections 1102, 1866(j), and 1871 of the Act (rather than section 1124(c)) as authority for this proposal.

As with the November 17, 2023, final rule, our intended form revisions would not involve regulatory changes.

8. Definition of ''Operational'' (§ 424.502)

a. Background and Provisions

Per § 424.510(d)(6), a provider must be ''operational'' to obtain Medicare billing privileges. ''Operational'' is defined in § 424.502 as meaning the provider meets all of the following:

- Has a qualified physical practice location.
- Is open to the public for the purpose of providing health care related services.
- Is prepared to submit valid Medicare claims.
- Is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services.

Over the years, we have received numerous queries about the meaning and scope of these requirements, such as ''properly staffed'', ''properly stocked'', and ''open to the public''. For instance, assume a provider has an adequate number of personnel at its site. This could appear to meet the ''properly staffed'' requirement, but perhaps many of these employees are unqualified for their positions (such as being unlicensed). The question thus becomes whether ''properly staffed'' refers to the number of employees, the employees' credentials, both, or something else entirely. The term ''open to the public,'' meanwhile, does not address (1) timeframes in which the provider must be open or (2) physical accessibility to the location. Indeed, it is possible that a provider might, on the surface, meet the letter of the existing ''open to the public'' criterion by being briefly ''open'' to the public but not the definition's intent if it is only open 1 hour per day. These issues are important, for the ''operational'' definition's core purpose is to help confirm that the provider is bona fide. We have, in fact, seen situations where a provider appears to meet the definition but turns out to be a fraudulent operation.

Our concerns about the definition are therefore twofold: that it lacks clarity and is too narrow. We believe additional criteria in the definition would better ensure the provider's operational status and legitimacy and assist us in preventing sham providers from entering Medicare. Therefore, we propose the following changes to our definition.

First, we propose an opening sentence to the definition that would read ''*Operational* means (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) the provider or supplier meets all of the following:''. The parenthetical—which is in the current definition—would clarify for stakeholders that: (1) certain components of our revised definition may not apply to all provider types; and (2) CMS would account for this in applying the definition.

[33] Ibid.

[34] Medicare Enrollment Application—Institutional Providers (OMB Control No. 0938–0635).

[35] 88 FR 80146.

[36] *https://journalofethics.ama-assn.org/issue/private-equity-health-care.*

[37] Lucy Xu, MD, and Matthew R. Naunheim, MD; ''What Are Physicians' Duties to Patients When They Sell Their Practices?''; May 2025.

[38] Ibid.

[39] Cheryl Erwin and Sheryl Tatar Dacso; ''When and How Should Patients Be Informed About Clinicians' or Organizations' Sale of a Clinical Practice to a Private Equity Buyer?'' May 2025.

[40] Mark Varvares, MD, et al.; ''Should Private Equity Firms Own Residency Slots?'' May 2025.

Second, the previously referenced four bulleted components of the existing definition would be designated as new paragraphs (1) through (4) therein. This would improve the definition's readability. (We are not proposing changes to the first requirement concerning a qualified practice location.)

Third, proposed paragraph (2) would explain that the requirement that the provider ''[i]s open to the public for the purpose of providing health care related services'' includes, but is not limited to, all of the following:

- The provider's location is fully accessible to all patients and lacks safety hazards.
- The provider's hours of business are sufficient to regularly serve patients.
- Medicare beneficiaries can contact and locate the provider's location based on publicly available information (for example, the internet).

We believe these three requirements would help verify the provider's compliance with this criterion. In our view, a provider whose location threatens patient safety, is inaccessible to beneficiaries, or cannot be found via public means raises doubts as to whether the location is truly ''open.''

To assist interested parties in understanding the term ''accessible'' for purposes of the ''operational'' definition, proposed paragraph (2)(i) would define it as meaning both of the following:

- The provider is located in an area and a building that patients can enter with reasonable ease.
- The location is compliant with all Federal Americans with Disabilities Act regulations and all applicable and equivalent State and local laws.

These requirements would make clear that providers must—from an accessibility standpoint—accommodate beneficiaries with disabilities and those without. We note that the phrase ''located in an area'' does not mean the provider's location must be, for instance, within a short drive or a mere 5-mile radius of the beneficiary's home. ''Area'' in this context would mean the location's immediate vicinity, such as the parking lot or a larger, multi-building complex in which the provider has its office. Also, nothing in the first bullet would prevent the provider from having security locks or security personnel between its office(s) and the building entrance. It instead references the beneficiary's ability to enter the building once access is granted (for instance, security staff signs in the beneficiary and directs the beneficiary to the provider's office).

Third, we propose in new paragraph (3) to change ''prepared'' to ''prepared and able''. If the provider lacks the administrative or logistical ability to submit valid claims—even if it may be ''prepared'' to do so—we do not believe the provider can be considered operational for purposes of Medicare enrollment.

Fourth, and similar to proposed paragraph (2), proposed paragraph (4) would include the following additional requirements concerning the ''properly staffed, properly equipped. . . .'' criterion:

- Provider staff must be qualified (such as licensed or certified if required under state law) to perform their health care-related functions.
- Equipment must be functional, appropriate for the services and items the provider intends to furnish, and in sufficient quantity to provide these items and services.
- Appropriate medications for the services and items the provider intends to furnish and in sufficient quantity to provide these items and services.

Each of these three requirements, to some extent, already fall within the existing ''properly staffed, properly equipped. . . .'' category. To illustrate, we do not believe that a provider with little to no working equipment that is needed to treat beneficiaries—or whose medical equipment has nothing to do with the services the provider plans to furnish—can be considered ''properly'' equipped under the current ''operational'' definition. We believe that specifying these three requirements in regulation would help interested parties understand the purview of this criterion.

We also maintain, though, that operationality should require more than proposed paragraphs (1) through (4), particularly with respect to administration, safety, and patient care. If, for instance, a provider lacks any written procedures or policies for these and related activities, this can indicate an inefficient, unprepared provider that is not ready to safely treat Medicare patients or to accurately bill Medicare—in short, one that is not genuinely ''operational''. Again, we believe the current ''operational'' definition's narrowness can enable questionable providers to meet it. To thus further strengthen it, we propose in new paragraph (5) that operationality requires the provider to have adequate written policies and records regarding its operations, such as, but not limited to, procedures for patient care, patient safety, medical and patient recordkeeping, and general administration.

b. Additional Considerations

We understand that our clarified and expanded definition may raise concerns about its breadth, applicability, and relationship to other CMS requirements. We wish to address these in advance. As already noted, there are numerous types of providers and suppliers, practice locations, and factual scenarios. Again, therefore, not every requirement in our revised definition would be applicable to every provider or situation. We seek to assure providers that while they must be operational under our proposed definition to enroll in Medicare, we would continue to account for situations where a particular requirement cannot realistically apply to the provider based on its type or circumstances. On the other hand, the reverse could also occur—specifically, the wide variety of provider types and scenarios might at times require us to consider information not addressed in our revised definition in order to determine the provider's operationality. Suppose a case arises where most of the definition's requirements are inapplicable to the provider, but this leaves insufficient remaining criteria for us to determine operational status. We believe we must have the ability to contemplate other information in this and other cases. We hence propose an additional (though un-numerated) paragraph at the end of our revised definition stating that CMS may consider any information in determining whether the provider is operational.

Proposed paragraph (2)—including the term ''regularly'' therein—does not establish an across-the-board, minimum hour requirement for providers to be open for business (for example, Provider X must be open 50 hours a week to be considered ''operational''). Our determination as to whether the provider meets paragraph (2) would, as presently, be made on a case-by-case basis.

Perhaps most importantly, our expanded definition would not—and is not intended to—supplant or supersede existing conditions of participation, conditions for coverage, certified provider or supplier survey or accreditation procedures, DMEPOS supplier and quality standards, and other provider or supplier-specific requirements (such as IDTF standards in § 410.33(g) and OTP conditions in § 424.67(b) and (e)). ''Operational'' status for purposes of provider enrollment is, and has always been, an entirely separate and distinct requirement, which the provider must meet along with all others needed for enrollment.

9. Signage (§ 424.510(f))

Sections 424.57(c)(7)(i)(D) and 410.33(g)(14)(ii) require DMEPOS suppliers and IDTFs, respectively, to maintain a visible sign posting its normal business hours. The former adds that if the supplier's place of business is located within a building complex, the sign must be visible at the main entrance of the building (or the hours can be posted at the entrance of the supplier). We propose in new § 424.510(f) to expand this requirement to include all providers and suppliers; § 424.510(f) would mirror the current language of § 424.57(c)(7)(i)(D). This would assist beneficiaries and site visit personnel in locating the provider's business, something that has occasionally proven difficult because the location contains no signage. To ensure consistency, we would also revise § 410.33(g)(14)(ii) to duplicate the language in proposed § 424.510(f).

Consistent with our proposed revisions to the definition of ''operational'' definition; however, § 424.510(f) is not intended to supersede any other Medicare requirements regarding signage. Section 424.510(f) is strictly an enrollment requirement. In addition, we recognize that our proposed signage requirement may not be practicable in all circumstances. This could be due to, for instance, the type of provider involved, its particular business circumstances, etc. Thus, we propose the following exceptions to the signage requirement:

- 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.

10. Retention and Furnishing of Documentation (§ 424.516)

We explained previously that under § 424.516(f)(1), providers and suppliers that furnish covered ordered, certified, referred, or prescribed Part A or B services, items or drugs are required to:

- Maintain the documentation described in § 424.516(f)(1)(ii) for 7 years from the date of service; and
- Upon CMS' or a Medicare contractor's request, provide access to that documentation.

The documentation described in § 424.516(f)(1)(ii) includes written and electronic documents (including the NPI of the physician or, when permitted, other eligible professional who ordered, certified, referred, or prescribed the Part A or B service, item, or drug) relating to written orders, certifications, referrals, prescriptions, and requests for payments for Part A or B services, items or drugs.

Section 424.516(f)(2) contains a similar documentation retention and submission requirement for physicians (or, when permitted, eligible professionals) who order, certify, refer, or prescribe Part A or B services, items or drugs. In addition, § 424.516(a)(10) permits revocation if the provider or supplier fails to comply with § 424.516(f) documentation and CMS access requirements. Section 424.516(f) helps CMS determine, for instance, whether the service was reasonable and necessary, whether fraud, waste, or abuse is involved, and whether the provider is compliant with Medicare requirements.

We propose 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. In our documentation reviews, we have seen: (1) patient charts missing medical director signatures; (2) hospice certifications signed before the face-to-face encounter; (3) certification end dates preceding the certification start dates; and (4) other types of inaccurate records. This makes it difficult for CMS and its contractors to verify the provider's adherence and the service's necessity; the program integrity benefits of § 424.516(f) are greatly reduced if the documentation is inaccurate or non-compliant. We accordingly believe § 424.516(f)(3) is necessary. However, we emphasize that our proposal is not intended to establish any new condition of payment. It would be restricted to the scope of the documents addressed in § 424.516(f).

11. Managing Employees (§ 424.502)

The term ''managing employee'' is defined in § 424.502. It means, in part, a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider. Managing employees have long been required to be disclosed on the provider's Medicare enrollment application. Since, as stated, managing employees sometimes have as much or more influence over a provider's daily operations as an owner, we must know whether such persons present risks to the Trust Funds.

Yet the risks are not merely financial. We have repeatedly noted over the years our obligation to protect the health and safety of Medicare beneficiaries. The provider enrollment process has assisted in this regard by collecting information on certain medical professionals within a provider organization. This includes, for example: (1) IDTF supervising physicians, interpreting physicians, and technicians; (2) ordering OTP personnel; and (3) hospice and SNF medical directors. The purpose is to ensure that such persons not only pose no payment safeguard threats but also are qualified for their roles (such as meeting State licensure requirements). Unqualified or unvetted medical personnel can harm Medicare patients.

So great is our concern about this matter that we believe additional clinical parties should be disclosed on the provider enrollment application. We hence propose to expand upon our aforementioned inclusion of hospice and SNF medical directors within the ''managing employee'' definition. The following persons would be added:

- Medical directors (not merely those at SNFs and hospices)
- Clinical directors
- Departmental heads (for example, a hospital's chief of cardiology)
- Supervising physicians (not simply those at IDTFs)
- Nursing directors
- Alternate administrators
- All other clinical personnel that meet the ''managing employee'' definition.

We note four things. First, these categories apply to all provider and supplier types, including SNFs and hospices. Second, we believe the persons in these categories already qualify as ''managing employees'' and should have always been reported. They clearly have direct or indirect control of the provider's day-to-day operations, and the fact that they are clinical personnel (rather than administrative) is irrelevant for purposes of determining whether a person is a managing employee. Our inclusion of them within the ''managing employee'' definition is, in large part, a reminder to stakeholders that clinical staff must be disclosed if the definition is met. Third, these seven new bulleted categories do not establish any minimum threshold for disclosure; for example, even if an individual has less influence than a departmental head, the person must still be reported as long as the managing employee definition is met. Fourth, and on the other hand, this does not mean that every clinical employee regardless of influence must be reported. Disclosure is only required if the person is a managing employee.

12. Corrective Action Plans (CAPs), Rebuttals, and Appeals

In certain situations, a provider or supplier may have an opportunity to correct a deficiency or contest a CMS finding regarding its enrollment by submitting, as applicable: (1) a CAP in response to a §§ 424.530(a)(1) or 424.535(a)(1) denial or revocation, respectively; (2) a rebuttal to a stay or deactivation of enrollment under §§ 424.541 or 424.546, respectively; or (3) an appeal of an initial determination under 42 CFR 498.3. We propose several revisions to these processes.

a. CAPs (§ 405.809)

Sections 424.530(a)(1) and 424.535(a)(1) permit CMS to deny or revoke enrollment, respectively, if the provider is not compliant with the enrollment requirements in Title 42 or in the enrollment application applicable for its provider type. The provider may submit a CAP in response to this denial or revocation, which allows the provider to remedy the deficiency or deficiencies in question and achieve compliance. As has long been CMS practice, though, §§ 424.530(a)(1) and 424.535(a)(1) are the only denial or revocation reasons under §§ 424.530 and 424.535 for which the provider may submit a CAP. While § 405.809(a)(1) makes this clear with respect to § 424.535(a)(1), it is silent as to § 424.530(a)(1). To incorporate this CAP policy into regulation, we propose to add § 424.530(a)(1) denials to § 405.809's purview. This would involve the following revisions:

- Section 405.809's title would change from ''Reinstatement of provider or supplier billing privileges following corrective action'' to ''Granting or reinstatement of provider or supplier billing privileges following corrective action.''
- In paragraph (a)(1), the language ''revocation for noncompliance under § 424.530(a)(1)'' would change to ''denial or revocation for non-compliance under § 424.530(a)(1) or § 424.535(a)(1)''.
- In paragraph (a)(2), ''revocation'' would change to ''denial or revocation''.
- In paragraph (b)(1), ''Reinstates'' would change to ''Approves or reinstates''.
- Paragraph (b)(1)(i) would be redesignated as paragraph (b)(1)(i)(B).
- Under new paragraph (b)(1)(i)(A), the effective date of the approval is based on the applicable timeframes described in §§ 424.520 and 424.521. This is consistent with existing practice.
- In paragraph (b)(1)(ii), ''reinstatement'' would change to ''approval or reinstatement''.
- In paragraph (b)(2), ''reinstate'' would change to ''approve or reinstate''.

b. Notification of Determinations

Section 498.3(b) lists several CMS or MAC provider enrollment decisions that are considered ''initial determinations''. These include, for example, enrollment denials, enrollment revocations, and inclusion of a provider on the preclusion list. The affected provider under § 498.5 may request a reconsideration of the initial determination, for which CMS or, if applicable, the MAC issues a reconsideration determination. Under §§ 498.20(a)(1) and 498.25(a)(1), CMS mails notice of the initial determination or reconsidered determination, respectively, to the provider. Furthermore, §§ 405.800 requires that denial and revocation notices (as well as notice regarding the addition of years to a reenrollment bar) be sent by certified mail. We propose to revise §§ 405.800(a), (b)(1), and (c)(1), 498.20(a)(1) and 498.25(a)(1) to include email as an acceptable form of notice. We believe this would facilitate faster notice to the provider without the expense of paper mailing.

c. Appeals of Reactivation Effective Dates

Along with listing types of initial determinations, paragraph (d) of § 498.3 outlines administrative actions that are not initial determinations and thus not appealable under part 498. One type of provider enrollment finding that is not mentioned in either § 498.3(b) or (d) is the effective date of a reactivation under § 424.540(b). Under § 424.540(d)(2), a reactivation effective date is the date on which the Medicare contractor received the provider's reactivation submission that the Medicare contractor processed to approval. Due to lack of clarity among some stakeholders as to whether an assigned reactivation effective date may be appealed or rebutted, we propose several regulatory changes.

First, we propose to add new paragraph (3) to § 424.540(d) stating that a provider or supplier may rebut their assigned reactivation effective date via the general deactivation rebuttal procedures in § 424.546. As deactivations are not considered initial determinations—and to ensure consistent approaches—we do not believe reactivation effective dates should, either. Yet we also believe the provider should have an opportunity to be heard on the matter, and a rebuttal would provide that.

To accommodate reactivation effective date rebuttals within § 424.546, we also propose to revise the latter as follows:

- Change the title from ''Deactivation rebuttals'' to ''Rebuttals of deactivations and of reactivation effective dates''.
- In paragraph (a)(1), insert the following between ''under § 424.540,'' and ''the provider or supplier has 15 calendar days'': ''or is assigned a reactivation effective date by CMS or its contractor under § 424.540(d)(2),''.
- In paragraph (b)(2), insert the following between ''effective date,'' and ''and the reasons'': ''(or with the assigned reactivation effective date)''.
- In paragraph (b)(3), insert the following after ''deactivation'': ''or the reactivation effective date''.
- Delete existing paragraph (d) and replace with the following: ''Upon receipt of a timely and compliant deactivation (or reactivation effective date) rebuttal, CMS reviews the rebuttal to determine whether the imposition of the deactivation and/or the designated effective date (or the assigned reactivation effective date) are correct.''

In this vein, we would also revise § 424.545(b) to include assignments of reactivation effective dates as a ground for rebuttal.

13. Fingerprinting (§ 424.518(c))

Section 424.518(c)(2)(ii)(A) states that 5 percent or greater individual owners of providers and suppliers in the ''high'' screening category must submit fingerprints for a national criminal background check. We propose to revise this paragraph to clarify that individuals subject to fingerprinting must use the CMS-designated fingerprinting contractor for this task. This would: (1) facilitate consistency in the fingerprinting process; and (2) inform individuals as to which fingerprinting entity to use, a matter that has caused some uncertainty in the provider community.

14. DMEPOS Accreditation (§ 424.58)

Consistent with §§ 424.57(c)(22) and 424.58, DMEPOS suppliers must be accredited by a CMS-approved accrediting organization (AO) to enroll and remained enrolled in Medicare. Section 424.58 details the general procedures and policies associated with DMEPOS accreditation. Many of these were added to § 424.58 in the CY 2026 HH PPS final rule (90 FR 55342) in an effort to strengthen CMS' oversight of the DMEPOS accreditation program in general and the DMEPOS AOs in particular. This included requirements regarding information and agreements that AOs must submit to CMS as part of their application/reapplication process.

Three of these requirements are as follows:

• Per § 424.58(c)(1)(xxiii)(D), agreeing to notify CMS in writing of any decision to terminate, revoke, withdraw, or amend the accreditation status of a specific DMEPOS supplier within 3 business days of the date the AO took action.

• Per § 424.58(c)(1)(xxii), describing the AO's processes for—

++ Detecting and addressing DMEPOS supplier fraud, waste, and abuse (including identifying the AO's definitions of fraud, waste, and abuse); and

++ Reporting this activity to CMS and, as applicable, law enforcement.

• Per § 424.58(c)(1)(vii)(D), outlining the AO's policies and procedures for avoiding conflicts of interest and the appearance thereof involving individuals who conduct surveys or participate in accreditation decisions.

Upon further reflection since these three provisions were promulgated, we propose the following changes.

One revision would change the 3-business day period in § 424.58(c)(1)(xxiii)(D) to 5 calendar days. This would better align with § 424.58(e)(5)(i), which requires approved AOs to report the same information to CMS within 5 calendar days. Having two different timeframes for reporting similar data has led to some confusion.

In addition, there currently is no timeframe in § 424.58 for reporting the fraud, waste, and abuse described § 424.58(c)(1)(xxii). We propose in new § 424.58(c)(1)(xxiii)(N) that the AO must agree to notify CMS in writing (and, if applicable, law enforcement) of suspected fraud, waste, and abuse—consistent with the AO's CMS-approved definitions of those terms—within 3 calendar days of the date on which the AO determines that fraud, waste, or abuse may have occurred. (Current § 424.58(c)(1)(xxiii)(N) would be redesigned as new § 424.58(c)(1)(xxiii)(O)). Given the seriousness of such conduct and the current lack of a reporting timeframe § 424.58, we believe a 3-calendar day requirement is warranted.

Notwithstanding the provisions of § 424.58(c)(1)(vii)(D) regarding conflicts of interest, none of them actually require the AO to report in its application/reapplication whether it has such conflicts. To help ensure that CMS makes fully informed AO approval decisions, we propose to revise § 424.58(c)(1)(vii)(D)(*4*) to require the AO to also disclose to CMS all conflicts of interest (as described in § 424.58(c)(1)(vii)(D)(*3*)) it currently has and explain how and when it will terminate them.

15. Affiliations

As indicated previously, and consistent with section 1866(j)(5) of the Act, § 424.519 states that upon a CMS request, an initially enrolling or revalidating provider or supplier (hereafter collectively ''provider'' unless otherwise noted) must disclose any and all affiliations that it or any of its owning or managing employees or organizations (per § 424.502's definitions of ''owner'' and ''managing employee'') has or, within the previous 5 years, had with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider that has a disclosable event (as defined in § 424.502). If CMS determines that the affiliation poses an undue risk of fraud, waste, or abuse, CMS may deny or revoke the provider's enrollment under §§ 424.530(a)(13) or § 424.535(a)(19), respectively.

Section 424.502 describes a disclosable event as any of the following: (1) a current uncollected debt to Medicare, Medicaid, or CHIP; (2) a payment suspension under a federal health care program; (3) an OIG exclusion; or (4) a denial, revocation or termination of a Medicare, Medicaid, or Children's Health Insurance Program enrollment.

For purposes of § 424.519, an ''affiliation'' under § 424.502 includes any of the following (outlined in paragraphs (1) through (5) of the ''affiliation'' definition, respectively):

• A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.

• A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.

• An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including sole proprietorships)—either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.

• An interest in which an individual is acting as an officer or director of a corporation.

• Any reassignment relationship under § 424.80.

These provisions were established via regulation in a final rule published in the **Federal Register** on September 10, 2019 (84 FR 47794).[41]

Since establishing the affiliation regulations, CMS has emphasized identifying current and past relationships between and among different providers and suppliers and, if an undue risk exists, denying or revoking the applicable provider(s). This helps protect the Trust Funds and beneficiaries from threats that certain provider associations can pose. Nevertheless, we have found three issues in § 424.519 that we believe hinder the provision's effectiveness.

One involves the aforementioned 5-year lookback period. We have seen situations where a relationship from more than 5 years ago still presents an undue risk of fraud, waste, abuse. In not requiring disclosure of these affiliations—and, in turn, being unable to deny or revoke enrollment under §§ 424.530(a)(13) or 424.535(a)(19)—we are effectively permitting a potentially significant fraud, waste, or abuse risk to remain. This is antithetical to our duty to protect the Medicare program.

The second pertains to the ''affiliation'' definition in § 424.502. While it covers several types of associations, there are other conceivably problematic relationships we have encountered in our program integrity efforts. Consider these hypotheticals:

• An individual or entity operates a small building with over 30 HHAs and hospices that list the building address as their practice location. Considering our earlier discussion of the high payment safeguard risk in such situations, the building operator might be involved with these providers in some type of fraud scheme.

• Based on CMS data, five physicians in a known geographic hotspot for fraud appear to be the primary physician for the same beneficiary, raising questions as to whether these doctors are sharing patients for improper purposes.

• A provider had a relationship with a financial services company that had several high-level officials convicted of fraudulent activity.

• A provider hired Marketing Firm X. X had solicited beneficiaries for four DMEPOS suppliers, all of which were later revoked with a 10-year reenrollment bar.

These and other scenarios demonstrate that numerous associations beyond those listed in the ''affiliation'' definition can endanger the Medicare program, for nefarious parties of all types constantly seek new means of perpetuating Medicare fraud.

[41] ''Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process.''

The third issue also involves the ''affiliation'' definition, though on a narrower level—specifically, paragraph (3) thereof. As noted, paragraph (3) addresses relationships where an individual or entity has operational or managerial control over (or directly or indirectly conducts) the day-to-day operations of another organization. (This mirrors our current definitions of ''managing employee'' and ''managing organization in § 424.502.) A recent situation arose where an individual was a medical director (Dr. A) of two providers—B and C. C was revoked from Medicare. Since a medical director is a managing employee under § 424.502, B was revoked under § 424.535(a)(19) consistent with paragraph (3) of the affiliation definition; that is, Dr. X was an individual with operational or managerial control over another entity—Providers B and C. This established the affiliation between B and C, with Dr. X as the clear link—a view that aligns not only with our longstanding interpretation of paragraph (3) but also with section 1866(j)(5) of the Act. Moreover, we believe our position helps ensure the usefulness of section 1866(j)(5) of the Act. A provider generally acts through its owners, managers, and other personnel. If we applied paragraph (3) only to situations where a provider operates or manages another provider, we would be unable to address other cases where the real fraud, waste, and abuse risk is posed by parties affiliated with both providers. In other words, we need the ability to go within the provider organization to the operators and managers to address threats they present.

With all three issues, we believe the fraud, waste, and abuse risk itself is much more important than when the relationship triggering the risk occurred, whether the provider entity poses the risk or, instead, the managing employee, etc. Accordingly, we propose the following revisions to our affiliation provisions in part 424, subpart P:

- We propose to remove the 5-year period from § 424.519(b). So long as the requirements for disclosure are otherwise met, the affiliation would have to be reported regardless of how long ago it occurred or ended.
- We propose to add new paragraph (6) to the ''affiliation'' definition. Consistent with the second issue, this paragraph would include any marketing, business, fulfillment, financial, managerial, or beneficiary relationship. (The ''managerial'' relationships in paragraph (6) would be those not otherwise falling within paragraph (3) of the ''affiliation'' definition.)
- To reiterate the scope of our affiliation provisions (per our interpretation of the aforementioned paragraph (3)), we propose to do the following:

++ In paragraph (3), insert the following language between ''individual or entity,'' and ''exercises operational'': ''or any of its owning or managing employees or organizations,''.

++ In §§ 424.530(a)(13) and § 424.535(a)(19), insert the following language between ''provider or supplier'' and ''has or has had'': ''or any of its owning or managing employees or organizations,''.

16. Savings, Costs, and Other Impacts Concerning the Provider Enrollment Provisions

a. Monetary Effects

As explained in the RIA section of this proposed rule, we project annual savings from our proposed enrollment provisions of approximately $82 million. This would stem from our expansion of retroactive revocation grounds. Additional savings could accrue from several proposed new and expanded revocation reasons; however, we are unable to devise an estimate because we cannot predict how frequently these authorities would be utilized.

Per our discussion in the ICR section of this proposed rule, we do not anticipate any ICR costs stemming from our proposed provisions. Yet we project approximately $1.4 million in annual survey or accreditation costs due to our revision to § 424.540(b)(3).

b. Additional Impacts

The following discusses other possible impacts of our most prominent proposals.

(1) New and Expanded Grounds for Revocation or Denial

We do not anticipate a significant impact on providers, suppliers, or beneficiaries resulting from our proposed denial and revocation grounds. We have in numerous past rules proposed and finalized new denial/revocation reasons with no real effect on the universe of enrolled providers or on the availability of health care. Only a very small percentage of providers (roughly 3 percent, though this can vary somewhat) are revoked at least once during their Medicare enrollment, leaving well over 2 million enrolled providers able to continue furnishing services. Too, we do not anticipate a substantial increase in the number of denials and revocations stemming from our proposals; as we have repeatedly stated in prior rules, we only take denial/revocation action when appropriate and not as a matter of course.

(2) Retroactive Revocation Reasons

We recognize that some revoked providers and suppliers would be impacted by our expansion of retroactive revocation effective date provisions. The $82 million in aforementioned savings might otherwise be paid to these providers if the prospective effective date were retained. Again, though, revocations are infrequent, and the annual number of affected providers would—as explained in this proposed rule's RIA—be estimated at a mere 337 out of the 2 million-plus provider universe. The overall impact would therefore be quite limited, and health care availability would remain robust. Indeed, we also expanded the number of retroactive revocation effective dates in the CY 2026 HH PPS final rule (90 FR 55342), projecting savings of nearly $2.2 billion resulting from 1,442 annual revocations that would have new retroactive effective dates. However, this did not cause a material impact on the provider community or beneficiaries.

Perhaps the largest impact of our denial, revocation, and retroactive revocation proposals would be on the Trust Funds and, by extension, the American taxpayers via the saving of monies that should not have been paid to these providers due to their non-compliance with enrollment requirements.

(3) Reapplication Bar

While we are proposing to expand our bases for a reapplication bar to include any denial reason, reapplication bars would remain discretionary, meaning that not every denial would necessarily invoke said bar. Moreover, many providers would remain ineligible to enroll in Medicare long after the denial with or without a reapplication bar; this is because they would still not meet Medicare requirements. We hence do not foresee an appreciable impact on providers, suppliers, or beneficiaries from this proposal, as there would be little change in the number of enrolled and qualified providers.

(4) Temporary Moratoria

We do not expect a notable impact on providers and beneficiaries from our temporary moratoria modifications. Moratoria are rare (even with our three aforementioned current moratoria) and typically limited to certain provider types and, between 2013 and 2019, geographic regions. They also do not apply to currently enrolled providers

and suppliers but only to new enrollments. In addition, our changes to § 424.570 would be very restricted in scope. Healthcare access should thus remain unaffected.

(5) Hospice Reactivations

As discussed in more detail in the RIA, we project that only 226 hospices would be affected by our proposal that they must undergo a State survey or accreditation prior to reactivation. Given this very small number, we do not foresee this proposal having a substantial impact on hospices or beneficiaries.

(6) Expansion of ''Operational'' and ''Managing Employee'' Definitions, Signage, and Documentation Accuracy

We do not believe these proposals would have a material impact on providers or beneficiaries. In our experience, many providers likely: (1) meet the parameters of our proposed expanded ''operational'' definition and signage requirements; and (2) retain documentation under § 424.516(f) that is accurate and complete. We also previously noted that providers and suppliers should already be reporting the seven categories of individuals in our proposed ''managing employee'' definition expansion. Health care access should thus remain strong notwithstanding these proposals.

E. DME Benefit Expansion for Infusion Pumps and Drugs

1. Background

a. Home Infusion Therapy Benefit

In section 5012 of the 21st Century Cures Act (Pub. L. 114–255), Congress amended section 1861(s)(2) of the Act and added sections 1834(u) and 1861(iii) of the Act to establish a new Medicare home infusion therapy benefit effective January 1, 2021. This benefit covers certain professional services associated with the provision of home infusion therapy to a beneficiary who is under the care of a physician, nurse practitioner, or physician assistant. Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home through an external infusion pump. As indicated in a final rule, we published in the **Federal Register** on November 8, 2019, titled ''Medicare and Medicaid Programs; CY 2020 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements,'' the external infusion pump and other supplies, including home infusion drugs, necessary for the effective use of the pump are covered under the Part B DME benefit rather than the home infusion therapy benefit (84 FR 60612). Pursuant to section 1861(iii) of the Act, we published a final rule in the **Federal Register** on November 13, 2018, titled ''Medicare and Medicaid Programs; CY 2019 Home Health Prospective Payment System Rate Update and CY 2020 Case-Mix Adjustment Methodology Refinements; Home Health Value-Based Purchasing Model; Home Health Quality Reporting Requirements; Home Infusion Therapy Requirements; and Training Requirements for Surveyors of National Accrediting Organizations'' (83 FR 56406) to define the scope of ''home infusion therapy,'' ''home,'' ''qualified home infusion therapy supplier,'' and ''home infusion drug'' at 42 CFR 486 Subpart I.

Section 486.525(a) implements the definition of ''home infusion therapy'' set forth at section 1861(iii)(1) of the Act, defining the term to include professional services, including nursing services, furnished in accordance with the plan of care described under 42 CFR 486.520, patient training and education (not otherwise paid for as DME), remote monitoring and monitoring services for the provision of home infusion therapy services and home infusion drugs furnished by a qualified home infusion therapy supplier in the individual's home. Section 486.505 implements the definition of ''home'' set forth at section 1861(iii)(3)(B) of the Act, defining the term as a place of residence used as the home of an individual, including an institution that is used as a home. An institution that is used as a home may not be a hospital, critical access hospital (CAH), or skilled nursing facility (SNF) as defined in section 1861(e)(1), 1861(mm)(1), or 1819(a)(1) of the Act, respectively.

Section 486.505 implements the definition of ''qualified home infusion therapy supplier'' set forth at section 1861(iii)(3)(D)(i) of the Act, defining the term to mean a supplier of home infusion therapy that meets all of the following criteria which are set forth at section 1861(iii)(3)(D)(i) of the Act: (1) furnishes infusion therapy to individuals with acute or chronic conditions requiring administration of home infusion drugs; (2) ensures the safe and effective provision and administration of home infusion therapy on a 7-day-a-week, 24-hour-a-day basis; (3) is accredited by an organization designated by the Secretary in accordance with section 1834(u)(5) of the Act; and (4) meets such other requirements as the Secretary determines appropriate. A qualified home infusion therapy supplier may subcontract with a pharmacy, physician, provider of services, or supplier to meet these requirements.

Section 486.505 implements the definition of ''home infusion drug'' set forth at section 1861(iii)(3)(C) of the Act, currently defining the term as a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of DME, excluding insulin pump systems and self-administered drugs or biologicals on a self-administered drug exclusion list.

b. Durable Medical Equipment Benefit

Under the Medicare Part B benefit for DME, a limited number of home infusion drugs (as defined under 42 CFR 486.505) are covered if it is determined that it is medically necessary to use an external infusion pump classified as DME for administration of the home infusion drug, and the home infusion drug being used with the pump is, itself, reasonable and necessary for the treatment of an illness or injury (84 FR 60612).

For an external infusion pump and associated supplies to be covered under the Part B DME benefit, the pump must, among other statutory and regulatory requirements, be ''appropriate for use in the home'' (see 42 CFR 414.202). This requirement means that the equipment must be capable of being safely and effectively used by the beneficiary or caregiver in the home without the assistance of a healthcare professional (84 FR 60628). As noted previously, section 1861(iii)(3)(C) of the Act limits the home infusion therapy benefit to drugs administered in the patient's home through a pump covered under the DME benefit as defined under section 1861(n) of the Act. Therefore, historically, external infusion pumps and associated home infusion drugs that do not meet the ''appropriate for use in the home'' requirement have not been eligible for coverage under the DME benefit and services associated with administering the home infusion have not been covered under the Part B home infusion therapy benefit.

2. Current Issues

Section 6222(a) of the Consolidated Appropriations Act, 2026 (CAA, 2026) (Pub. L. 119–75) amended section 1861(n) of the Act to expand the scope of the Medicare Part B benefit for DME to include certain external infusion pumps and associated home infusion drugs (as defined in section

1861(iii)(3)(C) of the Act) or other associated supplies that would not otherwise qualify as DME because the use of such device would not meet the ''appropriate for use in the home'' requirement applied to the DME definition at 42 CFR 414.202. As stated in section V.E.1. of this proposed rule, CMS has historically interpreted the requirement that DMEPOS must be ''appropriate for use in the home'' to mean that the equipment must be capable of being safely and effectively used by the beneficiary or caregiver in the home without the assistance of a healthcare professional.

Effective for items furnished on or after April 1, 2027, section 6222(a) of the CAA, 2026, states an external infusion pump and associated home infusion drug (as defined in section 1861 (iii)(3)(C) of the Act) or other associated supplies that do not meet the appropriate for use in the home requirement applied to the definition of DME under 42 CFR 414.202 (or any successor to such regulation) shall be treated as meeting such requirement if each of the following criteria is satisfied:—

- The prescribing information approved by the FDA for the home infusion drug associated with the pump instructs that the drug should be administered by or under the supervision of a health care professional;
- A qualified home infusion therapy supplier, as defined in section 1861(iii)(3)(D) of the Act, administers or supervises the administration of the drug or biological in a safe and effective manner in the patient's home, as defined in section 1861(iii)(3)(B) of the Act; and
- The FDA-approved prescribing information instructs that the home infusion drug be infused at least 12 times per year:

++ Intravenously or subcutaneously; or

++ Infusion rates that the Secretary determines would require the use of an external infusion pump.

Section 6222(a) of the CAA, 2026 does not define the term ''health care professional''. We propose that the term ''health care professional'' would refer to any of the following clinicians, provided that such clinician is permitted to administer or supervise the administration of a home infusion drug in accordance with Federal and State law: physician (as defined in section 1861(r) of the Act); a clinical nurse specialist, nurse practitioner, or a physician assistant (as such terms are defined in section 1861(aa)(5) of the Act and regulations at 42 CFR 410.74 through 410.76); or a registered nurse otherwise licensed to practice nursing in the State in which the home infusion drug is administered. To ensure consistency across the Medicare program, we propose to define physician, clinical nurse specialist, nurse practitioner, and physician assistant as such terms are defined under the Medicare home health benefit. Given that sections 1861(r) and (aa)(5) of the Act (as codified at 42 CFR 410.74 through 410.76) do not define ''registered nurse'', we propose to define ''registered nurse'' as a clinician licensed to practice nursing in the State in which the home infusion drug is administered.

Because of the risks associated with administering certain home infusion drugs in the home under the expanded DME benefit, we propose limiting the definition of ''health care professional'' to these practitioners. We are aware of at least one drug, patisiran, that presents heighted safety risks and that may meet the new criteria and definition of home infusion drug under the revised definition of DME at section 1861(n) of the Act. In accordance with the prescribing information for the drug patisiran, adverse reactions during clinical trials included upper respiratory tract infections as well as infusion-related reaction symptoms including dizziness, headaches, chest pain, and other symptoms. Four serious adverse reactions of atrioventricular (AV) heart block (2.7 percent) occurred in patients treated with patisiran, including three cases of complete AV block. Warnings and precautions regarding infusion-related reactions under the highlights of prescribing information include the need to monitor for signs and symptoms of reactions during infusion, slow or interrupt the infusion if clinically indicated, and discontinue the infusion if a serious or life-threatening infusion-related reaction occurs. Infusion-related reactions for other home infusion drugs that may be covered under the expansion of the DME benefit could be even more serious and require emergency medical assistance in certain situations. Based on our review, we believe that such safety concerns may be adequately monitored and mitigated if either a physician, clinical nurse specialist, nurse practitioner, physician assistant, or registered nurse administers or supervises the administration of the home infusion drug. We believe any of these clinicians, if available on hand, could address any emergency medical events that occur during the course of the infusion of the drug. We are soliciting comments on this proposal, including whether there are other clinicians that may be equally qualified to administer or supervise the infusions of the drugs in the home and also address any emergency medical events that occur during the course of the infusion of the drug.

Note, we are not proposing that the term ''health care professional'' be defined to include a licensed practical nurse (LPN) or licensed vocational nurse (LVN) under the supervision of a registered nurse or physician. State law varies in terms of whether an LPN or LVN can perform certain emergency services such as delivering emergency medications. Thus, it is not clear that addressing the adverse affects associated with the administration of certain home infusion drugs would consistently fall under an LPN's or LVN's scope of practice. Additionally, as LPNs and LVNs practice under supervision without the same level of independent clinical authority as the professionals identified above, we believe they are less suited to serve as a health care professional for administering complex home infusion drugs under the expanded Medicare DME benefit. In addition, we do not believe that supervising the administration of the drug in the home should be done remotely as this could violate state laws and compromise the safety of the home infusion therapy as a health care professional would not be present to perform any necessary emergency services. In order to be present and able to perform emergency services in the home setting if necessary for the safety and health of the beneficiary, we are proposing that the health care professional be on site at the home to administer or directly supervise the administration of a home infusion drug covered under the expanded DME benefit. We are soliciting comments on this proposal.

As stated previously, section 6222(a) of the CAA, 2026 expands the DME benefit category to include external infusion pumps and associated home infusion drugs to include home infusion drugs that: (1) are infused at least 12 times per year intravenously or subcutaneously (section 1861(n)(3)(A) of the Act); or (2) infused at infusion rates that the Secretary determines would require the use of an external infusion pump (section 1861(n)(3)(B) of the Act). Based on our review, there do not currently appear to be any home infusion drugs that must be infused at rates that would require the use of an external infusion pump that do not otherwise already fall under the criterion set forth under section

1861(n)(3)(A) of the Act. Therefore, we are not proposing at this time to include additional drugs under the scope of this DME benefit category expansion that do not already meet the criterion set forth under section 1861(n)(3)(A) of the Act. The criterion specified in section 1861(n)(3) of the Act is that the drug must be infused at least 12 times per year. Because of the way dosing information is typically framed in the prescribing information, we propose that to meet this requirement, the drug must be infused at least once per month. We believe such limitation would be appropriate given that it is aligned with how home infusion drugs are typically framed in the prescribing information. We therefore propose that home infusion drugs covered under this expanded DME benefit must be infused at least once a month. We are soliciting comments on this proposal.

Note, we are not proposing a minimum or maximum number of times a drug must be infused to qualify as a ''home infusion drug''. The duration of treatment is not always clear and is often patient-dependent. Prescribing information for infusion drugs will often call for infusions to continue indefinitely, until toxicity, or until adverse reactions preclude further treatment.

Finally, section 6222(b) of the CAA, 2026 requires the Secretary to ensure that patients are notified of the cost sharing for electing home infusion therapy compared to other applicable settings of care for the furnishing of infusion drugs under the Medicare program. We plan to implement this provision through sub regulatory guidance.

3. Provisions of the Proposed Regulation

We propose to revise the definition of DME under 42 CFR 414.202 to incorporate the amendments to section 1861(n) of the Act for implementation of section 6222(a) of the CAA, 2026, effective April 1, 2027. Specifically, we propose to provide that certain external infusion pumps, associated home infusion drugs, and related supplies will be treated as meeting the ''appropriate for use in the home'' requirement when the following three criteria under paragraphs (1) through (3) of section 1861(n) of the Act are satisfied:

- The prescribing information approved by the FDA for the home infusion drug (as defined in § 486.505) associated with the pump instructs that the drug should be administered by or under the supervision of a health care professional. The health care professional must be a clinical nurse specialist (as defined § 410.76), nurse practitioner (as defined § 410.75), physician assistant (as defined § 410.74), physician as defined in section 1861(r) of the Act, or a registered nurse otherwise licensed to practice nursing in the State in which the home infusion drug is administered. The health care professional must be on site at the home to administer or supervise the administration of the home infusion drug.
- A qualified home infusion therapy supplier (as defined in § 486.505) administers or supervises the administration of the home infusion drug in a safe and effective manner in the patient's home (as defined in § 486.505)
- The prescribing information instructs that the home infusion drug be infused at least 12 times per year (at least once a month), either intravenously or subcutaneously, or at infusion rates that the Secretary determines would require the use of an external infusion pump. We are soliciting comments on this proposal.

D. DMEPOS Competitive Bidding Program—Country of Origin

CMS is planning to request to revise the information collection for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP), under OMB Control Number 0938–1408 (CMS–10744), to collect from DMEPOS CBP contract suppliers the country of origin for the lead items furnished during the DMEPOS CBP contract's period of performance.

DMEPOS CBP contract suppliers are required to use a reporting form, known as Form C, to provide product information (manufacturer name, model name, and model number) for the lead item they furnish. During an active round of the DMEOPS CBP, the information provided in the form is included in the Supplier Directory on the *Medicare.gov* website with the products the supplier plans to provide during the next 6-month period. Contract suppliers are required, as a term of their contracts, to maintain the accuracy of their product information for the lead item they furnish using Form C. Form C includes an attestation that all the reported information is accurate and up to date. This attestation needs to be completed to fulfill a Form C submission requirement.

We plan to request to revise the information collection to include the country of origin for each lead item they report on a new ''country of origin'' field on Form C. As done historically with the product information reported on Form C by a contract supplier, the reported country of origin information would be populated on the Medicare Supplier Directory for the contract supplier during the contract period of performance. This information would allow beneficiaries and interested parties to have access to the information on the country from which the DMEPOS item originated, if interested.

Contract suppliers would identify the country of origin based on the markings on the product for the lead item, or where an exemption to marking applies, obtain documentation from the manufacturer or distributor. Under U.S. Customs and Border Protections rules, imported goods must be properly marked with: ''Made in [Country],'' unless an exemption applies (for example, an item that is incapable of being marked, like a catheter), as explained at 19 CFR 134.32.

To correctly identify the country of origin for a product in the absence of a marking or to verify a marking, contract suppliers may need to obtain documentation from the manufacturer or distributor indicating the country of origin for its product, which could include one or a combination of the following: manufacturer certifications, bills of materials, manufacturing process descriptions, commercial invoices, U.S. Customs and Border Protection entry documentation, or a Harmonized Tariff Schedule classification.

The details for this update to Form C will be included under OMB Control Number 0938–1408 (CMS–10744).

VI. Collection of Information Requirements

A. Statutory Requirement for Solicitation of Comments

Under the Paperwork Reduction Act of 1995, we are required to provide a notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

B. Information Collection Requirements (ICRs)

In this HH PPS proposed rule, we are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs). Failure to submit HH QRP data required under section 1895(b)(3)(B)(v) of the Act with respect to a program year would result in the reduction of the annual home health market basket percentage increase otherwise applicable to an HHA for the corresponding calendar year by 2 percentage points.

1. ICRs for HH QRP

As discussed in section III of this proposed rule, we are proposing to revise the HH QRP data submission deadlines beginning with the CY 2027 HH QRP. CMS is also proposing to revise the HH QRP OASIS and HHCAHPS Annual Payment Update (APU) reporting timeframe to report a calendar year of data (January 1 through December 31). CMS proposes some revisions to regulatory text in support of rule proposals or to improve digital transfer of information during the reconsiderations process. Finally, we are soliciting public comments on one Request for Information (RFI) on future measure concepts for the HH QRP.

The net effect of these proposals is no changes to expected burden associated with OASIS data collection.

2. ICRs for the Expanded HHVBP Model

There are no proposals for the expanded HHVBP Model.

3. ICRs for DMEPOS Requirements for Identical Replacement Items

This proposed clarification neither imposes new information collection requirements nor eliminates existing ones. Rather, it further explains and reinforces the intent of this section when the item furnished is a replacement item. The PRA package for Medicare Fee-for-Service Prepayment Review of Medical Records is CMS–10417 and approved under OMB control number 0938–0969. In section V.B. of this proposed rule, we clarify that a new face-to-face encounter and related documentation are not required to support payment for replacement durable medical equipment, prosthetic, orthotic and supply (DMEPOS) items. Under existing Medicare requirements, suppliers and providers are already obligated to maintain documentation sufficient to demonstrate compliance with coverage requirements under 42 CFR 410.38 at the time the item is furnished. This rule clarifies that CMS does not consider an additional comprehensive beneficiary examination necessary to ''gather[ ] subjective and objective information associated with diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered'' when the item being furnished is a replacement item. If a claim for a replacement DMEPOS item is subject to audit, the provider must nevertheless submit documentation from the original face-to-face encounter to demonstrate that medical necessity, billing and coverage requirements have been satisfied. Accordingly, the intent of 42 CFR 410.38, which requires a face-to-face encounter for certain DMEPOS items, would continue to apply when the item is initially furnished; however, the requirement would not need to be repeated solely for replacement items. Therefore, we assume this clarification would have a negligible monetary impact.

4. ICRs for Provider Enrollment

We do not believe that any of our proposed provider enrollment regulatory revisions would impose an information collection burden on interested parties. However, there are several provisions about which clarification on this matter is needed.

a. Signage

Proposed § 424.510(f) would require all providers and suppliers (regardless of type) to maintain a permanent visible sign in plain view and post their hours of operation. We believe the vast majority of providers and suppliers already do so; in accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), providers and suppliers typically maintain such policies and records as a usual and customary business practice. Therefore, we have not assigned any burden to this requirement.

b. Clarification of ''Managing Employee'' Definition

All providers and suppliers must report their managing employees (and any changes in their managing employees) to CMS. This reporting requirement falls within the overall OMB-approved ICR burden for the following forms:

- Form CMS–855A (Medicare Enrollment Application for Institutional Providers; OMB Control No. 0938–0685).
- Form CMS–855B (Medicare Enrollment Application—Clinics/Group Practices and Certain Other Suppliers; OMB Control No. 0938–1377).
- Form CMS–855I (Medicare Enrollment Application—Physicians and Non-Physician Practitioners; Clinics/Group Practices and Certain Other Suppliers; OMB Control No. 0938–1355).
- Form CMS–855S (Medicare Enrollment Application—Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers; OMB Control No. 0938–1056).

We are proposing to revise the definition of ''managing employee'' in § 424.502 to identify certain individuals who fall within this definition. This would not impose an additional ICR burden, though, because these persons have always qualified as managing employees and thus must be reported. We are simply identifying them in § 424.502 to reiterate this point.

c. Documentation

(1) ''Operational''

Proposed paragraph (5) of our proposed revised definition of ''operational'' in § 424.502 would require, in part, that the provider or supplier have adequate written policies and records regarding its operations. We do not believe this would impose an additional information collection burden on providers and suppliers. In accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), providers and suppliers typically maintain such policies and records as a usual and customary business practice. Therefore, we have not assigned any burden to this requirement.

(2) Section 424.516(f)

Section 424.516(f) requires providers and suppliers to maintain certain types of documentation. We are proposing to revise this paragraph to make clear that said documentation must be accurate, complete, and consistent with CMS requirements. We do not believe this would impose an additional information collection burden on providers and suppliers. In accordance with the implementing regulations of the PRA at 5 CFR 1320.3(b)(2), providers and suppliers typically maintain such policies and records as a usual and customary business practice. Therefore, we have not assigned any burden to this requirement.

d. Private Equity Companies (PECs) and Real Estate Investment Trusts (REITs)

The Form CMS–855A enrollment application for certified providers and certain certified suppliers (Medicare Enrollment Application for Institutional Providers OMB Control No. 0938–0685) requires providers and suppliers to report whether any party listed on the

application is a PEC or a REIT. We are announcing in this proposed rule our intention to expand this requirement to the following Medicare provider and supplier enrollment forms:

- Form CMS–855B (Medicare Enrollment Application—Clinics/Group Practices and Certain Other Suppliers; OMB Control No. 0938–1377).
- Form CMS–855S (Medicare Enrollment Application—Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers; OMB Control No. 0938–1056).
- Form CMS–20134 (Medicare Diabetes Prevention Program (MDPP) Suppliers).

Although this announcement would not, in and of itself, impose an information collection burden, the revisions of the Forms CMS–855B and CMS–855S, to collect PEC and REIT data would do so. The Forms CMS–855B and CMS–855S burdens will be addressed in the information collection requests that CMS will submit to the Office of Management and Budget to request revisions to these two forms. However, the Form CMS–20134 is exempt under section 1115(a) of the Affordable Care Act.

e. Disclosure of Affiliations

As discussed in section V.C. of this proposed rule, we are proposing to revise our affiliation provisions in §§ 424.502 and 424.519. We solicit comment from interested parties as to whether any additional ICR burden would ensue from these changes.

f. Reactivation Effective Dates

We are proposing to permit providers that have been assigned an effective date for their reactivation to submit a rebuttal if they disagree with said date. We believe the rebuttal and the associated burden would be incurred subsequent to an administrative action. In accordance with the implementing regulations for the PRA (5 CFR 1320.4(a)(2) and (c)), the burden associated with any information collected subsequent to the administrative action is exempt from the requirements of the PRA (that is, the rebuttal submitted subsequent to the assignment of the reactivation effective date).

5. ICRs for Country of Origin

When ready, the following changes will be submitted to OMB for review under control number 0938–1408 (CMS–10744) using the standard, non-rule related PRA process (which includes the publication of 60- and 30-day **Federal Register** notices) to facilitate the change.

As discussed in section V.E. of this proposed rule, we plan to revise Form C (Semi-Annual Report) to collect the country of origin information for the lead items furnished during the DMEPOS CBP contract's period of performance. Because contract suppliers are required to submit Form C once every 6 months during January and July throughout the DMEPOS Competitive Bidding Program contract's period of performance, contract suppliers would be required to report this information twice a year. A DMEPOS CBP contract supplier would continue to be required as a term of its contract to maintain the accuracy of its product information (manufacturer name, model name, and model number) for the lead item it furnishes on Form C, and they would now be required to also maintain the accuracy of the country of origin for each product it reports in a newly added ''country of origin'' field on Form C. Form C would continue to require an attestation that all the reported information is accurate and up to date.

Contract suppliers should be able to identify the country of origin based on the markings on the product for the lead item. For example, under U.S. Customs and Border Protections rules, imported goods must be properly marked with: ''Made in [Country],'' unless an exemption applies (for example an item that is incapable of being marked, like a catheter), as explained at 19 CFR 134.32. To correctly identify the country of origin for a product in the absence of a marking or to verify a marking, contract suppliers may need to refer to readily available documentation from the manufacturer or distributor indicating the country of origin for its product, which could include a combination of the following: manufacturer certifications, bills of materials, manufacturing process descriptions, commercial invoices, U.S. Customs and Border Protection entry documentation, or a Harmonized Tariff Schedule classification.

At this time, we estimate that each annual response would take 0.2 hours (1 bidder/year × 0.1 hr/response × 2 responses/year) at a cost of $20.84 (0.2 hr × $104.22/hr). Given that the number of suppliers that will be awarded a Round 2028 DMEPOS CBP contract is not yet finalized, we are providing an estimated annual response time as opposed to an aggregate figure that considers the total number of awarded suppliers. Our proposed number of respondents and other burden estimates will be revised once the number of DMEPOS CBP contracts for Round 2028 is finalized, and will be restated when we publish our 60- and 30-day **Federal Register** notices. This information will be updated when the final rule is published.

TABLE 35: DMEPOS CBP Country of Origin Annual Burden Estimates

Collection	Respondents	Annual Responses (per respondent)	Total Annual Responses	Time per Response	Total Annual Time (non-aggregate)	Labor Rate ($/hr)	Total Cost ($) (non-aggregate)
CMS-10744 (OMB 0938-1408)	1 Contract Supplier	2	TBD	6 min (0.1 hr)	12 min (0.2 hr)	104.22	20.84

VII. Regulatory Impact Analysis

A. Statement of Need

1. HH PPS

Section 1895(b)(1) of the Act requires the Secretary to establish an HH PPS for all costs of home health services paid under Medicare. In addition, section 1895(b) of the Act requires: (1) the computation of a standard prospective payment amount include all costs for home health services covered and paid for on a reasonable cost basis and that such amount be initially based on the most recent audited cost report data available to the Secretary; (2) the prospective payment amount under the HH PPS to be an appropriate unit of service based on the number, type, and duration of visits provided within that unit; and (3) the standard prospective

payment amount be adjusted to account for the effects of case-mix and wage levels among HHAs. Section 1895(b)(3)(B) of the Act addresses the annual update to the standard prospective payment amounts by the home health applicable percentage increase. Section 1895(b)(4) of the Act governs the payment computation. Sections 1895(b)(4)(A)(i) and (b)(4)(A)(ii) of the Act require the standard prospective payment amount be adjusted for case-mix and geographic differences in wage levels. Section 1895(b)(4)(B) of the Act requires the establishment of appropriate case-mix adjustment factors for significant variation in costs among different units of services. Lastly, section 1895(b)(4)(C) of the Act requires the establishment of wage adjustment factors that reflect the relative level of wages, and wage-related costs applicable to home health services furnished in a geographic area compared to the applicable national average level.

Section 1895(b)(3)(B)(iv) of the Act provides the Secretary with the authority to implement adjustments to the standard prospective payment amount (or amounts) for subsequent years to eliminate the effect of changes in aggregate payments during a previous year or years that were the result of changes in the coding or classification of different units of services that do not reflect real changes in case-mix. Section 1895(b)(5) of the Act provides the Secretary with the option to make changes to the payment amount otherwise paid in the case of outliers because of unusual variations in the type or amount of medically necessary care. Section 1895(b)(3)(B)(v) of the Act requires HHAs to submit data for purposes of measuring health care quality and links the quality data submission to the annual applicable percentage increase.

Sections 1895(b)(2) and 1895(b)(3)(A) of the Act, as amended by sections 51001(a)(1) and 51001(a)(2) of the BBA of 2018 respectively, required the Secretary to implement a 30-day unit of payment, for 30-day periods beginning on and after January 1, 2020. Section 1895(b)(3)(D)(i) of the Act, as added by section 51001(a)(2)(B) of the BBA of 2018, requires the Secretary to annually determine the impact of differences between assumed behavior changes, as described in section 1895(b)(3)(A)(iv) of the Act, and actual behavior changes on estimated aggregate expenditures under the HH PPS with respect to years beginning with 2020 and ending with 2026. Section 1895(b)(3)(D)(ii) of the Act requires the Secretary, at a time and in a manner determined appropriate, through notice and comment rulemaking, to provide for one or more permanent increases or decreases to the standard prospective payment amount (or amounts) for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures, as determined under section 1895(b)(3)(D)(i) of the Act. Additionally, 1895(b)(3)(D)(iii) of the Act requires the Secretary, at a time and in a manner determined appropriate, through notice and comment rulemaking, to provide for one or more temporary increases or decreases to the payment amount for a unit of home health services for applicable years, on a prospective basis, to offset for such increases or decreases in estimated aggregate expenditures, as determined under section 1895(b)(3)(D)(i) of the Act. The HH PPS wage index utilizes the wage adjustment factors used by the Secretary for purposes of sections 1895(b)(4)(A)(ii) and (b)(4)(C) of the Act for hospital wage adjustments.

2. HH QRP

Section 1895(b)(3)(B)(v) of the Act authorizes the HH QRP, which requires HHAs to submit data in accordance with the requirements specified by CMS. Failure to submit data required under section 1895(b)(3)(B)(v) of the Act with respect to a program year will result in the reduction of the annual home health market basket percentage increase otherwise applicable to an HHA for the corresponding calendar year by 2 percentage points.

3. Expanded HHVBP Model

In the CY 2022 HH PPS final rule (86 FR 62292 through 62336) and codified at 42 CFR part 484, subpart F, we finalized our policy to expand the HHVBP Model to all Medicare certified HHAs in the 50 States, territories, and District of Columbia beginning January 1, 2022. CY 2022 was a pre-implementation year. CY 2023 was the first performance year in which HHAs individual performance on the applicable measures affects their Medicare payments in CY 2025. We are not proposing any expanded HHVBP Model-specific changes in this proposed rule.

4. DMEPOS Requirements for Identical Replacement Items

In this proposed rule, we would clarify that a new face-to-face encounter and related documentation, as described in 42 CFR 410.38, is not necessary to support the payment of replacement DMEPOS items.

5. Provider Enrollment

Consistent with section 1866(j) of the Act, we are proposing a number of Medicare provider enrollment provisions to strengthen and clarify certain aspects of the provider enrollment process. These include but are not limited to: (1) adding and modifying grounds for denying or revoking a provider's or supplier's Medicare enrollment; and (2) expanding the reasons for which CMS can apply a retroactive effective date for provider and supplier revocations. These changes are necessary to help ensure that payments are made only to qualified providers and suppliers, which we believe would assist in protecting the Trust Funds and Medicare beneficiaries.

6. DMEPOS Coverage of External Infusion Pumps

With section 6222 of the Consolidated Appropriations Act, 2026, Congress modified section 1861(n) of the Act to expand the scope of the DME benefit to enable coverage for home infusion of drugs that: (1) must be administered by or under the supervision of a health care professional; (2) are administered by a qualified home infusion therapy supplier; and (3) have prescribing information that requires infusion at least 12 times per year. This regulatory action implements the changes made by section 6222 of the CAA, 2026 to the definition of DME.

7. DMEPOS Competitive Bidding—Country of Origin

For the DMEPOS CBP, we discuss requesting to revise the information collection under OMB Control Number 0938–1408 (CMS–10744) to collect from DMEPOS Competitive Bidding contract suppliers the country of origin for the lead items furnished during the DMEPOS CBP contract's period of performance.

The reported country of origin information would be populated on the Medicare Supplier Directory for the contract supplier during the contract period of performance so beneficiaries and interested parties may learn where the DMEPOS item originated, if interested.

B. Overall Impact

We have examined the impacts of this proposed rule as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96 354);

section 1102(b) of the Social Security Act; and section 202 of the Unfunded Mandates Reform Act of 1995.

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; and distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of Executive Order 12866. Based on our estimates, OMB's Office of Information and Regulatory Affairs has determined this rulemaking is significant per section 3(f)(1) of Executive Order 12866. Accordingly, we have prepared a regulatory impact analysis that presents the cost and benefit of the rulemaking to the best of our ability.

C. Detailed Economic Analysis

1. Effects of the Proposed Changes for the CY 2027 HH PPS

This rule proposes to update Medicare payments under the HH PPS for CY 2027. The net transfer impact related to the changes in payments under the HH PPS for CY 2027 is estimated to be $420 million (2.4 percent) above the current projected CY 2026 baseline of $17.575 billion, leading to total projected spending of approximately $18 billion for 2027. The $420 million increase in estimated payments for CY 2027 reflects the effects of the proposed CY 2027 home health payment update percentage of 2.1 percent ($370 million increase), and an estimated 0.3 percent increase that reflects the updated FDL ($50 million increase).

We use the latest data and analysis available. However, we do not adjust for future changes in such variables as number of visits or case-mix. This analysis incorporates the latest estimates of growth in service use and payments under the Medicare home health benefit, based primarily on Medicare claims data for periods that ended on or before December 31, 2025. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, susceptible to errors resulting from other changes in the impact time period assessed. Some examples of such possible events are newly legislated general Medicare program funding changes made by the Congress or changes specifically related to HHAs. In addition, changes to the Medicare program may continue to be made as a result of new statutory provisions. Although these changes may not be specific to the HH PPS, the nature of the Medicare program is such that overall changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon HHAs.

Table 36 represents how HHA revenues are likely to be affected by the proposed policy changes for CY 2027. For this analysis, we used an analytic file with linked CY 2025 OASIS assessments and home health claims data for dates of service that ended on or before December 31, 2025. The first column of table 36 classifies HHAs according to a number of characteristics including provider type, geographic region, and urban and rural locations. The second column shows the number of facilities in the impact analysis. The third column shows the payment effects of the recalibration of the case-mix weights offset by the case-mix weight budget neutrality factor. The fourth column shows the payment effects of updating the CY 2027 wage index (that is, the FY 2027 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2022, and before October 1, 2023 (FY 2023 cost report data) with a 5-percent cap on wage index decreases. The aggregate impact of the changes in the fourth column is zero percent, due to the wage index budget neutrality factor. The fifth column shows the payment effects of the proposed CY 2027 home health payment update percentage. The sixth column shows the payment effects of the proposed FDL. The seventh column shows the payment effects of the proposed temporary adjustment on all payments. The aggregate impact of the proposed temporary adjustment reflected in the seventh column equals zero percent because both the CY 2026 and CY 2027 payment rates would include a 3.0 percent temporary adjustment. The last column shows the combined effects of all the proposed provisions.

Overall, it is projected that aggregate payments in CY 2027 would increase by 2.4 percent, which reflects the proposed 2.1 percent increase to the home health payment update percentage and the 0.3 percent increase from the updated FDL. As illustrated in table 36, the combined effects of all changes vary by specific types of providers and by location. We note that some individual HHAs within the same group may experience different impacts on payments than others due to the distributional impact of the CY 2027 wage index, the percentage of total HH PPS payments that were subject to the LUPA or paid as outlier payments, and the degree of Medicare utilization.

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TABLE 36: PROPOSED CY 2027 HHA IMPACTS BY FACILITY TYPE AND AREA OF THE COUNTRY

	Number of Agencies	CY 2027 Case-Mix Weights Recalibration Neutrality Factor	CY 2027 Updated Wage Index (with 5% cap)	CY 2027 Proposed HH Payment Update Percentage	CY 2027 Fixed-Dollar Loss (FDL) Update	Temporary Adjustment	Total
All Agencies	**9,975**	**0.0%**	**0.0%**	**2.1%**	**0.3%**	**0.0%**	**2.4%**
Facility Type and Control							
Free-Standing/Other Vol/NP	669	-0.1%	0.4%	2.1%	0.4%	0.0%	2.8%
Free-Standing/Other Proprietary	8,379	0.0%	-0.1%	2.1%	0.3%	0.0%	2.3%
Free-Standing/Other Government	97	0.1%	0.7%	2.1%	0.5%	0.0%	3.4%
Facility-Based Vol/NP	362	0.0%	0.3%	2.1%	0.5%	0.0%	2.9%
Facility-Based Proprietary	20	0.3%	0.6%	2.1%	0.4%	0.0%	3.4%
Facility-Based Government	159	0.0%	1.1%	2.1%	0.5%	0.0%	3.7%
Subtotal: Freestanding	9,157	0.0%	0.0%	2.1%	0.3%	0.0%	2.4%
Subtotal: Facility-based	541	0.0%	0.4%	2.1%	0.5%	0.0%	3.0%
Subtotal: Vol/NP	1,032	-0.1%	0.4%	2.1%	0.4%	0.0%	2.8%
Subtotal: Proprietary	8,417	0.0%	-0.1%	2.1%	0.3%	0.0%	2.3%
Subtotal: Government	256	0.0%	1.0%	2.1%	0.5%	0.0%	3.6%
Facility Type and Control: Rural							
Free-Standing/Other Vol/NP	159	-0.1%	1.8%	2.1%	0.4%	0.0%	4.2%
Free-Standing/Other Proprietary	857	0.0%	0.0%	2.1%	0.2%	0.0%	2.3%
Free-Standing/Other Government	59	0.4%	0.8%	2.1%	0.5%	0.0%	3.8%
Facility-Based Vol/NP	139	0.1%	0.0%	2.1%	0.5%	0.0%	2.7%
Facility-Based Proprietary	8	0.2%	-0.4%	2.1%	0.5%	0.0%	2.4%
Facility-Based Government	113	0.1%	1.6%	2.1%	0.6%	0.0%	4.4%
Facility Type and Control: Urban							
Free-Standing/Other Vol/NP	510	-0.1%	0.3%	2.1%	0.4%	0.0%	2.7%
Free-Standing/Other Proprietary	7,522	0.0%	-0.1%	2.1%	0.3%	0.0%	2.3%
Free-Standing/Other Government	38	-0.1%	0.7%	2.1%	0.5%	0.0%	3.2%
Facility-Based Vol/NP	223	0.0%	0.4%	2.1%	0.5%	0.0%	3.0%
Facility-Based Proprietary	12	0.3%	1.3%	2.1%	0.3%	0.0%	4.0%
Facility-Based Government	46	-0.1%	0.6%	2.1%	0.4%	0.0%	3.0%
Facility Location: Urban or Rural							
Rural	1,379	0.0%	0.3%	2.1%	0.3%	0.0%	2.7%
Urban	8,596	0.0%	0.0%	2.1%	0.3%	0.0%	2.4%
Facility Location: Region of the Country (Census Region)							
New England	299	-0.1%	0.7%	2.1%	0.3%	0.0%	3.0%
Mid Atlantic	360	-0.1%	1.2%	2.1%	0.4%	0.0%	3.6%
East North Central	1,315	-0.1%	-0.5%	2.1%	0.3%	0.0%	1.8%
West North Central	533	-0.2%	0.3%	2.1%	0.4%	0.0%	2.6%
South Atlantic	1,550	-0.1%	-0.3%	2.1%	0.3%	0.0%	2.0%
East South Central	354	-0.1%	-0.5%	2.1%	0.2%	0.0%	1.7%
West South Central	1,924	0.0%	-0.7%	2.1%	0.3%	0.0%	1.7%
Mountain	716	0.1%	-0.5%	2.1%	0.4%	0.0%	2.1%
Pacific	2,880	0.2%	0.4%	2.1%	0.3%	0.0%	3.0%

	Number of Agencies	CY 2027 Case-Mix Weights Recalibration Neutrality Factor	CY 2027 Updated Wage Index (with 5% cap)	CY 2027 Proposed HH Payment Update Percentage	CY 2027 Fixed-Dollar Loss (FDL) Update	Temporary Adjustment	Total
Outlying	44	0.3%	0.9%	2.1%	0.3%	0.0%	3.6%
Facility Size (Number of 30-day Periods)							
< 100 periods	2,388	0.6%	-0.2%	2.1%	0.4%	0.0%	2.9%
100 to 249	1,615	0.4%	-0.1%	2.1%	0.4%	0.0%	2.8%
250 to 499	1,805	0.3%	-0.1%	2.1%	0.4%	0.0%	2.7%
500 to 999	1,896	0.1%	0.0%	2.1%	0.3%	0.0%	2.5%
1,000 or More	2,271	-0.1%	0.0%	2.1%	0.3%	0.0%	2.3%

Source: CY 2025 Medicare claims data for periods with matched OASIS records ending in CY 2025 (as of March 12, 2026).

Notes: Both the CY 2026 and CY 2027 payment rates include a -3% temporary adjustment. The "CY 2027 Updated Wage Index (with 5% cap)" column reflects a 5-percent cap on wage index decreases. The "CY 2027 Fixed Dollar Loss (FDL) Update" column reflects a change in the FDL from 0.37 to 0.29. Due to missing Provider of Services file information (from which home health agency characteristics are obtained), some subcategories in the impact tables have fewer agencies represented than the overall total (of 9,975): totals involving facility type (only) add up to 9,698 and totals involving control type add up to 9,705.

REGION KEY:
New England=Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Middle Atlantic=Pennsylvania, New Jersey, New York
South Atlantic=Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia
East North Central=Illinois, Indiana, Michigan, Ohio, Wisconsin
East South Central-Alabama, Kentucky, Mississippi, Tennessee
West North Central=Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota
West South Central=Arkansas, Louisiana, Oklahoma, Texas
Mountain=Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming
Pacific=Alaska, California, Hawaii, Oregon, Washington
Other=Guam, Puerto Rico, Virgin Islands

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2. Effects of the Proposed Changes for the HH QRP for CY 2027

Failure to submit HH QRP data required under section 1895(b)(3)(B)(v) of the Act with respect to a program year will result in the reduction of the annual home health market basket percentage increase otherwise applicable to an HHA for the corresponding calendar year by 2 percentage points. For the CY 2023 program year, 820 of the 11,549 active Medicare-certified HHAs, or approximately 7.1 percent, did not receive the full annual percentage increase because they did not meet assessment submission requirements. The 820 HHAs that did not satisfy the reporting requirements of the HH QRP for the CY 2023 program year represent $149 million in home health claims payment dollars during the reporting period out of a total $16.4 billion for all HHAs.

This proposed rule proposes to revise the HH QRP data submission deadlines beginning with the CY 2027 HH QRP. We also propose to revise the HH QRP OASIS and HHCAHPs annual payment update (APU) reporting timeframe to report a calendar year of data (January 1 through December 31). We propose revisions to regulatory text in support of rule proposals to improve digital transfer of information during the reconsiderations process. Finally, we are soliciting public comments on one Request for Information (RFI) on future measure concepts for the HH QRP. The net effect of these proposals is no change in burden for OASIS data collection.

3. Effects of the Expanded HHVBP Model

In the CY 2022 HH PPS final rule (88 FR 77676), we estimated that the expanded HHVBP Model would generate a total projected 5-year gross FFS savings of $3,376,000,000. Given that we are not proposing any expanded HHVBP Model specific changes in this proposed rule, these estimates are unchanged.

4. DMEPOS Requirements for Identical Replacement Items

This proposed provision would clarify that a face-to-face encounter and related documentation, as described in 42 CFR 410.38, is not necessary to support the payment of replacement DMEPOS items. The fiscal impact of this clarification cannot be estimated as this rule only identifies whether a face-to-face encounter is required for payment for replacement of DMEPOS items. Given the volume of Medicare beneficiaries and associated claims for payment, we do not audit all claim submissions for compliance with Medicare conditions of payment—including the face-to-face encounter. In addition, for those claims audited, it is one of many Medicare coverage requirements, and therefore delineating its compliance rate is not operationally feasible. This situation can only be identified upon medical record review, and replacements were not the sole focus of a medical review audit. Rather, varied medical review decision-making and the need for this clarification was identified anecdotally. As such, we cannot reliably forecast any cost for this limited subset of claims for replacement items

5. Provider Enrollment

As previously noted, we are proposing a number of provider enrollment provisions to strengthen and clarify certain aspects of the provider enrollment process. This RIA addresses provisions that: (1) we believe would have a financial impact; and (2) would not, in our view, have such an impact but which require explanation.

a. Revocation Effective Dates

Existing § 424.535(g)(1) states that except as described in § 424.535(g)(2) and (3), a revocation becomes effective 30 days after CMS or its contractor mails notice of its determination to the provider or supplier (hereafter occasionally and collectively ''providers''). Under current § 424.535(g)(2)(i) through (xv), there are grounds for which CMS can revoke a provider's enrollment retroactively to the date the provider's non-compliance commenced. Retroactive revocation allows CMS to collect monies that have been paid to the provider since the beginning of its non-compliance. We explained in section V.C. of this proposed rule that we are proposing to make the effective dates of all of our revocation reasons in § 424.535 retroactive. Existing revocation grounds that are currently applied prospectively but would become retroactive are listed as follows (along with their proposed retroactive effective dates):

- *§ 424.535(a)(1) (Noncompliance with enrollment requirements):* The date the non-compliance began (per CMS' or the CMS contractor's determination).
- *§ 424.535(a)(5)(b)(ii) (Noncompliance with enrollment requirements):* The date the Medicare enrollment requirement was not satisfied.
- *§ 424.535(a)(7):* The date on which the conduct resulting the revocation occurred.
- *§ 424.535(a)(6) (Application fee noncompliance):* The date on which CMS or its contractor determines that the provider should be revoked under paragraph (a)(6).
- *§ 424.535(a)(10)(i) (Document retention):* The date on which CMS or the CMS contractor determines that the provider has not complied with this retention requirement.
- *§ 424.535(a)(10)(ii) (Document access to CMS):* The day after the date by which the provider was required to furnish access.
- *§ 424.535(a)(11) (Capitalization):* The day after the date by which the provider was required to furnish the requested documentation.
- *§ 424.535(a)(14) (Abusive prescribing):* The date of the last prescription in the applicable pattern or practice.
- *§ 424.535(a)(15) (False Claims Act judgments):* The date of the judgment.
- *§ 424.535(a)(17) (Referral of debt to Treasury):* The date on which CMS referred the debt to the Department of Treasury.
- *§ 424.535(a)(18) (Revoked under different name or identifier):* The effective date of the provider's current enrollment.
- *§ 424.535(a)(19) (Undue risk):* The date on which CMS or its contractor determines that the provider should be revoked under paragraph (a)(19).
- *§ 424.535(a)(20) (Billing from non-compliant location):* The earliest date on the claims for the non-compliant location that are triggering the revocation.
- *§ 424.535(a)(21) (Abusive ordering, certifying, etc.):* The date of the last order, certification, referral, or prescription in the applicable pattern or practice.
- *§ 424.535(a)(22) (Patient harm):* The date of the prior action resulting in the revocation.
- *§ 424.535(a)(23) (Condition or standard noncompliance):* Under § 424.535(g)(xv)(D), the current paragraph (a)(23) revocation effective date for all standard orcondition violations other than those listed in § 424.535(g)(xv)(A) through (C) is prospective; that is, it is 30 days after the date that CMS or the CMS contractor mails the revocation letter to the provider or supplier. We are proposing to make these (a)(23) prospective effective dates retroactive back to the date of the violation or non-compliance (per CMS' or the CMS contractor's determination).

Table 37 contains several data categories. The first identifies those new retroactive revocation grounds for which we are able to calculate savings to the Medicare program. The second is the average annual number of revocations that occur for each of these revocation grounds. The third is the average length of time between when the non-compliance begins in these situations and 30 days after the revocation letter is sent to the provider in question. For instance, suppose a provider undergoes a change in its billing agency's address effective May 1 but fails to report it to CMS within 90 days. The provider is revoked under § 424.535(a)(9). The revocation letter is mailed to the provider on August 15, meaning the effective date under existing § 424.535(g)(1) is September 15. The period between the date of non-compliance and the effective date under current paragraph (g)(1) is thus 45 days (that is, the period between July 31 (the day after the 90-day reporting deadline) and September 15). Under our proposal, though, the provider would be ineligible for payments for services furnished during this 45-day period because its revocation would now be retroactive back to the date of non-compliance (July 31).

The last two categories address the savings that would accrue to Medicare from the proposed retroactive grounds listed in the first column. Based on internal CMS data, we calculated in the fourth column of table 37 the average amount of actual payments made to the providers in each of the table's proposed retroactive revocation reasons during the time period in the table's third column. To illustrate, table 37 indicates that 17 providers per year are revoked under § 424.535(a)(22), with the third column identifying a 95-day period. The fourth column reflects the average annual payments each of these 17 providers receive during their respective 95-day periods (or $20,586).

The fifth column estimates the total savings for each of our proposed retroactive revocation reasons—specifically, we multiplied the figures in the second column by those in the fourth. Using our § 424.535(a)(22) example, the total annual savings figure is $349,962 (or 17 × $20,586).

We used this same approach when calculating projected savings for the new retroactive revocation grounds we finalized in the CY 2026 HH PPS final rule (90 FR 55342).

TABLE 37: RETROACTIVE REVOCATION GROUNDS

New Retro Revocation Basis Under § 424.535	Number of Revocations Per Year	Estimated Length of Time (in Days) Between When the Non-Compliance Occurs and 30 Days After the Revocation Letter is Sent	Average Payments Made to the Revoked Provider During Estimated Non-Compliance Time Period ($)	Estimated Total Annual Savings (Number of Revocations x Average Payments) ($)
(a)(1)	10	90	225,896	2,258,960
(a)(5)(ii)	20	45	1,955,854	39,117,080
(a)(10)	19	65	187,087	3,554,653
(a)(13)(i) (for DEA certificate revocations and suspensions)	9	90	18,743	168,687
(a)(14)	1	100	4,721	4,721
(a)(17)	6	730 (2 years)	892	5,352
(a)(19)	255	30	143,153	36,504,015
(a)(22)	17	95	20,586	349,962
TOTALS & AVERAGES	**337**	**156**	**N/A**	**81,963,430**

Accordingly, we project annual savings of $81,963,430 stemming from our retroactive revocation proposals.

b. Expanded and New Revocation Reasons

As discussed in section V.B. of this proposed rule, we are proposing the following expanded and new revocation grounds:

- We would expand existing § 424.535(a)(4) to permit revocation if the provider submits false or misleading information on or associated with any provider enrollment-related CMS or Medicare form (including forms created by and/or submitted to CMS contractors). Section 424.535(a)(4) would no longer be limited to false or misleading information on the enrollment application.
- Revised § 424.535(a)(16) would include a new revocation ground permitting enrollment if the provider—or any owner, managing employee, managing organization, officer, or director thereof—was convicted of a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.
- New § 424.535(a)(24) would permit revocation if CMS determines that the provider's enrollment presents a high risk of fraud, waste, or abuse due to the provider's location within a limited geographic area that has an excessive number of providers and suppliers.
- New § 424.535(a)(25) would permit revocation if CMS determines that the HHA, hospice, or DMEPOS supplier did not comply with the provisions and requirements of, as applicable, § 424.550(b) or § 424.551.

As we cannot predict the number of instances in which we would utilize these new and expanded, we are unable to establish a savings estimate.

c. Preclusion List

The preclusion list is a compilation of providers that are prohibited from receiving Medicare Advantage or Part D payments. One ground for which a provider can be placed on the preclusion list if it has a felony conviction with the past 10 years. We are proposing to expand this to include felony convictions of the provider's owner, managing employee/organization, or corporate officer/director. As with our proposed revocation provisions, though, we are unable to establish a savings estimate for this expansion. This is because we cannot predict the number of instances where we would place a provider on the preclusion based on an owner's, managing employee's, etc., felony conviction.

d. Hospice Reactivations

Section 424.540(b)(3)(i) states that an HHA whose Medicare billing privileges are deactivated under § 424.540 must obtain an initial State survey or accreditation before its Medicare billing privileges can be reactivated. We are proposing to expand § 424.540(b)(3)(i) to include hospices.

An average of roughly 226 hospices each year seek to reactivate their enrollments. Although hospice surveys and accreditation costs vary widely, we project—solely for purposes of this estimate—that the average cost would be $6,000. This results in an annual cost of our proposed § 424.540(b)(3)(i) expansion of $1,356,000. We welcome comments on this projection.

e. Conclusion

We do not believe our proposals would negatively impact access to care, including in rural areas. We have promulgated numerous denial and revocation provisions in prior CMS provider enrollment regulations with no such impact, and we do not anticipate that our new denial and revocation grounds (and expansions of existing ones) would result in large numbers of denial and revocations.

We solicit comment from interested parties regarding any additional costs that may arise from our proposed enrollment provisions.

6. DMEPOS Coverage of External Infusion Pumps

This proposed rule would expand the scope of the Medicare Part B benefit for DME by revising the interpretation of the ''appropriate for use in the home'' requirement in the definition of DME at 42 CFR 414.202 for certain drugs or biologicals infused in the home that fulfill specific requirements outlined in the statute. Since drugs or biologicals administered through an external infusion pump that is classified as DME can be covered under the Medicare Part B benefit as supplies necessary for the effective use of the external infusion pump, expanding the scope of the DME benefit has the effect of expanding coverage to drugs or biologicals that were not previously covered through home infusion. At this time, we expect that there is only one drug that did not previously meet the requirements for coverage through home infusion but does meet the requirements as modified by section 6222 of the Consolidated Appropriations Act, 2026, and will be used by a sufficient number of Medicare beneficiaries to warrant consideration: patisiran. While there may be other drugs that meet the basic requirements for coverage, we believe that use through home infusion would be negligible. In addition, it is possible that pharmaceutical makers may introduce new drugs or biologicals, or reformulate existing products, that will qualify for coverage under this expanded scope, but we cannot predict or estimate what impact this may have.

This expanded scope mirrors changes that had been proposed in 2020 rulemaking, ''Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Policy Issues and Level II of the Healthcare Common Procedure Coding System (HCPCS)'' (85 FR 70358). At that time, we had estimated Medicare savings of roughly $3 million per year. Since then, claims data show that significantly fewer beneficiaries have been receiving patisiran infusions. Claims data for 2025 show that only 69 beneficiaries received patisiran infusions. As we noted in the previous proposed rule, the primary impact of this expanded scope relates to the difference in beneficiary cost sharing between infusion therapy received in an outpatient clinic setting and home infusion therapy: cost sharing for each outpatient infusion is the normal 20 percent Part B coinsurance limited to the Part A deductible ($1,736 in 2026), while cost sharing for home infusion therapy is not limited.

Claims data show that the annual cost of patisiran for each beneficiary receiving it in 2025 was approximately $313,000. Based on the typical infusion every three weeks, these patients likely received 17 infusions each year. When received in an outpatient setting, the capped cost sharing would apply, so each beneficiary would pay $1,736 per infusion or approximately $29,500 for the year. If, instead, patisiran were received as home infusion, cost sharing for the patisiran alone would be approximately $3,700 per infusion, or $62,900 per year. There would also be additional charges for home infusion (for example, home infusion services, pump rental, other supplies) that exceed the charges for outpatient infusion, and CMS believes these would cost Medicare approximately $7,000 per beneficiary per year, and the beneficiary approximately $2,000 in cost sharing (additional charges for outpatient infusion would cost Medicare approximately $4,000). Taken together, a beneficiary that receives patisiran through home infusion instead of outpatient infusion would save Medicare approximately $31,000 per year because of the higher cost sharing (the beneficiary would pay an additional $34,000) offset by the higher total cost of home infusion (additional $3,000 net cost to Medicare).

Given this substantial cost sharing difference, we believe it is unlikely that beneficiaries would consider home infusion for patisiran unless they are either enrolled in Medicaid or have purchased Medicare supplement insurance (Medigap). While CMS does not directly track how many beneficiaries have enrolled in private Medigap plans, a recent report from the Kaiser Family Foundation (''Key Facts About Medigap Enrollment and Premiums for Medicare Beneficiaries,'' 2024. Retrieved from *https://www.kff.org/medicare/key-facts-about-medigap-enrollment-and-premiums-for-medicare-beneficiaries/*) suggests that approximately 40 percent of original Medicare beneficiaries have Medigap plans. CMS data show that approximately 17 percent of Medicare beneficiaries are also enrolled in Medicaid. CMS has no practical way of knowing, specifically, whether beneficiaries receiving infusion therapy are more or less likely than the overall Medicare population to have non-Medicare insurance that limits the impact of Medicare cost sharing. For purposes of estimating regulatory impact, we assume that approximately one-third of beneficiaries receiving patisiran would not consider home infusion because of the higher cost sharing. Of the remainder, we estimate that approximately 50 percent may not switch to home infusion, either because they prefer to receive it in an outpatient setting or because, in consultation with their medical providers, they have concluded that home infusion is not

appropriate for them. Therefore, we estimate that roughly one-third of beneficiaries receiving patisiran would switch to home infusion therapy, although there is substantial uncertainty associated with this estimate. Based on this estimate of the number who might switch, and the savings to Medicare of $31,000 per beneficiary who switches, we estimate initial aggregate savings to the Medicare program would be approximately $800 thousand per year.

We note that many Medicare beneficiaries have chosen to receive their Medicare benefits through Part C (Medicare Advantage). The differences in cost sharing discussed here apply strictly to those who have chosen original Medicare (Parts A and B). Medicare Advantage plans set their own cost sharing policies, and we have no way to estimate whether and how these changes in coverage for home infusion therapy would lead Medicare Advantage plans to change their policies and the cost sharing beneficiaries may face in different settings.

We also note that, by definition, infusion drugs that were not previously covered by Part B in the home infusion setting would have been covered by Part D. However, the drugs that are covered by this new benefit require infusion under the supervision of a medical professional, and the service charges related to such supervised infusion, together with rental of the infusion equipment, would not have previously been payable under Part B or Part D. Therefore, we do not believe that a significant number of beneficiaries would be switching from Part D coverage to this new benefit under Part B, given the significant out of pocket payments that would have been required.

7. DMEPOS Competitive Bidding—Country of Origin

As explained earlier, for the DMEPOS CBP, we are proposing to revise the collection currently approved under OMB Control Number 0938–1408 (CMS–10744) to collect from DMEPOS Competitive Bidding contract suppliers the country of origin for the lead items furnished during the DMEPOS CBP contract's period of performance.

Specifically, contract suppliers under a DMEPOS CBP contract will continue to be required as a term of their contracts to maintain the accuracy of the product information (manufacturer name, model name, and model number) for the lead item the supplier furnishes on Form C, and would now be required to also include the country of origin for each product it reports on a new ''country of origin'' field on Form C. Contract suppliers are required to submit Form C once every 6 months during January and July throughout the DMEPOS Competitive Bidding Program Contract's period of performance, and Form C includes an attestation that all the reported information is accurate and up to date. This attestation would need to be completed to fulfill a Form C submission requirement. The details for this update to Form C would be included in advance of the required reporting through an updated CMS–1074.

As done historically with the product information reported on Form C by a contract supplier, the reported country of origin information would be populated on the Medicare Supplier Directory for the contract supplier during the contract period of performance. This information would allow beneficiaries and interested parties to learn the country from which the DMEPOS item originated, if interested.

Contract suppliers should be able to identify the country of origin based on the markings on the product for the lead item. Under US Customs and Border Protections rules, imported goods must be properly marked with: ''Made in [Country],'' unless an exemption applies (for example, an item that is incapable of being marked, like a catheter), as explained at 19 CFR 134.32. To correctly identify the country of origin for a product in the absence of a marking or to verify a marking, contract suppliers may need to refer to available documentation from the manufacturer or distributor indicating the country of origin for its product, which could include a combination of the following: manufacturer certifications, bills of materials, manufacturing process descriptions, commercial invoices, U.S. Customs and Border Protection entry documentation, or a Harmonized Tariff Schedule classification.

D. Regulatory Review Cost Estimation

If regulations impose administrative costs on private entities, such as the time needed to read and interpret this rule, we should estimate the cost associated with regulatory review. Due to the uncertainty involved with accurately quantifying the number of entities that will review the rule, we assume that the total number of unique commenters on last year's proposed rule will be the number of reviewers of this proposed rule. We acknowledge that this assumption may understate or overstate the costs of reviewing this rule. It is possible that not all commenters reviewed last year's rule in detail, and it is also possible that some reviewers chose not to comment on the proposed rule. For these reasons we thought that the number of past commenters would be a fair estimate of the number of reviewers of this rule. We welcome any comments on the approach used in estimating the number of entities reviewing this proposed rule.

We recognize that different types of entities are in many cases affected by mutually exclusive sections of this proposed rule. Therefore, for the purposes of our estimate we assume that each reviewer reads approximately 50 percent of the rule. Finally, in our estimates, we have used the 347 number of timely pieces of correspondence on the CY 2026 HH PPS proposed rule as our estimate for the number of reviewers of this rule. We continue to acknowledge the uncertainty involved with using this number, but we believe it is a fair estimate due to the variety of entities affected and the likelihood that some of them choose to rely (in full or in part) on press releases, newsletters, fact sheets, or other sources rather than the comprehensive review of preamble and regulatory text. We seek comments on this assumption. Using the median hourly wage information from the BLS for medical and health service managers (Code 11–9111), we estimate that the cost of reviewing the proposed rule is $96.36 per hour, including overhead and fringe benefits (*https://www.bls.gov/oes/current/oes_nat.htm*). Assuming an average reading speed, we estimate that it would take approximately 2.77 hours for the staff to review half of this proposed rule. For each entity that reviews this proposed rule, the estimated cost is $266.92 (2.77 hours × $96.36). Therefore, we estimate that the total cost of reviewing this proposed rule is $92,621 ($266.92 × 347 reviewers).

E. Alternatives Considered

1. HH PPS

In section II.C.1.e. of this proposed rule, we describe that to achieve budget neutrality as required by law, we calculated an illustrative permanent adjustment by determining what the 30-day base payment amount should have been in CYs 2020, 2021, 2022, 2023, 2024, and 2025 in order to achieve the same estimated aggregate expenditures as obtained from the simulated 60-day episodes as required by statute. We proposed not implementing a permanent adjustment to the CY 2027 30-day base payment rate. One alternative to not proposing a permanent adjustment included proposing a −1.024 percent permanent adjustment for CY 2027 if we could

show that the observed behavior changes in CY 2025 claims could be directly attributed to the implementation of the PDGM as we discussed in the CY 2026 final rule (90 FR 55366 through 55367). However, we continue to believe that implementing a permanent adjustment would not be appropriate because our analysis suggests that the majority of the behavior change related to the implementation of the PDGM occurred in CYs 2020 through 2022 and that the behavior change observed in CYs 2023 through 2025 is related to factors other than the implementation of the PDGM.

We are proposing to implement a temporary adjustment to continue reconciling retrospective overpayments from CYs 2020, 2021, 2022, 2023, 2024 and 2025, as discussed in section II.C.1.f. of this proposed rule. Section 1895(b)(3)(D)(iii) of the Act gives CMS the authority to make a temporary adjustment in a time and manner appropriate through notice and comment rulemaking.

We considered not proposing implementing a temporary adjustment. However, due to the growing temporary adjustment amount calculated from CYs 2020 through 2025, to delay the implementation of a temporary adjustment would lead to many more years of reductions to the payment rate to reach budget neutrality. Another alternative would be to apply a temporary adjustment factor to the CY 2027 payment rate that would recoup the full calculated temporary adjustment dollar amount, to date, of $4.9 billion. However, we believe that applying a temporary adjustment factor accounting for the temporary adjustment dollar amount of $4.9 billion to the CY 2027 payment rate may adversely affect HHAs given the magnitude of this adjustment to the payment rate in a single year. Although we are not establishing a timeframe to recoup the calculated temporary adjustment dollar amount of $4.9 billion (to date), we believe it is prudent to continue implementing an adjustment to account for some of this amount to slow its continued growth. Postponing any collection of this large dollar amount would lead to an extended duration of temporary adjustments or larger reductions to the payment rates in future years to reach budget neutrality sooner.

Therefore, we believe it is best to propose implementing a temporary adjustment decrease of 3.0 percent to the CY 2027 base payment rate.

2. HH QRP

With regard to the proposal to revise the HH QRP assessment data submission deadline from 4.5 months to no later than the 15th day of the second month after the end of each quarter, we considered keeping the deadline unchanged. We determined that the revised timeframe is a reasonable amount of time for HHAs to submit data and make any necessary corrections, and that the benefits of this shortened timeframe include making the data timelier and more actionable which increases the value of publicly reported data both for consumers and their families and for HHAs to use in their quality improvement activities.

With regard to the proposal to revise the HH QRP OASIS and HHCAHPs annual payment update (APU) reporting timeframe to report a calendar year of data (January 1 through December 31), we believe this update will provide clarity to HH payment updates and facilitate the alignment of the HH QRP pay-for-reporting policies with other HH payment policies without adding burden to providers.

3. Provider Enrollment

There were two principal alternatives we considered. First, we considered retaining the existing prospective effective dates for some of our revocation grounds. However, as explained in section V.C. of this proposed rule, we do not believe that providers are entitled to payment for services and items furnished while non-compliant. Second, and in a similar vein, we contemplated adding no more than a few denial grounds as bases for a reapplication bar. Yet because of the concerning provider conduct behind some denials, we believe we must have the discretion to bar such providers from repeatedly attempting to enter Medicare by submitting multiple applications.

4. DMEPOS Competitive Bidding—Country of Origin

We considered having all DMEPOS suppliers submit the country of information for their product at the time they submit a bid for the DMEPOS CBP, instead of first submitting it on day one of their DMEPOS CBP contract, if awarded. However, this would have presented two issues. First, because the purpose is to make the country of origin available to beneficiaries and interested parties on the Supplier Directory, it would be unnecessary to require all bidders to submit this information at the time they submit a bid when only a subset of bidders will ultimately receive a DMEPOS CBP contract (and have its information available on the Supplier Directory). Secondly, we believe it would be unnecessary to require this information at the time of bid submission, approximately 1 year before contracts are awarded, as it would not be used in the bid evaluation process. As a result, we believe it is most appropriate that only contract suppliers be required on a routine basis to submit accurate and up-to-date country of origin information for its products on Form C.

F. Accounting Statement and Table

Consistent with OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/2025/08/CircularA-4.pdf*) in table 38, we have prepared an accounting statement showing the classification of the impacts associated with the provisions of this proposed rule.

TABLE 38: ACCOUNTING STATEMENT

HH PPS (FROM CY 2026 TO CY 2027)		
Category	**Primary Estimate**	
Annualized Monetized Transfers	$420 million	
From Whom To Whom	Federal Government To Medicare HHAs	
PROVIDER ENROLLMENT PROVISIONS (CY 2027)		
Category	**Primary Estimate**	
Annualized Monetized Transfers from New Retroactive Revocation Reasons	-$82 million	
From Whom To Whom	Federal Government To Medicare Providers and Suppliers	
Category	**Primary Estimate**	
Annualized Monetized Transfers for Reactivating Hospices	$1.4 million	
From Whom to Whom	Hospices to State Survey Agencies or Accrediting Organizations	
DMEPOS COVERAGE OF EXTERNAL INFUSION PUMPS (CYs 2027-2031)		
Category	**Primary Estimate**	**Discount Rate**
Annualized Monetized Transfers	-$1.9 million	3%
	-$2.1 million	7%
From Whom To Whom	Federal Government To Beneficiaries	
Category	**Primary Estimate**	**Discount Rate**
Annualized Monetized Transfers	$1.22 million	3%
	$1.34 million	7%
From Whom To Whom	From Beneficiaries To DME and Home Infusion Suppliers	

G. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. In addition, HHAs are small entities, as that is the term used in the RFA. Individuals and States are not included in the definition of a small entity.

The North American Industry Classification System (NAICS) was adopted in 1997 and is the current standard used by the Federal statistical agencies related to the U.S. business economy. We utilized the NAICS U.S. industry title ''Home Health Care Services'' and corresponding NAICS code 621610 in determining impacts for small entities. The NAICS code 621610 has a size standard of 19 million [42] and approximately 96 percent of HHAs are considered small entities. We estimate that almost all home infusion therapy suppliers are, similarly, small entities. Table 39 shows the number of firms, revenue, and average revenue per firm for the home health care services category (NAICS 621610). Table 40 shows the number of nonemployer establishments, total, and average revenue per nonemployer establishment.

[42] *https://www.sba.gov/sites/sbagov/files/2023-03/Table%20of%20Size%20Standards_Effective%20March%2017%2C%202023.xlsx.*

TABLE 39: NUMBER OF FIRMS, REVENUE, AND AVERAGE REVENUE PER FIRM OF HOME HEALTH CARE SERVICES FOR NAICS CODE 621610

NAICS	NAICS Description	Enterprise Size ($1,000)	Number of Firms	Receipts ($1,000)	Average Receipts Per Firm ($1,000)
621610	Home Health Care Services	<100	6,361	232,967	$37
621610	Home Health Care Services	100-499	7,099	1,869,713	$263
621610	Home Health Care Services	500-999	3,866	2,829,374	$732
621610	Home Health Care Services	1,000-2,499	5,218	8,370,496	$1,604
621610	Home Health Care Services	2,500-4,999	2,560	8,833,076	$3,450
621610	Home Health Care Services	5,000-7,499	885	5,275,636	$5,961
621610	Home Health Care Services	7,500-9,999	450	3,789,016	$8,420
621610	Home Health Care Services	10,000-14,999	466	5,256,982	$11,281
621610	Home Health Care Services	15,000-19,999	235	3,621,448	$15,410
621610	Home Health Care Services	>20,000	1,058	73,271,709	$69,255
621610	Home Health Care Services	Total	28,198	113,350,417	$4,020

Source: Data obtained from United States Census Bureau table "us_6digitnaics_rcptsize_2022" (SOURCE: 2022 SUSB Annual Data Tables by Establishment Industry) Release Date: 4/10/2025: *https://www2.census.gov/programs-surveys/susb/tables/2022/us_6digitnaics_rcptsize_2022.xlsx.*

Notes: The 'Average Receipts Per Firm' column is calculated as the Receipts ($1,000)/Number of firms. The 'Total' row represents all the home health care services firms under NAICS 621610. Overall receipts (revenue) for the 28,198 firms (NAICS 621610) are approximately $113 billion.

TABLE 40: NUMBER, TOTAL, AND AVERAGE REVENUE OF NONEMPLOYER ESTABLISHMENTS OF HOME HEALTH CARE SERVICES BY NAICS CODE 621610

NAICS	NAICS Description	Establishments With Sales, Value of Shipments, or Revenue Size of Establishments Code	Number of Nonemployer Establishments	Total Nonemployer Sales, Value of Shipments, Or Revenue ($1,000)	Average Revenue Per Nonemployer Establishment ($1,000)
621610	Home Health Care Services	All Establishments	412,098	9,525,542	**$23.115**

Source: Data obtained from United States Census Bureau table title "All Sectors: Nonemployer Statistics by Legal Form of Organization and Receipts Size Class for the U.S., States, and Selected Geographies: 2023" (SOURCE: U.S. Census Bureau, 2023 Economic Surveys) Release Date: 05/15/2025: https://data.census.gov/table?q=NONEMP2023.NS2300NONEMP&codeset=naics~62161

Notes: Estimated average revenue is calculated as Total Nonemployer Sales, Value of Shipments, or Revenue ($1,000)/Number of Nonemployer Establishments. For the total, this is the average estimated impact across all number of firms.

The economic impact assessment is based on estimated Medicare payments (revenues) and HHS's practice in interpreting the RFA is to consider effects economically ''significant'' only if greater than 5 percent of providers reach a threshold of 3 to 5 percent or more of total revenue or total costs. The majority of HHAs' visits are Medicare paid visits and therefore the majority of HHAs' revenue consists of Medicare payments. Based on our analysis, we conclude that the policies proposed in this rule would result in an estimated total impact of 3 to 5 percent or more on Medicare revenue for greater than 5 percent of HHAs. Therefore, the Secretary has determined that the payment policies in this proposed HH PPS rule would have a significant positive economic impact on a substantial number of small entities.

Specifically, we estimate that the net impact of the payment policies in this proposed rule would be a positive 2.4 percent impact in the aggregate for CY 2027 or approximately $420 million. As discussed in the preamble, the net increase in CY 2027 is mostly driven by the impact of the proposed CY 2027 home health payment update percentage and proposed updated FDL. Table 36 details the total percentage payment increase by number of 30-day periods and impact by facility type, size, and location. As shown in table 36, when examining the distribution of projected payment impacts across individual agency groups, a substantial share of HHAs are projected to receive a payment increase of 3 percent or more. For example, agencies in the New England (299 agencies, 3.0 percent), Mid-Atlantic (360 agencies, 3.6 percent), Pacific (2,880 agencies, 3.0 percent), and outlying (44 agencies, 3.6 percent) census regions alone account for approximately 3,583 agencies. This represents roughly 36 percent of all 9,975 HHAs which are each projected to receive a total payment impact of at least 3.0 percent. Additional groups projected to receive impacts of 3 percent or more include free-standing/other government (97 agencies, 3.4 percent), facility-based proprietary (20 agencies, 3.4 percent), facility-based government (159 agencies, 3.7 percent), and several rural and urban facility subcategories. Collectively, these groups confirm that more than 5 percent of HHAs are projected to experience a payment impact of 3 percent or more. We estimate that smaller HHAs (those with less than 100 periods of care and thereby lower overall revenues) would

receive a 2.9 percent payment impact in CY 2027. Also, we estimate that larger HHAs (those with more than 1,000 periods of care and thereby higher overall revenues) would receive a 2.3 percent payment impact in CY 2027. We estimate that HHAs located in the Mid-Atlantic and outlying regions would receive the largest impact reflecting a 3.6 percent payment impact. The East South Central and West South Central region would receive the lowest impact reflecting a 1.7 percent increase.

In summary, the payment policies in this proposed rule would increase Medicare payments to home health agencies, with small agencies receiving a slightly larger percentage increase than large ones. We solicit comments on this RFA analysis on small entities.

Regarding options for regulatory relief, we note that section 1895(b)(3)(D)(i) of the Act requires CMS to annually determine the impact of differences between the assumed behavior changes finalized in the CY 2019 HH PPS final rule with comment period (83 FR 56455) and actual behavior changes on estimated aggregate expenditures under the HH PPS with respect to years beginning with 2020 and ending with 2026. Additionally, section 1895(b)(3)(D)(ii) and (iii) of the Act requires us to make permanent and temporary adjustments to the payment rate to offset for such increases or decreases in estimated aggregate expenditures through notice and comment rulemaking.While our analysis of claims suggests that the majority of the behavior change related to the implementation of the PDGM occurred in CYs 2020 through 2022 and that the behavior change observed in CYs 2023 through 2025 is related to factors other than the implementation of the PDGM, we determined that it was not necessary to propose implementing a permanent adjustment because we do not consider behavior changes directly attributed to the implementation of PDGM We include the calculations described in section II.C.1.f. of this proposed rule to illustrate the impact of differences between the assumed behavior changes and actual behavior changes if such behaviors were attributable to the implementation of the PDGM. We note that the law requires us to annually calculate the impact of differences between the assumed behavior changes and actual behavior changes through 2026 claims. We will also continue to reprice claims, per the finalized methodology, and make any additional adjustments at a time and manner deemed appropriate in future rulemaking.

As discussed previously in the Alternatives Considered section of this proposed rule, we explored alternatives to the proposed 3.0 percent temporary adjustment including proposing a temporary adjustment factor to the CY 2027 payment rate that would recoup the full calculated temporary adjustment dollar amount, to date, of $4.9 billion. However, we believe that applying a temporary adjustment factor accounting for the temporary adjustment dollar amount of $4.9 billion to the CY 2027 payment rate may adversely affect HHAs given the magnitude of this adjustment to the payment rate in a single year. We solicit comments on the overall HH PPS RFA analysis.

This rule does not affect health care enterprises operated by small government entities such as counties or towns with populations 50,000 or less. HHS generally uses a revenue impact of 3 to 5 percent as a significance threshold under the RFA. The RFA threshold analysis, therefore, indicates that there is not a significant economic impact on a substantial number of small entities. Furthermore, the regulation review costs mentioned previously, is de minimis and will not impose any additional burden on these small businesses. The statement of need for the various proposed policies in this rule is discussed in section VII.A. of the proposed rule. Additionally, the alternatives considered for the various proposed policies in this rule are discussed in section VII.E. of the proposed rule. We considered potential alternatives for the policies proposed in this rule, including routine technical rate-setting updates and temporary adjustment. The home health payment update percentage is established annually in accordance with existing statutory requirements of section 1895(b) of the Act. We maintain that limiting the application of the permanent adjustment to analysis of data from CYs 2020 through 2022 continues to be the most accurate application of the law. The data continues to show minimal changes that could be attributed to the PDGM implementation after CY 2022 by a large proportion of home health providers. We also continue to acknowledge the difficulty in attributing any behavior change occurring from CYs 2023 through 2025 directly to the PDGM implementation and its effects on expenditures from the other changes occurring in those years. After completing the analysis required by law, we determined that it was not necessary to apply a permanent adjustment. For the temporary adjustment, we explored alternatives to delay, reduce, or increase the temporary adjustments; however, this would delay progress on the BBA of 2018 requirement and may adversely affect HHAs if reductions to the payment rate are too high in a single year. The proposed policy is expected to increase revenue for small HHAs. Therefore, the Secretary has determined that this proposed HH PPS rule would have a significant positive economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area for Medicare payment regulations and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined, and the Secretary certifies, that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. Since this regulation does not impose any costs on State or local governments, the requirements of Executive Order 13132 are not applicable.

H. Unfunded Mandates Reform Act (UMRA)

Section 202 of UMRA of 1995 UMRA also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2026, that threshold is approximately $193 million. This proposed rule would not impose a mandate that will result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of more than $193 million in any 1 year.

I. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct

requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. We have reviewed this proposed rule under these criteria of Executive Order 13132 and have determined that it would not impose substantial direct costs on State or local governments.

J. Unleashing Prosperity Through Deregulation

Executive Order 14192, titled ''Unleashing Prosperity Through Deregulation'' was issued on January 31, 2025, and requires that ''any new incremental costs associated with new regulations shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least 10 prior regulations''

K. Conclusion

In conclusion, we estimate that the provisions in this proposed rule would result in an estimated net increase in home health payments of 2.4 percent for CY 2027 ($420 million). The $420 million increase in estimated payments for CY 2027 reflects the effects of the proposed CY 2027 home health payment update percentage increase of 2.1 percent ($370 million increase), and an estimated 0.3 percent increase that reflects the effects of an updated FDL ($50 million).

VII. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on July 1, 2026.

List of Subjects

42 CFR Part 405

Administrative practice and procedure, Diseases, Health facilities, Health professions, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Diseases, Health facilities, Health professions, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 414

Administrative practice and procedure, Biologics, Diseases, Drugs, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 422

Administrative practice and procedure, Health facilities, Health maintenance organizations (HMO), Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 423

Administrative practice and procedure, Emergency medical services, Health facilities, Health maintenance organizations (HMO), Health professionals, Incorporation by reference, Medicare, Penalties, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 484

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR parts 405, 410, 414, 422, 423, 424, 484, and 498 as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ X. The authority for part 405 continues to read as follows:

Authority: 42 U.S.C. 263a, 405(a), 1302, 1320b–12, 1395x, 1395y(a), 1395ff, 1395hh, 1395kk, 1395rr, and 1395ww(k).

§ 405.400 [Amended]

■ X. Section 405.400 is amended in the definition of ''opt-out period'' by removing the phrase ''the date the affidavit is signed'' and adding in its place the phrase ''the date the first submitted affidavit is signed''.

§ 405.450 [Amended]

■ X. Section 405.450 is amended in paragraph (a) by removing the phrase ''renew opt-out'' and adding in its place the phrase ''cancel automatic renewal''.

§ 405.800 [Amended]

■ X. Section 405.800 is amended by removing the term ''certified mail'' and adding in its place the phrase ''certified mail or email'' in paragraphs (a), (b)(1), and (c)(1).

■ X. Section 405.809 is amended as follows:

■ a. Revising the section heading and paragraph (a)(1);

■ b. In paragraph (a)(2), removing the term ''revocation'' and adding in its place the phrase ''denial or revocation'';

■ c. In paragraph (b)(1) introductory text, removing the term ''Reinstates'' and adding in its place the phrase ''Approves or reinstates'';

■ d. Revising paragraph (b)(1)(i);

■ e. In paragraph (b)(1)(ii), removing the term ''reinstatement'' and adding in its place the phrase ''approval or reinstatement'';

■ f. In paragraph (b)(2), removing the term ''reinstate'' and adding in its place the phrase ''approve or reinstate''.

The revisions are as follows:

§ 405.809 Granting or reinstatement of provider or supplier billing privileges following corrective action.

(a)(1) May only submit a corrective action plan for a denial or revocation for non-compliance under §§ 424.530(a)(1) or 424.535(a)(1) of this chapter; and

* * * * *

(b) * * *

(1) * * *

(i) The effective date of the—

(A) Approval is based on the applicable timeframes described in §§ 424.520 and 424.521; and

(B) Reinstatement is based on the date the provider or supplier is in compliance with all Medicare requirements.

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

Authority: 42 U.S.C. 1302, 1395m, 1395hh, 1395rr, and 1395ddd.

■ X. Section 410.33 is amended by revising paragraph (g)(14)(ii) to read as follows:

§ 410.33 Independent diagnostic testing facility.

* * * * *

(g) * * *

(14) * * *

(ii) Maintain a permanent visible sign in plain view and posts hours of operation. If the IDTF's place of business is located within a building complex, the sign must be visible at the main entrance of the building or the

hours can be posted at the entrance of the IDTF.

* * * * *

■ X. Section 410.38 is amended by adding paragraph (d)(2)(iii) to read as follows:

§ 410.38 Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS): Scope and conditions.

* * * * *

(d) * * *

(2) * * *

(iii)(A) For purposes of § 410.38(d), replacement item means an item identified by the same Healthcare Common Procedure Coding System (HCPCS) code as the original item, that has been—

(*1*) In continuous use by the same beneficiary and is at the end of its reasonable useful lifetime; or

(*2*) Lost, stolen, or irreparably damaged.

(B) Items ordered as replacement items do not require a new face-to-face encounter. All other requirements specified in § 410.38 continue to apply.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

■ X. The authority citation for part 414 continues to read as follows:

Authority: 42 U.S.C. 1302, 1395hh, and 1395rr(b)(l).

■ X. Section 414.202 is amended by revising the definition of ''Durable medical equipment'' to read as follows:

§ 414.202 Definitions.

* * * * *

Durable medical equipment means:

(1) Equipment, furnished by a supplier or a home health agency that meets the following conditions:

(i) Can withstand repeated use.

(ii) Effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years.

(iii) Is primarily and customarily used to serve a medical purpose.

(iv) Generally is not useful to an individual in the absence of an illness or injury.

(v) Is appropriate for use in the home except as provided in paragraph (2) of this definition.

(2) On or after April 1, 2027, an external infusion pump that meets all conditions in paragraphs (1)(i) through (iv) of this definition provided that the following criteria are satisfied:

(i) The prescribing information approved by the FDA for the home infusion drug (as defined in § 486.505) associated with the pump instructs that the drug should be administered by or under the supervision of a health care professional.

(A) The health care professional must be one of the following:

(*1*) A registered nurse licensed to practice nursing in the State in which the home infusion drug is administered.

(*2*) A clinical nurse specialist as defined in section 1861(aa)(5) of the Act.

(*3*) Nurse practitioner as defined in section 1861(aa)(5) of the Act.

(*4*) Physician assistant as defined in section 1861(aa)(5) of the Act.

(*5*) A physician as defined in section 1861(r) of the Act; and

(B) The health care professional must be on site at the home to administer or supervise the administration of the home infusion drug.

(ii) A qualified home infusion therapy supplier (as defined in § 486.505) administers or supervises the administration of the home infusion drug in a safe and effective manner in the patient's home (as defined in § 486.505).

(iii) The prescribing information instructs that the home infusion drug be infused at least 12 times per year (at least once a month)—

(A) Either intravenously or subcutaneously; or

(B) At infusion rates that the Secretary determines would require the use of an external infusion pump.

* * * * *

PART 422—MEDICARE ADVANTAGE PROGRAM

■ X. The authority continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395w–21 through 1395w–28, and 1395hh.

■ X. Section 422.2 is amended by revising paragraph (3) introductory text for the definition of ''Preclusion list'' to read as follows:

§ 422.2 Definitions.

* * * * *

Preclusion list * * *

(3) The individual or entity—or any owner, managing employee, managing organization, officer, or director thereof (as those terms are defined in § 424.502)—regardless of whether they are or were enrolled in Medicare, has been convicted of a felony under Federal or State law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program. Factors that CMS considers in making such a determination under this paragraph (3) are—

* * * * *

PART 423—VOLUNTARY MEDICARE PRESCRIPTION DRUG BENEFIT

■ X. The authority citation continues to read as follows:

Authority: 42 U.S.C. 1302, 1306, 1395w–101 through 1395w–152, and 1395hh.

■ X. Section 423.100 is amended by revising paragraph (3) introductory text for the definition of ''Preclusion list'' to read as follows:

§ 423.100 Definitions.

* * * * *

Preclusion list * * *

(3) The prescriber—or any owner, managing employee, managing organization, officer, or director thereof (as those terms are defined in § 424.502)—regardless of whether they are or were enrolled in Medicare, has been convicted of a felony under Federal or State law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program. Factors that CMS considers in making such a determination under this paragraph (3) are—

* * * * *

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ X. The authority for part 424 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ X. Section 424.58 is amended by—

■ a. Revising paragraph (c)(1)(vii)(D)(*4*);

■ b. In paragraph (c)(1)(xxiii)(D), removing the phrase ''3 business days'' and adding in its place the phrase ''5 calendar days'';

■ c. Redesignating paragraph (c)(1)(xxiii)(N) as paragraph (c)(1)(xxiii)(O); and

■ d. Adding new paragraph (c)(1)(xxiii)(N).

The revision and addition read as follows:

§ 424.58 Accreditation.

* * * * *

(c) * * *

(1) * * *

(vii) * * *

(D) * * *

(4) For notifying CMS when a conflict of interest is discovered. This includes disclosing to CMS all conflicts of interest (as defined in § 424.58(c)(1)(vii)(D)(*5*)) it currently has and explaining how and when it will terminate them.

* * * * *

(xxiii) * * *

(N) Agrees to notify CMS in writing (and, if applicable, notify other law enforcement) of suspected fraud, waste,

or abuse—consistent with the accrediting organization's CMS-approved definitions of those terms per paragraph (c)(1)(xxii) of this section—within 3 calendar days of the date on which the accrediting organization determines that fraud, waste, or abuse may have occurred.

* * * * *

■ X. Section 424.502 is amended by—
■ a. In the definition of ''Affiliation''—
■ i. Republishing the introductory text;
■ ii. Revising paragraph (3); and
■ iii. Adding new paragraph (6);
■ b. In the definition of ''Final adverse action'';
■ i. Republishing the introductory text; and
■ ii. Adding new paragraph (6);
■ c. Revising paragraph (1) of the definition of ''Managing employee''; and
■ d. Revising the definition of ''Operational''

The additions and revisions are as follows:

§ 424.502 Definitions.

* * * * *

Affiliation means, for purposes of applying § 424.519, any of the following:

* * * * *

(3) An interest in which an individual or entity—or any of its owning or managing employees or organizations—exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of this paragraph (3), sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.

* * * * *

(6) Any marketing, business, fulfillment, financial, managerial, or beneficiary relationship

* * * * *

Final adverse action means one or more of the following actions—

* * * * *

(6) *Misdemeanor conviction.* A conviction of a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years preceding enrollment, revalidation or reenrollment.

* * * * *

Managing employee means—

(1) A general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the provider or supplier. For purposes of this definition, this includes not only a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director but also any of the following:

(i) Medical directors other than skilled nursing facility and hospice medical directors.

(ii) Clinical directors.

(iii) Departmental heads (for example, a hospital's chief of cardiology).

(iv) Supervising physicians (not simply those at independent diagnostic testing facilities).

(v) Nursing directors.

(vi) Alternate administrators.

(vii) All other clinical personnel not listed in paragraphs (1)(i) through (vi) of this definition who meet the ''managing employee'' definition.

* * * * *

Operational means (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) the provider or supplier meets all of following requirements:

(1) Has a qualified practice location.

(2) Is open to the public for the purpose of providing health care related services, which includes, but is not limited to, all of the following:

(i) The provider's or supplier's location is fully accessible to all patients and lacks safety hazards. For purposes of this paragraph (2)(i), accessible means—

(A) The provider or supplier is located in an area and a building that patients can enter with reasonable ease; and

(B) The location is compliant with all federal Americans with Disabilities Act regulations and all applicable and equivalent state and local laws.

(ii) The provider's or supplier's hours of business are sufficient to regularly serve patients.

(iii) Medicare beneficiaries can contact and locate the provider's or supplier's location based on publicly available information (for example, the internet).

(3) Is prepared and able to submit valid Medicare claims.

(4) Is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered, to furnish these items or services. This includes, but is not limited to, the following:

(i) Provider or supplier staff must be qualified (such as licensed or certified if required under state law) to perform their health care-related functions.

(ii) Equipment must be functional, appropriate for the services and items the provider or supplier intends to furnish, and in sufficient quantity to provide these items and services.

(iii) Appropriate medications for the services and items the provider or supplier intends to furnish and in sufficient quantity to provide these items and services.

(5) Has adequate written policies and records regarding its operations, such as, but not limited to, procedures for patient care, patient safety, medical and patient recordkeeping, and general administration.

* * * * *

■ X. Section 424.510 is amended by adding paragraph (f) to read as follows:

§ 424.510 Requirements for enrolling in the Medicare program.

* * * * *

(f) *Signage.* (1) The provider or supplier must maintain a permanent visible sign in plain view and post hours of operation. If the provider's or supplier's place of business is located within a building complex, the sign must be visible at the main entrance of the building or the hours can be posted at the entrance of the provider or supplier.

(2) The requirement in paragraph (f)(1) of this section does not apply if the provider or supplier—

(i) Shares office space with another provider or supplier (for example, physicians in a group practice sharing a common suite, though the group itself must have signage);

(ii) Treats patients in the patients' homes;

(iii) Treats patients in the provider's or supplier's home and only uses the provider's or supplier's address for administrative purposes.

(iv) Performs telehealth services from home.

■ X. Section 424.516 is amended by adding paragraph (f)(3) to read as follows:

§ 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare program.

* * * * *

(f) * * *

(3) All documentation required to be retained and furnished under this paragraph (f) must be accurate, complete, and compliant with all CMS requirements.

* * * * *

■ X. Section 424.518 is amended by revising paragraph (c)(2)(ii)(A) to read as follows:

§ 424.518 Screening levels for Medicare providers and suppliers

* * * * *

(c) * * *

(2) * * *

(ii)(A) Using the CMS-designated fingerprinting contractor, requires the submission of a set of fingerprints for a national background check from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier; and

* * * * *

§ 424.519 [Amended]

■ X. Section 424.519 is amended in paragraph (b) by removing the phrase ''has or, within the previous 5 years, had'' and adding in its place the phrase ''has or had''.

■ X. Section 424.530 is amended by—

■ a. Revising paragraph (a)(4); (6)(i), (ii) introductory text, (ii)(A), and (iii) introductory text; (7)(i) and (ii); (13); (14); and (16);

■ b. Adding paragraphs (a)(19) through (22);

■ c. Revising paragraph (f) introductory text;

■ d. Removing paragraphs (f)(2)(i) through (iv); and

■ e. Redesignating paragraphs (f)(3)(i) and (ii) as revised paragraphs (f)(2)(i) and (ii).

The revisions and additions read as follows:

§ 424.530 Denial of enrollment in the Medicare program.

(a) * * *

(4) *False or misleading information.* The provider or supplier submits false or misleading information on or associated with any CMS or Medicare provider enrollment-related form. (Offenders may be referred to the Office of Inspector General for investigation and possible criminal, civil, or administrative sanctions.) This includes but is not limited to:

(i) Enrollment-related forms created by or submitted to CMS contractors;

(ii) Documentation furnished as part of the completion or submission of the CMS or Medicare enrollment-related form.

(iii) Form CMS–588 (Electronic Funds Transfer (EFT) Authorization Agreement; OMB Control Number 0938–0626).

(iv) Documents required to demonstrate compliance with HHA capitalization requirements in § 489.28.

(v) Opt-out affidavits under 42 CFR part 405, subpart D.

(vi) Letters from a provider demonstrating that a particular provider official qualifies as an authorized or delegated official under § 424.502.

(vii) Any other required or requested enrollment-related documentation.

* * * * *

(6) *Medicare debt.* (i) The enrolling provider or supplier—or any owner, managing employee, managing organization, or individual or entity with any other form of business or financial relationship with the provider or supplier (hereafter collectively ''associated party'' for purposes of paragraph (a)(6) of this section)—has an existing Medicare debt.

(ii) The enrolling provider or supplier or associated party thereof was previously an associated party of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated, or revoked, and all of the following criteria are met:

(A) The associated party left the provider or supplier with the Medicare debt within 1 year before or after that provider or supplier's voluntary termination, involuntary termination or revocation.

* * * * *

(iii) A denial of Medicare enrollment under this paragraph (a)(6) of this section can be avoided if the enrolling provider or supplier (or associated party thereof) does either of the following:

* * * * *

(7) *Payment suspension.* (i) The provider or supplier—or any owner, managing employee, managing organization, or individual or entity with any other form of business or financial relationship with the provider or supplier (hereafter collectively ''associated party'' for purposes of paragraph (a)(7) of this section)—is currently under a Medicare or Medicaid payment suspension as defined in §§ 405.370 through 405.372 or in § 455.23 of this chapter.

(ii) CMS may apply this paragraph (a)(7) of this section to the provider or supplier under any of the provider's, supplier's, or associated party's current or former names, numerical identifiers, or business identities or to any of its existing enrollments.

* * * * *

(13) *Affiliation that poses undue risk.* CMS determines that the provider or supplier—or any of its owning or managing employees or organizations—has or has had an affiliation under § 424.519 that poses an undue risk of fraud, waste, or abuse to the Medicare program.

* * * * *

(14) *Other program termination or suspension.* (i) The provider or supplier—or any owner, managing employee, or managing organization thereof—is currently terminated or suspended (or otherwise barred) from participation in a State Medicaid program or any other federal health care program, or the provider's or supplier's license is currently revoked or suspended (or voluntarily surrendered in lieu of further action) in a State other than that in which the provider or supplier is enrolling. In determining whether a denial under this paragraph (a)(14) is appropriate, CMS considers the following factors:

(A) The reason(s) for the termination, suspension, revocation, or surrender.

(B) Whether, as applicable, the provider or supplier—or owner, managing employee, or managing organization thereof—is currently terminated or suspended (or otherwise barred) from more than one program (for example, more than one State's Medicaid program), or has been subject to any other sanctions during its participation in other programs or by any other State licensing boards.

(C) Any other information that CMS deems relevant to its determination.

(ii) CMS may apply paragraph (a)(14)(i) of this section to the provider or supplier under any of the provider's or supplier's—or owner's, managing employee's, or managing organization's—current or former names, numerical identifiers or business identities, and regardless of whether any appeals are pending.

* * * * *

(16) *Misdemeanor conviction.* The provider or supplier—or any owner, managing employee, managing organization, officer, or director thereof—was convicted of a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.

* * * * *

(19) *Same suite.* The provider's or supplier's practice location is in the same suite or office as another provider or supplier whose Medicare enrollment has been revoked or denied under § 424.535 or § 424.530.

(20) *Hospice medical director or administrator.* A hospice's enrollment may be denied if any of the following apply:

(i) The hospice's medical director is either of the following:

(A) The medical director of multiple other hospices.

(B) 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 required under 42 CFR 418.

(ii) The hospice's administrator is either of the following:

(A) The administrator of multiple other hospices.

(B) Located at such a distance from the enrolling hospice that the administrator cannot realistically perform all administrator functions required under 42 CFR 418.

(ii) The hospice's medical director does not have an active physician medical license in the State in which they are practicing.

(21) *Misuse of identity.* The provider or supplier is attempting to enroll under another party's identity.

(22) *Change in majority ownership non-compliance.* CMS determines that the HHA, hospice, or DMEPOS supplier has failed to comply with the provisions and requirements of, as applicable, § 424.550(b) or § 424.551.

* * * * *

(f) *Reapplication bar.* CMS may prohibit a prospective provider or supplier from enrolling in Medicare for up to 10 years if their enrollment application is denied for any reason under § 424.530.

* * * * *

■ X. Section 424.535 is amended by—

■ a. Revising paragraph (a)(4);

■ b. Revising paragraph (a)(8)(ii) introductory text;

■ c. Removing paragraphs (a)(8)(ii)(A) through (D) and (a)(8)(iii);

■ d. Revising paragraph (a)(16);

■ e. Revising paragraph (a)(19);

■ f. Adding paragraphs (a)(24) and (25).

■ g. Revising paragraph (g)(1);

■ h. Removing paragraph (g)(3);

■ i. Redesignating paragraph (g)(3) as (g)(2);

■ j. Revising paragraphs (h)(1)(i) and (ii).

■ k. Revising paragraph (i)(1).

The revisions and additions read as follows:

§ 424.535 Revocation of enrollment in the Medicare program.

* * * * *

(a) * * *

(4) *False or misleading information.* The provider or supplier submits false or misleading information on or associated with any CMS or Medicare provider enrollment-related form. (Offenders may be referred to the Office of Inspector General for investigation and possible criminal, civil, or administrative sanctions.) This includes but is not limited to—

(i) Forms created by and/or submitted to CMS contractors.

(ii) Documentation furnished as part of the completion or submission of the CMS or Medicare enrollment-related form.

(iii) Form CMS–588 (Electronic Funds Transfer (EFT) Authorization Agreement; OMB Control Number 0938–0626), which must be submitted with the enrollment application.

(iv) Documents required to demonstrate compliance with HHA capitalization requirements in § 489.28.

(v) Opt-out affidavits under 42 CFR part 405, subpart D.

(vi) Letters from a provider demonstrating that a particular provider official qualifies as an authorized or delegated official under § 424.502.

(vii) Any other required or requested enrollment-related documentation.

* * * * *

(8) * * *

(ii) CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

* * * * *

(16) *Misdemeanor conviction.* The provider or supplier—or any owner, managing employee, managing organization, officer, or director thereof—was convicted of a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.

* * * * *

(19) *Affiliation that poses undue risk.* CMS determines that the provider or supplier—or any of its owning or managing employees or organizations—has or has had an affiliation under § 424.519 that poses an undue risk of fraud, waste, or abuse to the Medicare program.

* * * * *

(24) *High-risk based on excess providers in area.* CMS determines that the provider's or supplier's enrollment presents 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.

(25) *Change in majority ownership non-compliance.*—CMS determines that the HHA, hospice, or DMEPOS supplier did not comply with the provisions and requirements of, as applicable, § 424.550(b) or § 424.551.

* * * * *

(g)(1) Except as described in paragraph (g)(2) of this section, the effective dates of the revocations identified in this section are as follows:

(i) For revocations under paragraph (a)(1) of this section:

(A) If the revocation is based on non-compliance with the enrollment requirements in Title 42 or in the enrollment application applicable to the provider or supplier type, the date the non-compliance began (per CMS' or the CMS contractor's determination).

(B) If the revocation is based on a State license revocation, suspension, or surrender in lieu of further disciplinary action, the date of the license revocation, suspension, or surrender.

(C) For revocations based on termination of a provider agreement under part 489 of this chapter, and as applicable to the type of provider involved, the later of—

(*1*) The date of the provider agreement termination; or

(*2*) The date that CMS establishes under § 489.55.

(ii) For revocations under paragraph (a)(2) of this section, the date of the exclusion or debarment.

(iii) For revocations under paragraph (a)(3) of this section, the date of the felony conviction.

(iv) For revocations under paragraph (a)(4) of this section, and as applicable to the situation, the date the certification statement was signed or the false or misleading information was submitted.

(v)(A) For revocations under paragraph (a)(5)(i) of this section, the date on which the provider's or supplier's practice location was no longer operational (per CMS' or the CMS contractor's determination).

(B) For revocations under paragraph (a)(5)(ii) of this section, the date the Medicare enrollment requirement was not satisfied.

(vi) For revocations under paragraph (a)(6) of this section, the date on which CMS or its contractor determines that the provider or supplier should be revoked under paragraph (a)(6).

(vii) For revocations under paragraph (a)(7) of this section, the date on which the conduct resulting in the revocation occurred.

(viii)(A) For revocations under paragraph (a)(8)(i) of this section, the earliest date of service on the claim or claims that is or are triggering the revocation.

(B) For revocations under paragraph (a)(8)(ii) of this section, the last date of service on the claims in the applicable pattern or practice.

(ix) For revocations under paragraph (a)(9) of this section, the day following the date by which the provider or supplier was required to report the applicable change, addition, or deletion.

(x)(A) For revocations under paragraph (a)(10) of this section based on a failure to retain documentation, the date on which CMS or the CMS contractor determines that the provider or supplier has not complied with this retention requirement.

(B) For revocations under paragraph (a)(10) of this section based on a failure to provide access to the documentation, the day after the date by which the provider or supplier was required to furnish access.

(xi) For revocations under paragraph (a)(11) of this section, the day after the date by which the HHA was required to submit the requested documentation.

(xii) For revocations under paragraph (a)(12) of this section, the date of the termination, revocation, or bar.

(xiii)(A) For revocations under paragraph (a)(13)(i) of this section, the date of the certificate revocation, suspension, or surrender.

(B) For revocations under paragraph (a)(13)(ii) of this section, the date of the revocation or suspension of the ability to prescribe.

(xiv) For revocations under paragraph (a)(14) of this section, the date of the last prescription in the applicable pattern or practice.

(xv) For revocations under paragraph (a)(15) of this section, the date of the judgment.

(xvi) For revocations under paragraph (a)(16) of this section, the date of the conviction.

(xvii) For revocations under paragraph (a)(17) of this section, the date on which CMS referred the debt to the Department of Treasury.

(xviii) For revocations under paragraph (a)(18) of this section, the effective date of the provider's or supplier's current enrollment.

(xix) For revocations under paragraph (a)(19) of this section, the date on which CMS or its contractor determines that the provider or supplier should be revoked under this paragraph.

(xx) For revocations under paragraph (a)(20) of this section, the earliest date on the claims for the non-compliant location that are triggering the revocation.

(xxi) For revocations under paragraph (a)(21) of this section, the date of the last order, certification, referral, or prescription in the applicable pattern or practice.

(xxii) For revocations under paragraph (a)(22) of this section, the date of the prior action resulting in the revocation.

(xxiii)(A) For revocations under paragraph (a)(23) of this section—

(*1*) If the standard or condition violation involves the suspension, revocation, or termination (or surrender in lieu of further disciplinary action) of the provider's or supplier's Federal or State license, certification, accreditation, or MDPP recognition, the effective date is the date of the license, certification, accreditation, or MDPP recognition suspension, revocation, termination, or surrender.

(*2*) If the standard or condition violation involves a non-operational practice location, the effective date is the date the non-operational status began (per CMS' or the CMS contractor's determination).

(*3*) If the standard violation involves a felony conviction of an individual or entity described in § 424.67(b)(6)(i), the effective date is the date of the felony conviction.

(B) For all other revocations under paragraph (a)(23) of this section based on a condition or standard violation, the effective date is the date of non-compliance with the condition or standard.

(xxiv) For revocations under paragraph (a)(24) of this section, the date on which CMS or its contractor determines that the provider or supplier should be revoked under paragraph (a)(24).

(xxv) For revocations under paragraph (a)(25) of this section, the date on which CMS or its contractor determines that the provider or supplier should be revoked under paragraph (a)(25).

(xxvi) For revocations under paragraph (i) of this section, the effective date of the revocation (or date of the denial) that triggered the revocation(s) of the other enrollment(s).

* * * * *

(h)(1)(i) Except for HHAs as described in paragraph (h)(1)(ii) of this section, a revoked provider or supplier must, within 15 calendar days of the date of the revocation letter, submit all claims for items and services furnished before the date of the effective date of the revocation.

(ii) A revoked HHA must, within 15 calendar days of the date of the revocation letter, submit all claims for items and services furnished before the later of the following:

* * * * *

(i) * * *

(1) If a provider's or supplier's Medicare enrollment is revoked under paragraph (a) of this section or denied under § 424.530, CMS may revoke any and all of the provider's or supplier's Medicare enrollments, including those under different names, numerical identifiers or business identities and those under different types.

* * * * *

■ X. Section 424.540 is amended by—

■ a. In paragraph (b)(3)(i), removing the term ''HHA'' and adding in its place the phrase ''HHA or hospice''; and

■ b. Adding paragraph (d)(3).

The addition reads as follows:

§ 424.540 Deactivation of Medicare billing privileges.

* * * * *

(d) * * *

(3) A provider or supplier may rebut their assigned reactivation effective date via the procedures in § 424.546.

* * * * *

■ X. Section 424.545 is amended by revising paragraph (b) to read as follows:

§ 424.545 Provider and supplier appeal rights

* * * * *

(b) A provider or supplier whose billing privileges are deactivated or has been assigned a reactivation effective date may file a rebuttal in accordance with § 424.546 of this chapter.

* * * * *

■ X. Section 424.546 would be amended as follows:

■ a. Revising the section heading, and paragraphs (a)(1) and (b)(2);

■ d. In paragraph (b)(3), removing the term ''deactivation'' and adding in its place the phrase ''deactivation or reactivation effective date''; and

■ e. Revising paragraph (d).

The revisions read as follows:

§ 424.546 Rebuttals of deactivations and of reactivation effective dates.

(a)(1) If a provider or supplier receives written notice from CMS or its contractor that the provider's or supplier's billing privileges are to be or have been deactivated under § 424.540 or is assigned a reactivation effective date by CMS or its contractor under § 424.540(d)(2), the provider or supplier has 15 calendar days from the date of the written notice to submit a rebuttal to CMS as permitted under § 424.545(b).

* * * * *

(b) * * *

(2) Specify the facts or issues about which the provider or supplier disagrees with the deactivation's imposition and/or the effective date (or with the assigned reactivation effective date), and the reasons for disagreement.

* * * * *

(d) Upon receipt of a timely and compliant deactivation (or reactivation effective date) rebuttal, CMS reviews the rebuttal to determine whether the imposition of the deactivation and/or the designated effective date (or the assigned reactivation effective date) are correct.

* * * * *

■ X. Section 424.570 is amended as follows:

■ a. Revising paragraphs (a)(1)(i) and(1)(iii)(C);

■ b. Redesignating paragraph (a)(1)(iv) as paragraph (a)(1)(iv)(A).

■ c. Adding paragraph (a)(1)(iv)(B).

The revisions and addition read as follows:

§ 424.570 Moratoria on newly enrolling Medicare providers and suppliers.

(a) * * *

(1) * * *

(i) CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. Solely for purposes of this section, the term ''new'' means any of the following application types:

(A) Initial enrollment applications.

(B) Change of ownership applications that require an initial enrollment per § 424.570(a)(1)(iii)(C).

(C) Enrollment applications from revoked providers or suppliers whose reenrollment bars under § 424.535(c) have expired and are seeking to enroll again in the Medicare program.

(D) Reactivation applications.

(E) Enrollment applications from voluntarily terminated providers/suppliers seeking to enroll again in the Medicare program.

* * * * *

(iii) * * *

(C) Changes in ownership (except changes in ownership that require an initial enrollment, such as, but not limited to, an HHA, hospice, or DMEPOS supplier change in majority ownership under § 424.550(b) or § 424.551).

(iv)(A) A temporary moratorium does not apply to any enrollment application that has been received by the Medicare contractor prior to the date the moratorium is imposed.

(B) The date the moratorium is imposed is the moratorium's effective date, which is the date on which the moratorium notice is filed for public inspection at the Office of the Federal Register (OFR).

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PART 484—HOME HEALTH SERVICES

■ X. The authority citation for part 484 continues to read as follows:

Authority: 42 U.S.C. 1302 and 1395hh.

■ X. Section 484.245 is amended by—

■ a. In paragraph (b)(2)(ii)(A), removing the parenthetical phrase ''(July 1 through June 30)'' and adding in its place the parenthetical phrase ''(January 1 through December 31)'';

■ b. In paragraph (d)(1)(i), removing the phrase ''a letter of noncompliance'' and adding in its place the phrase ''receive notification of non-compliance'';

■ c. In paragraph (d)(2) introductory text, removing the hyperlink ''*HHAPureConsiderations@cms.hhs.gov*'' and adding in its place the hyperlink ''*HHAPUReconsiderations@cms.hhs.gov*'';

■ d. In paragraph (d)(2)(v), removing the phrase ''non-compliance letter'' and adding in its place the phrase ''non-compliance notification''; and

■ e. Revising paragraph (d)(4)(i);

The revision reads as follows:

§ 484.245 Requirements under the Home Health Quality Reporting Program (HH QRP).

* * * * *

(d) * * *

(4)(i) CMS notifies the HHA of its final decision regarding any reconsideration request through a CMS designated data submission system.

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PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/IID AND CERTAIN NFs IN THE MEDICAID PROGRAM

■ X. The authority for part 498 continues to read as follows:

Authority: 42 U.S.C. 1302, 1320a–7j, and 1395hh.

§ 498.3 [Amended]

■ X. Section 498.3 is amended in paragraph (b)(19) by removing the term ''renew opt-out'' and add in its place the phrase ''cancel automatic renewal''.

§ 498.20 [Amended]

■ X. Section 498.20 is amended in paragraph (a)(1) by removing the term ''mails'' and add in its place the phrase ''mails or emails''.

§ 498.25 [Amended]

■ X. Section 498.25 is amended by revising paragraph (a)(1) to remove the term ''mails'' and add in its place the phrase ''mails or emails''.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2026–13602 Filed 7–1–26; 4:15 pm]

BILLING CODE 4169–69–P