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 (CMS-1844-P) Proposed Rule Summary

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I. Introduction

On July 6, 2026, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register (91 FR 41216) a proposed rule that updates the payment rates for home health agencies (HHAs) for calendar year 2027.[1] This rule also proposes several provider enrollment provisions including retroactive revocations and adding or expanding the ground for revocation or denial of enrollment that would provide the agency with broader authority. It also includes several proposals related to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). These include a proposal to amend the definition of DME based on statutory

[1] Henceforth in this document, a year is a calendar year unless otherwise specified.

requirements, that would expand coverage under the DME benefit to certain external infusion pumps and associated home infusion drugs that would be considered appropriate for home use if certain criteria are met. CMS also proposes a temporary one-year adjustment to the 2027 home health payment rate of 3.0 percent to account for the impact of the implementation of the Patient-Driven Groupings Model (PDGM).[2] In addition, this proposed rule provides information on home health utilization trends to monitor the effect of the PDGM.

For the Home Health Quality Reporting Program (HH QRP), CMS summarizes (but does not seek comment on) potential initiatives it has identified as opportunities to improve alignment between the HH QRP and the expanded Home Health Value-Based Purchasing (HHVBP) Model. In addition, CMS proposes reducing the HH QRP assessment data submission timeframe and revising the HH QRP Outcome and Assessment Information Set (OASIS) and HHCAHPS Annual Payment Update (APU) reporting timeframes to report a calendar year of data.[3] CMS also solicits comment on a request for information (RFI) on future measure concepts specifically related to advanced care planning. CMS is not proposing any expanded HHVBP Model-specific policy changes in this proposed rule.

CMS estimates that the net impact of the proposed home health policies would increase Medicare payments to HHAs in 2027 by 2.4 percent (+$420 million). This increase reflects the effects of the proposed +2.1 percent home health payment update and an estimated +0.3 percent increase from the update to the fixed-dollar loss ratio (FDL) used in determining outlier payments.

The deadline for public comment is August 31, 2026.

II. Home Health Prospective Payment System

A. Overview

CMS reviews the statutory and regulatory history of the HH PPS from 1997. As required by the Bipartisan Budget Act of 2018 (BBA of 2018) on January 1, 2020, CMS implemented the home health Patient Driven Groupings Model (PDGM) and a 30-day unit of payment. In 2024, as required by the Consolidated Appropriations Act, 2023 (CAA, 2023), CMS established separate payment for furnishing negative pressure wound therapy (NPWT) for the device (not for nursing and therapy services as these are already included under the HH PPS).

Medicare makes payment under the HH PPS based on a national, standardized 30-day period payment rate that is adjusted for the applicable case-mix and wage index. The national, standardized 30-day period rate includes the six home health disciplines: skilled nursing (SN), home health aide, physical therapy (PT), speech-language pathology (SLP), occupational therapy (OT), and medical social services (MSS). Payment for non-routine supplies (NRS), previously paid through a separate adjustment, are now part of the national, standardized 30-day period rate.

[2] The aggregate impact of the proposed temporary payment adjustment equals zero percent because both the 2026 and 2027 payments rates would include a 3.0 percent temporary adjustment (thus, no change from prior year). CMS did not propose a permanent adjustment.
[3] HHCAHPS refers to the Home Health Care Consumer Assessment of Healthcare Providers and Systems Survey.

Durable medical equipment provided as a home health service is not included in the national, standardized 30-day period payment. The 30-day period payment rate does not include payment for certain injectable osteoporosis drugs and NPWT using a disposable device; these drugs and services must be billed by the HHA while a patient is under a home health plan of care.

The PDGM is a patient case-mix adjustment methodology that shifts the focus from volume of services to a model that relies more on patient characteristics. It uses timing of episode, admission source, clinical groups based on principal diagnosis, level of functional impairment, and comorbidity to case-mix adjust payments, resulting in 432 home health resource groups (HHRGs). Patient characteristics and other clinical information are drawn from Medicare claims and the Outcome and Assessment Information Set (OASIS). Each HHRG has an associated case-mix weight that is used in calculating the payment for a 30-day period of care.

For low-utilization episodes, HHAs are paid national per-visit rates based on the discipline(s) providing the services; this payment adjustment is referred to as a low-utilization payment adjustment (LUPA). The national, standardized 30-day episode payment rate is also adjusted for certain intervening events that are subject to a partial episode payment (PEP) adjustment. In addition, an outlier adjustment may be available for certain cases that exceed a specific cost threshold.

B. Monitoring the Effects of the Implementation of PDGM

1. Routine PDGM Monitoring

Section 1895(b)(3)(D) of the Act requires CMS to annually determine the impact of assumed versus actual behavioral changes on aggregate expenditures under the HH PPS for 2020 through 2026. Analysis for routine monitoring may include analyzing overall total 30-day periods of care and average periods of care per HHA user; the distribution of visits in a 30-day period of care; the percentage of periods that receive a LUPA; the percentage of 30-day periods of care by clinical group, comorbidity adjustment, admission source, timing, and functional impairment level; and the proportion of 30-day periods of care with and without any therapy visits.

In this proposed rule, CMS examines simulated data for 2018 and 2019 and actual data for 2020, 2021, 2022, 2023, 2024 and 2025 for 30-day periods of care. CMS refers readers to the 2022 HH PPS final rule[4] for a discussion about the simulated data for 2018 and 2019.

a. Utilization

Tables 2, 3, and 4 in the proposed rule provide data on trends in utilization from 2018 to 2025.

- Table 2 shows the overall utilization of home health services, which shows declines in 30-day periods of care and unique beneficiaries. For example, the total number of 30-day periods of care decreased by 17.6% from 9.34 million to 7.7 million from 2018 to 2025.
- Table 3 shows the average utilization of visits per 30-day period of care by home health discipline over time. Average utilization of visits per 30 days across all disciplines

[4] 86 FR 35881

decreased 21.2% from 9.86 to 7.77. Each home health discipline (i.e., skilled nursing, physical therapy, occupational therapy, speech therapy, home health aide, social worker) showed a decrease from 2018 to 2025.

- 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 average number of LUPA home health visits for skilled nursing declined from 1.15 to 0.98, while physical therapy increased from 0.43 to 0.52 during this period. Trends for occupational therapy, speech therapy, home health aide, and social worker remained about the same.

Table 2: Overall Utilization of Home Health Services, 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 (in millions)	9.34	8.74	8.42	9.27	8.59	8.32	8.28	7.72
Unique Beneficiaries (in millions)	2.98	2.80	2.85	3.02	2.83	2.72	2.66	2.50
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 payment adjustments, 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, 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	3.30	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 and Note: Same as Table 2.

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	6.7%	6.8%	8.7%	7.9%	7.8%	6.9%	6.9%	6.6%

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**
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	**1.69**	**1.71**	**1.84**	**1.79**	**1.81**	**1.61**	**1.63**	**1.62**
Source and Note: Same as Table 2.								

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

CMS examined 2024 HHA Medicare cost reports (the most recent and complete cost report data available) and 2025 30-day period of care home health claims, to estimate 30-day period of care costs. CMS excluded LUPAs and visits with PEPs in the average number of visits. The 2024 average NRS cost per visit is $4.89. CMS updated the estimated 30-day period of care costs, by multiplying the 2024 average costs per visit with NRS for each discipline by the 2025 home health payment update percentage of 1.027 percent. The amount for each discipline is then multiplied by the 2025 average number of visits by discipline to determine the 2025 estimated 30-day period costs.

Table 5, reproduced below, shows the estimated average costs for 30-day periods of care by discipline NRS and the total 30-day period of care costs with NRS for 2025.

Table 5: Estimated Costs for 30-Day Periods of Care in CY 2025				
Discipline	**2024 Average Costs per visit**	**2025 Average Number of Visits**	**2025 Market Basket Update Factor**	**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 Aides	$114.27	0.40	1.027	$46.94
Total				**$1,532.84**
Source: 2024 Medicare cost report data obtained during January 2026. Home health visit information came from 30-day periods of care with a through date in CY 2025 (obtained from the CCW VRDC on January 15, 2026). **Note:** The average number of visits in 2025 excludes LUPAs and PEPs.				

CMS notes the 2025 national, standardized 30-day period payment was $2,057.35, which is approximately 34 percent more than the estimated 2025 30-day period average facility cost of $1,532.84. The Medicare Payment Advisory Commission (MedPAC) noted that for more than a

decade, payments under the HH PPS have significantly exceeded HHA's costs because agencies reduced episode costs by reducing the average number of visits per episode.[5]

c. Clinical Groupings and Comorbidities

Each 30-day period of care is grouped into one of 12 clinical groups describing the primary reason patients are receiving home health services. The clinical grouping is based on the principal diagnosis reported on the HH claim. Table 6, reproduced below, 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%
Wounds	14.5%	15.1%	14.2%	13.9%	13.7%	14.0%	14.1%	14.2%

Source: Same as Table 2.

Note: All 30-day periods of care claims were included (e.g., LUPAs, partial payment adjustments, and outliers). MMTA is Medication Management, Teaching, and Assessment.

Thirty-day periods of care receive a comorbidity adjustment based on the presence of certain secondary diagnoses reported on home health claims; the comorbidity adjustment can be a low or a high comorbidity adjustment, or have no comorbidity adjustment.[6] Table 7, reproduced below, shows the distribution of 30-day periods of care by comorbidity adjustment category.

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%	36.9%	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 and Note: Same as Table 2.

[5] Report to Congress, Medicare Payment Policy. Home Health Care Services, Chapter 7. MedPAC. March 2024 https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch7_MedPAC_Report_To_Congress_SEC.pdf

[6] The comorbidity adjustment categories are discussed in the 2020 HH PPS final rule, 84 FR 60493.

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 health care setting was utilized in the 14 days prior to receiving home health care.[7] 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 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 period of care and the start of another. The timing of a 30-day period of care comes from the HH claims data. Table 8, reproduced below, shows the distribution of 30-day periods of care by admission source and timing over time.

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%	63.2%	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 and Note: Same as Table 2.

e. Functional Impairment Level

Each 30-day period of care is placed into a functional level based on responses to certain OASIS functional items associated with grooming, bathing, dressing, ambulating, transferring, and risk for hospitalization.[8,9] The functional impairment level remains the same for the first and second 30-day periods of care unless there has been a significant change in condition that warranted an "other follow-up" assessment prior to the second 30-day period of care. Table 9, reproduced below, shows the distribution of 30-day periods by functional status.

[7] Thirty-day periods of care for beneficiaries with any inpatient acute care hospitalizations, inpatient psychiatric facility stays, skilled nursing facility stays, inpatient rehabilitation facility stays, or long-term care hospital stays within 14 days prior to a HH admission are designated as institutional stays. The institutional source category also includes patients with 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.

[8] The specific OASIS items used for the functional impairment level are listed in Table B7 in the 2020 HH PPS final rule, 84 FR 60490.

[9] A detailed description of these response categories can be found in the technical report, "Overview of the HH Groupings Model" posted on the HHA web page (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM)

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%	23.2%	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 and Note: Same as Table 2.								

f. Therapy Visits

Prior to the implementation of the PDGM, HHAs could receive a payment adjustment based on the number of therapy visits provided during a 60-day episode of care.[10] CMS examined the proportion of simulated 30-day periods with and without any therapy visits. Table 10, reproduced below, shows the proportion of 30-day periods of care for various therapy options. CMS also examined the proportion of 30-day periods of care by the number of therapy visits provided during 30-day periods of care (Figure 2 in proposed rule). CMS' analysis shows modest changes in the distribution of both therapy and non-therapy visits in 2025 compared to 2023 and 2024. The proportion of 30-day periods of care with no therapy (36.6%) has trended downward towards pre-PDGM levels after peaking in 2020 (42.6%). CMS' comparison of therapy utilization before the PDGM (2018 and 2019) to after the implementation of the PDGM (2020-2024) shows a decline in therapy visits across all clinical groups (Figure 3 in proposed rule).

Table 10: Proportion of 30-Day Periods of Care With Only Therapy, At Least One 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%	17.8%	19.3%	20.0%	20.4%	20.9%
Therapy + Non-therapy	48.2%	48.4%	42.2%	42.3%	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 and Note: Same as Table 2.								

CMS also examined the proportion of 30-day periods of care with and without skilled nursing, social work, or home health aide visits for 2018-2024 (Tables 11 and 12, reproduced below).

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**

[10] Section 1895(b)(4)(B)(ii) of the Act eliminated the use of therapy thresholds in calculating payments for 2020 and subsequent years.

Source and Note: Same as Table 2.

Table 12: Proportion of 30-Day Periods of Care With and Without Home Health Aide 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 home health aide or social worker	16.6%	15.9%	13.2%	12.2%	11.3%	10.9%	10.3%	9.8%
No home health aide 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**	**8,269,971**	**8,593,266**	**8,319,064**	**8,275,089**	**7,719,986**
Source and Note: Same as Table 2.								

g. Home Health Services Using Telecommunications Technology

In 2023, CMS began collecting data on the use of telecommunications technology used during a home health period using three new G-codes reported on home health claims (Tables 13 and 14, reproduced below). It began collecting this data on a voluntary basis on January 1, 2023 and then required this information to be reported starting on July 1, 2023. The three new 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 system (G0321); and the collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency, that is, remote patient monitoring (G0322). CMS found that the use of telecommunications services reported on 2024 home health claims is low (roughly 2 percent) and is mainly associated with skilled nursing. For 2025, CMS found that the use of telecommunications services reported on claims declined from the prior year's monitoring and continues to be mainly associated with skilled nursing.

Table 13: Telehealth Visits Recorded on Home Health Claims (CYs 2024 and 2025)				
Calendar Year	**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**
2024				
Skilled Nursing	139,730	284,854	96,535	1,087
PT	26,362	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
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 Monitoring Days Recorded on Home Health Claims (Cys 2024 and 2025)

Calendar Year	Claims with at Least 1 Day of Remote Patient Monitoring	Number of Remote Patient Monitoring	Unique Beneficiaries with at Least 1 Day of Remote Patient Monitoring	Unique Providers with at Least 1 Day of Remote Patient Monitoring
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
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).

C. Proposed 2027 Payment Adjustments Under the HH PPS

1. Proposed Behavior Assumption Adjustments under the HH PPS

a. Background

As directed by section 1895(b)(2)(B) of the Act, beginning in 2020, CMS adopted a 30-day period of home health service in place of a 60-day period. Section 1895(b)(4)(B) of the Act further required CMS to eliminate use of therapy thresholds in assigning an episode to a case mix adjusted payment group. For 2020, section 1895(b)(3)(A)(iv) of the Act required CMS to adopt the change to a 30-day episode of care as budget neutral taking into account behavior changes from the new period of service and eliminating the use of therapy thresholds to assign a case to a payment group.

Section 1895(b)(3)(A)(iv) of the Act requires CMS to make a prospective adjustment for 2020 to maintain budget neutrality, while section 1895(b)(3)(D)(i) of the Act requires CMS to revisit the adjustment retrospectively for each year beginning with 2020 and ending with 2026. If CMS' retrospective review reveals that behavioral changes were different than assumed in the prospective adjustment, CMS is required to make both permanent and temporary adjustments to

the home health rate to ensure aggregate spending neither increased nor decreased as a result of the new unit of payment and elimination of therapy thresholds. The temporary adjustment is made to either recoup past overspending or repay past underspending, while the permanent adjustment ensures that future spending neither increased nor decreased relative to continuing the prior policies.

CMS applied a prospective budget neutrality adjustment including its behavior assumption of -4.36 percent when setting the 2020 30-day payment rate of $1,864.03. CMS did not propose any changes for 2021 and 2022 relating to the behavior assumptions.

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 2020-2026, the datasets underlying the simulated 60-day episodes, and the opportunity for stakeholder input. It complied with these requirements by posting online the supplemental LDS and descriptive files and the description of actual behavior changes that affected the 2023 payment rate development. CMS also conducted a webinar on these issues on March 29, 2023.[11]

b. Methodology

In the 2023 HH PPS final rule, CMS finalized the methodology to evaluate the impact of the differences between assumed and actual behavior changes on estimated aggregate expenditures. For 2020 through 2026, CMS evaluates if the 30-day budget neutrality payment rate and resulting aggregate expenditures are equal under the PDGM to what they would have been under the 153-group case-mix system and 60-day unit of payment. In the 2024 HH PPS final rule,[12] CMS provided an overview of the methodology and detailed instructions on each of the following steps:

- Create simulated 60-day episodes from 30-day periods;
- Price out the simulated 60-day episodes and determine aggregate expenditures;
- Price out only the 30-day periods which were used to create the simulated 60-day episodes and determine aggregate expenditures;
- Compare aggregate expenditures between the simulated 60-day episodes and actual 30-day periods; and
- Determine what the 30-day payment rate should have been to equal aggregate expenditures.

Due to an update of the OASIS instrument, in the 2025 HH PPS final rule CMS updated two methodological assumptions related to mapping and imputation of OASIS-D responses from OASIS-E. CMS refers readers to the 2024 and 2025 HH PPS final rules for further information about the methodology.

[11] These materials can be found at https://www.cms.gov/medicare/medicare-fee-for-service-payment/homehealthpps/hh-pdgm
[12] 87 FR 66804

c. Calculating Permanent and Temporary Payment Adjustments

To calculate a permanent prospective adjustment, CMS calculates what the 30-day base payment amount should have been in order to achieve the same estimated aggregate expenditures as obtained from the simulated 60-day episodes. This is the recalculated base payment rate. The percent change between the actual 30-day base payment rate and the recalculated 30-day base payment rate would be the permanent prospective adjustment.

To calculate a temporary retrospective adjustment for each year, CMS determines the dollar amount difference between the following:

- Estimated aggregate expenditures from 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 the same year.

The temporary adjustment is applied on a prospective basis and applies only with respect to the year for which such temporary increase or decrease is made. CMS refers readers to the 2024 HH PPS final rule (88 FR 77689 through 77694) for analysis for 2020 through 2022 claims, the 2025 HH PPS final rule (89 FR 88366 through 88369) for analysis of 2023 claims, and the 2026 HH PPS final rule (90 FR 55365 through 55367) for analysis of 2024 claims.

d. 2025 Preliminary Claims Results

CMS notes that in the 2026 HH PPS final rule (90 FR 55365) that it was exercising its authority expressly delegated under the statute to apply permanent adjustments "at a time and in a manner appropriate" and thus did not apply any permanent adjustment for 2026 based on 2023 or 2024 data. CMS explained that these years may contain data with behaviors attributable to factors beyond the implementation of the PDGM and a 30-day unit payment.

CMS notes that its 2025 claims analysis presented in this proposed rule is preliminary and will be updated in the final rule as more data become available from the latter half of 2025. It followed the same methodology described previously. After all exclusions and assumptions were applied, the final dataset for this proposed rule included 6,557,369 actual 30-day periods of care and 3,860,954 simulated 60-day episodes of care for 2025.

e. 2026 Permanent and Temporary Adjustments

CMS determined that a permanent prospective adjustment of -0.919 percent to the 2025 30-day payment rate (which assumes all other adjustments from prior years were already taken) would be required to offset such increases in estimated aggregate expenditures in future years. It also calculates that a temporary adjustment of -$746.1 million would be required to achieve budget neutrality. Table 15 (reproduced below) details these results.

Table 15: CY 2025 Final Permanent and Temporary Adjustments			
	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	$16,644,686,087**	$15,898,581,795	**Temporary** -$746,104,292
Source: CY 2025 Home Health Claims Data, periods that end in CY 2025 accessed on the CCW March 12, 2026. * This amount 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).			

f. Proposed 2027 Permanent and Temporary Adjustments

The calculation in this section includes any of the remaining adjustments not applied in previous years (that is, 2020 to 2024), as well as the adjustment needed to account for 2025 claims. In calculating the full permanent adjustment needed to the 2027 30-day payment rate, CMS compares estimated aggregate expenditures under the PDGM and the prior system. Unlike the annual adjustments described in Table 15, CMS does not assume the full adjustment from prior years had been taken.

Permanent Adjustment

As shown in Table 16, a permanent prospective adjustment of -5.043 percent to the 2026 30-day payment rate for 2020 through 2025 would be required to offset for such increases in estimated aggregate expenditures in future years. For 2023, 2024, and 2025, CMS previously applied reductions of 3.925%, 2.890%, and 1.975%, respectively, which were half of the estimated required permanent adjustment. CMS also applied a permanent adjustment of -1.023% in 2026.

Table 16: 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, CMS recognizes that for CY 2027 CMS must also account for adjustment made in CY 2026.		

Taking into account the permanent adjustment applied in prior years, CMS calculates that the current remaining permanent adjustment of **-4.062 percent** in 2027 would account for the permanent adjustments for 2020-2025.

CMS proposes to not apply a permanent adjustment to the 2027 payment rate. As discussed in 2026 HH PPS final rule, CMS reiterates in this rule the difficulty attributing any behavior change occurring from 2023 through 2025 directly to the PDGM implementation and its effects on expenditures from the other changes occurring in those years. It cited several policy changes that made this difficult, including recalibration of case-mix weights and LUPA visit thresholds, reassignment of certain ICD-10-CM codes related to the PDGM clinical groups and comorbidity groups, prior year finalized permanent adjustments, and the introduction of OASIS and related mapping changes. CMS states, however, as required by law, it will continue to analyze data through 2026 claims to determine if any additional permanent adjustments are needed.

Temporary Adjustment

Table 18 in the proposed rule (reproduced below) shows the temporary adjustment of dollar amounts by year. CMS notes that even though it cannot calculate the temporary dollar amounts for 2026 (these estimates will be provided in next year's proposed rule) the cumulative amounts for 2020 through 2025 are substantial at $4.91 billion. CMS notes that collecting the full temporary dollar amount of $4.91 billion in one year would adversely affect HHAs given the magnitude of this adjustment to the payment rate in a single year.[13]

Table 19: Summary of Anticipated Temporary Adjustments Calculated 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 (as of proposed rule)	-$430,435,218
CY 2025	-$152,365,174
CY 2026	TBD
Total	-$4,908,531,936
Source: Estimates are based on historical HH claims data from the CCW that are specified in more detail in the proposed rule. **Note**: The anticipated temporary adjustments of approximately $4.9 billion (through 2025) will require temporary adjustment(s) to the base payment rate to offset for such increases in estimated aggregate expenditures. The dollar amount would be converted to a factor when implemented in future rulemaking.	

CMS instead argues that a smaller temporary adjustment for 2027 is appropriate. Specifically, CMS proposes implementing a 3.0 percent reduction in 2027 (equivalent to a 0.9700 temporary adjustment factor) to the 2027 national, standardized payment rate. This equates to collecting approximately $500 million of the total temporary adjustment.[14]

[13] CMS did not provide an exact percent reduction to the 2027 base payment rate needed to fully account for the temporary adjustments, but CMS estimated in last year's rule the percent reduction would have been about 34 percent.

[14] CMS notes that the actual dollar amount collected would depend on the number of actual 30-day periods that occurred in 2027.

The temporary adjustment is applied on a prospective basis and would only apply to 2027. CMS states that to continue recoupment of the retrospective overpayments it may propose additional temporary adjustments in future rulemaking and is not proposing that the -3.0 percent temporary adjustment would be applied to 2028 or subsequent years. CMS states it will continue to analyze the data and then, in a time and manner deemed appropriate, it will propose one or more temporary adjustments to account for retrospective overpayments.

CMS seeks comment on its proposals to not apply a permanent adjustment and to apply the -3.0 percent temporary adjustment to the 2027 home health base payment rate.

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

1. 2027 PDGM LUPA Thresholds

LUPAs are paid when a certain visit threshold for a payment group during a 30-day period of care is not met. LUPA thresholds are set at the 10^{th} percentile value of visits, or 2 visits, whichever is higher for each payment group. That is, the LUPA threshold for each 30-day period of care varies based on the PDGM payment group to which it is assigned. If the LUPA threshold is met, the 30-day period of care is paid the full 30-day period payment. If a 30-day period of care does not meet the PDGM LUPA visit threshold, then payment is made using the per-visit payment amount.

CMS adopted a policy that the LUPA thresholds would be updated each year based on the most current utilization data available. For 2027, CMS proposes to update the LUPA thresholds using 2025 home health claims utilization data (as of March 15, 2026). The proposed LUPA thresholds for the 2027 PDGM payment groups with the corresponding Health Insurance Prospective Payment System (HIPPS) codes and the case-mix weights are listed in Table 24 of the proposed rule.

2. 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. A home health period of care receives points based on responses from these functional OASIS items, which are converted to a table of points. The sum of all these points is used to group home health periods into low, medium, and high functional impairment levels, designed so that about one-third of home health periods fall within each level.

For 2027, CMS proposes to use the 2025 claims data to update the functional points and functional impairment levels by clinical group and to use the same methodology previously finalized to update the functional impairment levels. The updated OASIS functional points table and the table of functional impairment levels by clinical group for 2027 are listed in Tables 19 and 20, respectively.

3. 2027 Comorbidity Subgroups

Thirty-day periods of care receive a comorbidity adjustment based on the presence of certain secondary diagnoses reported on home health claims. These diagnoses are based on a home health list of clinically and statistically significant secondary diagnosis subgroups with similar resource use. A comorbidity adjustment is applied to the 30-day period of care when there is the following: (1) low comorbidity adjustment – a reported secondary diagnosis on the health-specific comorbidity subgroup list that is associated with higher resource use; or (2) a high comorbidity adjustment – two or more secondary diagnoses on the home health-specific comorbidity subgroup list.

For 2027, CMS proposes to use the same methodology used to establish the comorbidity subgroups to update the comorbidity subgroups using 2025 home health data with linked OASIS data (as of March 15, 2026). Using this data, CMS proposes to update the comorbidity subgroups to include 21 low comorbidity adjustment subgroups and 100 high comorbidity adjustment interaction subgroups as identified in Tables 21 and 22 in the proposed rule.

4. 2027 PDGM Case-Mix Weights

The PDGM case-mix methodology (as finalized in the 2019 HH PPS final rule) results in 432 unique case-mix groups called home health resource groups (HHRGs). CMS annually recalibrates the PDGM case-mix weights using a fixed effects regression model with the most recent and complete utilization data available at the time of annual rulemaking. For 2027, CMS proposes to generate the recalibrated case-mix weights using 2025 home health claims data with linked OASIS assessment data (as of March 15, 2026). CMS believes that recalibrating the case-mix weights using data from 2025 would be reflective of PDGM utilization and patient resource use for 2027. These weights will be updated based on more complete 2025 claims data for the final rule.

Table 23 in the proposed rule shows the coefficients of the payment regression used to generate the weights and the coefficients divided by average resource use for PDGM payment groups. The proposed 2027 case-mix weights are provided in Table 24 in the proposed rule and will also be posted on its HHA Center webpage.

To determine the case-mix budget neutrality factor for 2027, CMS continues its practice of using the most recent complete home health claims data at the time of rulemaking, which is 2025 data. CMS calculates a case-mix budget neutrality factor for 2027 of 1.0045.

E. Home Health Payment Rate Updates

1. 2027 Home Health Market Basket Update

The update will equal the projected increase in the market basket adjusted for changes in economy-wide productivity. Based on IHS Global Insight Inc.'s first-quarter 2026 forecast for 2027 with historical data through fourth-quarter 2025, the proposed HH PPS market basket update is as follows:

Market Basket Update	Change (in %)
Market basket forecast	3.1
Total factor productivity	-1.0
Net update for HHAs reporting quality data	**2.1**
Net update for HHAs NOT reporting quality data	**0.1**

More recent forecasts for 2027 will be used for the final rule, if available. As noted below, the final update factor also includes budget neutrality adjustments for the wage index and case-mix recalibration.

2. 2027 Home Health Wage Index

CMS proposes to continue to use the pre-floor, pre-reclassified hospital wage index as the wage index to adjust the labor portion of HH PPS rates for 2027, using FY 2023 hospital cost report data as its source for the updated wage data. The proposed 2027 HH PPS wage index would not take into account any geographic reclassification of hospitals, but it would include the 5 percent cap on wage index decreases. In the 2023 HH PPS final rule (87 FR 66851 through 66853), CMS finalized for 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. In addition, if a geographic area's prior calendar year wage index is calculated based on the 5 percent cap, then the following year's wage index would not be less than 95 percent of the geographic area's capped wage index. In the 2025 HH PPS final rule (89 FR 88354) CMS finalized its proposal to adopt the revised OMB delineations from OMB Bulletin 23-01 with a 5 percent cap on wage index decreases at the core-based statistical area (CBSA) level as well as at the county level.

CMS makes special provisions for 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. For urban areas without inpatient hospitals, CMS uses the average wage index of all urban areas within the state as a reasonable proxy for the wage index for that CBSA. For 2027, the only urban area without inpatient hospital wage data is Hinesville, GA (CBSA 25980), and CMS calculates a proxy 2025 wage index value for this area of 0.8797. For rural areas that do not have inpatient hospitals, CMS continues to use the average wage index from all contiguous CBSAs as a reasonable proxy. As a result of adopting the revised OMB delineations, rural North Dakota became a rural area without a hospital from which hospital wage data can be derived. Based on this approach, CMS calculates a proposed 2027 HH PPS wage index of 0.8210 for rural North Dakota. For Puerto Rico, CMS proposes a wage index value of 0.3470 (5 percent cap adjusted), instead of the previously available wage index value of 0.4047. In addition, based on the adoption of the revised OMB delineations, Delaware now has one rural area with a hospital from which hospital wage data can be derived and CMS proposes a 2027 wage index of 0.9590 for this area. CMS also calculates a wage index value for American Samoa and Northern Mariana Islands of 0.9611 using Guam as a reasonable proxy.

The proposed wage 2027 wage index is available on the CMS website at: Home Health PPS Wage Index | CMS.

3. 2027 Annual Payment Update

a. Background

CMS discusses the methodology it uses to compute the case-mix and wage-adjusted 30-day period rates as set forth in §484.220. It first multiplies the national, standardized 30-day period rate by the patient's applicable case-mix weight. It then divides the case-mix adjusted amount into labor (74.9 percent) and non-labor (25.1 percent) portions.[15] The labor portion is multiplied by the appropriate wage index based on the site of service and summed to the non-labor portion. In the 2024 HHS PPS final rule (88 FR 77726), CMS finalized a rebasing of the home health market basket to reflect 2021 cost report data.

Next, CMS may adjust the resulting 30-day case-mix and wage-adjusted payment based on the information submitted on the claim to reflect:

- A LUPA provided on a per-visit basis (§§484.205(d)(1) and 484.230).
- A partial episode payment (PEP) adjustment (§§484.205(d)(2) and 484.235).
- An outlier payment (§§484.205(d)(3) and 484.240).

Implementation of the PDGM and the 30-day unit of payment began in 2020, and CMS is required to annually analyze data (for 2020 through 2026) to assess the impact of the differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures. In the 2026 HH PPS final rule, CMS finalized the implementation of a temporary 3.0 percent reduction to the 2026 base payment rate, which was equal to a final temporary adjustment factor of 0.97.

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

To calculate the 2027 national, standardized 30-day period payment amount, CMS first applies an adjustment factor of 1.03093 (equal to 1 divided by 0.97) to remove the temporary adjustment factor from the 2026 national standardized 30-day period payment amount. CMS then applies a proposed case-mix weights recalibration budget neutrality factor, a wage index budget neutrality factor, the home health payment update, and temporary adjustment factor.[16]

The proposed 2027 30-day payment amount would be 2.65 percent more than the 2026 30-day payment amount.

The following table shows the proposed standardized amounts, as displayed in Tables 26 and 27. For illustrative purposes, CMS shows the calculation without the 2027 temporary adjustment applied.

[15] A detailed description of how CMS rebased the HHA market basket and labor-related share is available in the 2024 HH PPS final rule (88 FR 77726 through 77742).

[16] The removal of the 3.0 percent 2026 temporary adjustment and the addition of the 3.0 percent 2027 temporary adjustment effectively result in no change related to this factor from 2026 to 2027.

Proposed 2027 National, Standardized 30-Day Episode Payment Amount for HHAs Submitting and Not Submitting Quality Data		
	HHAs submitting quality data	HHAs not submitting quality data
2026 30-day budget neutral standardized amount (without temporary adjustment)	$2,101.26	
Case-mix weights recalibration neutrality factor	x 1.0045	
Wage index budget neutrality factor	x 1.0009	
HH payment update percentage	x 1.021	x 1.001
2027 30-day payment amount (without temporary adjustment)	**$2,156.98**	**$2,114.73**
Temporary adjustment factor	0.9700	
2027 30-day payment amount (with temporary adjustment)	**$2,092.27**	**$2,051.29**

c. 2027 National Per-Visit Rates for 30-Day Periods of Care

Computations are presented for the 2027 proposed per-visit amounts for each type of service. These amounts are used for LUPAs and in outlier calculations. The proposed per-visit amounts for those HHAs submitting the required quality data (Table 28 in the proposed rule) are as follows:

HH Discipline	CY 2026 Per-Visit Rates	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

HHAs that do not submit required quality data would have the payment update for per-visit services reduced from 2.1 percent to 0.1 percent, resulting in the following payment rates (Table 29 in the proposed rule):

HH Discipline	CY 2026 Per-Visit Rates	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	1.001	$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

HH Discipline	CY 2026 Per-Visit Rates	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 HH Payment Update Factor	CY 2027 Per-Visit Payment Amount
Skilled Nursing	$176.96	0.9997	1.001	$177.08
Speech-Language Pathology	$210.25	0.9997	1.001	$210.40

d. LUPA Add-on Factors

Under previously adopted policy, to determine the LUPA add-on payment for a 30-day period of care, CMS multiplies the per-visit payment amount for the first skilled nursing, PT, or SLP visit in a LUPA period that is the first 30-day period of care or the initial 30-day period of care in a sequence of adjacent periods.

To enhance the accuracy and relevance of LUPA add-on factors to reflect current health care practices and costs, CMS updated the LUPA add-on factors for PT, SN, and SLP in the 2025 HH PPS final rule (89 FR 55378) using 2023 data. These factors had not been revised since the 2014 HH PPS final rule, during which 2012 data was used. Also, in the 2025 HH PPS final rule, CMS finalized its proposal to discontinue the use of the PT LUPA add-on factors as a proxy and established a definitive LUPA add-on factor for occupational therapy (OT). The LUPA add-on factors are 1.7200 for SN; 1.6225 for PT; 1.6696 for SLP; and 1.7238 for OT.

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

Under the HH PPS, outlier payments are made for episodes whose estimated costs exceed a threshold amount. The outlier threshold amount is the sum of the wage and case-mix adjusted PPS episode amount and a wage-adjusted 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 payment is defined to be a proportion of the wage-adjusted estimated cost for the episode that surpasses the wage-adjusted threshold; this proportion is referred to as the loss-sharing ratio.

CMS notes that the FDL amount and the loss-sharing ratio must be selected so that the estimated total outlier payments do not exceed the aggregate level of 2.5 percent of estimated total HH PPS payments, as required by statute. CMS has historically used a value of 0.80 for the loss-sharing ratio, meaning that Medicare pays 80 percent of the additional estimated costs above the outlier threshold amount. No changes are proposed to the loss-sharing ratio for 2027.

For 2027 payment, CMS proposes an FDL ratio of 0.29 for 2027 based on analysis of 2025 claims data (as of March 12, 2026). CMS will update the FDL, if needed, in the final rule based on more complete 2025 claims data.

F. Palliative Care Services as Home Health Services

In this section, CMS seeks to explain in what circumstances the Medicare home health benefit could be used when a patient needs palliative care, either during episodes of serious illness or near end of life, before choosing hospice care. CMS states it is seeking to advance its broader goal of promoting access to and utilization of palliative care services. Similarly, CMS includes an 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.

CMS reviews the regulatory requirements of Medicare coverage of home health services. Specifically, 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),[17] 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.

CMS also indicates that 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. CMS cites an example of palliative care services that it includes in chapter seven of the BPM 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.

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

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

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

CMS is soliciting comments from this RFI on information regarding the appropriateness of alternative data sources to construct a home health specific wage index that is consistent with its statutory and regulatory requirements. For 2027, CMS is proposing to continue using the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the HH PPS wage index, as it believes it continues to be the best Medicare data available to estimated costs per day.

CMS notes that it finalized changes to the ESRD PPS wage index using Bureau of Labor Statistics (BLS) occupation-level wage data in the 2025 ESRD PPS final rule (89 FR 89116). CMS is also considering the potential use of alternative data for the wage index in the prospective payment systems for inpatient psychiatric facilities, skilled nursing facilities, and hospices.

CMS also 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. In addition, CMS seeks feedback on the unique considerations applicable to HHAs that CMS should consider on the potential use of alternative data sources.

III. Home Health Quality Reporting Program (HH QRP)

A. Statutory Authority and Background

The HH QRP[18] is a pay-for-reporting program authorized under section 1895(b)(3)(B)(v) of the Act. Under the program the annual HH market basket percentage increase is reduced by 2 percentage points for HHAs that do not report required quality data.[19] The program was modified by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), which added requirements for HHAs to begin entering standardized patient assessment data elements (SPADEs) into the HH assessment tool, the Outcome and Assessment Information Set (OASIS).

CMS provides historical data that for the 2023 program year, 820 of the 11,549 HHAs (approximately 7.1 percent) did not receive the full annual percentage increase for failing to meet assessment submission requirements.

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[18] More information on the HH QRP can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits. The HH QRP regulations are under 42 CFR 484.245 and 484.250.

[19] Depending on the HH market basket percentage increase applicable for a particular year, as further reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act, the 2 percentage-point reduction may result in the 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.

B. Overview of Provisions Related to HH QRP

CMS summarizes potential initiatives to improve alignment between the HH QRP and expanded HHVBP model. In addition, CMS proposes to (i) revise the HH QRP data submission deadlines and (ii) revise the HH QRP OASIS and HHCAHPS annual payment update (APU) reporting timeframes for each to require collection of a calendar year of data. In addition, CMS seeks feedback on future measure concepts related to advance care planning for the HH QRP.

CMS invites comment on the proposals under this section.

C. Measures Currently Adopted

The HH QRP for the 2027 program year currently includes 18 measures. CMS is not proposing any changes to the measure set previously finalized. The table below lists the HH QRP measures as finalized in the 2026 HH PPS final rule.

Measures Previously Finalized for 2027 HH QRP

Short Name	Measure Full Name & Data Source
OASIS-based	
Ambulation	Improvement in Ambulation/Locomotion (CBE #0167)
Application of Falls	Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) (CBE #0674)
Bathing	Improvement in Bathing (CBE #0174)
Bed Transferring	Improvement in Bed Transferring (CBE #0175)
DRR	Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care (PAC) Home Health Quality Reporting Program
DC Function	Discharge Function Score
Dyspnea	Improvement in Dyspnea
Influenza	Influenza Immunization Received for Current Flu Season
Oral Medications	Improvement in Management of Oral Medication (CBE #0176)
Pressure Ulcer/Injury	Changes in Skin Integrity Post-Acute Care
Timely Care	Timely Initiation of Care (CBE #0526)
ToH-Patient	Transfer of Health Information to the Patient-PAC Measure
ToH-Provider	Transfer of Health Information to the Provider-PAC Measure
Claims-based	
PPH	Home Health Within Stay Potentially Preventable Hospitalization
DTC	Discharge to Community-Post Acute Care (PAC) HH QRP (CBE #3477)
MSPB	Total Estimated Medicare Spending Per Beneficiary (MSPB) –PAC HH QRP
PPR	Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH QRP
HHCAHPS Survey-based Composite Measure*	
Communication	How well did the home health team communicate with patients
Overall Rating	How do patients rate the overall care from the HHA
Professional Care	How often the home health team gave care in a professional way
Team Discussion	Did the home health team discuss medicines, pain, and home safety with patients
Willing to Recommend	Will patients recommend the HHA to friends and family
*The HHCAHPS has 5 components (all listed) that together are used to represent one measure.	

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

CMS discusses opportunities the agency has identified for aligning the HH QRP and expanded HHVBP model. It believes better alignment between the program and model could reduce administrative burden for HHAs as well as unnecessary complexity. CMS lists specific opportunities for alignment, including by updating the scoring methodology to incorporate HH QRP APU penalties in the expanded HHVBP model payment adjustments and factoring HH QRP quality assessments only (QAO) values into quality of patient care (QoPC) star ratings scoring as well as increasing alignment between the HH QRP and model in the following areas:

- QoPC star ratings measure sets;
- Measure reporting periods;
- HH QRP APU and expanded HHVBP model annual payment reporting periods;
- Expanded HHVBP model interim performance and HH QRP QoPC star rating reports;
- Timeframe of appeals/suppression review processes.

CMS is providing the list of opportunities for general awareness only and is not seeking comments on the list. Table 31 in the rule shows current and expected usage of measures for the HH QRP and expanded HHVBP model.

E. Form, Manner, and Timing of Data Submission

1. Proposal to Revise HH QRP Data Submission Deadlines Beginning With 2027 HH QRP

CMS is required by statute to publicly report the performance of post-acute care (PAC) providers, including HHAs, on the quality, resource, and other measures applicable to the PAC provider, to provide confidential feedback reports to PAC providers on their performance before it is made public, and to ensure that each PAC provider has the opportunity to review and submit corrections to the information that is to be made public prior to the data being made public.[20] The timeframe for HHAs to submit data required for the HH QRP is not specified in statute.

Currently, HHAs have approximately 4.5 months after the reporting quarter to make any needed corrections to the assessment-based data. During the time of data submission for a quarterly reporting period and up until the quarterly submission deadline, HHAs may review and correct errors in the assessment data used to calculate the measures. There is about a 9-month lag between the end of data collection and when measures are publicly reported, and the agency states that the biggest contributor to this lag is the 4.5-month timeframe for data submission. CMS describes that a goal of public reporting of data collected under the HH QRP and other quality reporting programs is to provide consumers with the most current information in order to facilitate informed decision-making. CMS believes that the time between when data on measures are submitted and when the data are made publicly available may be too long for those purposes.

CMS, therefore, proposes, beginning with the 2027 HH QRP to reduce the data submission timeframe by requiring HHAs to complete their data submissions and make corrections to their

[20] See section 1899B(g) of the Act.

OASIS assessment data, if necessary, not later than the 15th day of the second month after the end of the calendar quarter (or, if that 15th day falls on a Friday, weekend, or Federal holiday, the next business day). This would be approximately 45 days (rather than 4.5 months) after the end of the reporting quarter. Specifically, for the 2027 HH QRP, CMS proposes the deadlines shown below (from Table 32 of the rule) and that similar data submission deadlines would apply to future year payment determinations.

CY Quarter (Q)	Data Collection Timeframe	Final Data Submission Deadlines for 2029 Payment Determination
2027 Q1	January 1 – March 31, 2027	May 17, 2027
2027 Q2	April 1 – June 30, 2027	August 16, 2027
2027 Q3	July 1 – September 30, 2027	November 15, 2027
2027 Q4	October 1 – December 31, 2027	February 15, 2027

CMS believes that the lag between the end of the data collection period and public reporting could be reduced by up to three months if the data submission timeframe would be reduced as proposed. According to an analysis conducted by CMS on the potential impact of shortening the data submission timeframe, using 2024 data, 99.27 percent of all OASIS assessments were submitted within a 45-day timeframe.

2. Proposal to Revise the OASIS Annual Payment Update (APU) Reporting Timeframe

The existing OASIS APU reporting timeframe provides for data collection of 12 months of data from July 1 through June 30. However, this OASIS APU reporting timeframe differs from other CMS payment updates, including the expanded HHVBP model annual payment adjustment and the HH PPS updated, which are based on a calendar year timeline.

Therefore, CMS proposes to revise the OASIS APU data reporting timeframe to reflect a January 1 to December 31 reporting timeframe (i.e., move to a calendar year timeframe).

CMS proposes that 2028 be a transition year in which the current timeframe is moved to the proposed reporting timeframe. For that transition, six months (rather than 12 months) of 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 APU. Beginning with the 2029 APU, the data reporting timeframe would be on the revised calendar year basis.

The following table (reflecting the data in Table 33 of the rule) shows the current OASIS APU data reporting timeframe for 2027, the proposed transition reporting timeframe for 2028, and the proposed revised timeframe for 2029. The calendar year timeframe would continue for years after 2029 as well.

OASIS APU Issued	Data Reporting Timeframe
January 2027 (existing)	July 1, 2025 – June 30, 2026
January 2028 (proposed transition)	July 1, 2026 – December 31, 2026
January 2029 (proposed revised)	January 1, 2027 – December 31, 2027

3. Proposal to Revise HHCAHPS APU Reporting Timeframe

The existing HHCAHPS APU reporting timeframe provides for four quarters of data collection from April 1 through March 31. This differs from the calendar-based timeframe used for other annual HH payment updates.

CMS proposes, similar to the proposal discussed above for the OASIS APU reporting timeframe, to revise the HHCAHPS APU data reporting timeframe to be on a calendar-year basis.

CMS proposes that the 2028 APU be a transition year in which the current timeframe is moved to the proposed reporting timeframe. For that transition, 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 HH QRP 2028 APU. Beginning with the 2029 APU, the data reporting timeframe would be on the revised calendar year basis.

The following table (reflecting the data in Table 34 of the rule) shows the current HHCAHPS APU data reporting timeframe for 2027, the proposed transition reporting timeframe for 2028, and the proposed revised timeframe for 2029. The calendar year timeframe would continue for years after 2029 as well.

OASIS APU Issued	Data Reporting Timeframe
January 2027 (existing)	April 1, 2025 – March 31, 2026
January 2028 (proposed transition)	April 1, 2026 – December 31, 2026
January 2029 (proposed revised)	January 1, 2027 – December 31, 2027

4. Proposed Updates to Regulation Text Related to Reconsiderations

CMS proposes updates to the regulation text under §484.245(d)(1) regarding the reconsideration process, including revising the language to:

- Specify that HHAs that do not meet the quality reporting requirements for a program year would receive a notification of noncompliance via the CMS-designated data submission system (rather than via the United States Postal Service (USPS) and the CMS-designated data submission system).
- Specify that CMS would notify the HHA of its final decision regarding any reconsideration request through a CMS designated data submission system (rather than through at least one of the following: CMS designated data submission system, USPS, or email from the CMS MAC).

F. RFI: HH QRP Quality Measure Concepts Under Consideration for Future Years

CMS seeks input on the importance, relevance, appropriateness, and applicability of quality measure concepts related to advance care planning for the HH QRP. The agency states it would prioritize evidence-based outcome measures that promote person-centered care practices.

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

The CMS Center for Medicare and Medicaid Innovation (CMMI) tested under section 1115A of the Act the "original" Home Health Value-Based Purchasing Model (HHVBP-O) in 9 states during 2016 through 2021. Payments were adjusted based on performance on the model's measures as summed into a Total Performance Score (TPS). The model produced average annual savings to Medicare of $141 million as well as an average TPS increase of 4.6 percent, without evidence of adverse risks. The model's results met statutory criteria to be certified for expansion, as announced by CMS on January 8, 2021. Final payment adjustments under the HHVBP-O model were made during 2021.

The expanded HHVBP model[21] began January 1, 2022, starting with a "pre-implementation year" of 2022 during which agencies could familiarize themselves with the expanded model and their performance would not trigger future payment adjustments. Beginning with the 2023 performance year, measures are scored and TPSs calculated annually to trigger payment adjustments two years after each performance year. The first payment year was 2025 based on 2023 (the first performance year). CY 2027 will be the fifth performance year for the expanded HHVBP model. The model requires all Medicare-certified HHAs to participate and they are termed "competing HHAs." As finalized in the 2026 HH PPS final rule, the expanded HHVBP model uses 6 OASIS-based measures, 3 claims-based measures, and 2 HCAHPS survey-based measures.

CMS is not proposing any changes to the expanded HHVBP model. However, as discussed in section III.D, CMS has identified opportunities to better align the HH QRP and the expanded HHVBP model, including potential alignment of the measure sets. Table 31 of the proposed rule shows current and expected usage of measures for both the HH QRP and expanded HHVBP model.

V. Durable Medical Equipment and Provider Enrollment Provisions

A. Overview

In this section of the proposed rule, CMS proposes changes and seeks comment on the following DME and provider enrollment provisions, which are discussed in more detail in the sections below.

- In section V.B, CMS clarifies 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, CMS proposes a number of Medicare provider enrollment provisions to strengthen and clarify certain aspects of the provider enrollment process.
- In section V.D, CMS proposes to make changes to the Medicare Part B definition of DME regulations in accordance with statutory changes that would make certain external infusion pumps, associated home infusion drugs, and related supplies treated as meeting the "appropriate for use in the home" requirement when certain criteria are met.

[21] The expanded HHVBP Model regulations are under 42 CFR part 484, subpart F.

- In section V.E, CMS discusses requesting revisions to the information collection requirements that would require DMEPOS Competitive Bidding Program (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

As codified at §410.38, CMS outlines a condition of payment for certain items of 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 to 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. CMS has a process (as defined at (84 FR 60648)) 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"). The face-to-face encounter requirements are only applicable to items that are selected and placed on this list (via a notice comment process).

Separately, in its Medicare Benefit Policy Manual (100-02) (Chapter 15, Section 110.2 - Repairs, Maintenance, Replacement, and Delivery), CMS defines 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. Further, as specified at §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 at §410.38(d)(2)(iii) clarifies 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. CMS states that requiring this seems burdensome and redundant. CMS also proposes that 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. 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. 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

Regulations codifying enrollment procedures for a provider or supplier (collectively referred to as "provider" in this section) are found in subpart P of part 424. The statutory[22] and regulatory requirements for provider enrollment are designed to (i) prevent unqualified and potentially fraudulent individuals and entities from inappropriately billing the Medicare program, (ii) to protect Medicare beneficiaries and the Medicare Trust Funds, and (iii) to allow CMS to take action against providers for engaging in fraudulent or abusive behavior. Enrollment procedures are used in the case of initial enrollment, change of ownership, reactivation of billing privileges, and a change of information.

Changes proposed to subpart P would apply to all Medicare provider types except where the proposed change specifically indicates otherwise (e.g., provisions related to hospices, home health agencies and DMEPOS suppliers). Comment is welcomed on all the proposals.

2. Revocations and Denials of Enrollment

Section 424.535(a) provides a list of reasons for revocation of an existing enrollment of a Medicare provider in the program. If an enrollment is revoked, the provider is barred from reenrolling for a period of between 1 to 10 years depending on the severity of the basis of the revocation. Section 424.530(a) provides a list of reasons to deny enrollment of a Medicare provider in the program, some of which duplicate reasons for revocation under §424.535(a).

a. Modification of Current Revocation Provisions

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

CMS proposes to remove the list of factors it considers, and the requirement to consider those factors, in determining whether a provider has a pattern or practice of submitting claims that fail to meet Medicare requirements. It believes those factors constrain its ability to effectively address all the factual scenarios. CMS seeks to give itself maximum flexibility to use this reason for revocation, and it notes that a "pattern or practice" under revised §424.535(a)(8)(ii) might be established by a simple finding that several of the provider's claims do not meet Medicare requirements.

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

Revocation is allowed if a provider in its enrollment application certifies as "true" information that is misleading or false. CMS proposes to significantly broaden this authority by requiring

[22] See section 1866(j) of the Act for the specific mandate for enrollment as well as sections 1102 and 1871 of the Act.

only the submission of "false or misleading information on or associated with any CMS or Medicare provider enrollment-related form."

The proposed changes to this reason for revocation of enrollment would:

- Expand the documents and forms beyond provider enrollment forms CMS-855 and CMS-20134 (Medicare Enrollment Application: Medicare Diabetes Prevention Program (MDPP) Suppliers).[23] CMS states that providers must always submit truthful enrollment and enrollment-related information to CMS and its contractors regardless of the form or document involved;
- Expand the analysis of whether the provider submitted false or misleading information beyond application forms to include submissions made that were not necessarily intended to gain or maintain Medicare enrollment; and
- Remove the requirement that the information be certified as "true" in order for CMS to revoke enrollment under this revocation authority.

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

If a provider's enrollment is revoked under §424.535(a), then the agency may revoke any and all of the provider's other enrollments under §424.535(a). CMS proposes to expand §424.535(i) to allow it to revoke a provider's other enrollments if the provider's triggering enrollment is denied under §424.530(a). Thus, upon denial of a provider's enrollment application, the agency could consider other existing enrollments of that provider and decide to revoke those existing enrollments as well. CMS notes that a denial would not automatically lead to the revocation of the provider's current enrollments. Please see immediately below for CMS' proposed retroactive effective date of such a revocation.

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

Generally, the effect of a revocation is prospective, becoming effective 30 days after CMS or the CMS contractor mails notice of its determination to the provider. However, under circumstances specified in §424.535(g)(2) and (g)(3), the effective date of a revocation may be retroactive, which generally means back to the date on which the provider's non-adherence to Medicare requirements began.

The purpose of the retroactive revocation policies in paragraph (g)(2) is to prevent payments to a provider while it is out of compliance. The 2026 HH PPS final rule[24] made many of the revocation reasons retroactive. CMS proposes to make the remainder of current prospective revocation grounds retroactive; it believes this proposal would ensure "constant compliance" with Medicare requirements. To effectuate this proposal, current paragraph (g)(1) (allowing prospective revocations) would be struck and proposed retroactive revocations would be added. The table below shows the relevant revocation authorities and their associated proposed revocation dates. CMS also proposes reorganizing the entirety of this section §424.535(g)),

[23] These include EFT authorization agreements, opt-out affidavits, qualification letters, and any other required or requested enrollment-related documentation.
[24] 90 FR 55342, 55442

including consolidating provisions with the same retroactive effective date and making technical language changes; none of those changes are shown in the below table.

Revocation Authority	Proposed Retroactive Effective Date
§424.535(a)(1): Non-compliance with enrollment requirements or in enrollment application	The date the non-compliance began as determined by CMS or its contractor
§424.535(a)(4): Submission of false or misleading information with respect to enrollment or enrollment-related forms	The date the false/misleading information was submitted
§424.535(a)(5)(ii): Failure to satisfy any Medicare enrollment requirement	The date the Medicare enrollment requirement was not satisfied
§424.535(a)(6): Grounds related to provider and supplier screening requirements (e.g., failure to submit institutional provider application fee, failure to submit hardship exemption request, and inability of CMS to deposit fee)	The date on which CMS or its contractor determines that the provider or supplier should be revoked—not necessarily the date on which CMS could not deposit the funds
§424.535(a)(7): Misuse of billing number	The date on which the conduct resulting in the revocation occurred
§424.535(a)(9): Failure to report enrollment data changes (4 bases for revocation: §424.516(d) or (e), §410.33(g)(2), or §424.57(c)(2))	The day following the due date for reporting the change
§424.535(a)(10): Failure to comply with documentation retention requirements in §424.516(f)	The date on which CMS or its contractor found the provider failed to comply with the retention requirement
§424.535(a)(10): Failure to comply with CMS access requirements in §424.516(f)	The day after the date by which the provider was required to give access
§489.28: Failure of HHA to document satisfaction of "Initial Reserve Operating Fund" requirement	The day after the date by which the HHA was required to submit the requested documentation
§424.535(a)(13)(i): Prescribing authority suspension, revocation or surrender of DEA certificate of registration	The date revocation, suspension, or surrender of the certificate (note: currently the effective date is retroactive to the date of surrender)
§424.535(a)(14): Improper prescribing practices (for patterns or practices that are abusive, are a threat to health and safety of Medicare beneficiaries, or fail to meet Medicare requirements)	The date of the last prescription in the applicable pattern or practice
§424.535(a)(15): False Claims Act civil judgment	The date of the judgment
§424.535(a)(16): Misdemeanor Conviction^	The date of the conviction
§424.535(a)(17): Debt referred to the Department of Treasury	The date CMS referred the debt to Treasury
§424.535(a)(18): Provider enrollment revoked under different name or identity and reenrollment bar has not expired	The effective date of the provider's current enrollment*
§424.535(a)(19): Undue risk of fraud, waste, or abuse to the Medicare program	The date CMS or its contractor determines the provider or supplier should be revoked
§424.535(a)(20): Billing from non-compliant location	The earliest date on the claims for the non-compliant location that trigger the revocation
§424.535(a)(21): Abusive ordering, certifying, referring, or prescribing	The date of the last order, certification, referral, or prescription in the applicable pattern or practice

Revocation Authority	Proposed Retroactive Effective Date
§424.535(a)(22): Patient harm (i.e., physician or other eligible professional has been subject to prior action from a State oversight board etc., for improper conduct that led to patient harm)	The date of the prior action that resulted in the revocation
§424.535(a)(23): Supplier standard or condition violation (*e.g.*, IDTFs, DMEPOS suppliers, OTPs, MDPPs, and home infusion therapy suppliers)	For violations not described in (A), (B) or (C) below, the date of the non-compliance with the condition or standard (A) Suspension, revocation, or termination of provider's Federal or State license, certification, accreditation, or MDPP recognition; (B) Non-operational practice location;** and (C) Felony conviction of an individual or entity described in §424.67(b)(6)(i). No change to existing retroactive effective dates for violations described in (A), (B) and (C)
§424.535(a)(24): High-risk enrollments based on excess providers in area^	The date on which CMS or its contractor determines that the provider should be revoked
§424.535(a)(25): Change in majority ownership non-compliance (for HHAs, hospices and DMEPOS suppliers)^^	The date on which CMS or its contractor determines that the provider should be revoked
§424.535(i): Extension of revocation	The date of the triggering revocation or denial
^ This new revocation authority is described in V.A.2.a.(6) below. ^^ This new revocation authority is described in V.A.2.d below. * §424.535(a)(18) example: Provider X enrollment is revoked 2/1/25, and it reenrolls as provider Y on 7/1/25. Retroactive revocation date would be 7/1/25. ** §424.535(a)(23): CMS believes a lapse in the IDTF's comprehensive liability insurance under §410.33(g)(6) would be encompassed in (B) and no separate retroactive effective date is proposed for such a lapse.	

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

A revoked provider (other than an HHA) must submit all claims for items and services furnished before the date of the revocation letter by no later than 60 days after the revocation's effective date. Revoked HHAs must submit those claims within 60 days of the later of (i) the revocation effective date and (ii) the date that the HHA's last payable episode ends. CMS believes that 60 days is too long a period for revoked providers to submit claims. It is concerned that many of those claims could be improper.

CMS proposes to substantially reduce the 60-day periods described above to 15 days. Specifically, revoked providers (other than HHAs) would have to submit all claims for items and services furnished before the date of the effective date of the revocation within 15 calendar days of the date of the revocation letter. HHAs would have to, within 15 calendar days of the date of the revocation letter, submit claims for items and services furnished before the later of (i) the revocation effective date and (ii) the date that the HHA's last payable episode ends.

(6) New Revocation Reasons

CMS proposes to add new reasons for revocation of a provider's enrollment:

- High-risk enrollments based on excess providers in area.
- Certain misdemeanor convictions.

(i) High-risk Enrollments Based on Excess Providers in Area (§424.535(a)(24))

CMS is concerned by an increase in situations where numerous providers and suppliers (sometimes of the same type) are simultaneously operating within a very small geographic area, citing in particular the number of HHAs in Los Angeles County, California and Columbus, Ohio.

Lacking specific authority to revoke enrollment under these circumstances, CMS proposes a new authority to revoke a provider's enrollment if the agency deems the enrollment as presenting 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.

CMS does not propose to define the term "high risk," but it notes that the term does not necessarily mean the provider must be in the high screening level (under §424.518(c)) or that the region has traditionally posed a high risk of fraud, waste, and abuse, such as south Florida. CMS may consider these factors in these determinations; however, the main consideration of this "high risk" would be risk that a particular provider poses based on its proximity to other providers. CMS notes that the analysis would not focus on whether the providers are all the same type.

CMS proposes to give the terms "limited geographic area" and "excessive number" their ordinary, plain-language meanings. However, the agency's primary focus is on providers in smaller areas – common buildings and complexes, city and town blocks, neighborhoods, *etc*.

Of significant concern is that CMS proposes to permit revocation on these grounds even absent an actual finding of fraud, waste, or abuse by the provider or another provider in the area. These revocations would be based on the assessed risk and not whether the provider or nearby providers have engaged in fraudulent conduct. Also of note is that the agency does not propose to include any factors it must consider or criteria it must evaluate in order to revoke enrollment under these proposed new grounds. The proposed effective date of the retroactive revocation would be the date on which CMS or its contractor determines that the provider or supplier should be revoked.

The agency attempts to reassure stakeholders by stating that this proposal is not designed to revoke good-faith providers who otherwise present no apparent risks even though they might be in an area with numerous other providers. CMS understands many physicians and practitioners practice in the same building, complex, or other small area.

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

In the 2024 PFS proposed rule (88 FR 52262), CMS proposed new authority to deny or revoke enrollment if the provider (or any owner, managing employee or organization, officer, or director) 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. CMS did

not finalize that proposal in part because stakeholders were concerned about its extraordinary potential breadth.

CMS proposes a narrow version of the same policy—one that focuses on misdemeanor convictions for sexual assault and financial misconduct. Specifically, CMS would establish a reason for revocation if the provider (or any owner, managing employee, managing organization, officer, or director) 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. CMS does not define these terms though it indicates in the preamble that terms like "financial misconduct" would be based on their plain meanings. The proposed effective date of the retroactive revocation would be the date of the conviction.

b. Revised and New Denial Reasons (§424.530(a))

(1) Changes to Existing Denial Reasons

(i) Medicare Debt (§424.530(a)(6))

An application may be denied if the enrolling provider or its owner (i) has existing Medicare debt or (ii) 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. The purpose of this denial reason is to prevent providers (and their owners) from enrolling additional locations when they have Medicare debts through current enrollments that they have not paid. However, this regulation cannot prevent enrollment if a managing employee or organization of the prior provider that ran its daily operations was responsible for its accumulation of large debts, and it now seeks to re-enter Medicare through their ownership of the new provider.

To address this lack of authority, CMS proposes to expand the scope of this denial authority to include not only owners of the provider but also what it refers to as "associated parties" if they have an existing Medicare debt. That term would include managing employees, managing organizations, or individuals or entities with any other form of business or financial relationship with the provider. CMS notes that each case would be carefully judged on its own circumstances, and denial would only occur when warranted.

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

Section 424.530(a)(7) permits the agency to deny an enrollment application if the provider, or any owning or managing employee or organization of the provider, is currently under a Medicare or Medicaid payment suspension. CMS proposes to include associated parties (as described immediately above in the proposal for Medicare debt) in the scope individuals and entities that CMS would check for payment suspensions to deny enrollment.

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

Enrollment may be denied if the provider is currently terminated, suspended or barred from participation in a State Medicaid program or any other Federal health care program. CMS

proposes to expand the policy to also apply to the provider's owners, managing employees, and managing organizations within its purview if they are terminated, suspended or otherwise barred.

Enrollment may also be denied if provider's license is currently revoked or suspended in a State other than the State in which the provider is enrolling. CMS proposes to expand the scope of licenses under this denial reason to include licenses voluntarily surrendered in lieu of further disciplinary action.

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

Similar to the proposed changes for revocation of enrollments under §424.535(a)(4) above, CMS proposes to modify its ability to deny an application based on false or misleading information by (i) expanding the documents and forms beyond provider enrollment forms CMS-855 and CMS-20134 and (ii) expanding the analysis of whether the provider submitted false or misleading information beyond application forms to include submissions made that were not necessarily intended to gain Medicare enrollment.[25]

(2) New Denial Reasons

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

CMS proposes to add as a new denial reason the same misdemeanor conviction basis proposed as a revocation authority in §424.535(a)(16) (described above). Specifically, CMS could deny enrollment of a provider if the provider (or any owner, managing employee, managing organization, officer, or director) 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.

CMS also proposes to expand the definition of "final adverse action" in §424.502 to include the term "misdemeanor conviction" that would mean 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."

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

CMS proposes a new denial ground based on a provider having its practice location in the same suite or office as another provider whose Medicare enrollment has been revoked or denied. While similar to the proposed new revocation reason for excess providers in the same area (see description of §424.535(a)(24) above), CMS notes that this denial ground is based on the presence of providers in the same suite whose enrollment is denied or revoked whereas the proposed revocation ground is based merely on the number of providers nearby. The agency sees the proposals as complementing each other, and, acknowledging that situations are different, it states that this denial ground would only be used "when proper".

[25] These include EFT authorization agreements, opt-out affidavits, qualification letters, and any other required or requested enrollment-related documentation.

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

Citing what it calls serious program integrity issues involving hospices and specifically with the control medical directors and administrators have over the management of hospices, CMS proposes a new authority to deny enrollment of hospices on the following grounds:

- The enrolling hospice's medical director—
  - Is the medical director of multiple other hospices; or
  - Practices at such a distance (e.g., in a different State) from the enrolling hospice that the medical director cannot realistically perform all medical director required functions under 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 part 418.
- The hospice's medical director does not have an active physician medical license in the State in which they are practicing.

CMS states that the proposed new denial grounds would not "formally prohibit medical directors and administrators from serving at more than one hospice" but would allow the agency to address program integrity concerns.

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

While §424.535(a)(7) permits revocation if the provider knowingly sells to or allows another individual or entity to use its billing number (other than for valid reassignment of benefits or change in ownership), there is no basis for denial that specifically addresses misuse of identifiers. CMS proposes to establish a new basis for denial where a provider tries to enroll under another party's identity.

c. Reapplication Bar (§424.530(f))

Under §424.530(f), a prospective provider may be prohibited 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. CMS proposes to expand the bases under which it may impose a reapplication bar on a provider to include any denial reason listed in §424.530(a)—not just the submission of false or misleading information under §424.530(a)(4).

CMS also proposes to eliminate the factors listed in §424.530(f)(2), which the current regulation text indicates are used to determine the length of the bar. In the preamble, CMS refers to these factors as serving two purposes—whether to impose the bar and the length of the bar.

CMS emphasizes that it is not changing the discretionary nature of the reapplication bar authority, especially given the proposed expansion of the grounds for which it could be applied. No other changes are proposed to this denial authority.

d. Changes in Majority Ownership (CIMOs)

Under §§424.550(b) and 424.551, if an HHA, hospice or DMEPOS supplier undergoes a CIMO within 36 months of its initial enrollment (or within 36 months of its most recent CIMO), unless an exception applies, the provider's enrollment is terminated. The provider under its new majority ownership must enroll as a new provider and undergo a State survey or accreditation; DMEPOS suppliers must get a new accreditation. CMS believes the 36-month rule is helpful but notes that certain providers ignore or circumvent the rule, including by (i) failing to notify CMS of ownership changes and (ii) using managing agreements instead of formal sales agreements.

CMS proposes to give itself the authority to deny or revoke enrollment if it determines that the HHA, hospice, or DMEPOS supplier failed to comply with the provisions and requirements of §§424.550(b) or 424.551 (as applicable). As noted in the table above, the retroactive revocation effective date 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)

Providers and prescribers on the preclusion list are prohibited from receiving payment for MA items and services and for Part D drugs furnished, ordered, or prescribed by those providers or prescribers. One of the grounds for being added to the preclusion list is if the provider or prescriber 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.

CMS proposes to expand this ground to include felony convictions against the provider's or prescriber's owner, managing employee, managing organization, corporate director, or corporate officer because these parties typically exercise considerable influence over a provider's or prescriber's operations.

4. Temporary Moratoria (§424.570)

As of May 13, 2026, there are national moratoria on the enrollment of new HHAs, hospices, and DMEPOS medical supply companies. CMS identified several issues regarding moratoria for which it believes regulatory changes or clarifications are necessary.

Effective Date. CMS proposes to clarify that a moratorium's effective date is the date on which the moratorium notice is filed for public inspection at the Federal Register.

Ownership Changes. Under section 424.570(a)(1)(iii), a temporary moratorium does not apply to certain situations. In clause (C) of that section, a temporary moratorium does not apply to most changes in ownership. However, a temporary moratorium will apply to changes in ownership of home health agencies that would require an initial enrollment. CMS proposes to expand the types of changes in ownership that would be subject to a temporary moratorium to include providers with a change in ownership that requires an initial enrollment such as, but not limited to, HHAs, hospices and DMEPOS suppliers.

Other Applicability. Under §424.570(a)(1)(i), a moratorium may be imposed on enrollment of new Medicare providers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area. To address stakeholder questions about what qualifies as "new" under this moratorium authority, CMS proposes to list the following application types that (only for purposes of §424.570(a)) it considers to be new:

- Initial enrollment applications.
- Change of ownership applications requiring an initial enrollment.
- Enrollment applications from revoked providers whose reenrollment bars have expired and who seek to reenroll.
- Reactivation applications.
- Enrollment applications from voluntarily terminated providers seeking to reenroll.

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

Section 424.540(b)(3)(i) requires a deactivated HHA to obtain an initial State survey or accreditation before its billing privileges may be reactivated. CMS proposes to apply the same requirement to deactivated hospices that seek reactivation of billing privileges.

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

Section 1802(b)(1) of the Act allows certain physicians and practitioners to opt out of Medicare and to enter into private contracts with Medicare beneficiaries. In these opt-out situations, the beneficiary pays the physician directly, and no payment may be made and no reimbursement may be sought from Medicare. Opt-out periods are for two years and automatically renew absent a request to cancel. CMS proposes to make two regulatory clarifications with respect to opt-out periods, which the agency states reflect current policy.

Appeals §405.450(a). CMS proposes to replace the phrase "renew opt-out" in this section with the phrase "cancel automatic renewal" to reflect the fact that renewal of opt-out periods is automatic unless the physician or practitioner elects to cancel the automatic renewal.

Definition of out-out period 405.400. CMS proposes to replace the phrase "the date the affidavit is signed" in the definition with the phrase "the date the first submitted affidavit is signed" to reflect CMSs policy that 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)

Section 1124(c) of the Act, which requires SNFs to report detailed information about their ownership, management, and associated parties, was implemented in a November 17, 2023, final rule.[26] In that rule, CMS cited reports about the relationship between PEC and REIT ownership of SNFs and substandard SNF care, primarily due to these entities' emphasis on maximizing profits. CMS's concerns about the impact of PEC and REIT ownership of providers and

[26] "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)

suppliers on patient care and health care consolidation extend beyond SNFs. CMS believes it needs more information on the prevalence of PEC and REIT involvement with Medicare Part B suppliers.

CMS notifies stakeholders that it will 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).
- Form CMS-855S (Medicare Enrollment Application - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers).
- Form CMS-20134 (Medicare Diabetes Prevention Program (MDPP) Suppliers).

The revisions would not involve regulatory changes.

8. Definition of "Operational" (§424.502)

a. Proposed Revision to Definition.

A provider must be operational to get Medicare billing privileges. In response to many stakeholder questions over the years, CMS proposes to rewrite the definition of the term "operational" to address areas of confusion. The proposed definition would read as follows, and proposed changes are shown in italic font:

> 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.

The parenthetical addition to the beginning of the lead-in sentence is intended to clarify that certain components of the revised definition may not apply to all provider types and that CMS would account for this in applying the definition. The additions to paragraph (2) would clarify minimum expectations of what open to the public for purposes of providing health care related services involves, including facility accessibility issues. CMS clarifies that "located in an area" in paragraph (2)(i)(A) refers to the location's immediate vicinity, such as the parking lot or a larger, multi-building complex in which the provider has its office. The addition of "and able" in paragraph (3) seeks to clarify that the provider must have the administrative and logistical ability to submit claims.

The proposed additions to paragraph (4) would clarify minimum expectations for the properly staffed, equipped, and stock criterion, including medical qualifications, functional equipment, and appropriate medications in stock. The proposed new paragraph (5) would specify that operationality requires the provider to have adequate written policies and records regarding its operations.

b. Additional Considerations

Recognizing that its proposed changes to the definition of operational may add concerns regarding their breadth, applicability and relationship to other regulatory requirements, CMS seeks to assure providers that while they must be operational under the proposed definition to enroll in Medicare, CMS would continue to account for situations where a particular requirement cannot realistically apply to the provider based on its type or circumstances. However, it also notes that the wide variety of provider types and scenarios might require it to consider information not addressed in the revised definition to determine the provider's operationality. Thus, CMS proposes to add an un-numerated paragraph at the end of the proposed revised definition stating that it may consider any information in determining whether the provider is operational. (The text of this un-numerated paragraph is not shown in the proposed amendments made to the regulation text of §424.502 at the end of the rule.)

In the proposed new criterion in paragraph (2)(ii) (i.e., hours of business are sufficient to regularly serve patients), the addition of the adverb "regularly" is not intended to establish an across-the-board, minimum hour requirement for providers to be open for business. The determination of whether the requirement to regularly serve patients is met would be done on a case-by-case basis.

CMS emphasizes that the revised definition would not 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.

9. Signage (§424.510(f))

DMEPOS suppliers and IDTFs must maintain a visible sign posting its normal business hours.[27] CMS proposes to require all providers and suppliers (regardless of type) to maintain a permanent visible sign in plain view and post their 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 supplier.

CMS proposes the following exceptions to the requirement:

- The provider shares office space with another provider (e.g., 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(f))

Providers furnishing covered ordered, certified, referred, or prescribed Part A or B services, items or drugs must maintain the documentation (whether in written or electronic format) for 7 years from the date of service and must, upon CMS' or a Medicare contractor's request, provide access to that documentation. CMS proposes to add a new paragraph (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. The agency notes that the proposal is not intended to establish any new conditions of payment; the requirement would be restricted to the scope of the documents under §424.516(f).

11. Managing Employee (§424.502)

Under longstanding policies, managing employees must be disclosed on a provider's Medicare enrollment application because they may have as much influence as an owner over the provider's daily operations. Hospice and skilled nursing facility administrators and medical directors are specifically included in the definition of the term managing employee. CMS proposes to add the following additional personnel to this definition:

- Medical directors (other than skilled nursing facility and hospice medical directors).
- Clinical directors.
- Departmental heads (e.g., a hospital's chief of cardiology).
- Supervising physicians (not simply those at independent diagnostic testing facilities).
- Nursing directors.
- Alternate administrators.
- All other clinical personnel not listed above who meet the "managing employee" definition.

[27] See §§424.57(c)(7)(i)(D) for DMEPOS suppliers and 410.33(g)(14)(ii) for IDTFs.

CMS notes that these additional categories of personnel apply to all provider types. Additionally, CMS cautions that these new additional 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. However, CMS notes that not every clinical employee regardless of influence must be reported; reporting is only required if the person is a managing employee.

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

CAPs (§405.809). If a provider's enrollment is denied or revoked under §§424.530(a)(1) and 424.535(a)(1), it may submit a CAP to remedy the deficiency. However, the authority to do so under §405.809 only refers to revocation; CMS proposes to update §405.809 to also refer to denials.

Notification of Determinations. CMS proposes to revise §§405.800(a), (b)(1), and (c)(1), 498.20(a)(1) and 498.25(a)(1) (relating to requirements to send notice of determinations by mail and requirements to send notices of enrollment denials and revocations by certified mail) to include e-mail as an acceptable form of notice.

Appeals of Reactivation Effective Dates. 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. Stakeholders are unclear as to whether an assigned reactivation effective date may be appealed or rebutted. CMS proposes to add an explicit statement in new paragraph (d)(3) that providers may rebut their assigned reactivation effective date pursuant to the procedures in §424.546. CMS proposes conforming and clarifying changes to §§424.546 and 424.545(b) to accommodate rebuttals of a reactivation effective date.

13. Fingerprinting (§424.518(c))

Under §424.518(c)(2)(ii)(A), individuals who maintain a 5 percent or greater direct or indirect ownership interest in a provider must submit fingerprints for a national criminal background check. CMS proposes to modify that requirement to specify that those individuals must use the CMS-designated fingerprinting contractor for this task.

14. DMEPOS Accreditation (§424.58)

In order to enroll and remain enrolled in Medicare, DMEPOS suppliers must be accredited by a CMS-approved accrediting organization (AO). To be approved by CMS, an AO must meet certain requirements. CMS proposes to revise certain requirements and add another as follows:

- Paragraph (c)(1)(xxiii)(D) would be revised to require an AO to notify CMS in writing within 5 business days (as opposed to the current requirement for 3 business days) of an action the AO took to terminate, revoke, withdraw, or amend the accreditation status of a specific DMEPOS supplier.
- Paragraph (c)(1)(xxiii)(N) would be added to require an AO to notify CMS (and, if applicable, law enforcement) in writing of suspected fraud, waste, and abuse within 3

calendar days of the date on which the AO determines that fraud, waste, or abuse may have occurred.

- Paragraph (c)(1)(vii)(D)(*4*) would be revised to require an AO to disclose to CMS all conflicts of interest it currently has and explain how and when it will terminate them.

15. Affiliations (§424.502)

For purposes of §424.519 (relating to disclosure of affiliations), an "affiliation" includes any of the following:

1. A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.
2. A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.
3. 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.
4. An interest in which an individual is acting as an officer or director of a corporation.
5. Any reassignment relationship under §424.80 (prohibiting claims reassignments by suppliers).

CMS is concerned that the affiliation definition does not cover all the problematic relationships it has faced in its program integrity efforts. It also believes that the current 5-year lookback period for providers to report relationships with entities that had disclosable events[28] may be an insufficient period to prevent waste, fraud and abuse.

CMS proposes to remove the 5-year limitation on the lookback period in §424.519(b), which would require reporting problematic affiliations regardless of when they occurred. It also proposes to modify the third element of the definition of affiliation to expand it to include any of the owning or managing employees or organizations of the individual or entity. The revised prong would read as follows (additions shown in italic font):

> (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.

The agency seeks the ability to go within the provider organization to the operators and managers to address threats they present.

CMS also proposes to add a sixth element to the definition of affiliation to include marketing, business, fulfillment, financial, managerial, and beneficiary relationships.

[28] Disclosable events include (i) a current uncollected debt to Medicare, Medicaid, or CHIP; (ii) a payment suspension under a Federal health care program; (iii) an OIG exclusion; or (iv) a denial, revocation or termination of a Medicare, Medicaid, or CHIP enrollment.

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

a. Monetary Effects

CMS projects annual savings from these proposals of approximately $82 million, which are due in large part to the significant expansion of the grounds for retroactive revocation. CMS does not anticipate any information collection request (ICR) costs from the proposals; however, it projects costs of $1.4 million for annual survey or accreditation costs because of its proposal to require deactivated hospices that seek reactivation of billing privileges to obtain an initial State survey.

b. Additional Impacts

No significant impact on providers or beneficiaries is anticipated from any of the following proposals:

- The new and expanded grounds for denial and revocation.
- The proposed changes to the reapplication bar.
- The modifications to temporary moratoria.
- The new requirements for State surveys or accreditation for deactivated hospice programs prior to reactivation.
- The expansion of the definitions of the terms "operational" and "managing employee."
- The expansion of the signage requirement.
- The documentation retention requirements.

Notwithstanding the agency's projected savings of $82 million dollars each year because of its proposals to greatly expand grounds for retroactive revocation, CMS notes revocations are infrequent. It estimates that the annual number of affected providers would be 337 out of the 2 million-plus provider universe.

D. DME Benefit Expansion for Infusion Pumps and Drugs

1. Background

a. Home Infusion Therapy Benefit

In the 21st Century Cures Act (Pub. L. 114-255), Congress established 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. 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).

The definition of "home" is defined in statute 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).
The definition of "home infusion drug" is defined in statute 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 §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 §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 health care professional (84 FR 60628). 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. Provisions of the Proposed Regulation

CMS is proposing to amend the definition of DME at §414.202 to implement section 6222(a) of the CAA, 2026, effective April 1, 2027. Specifically, CMS proposes 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.

Section 6222(a) of the CAA, 2026 does not define the term "health care professional". CMS is limiting the definition of "health care professional" to a physician, clinical nurse specialist, nurse practitioner, physician assistant, or registered nurse that administers or supervises the administration of the home infusion drug. CMS is concerned about the adverse reactions and associated safety risks to beneficiaries and believes that these professions could address any emergency medical events that occur during the course of the infusion of the drug. CMS notes, for example, that it is aware of at least one drug, patisiran, that presents heightened safety risks that may meet the new criteria and definition of home infusion drug.

CMS further clarifies that is 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. CMS notes that state law varies in terms of whether an LPN or LVN can perform certain emergency services that may be required in addressing adverse effects associated with the administration of certain home infusion drugs under the expanded Medicare DME benefit. CMS also does not believe that the administration of the drug in home should be done remotely as this could violate state laws and potentially compromise the safety of the beneficiary. Thus, the health care professional must be on site at the home to administer or directly supervise the administration of a home infusion drugs covered under the expanded DME benefit.

The criterion specified in section 1861(n)(3) of the Act is that the drug must be infused at least 12 times per year. To meet this requirement, CMS proposes that home infusion drugs covered under this expanded DME benefit must be infused at least once a month. CMS states that it is not proposing a minimum or maximum number of times a drug must be infused to qualify as a "home infusion drug", as the duration of treatment is not always clear and is often patient-dependent.

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. CMS states it plans to implement this provision through sub regulatory guidance.

CMS solicits comments on its overall proposal. CMS also seeks comment on 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.

E. DMEPOS Competitive Bidding Program – Country of Origin

CMS is planning to request to revise the information collection for the 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. 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.

CMS plans 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).

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. Regulatory Impact Analysis

CMS estimates that the net impact of the HH PPS policies in this proposed rule is an increase of 2.4 percent, or $420 million, in Medicare payments to HHAs for 2027. The $420 million increase in estimated payments for 2027 reflects the effects of the proposed 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). The overall impact of the changes in the HH PPS system on payments to HHAs in 2027 is summarized in the following table.

Summary of Overall Impact of Proposed HH PPS Changes		
Policy	**2027 impact**	
HH PPS update	+2.1%	+$370 million
Updated FDL	+0.3%	+$50 million
Net impact	**+2.4%**	**+$420 million**

Table 36, reproduced below from the proposed rule, provides details on the impact by facility type and ownership, by rural and urban area, by census region and by facility size. The combined effects of all the changes vary by specific types of providers and by location. The table breaks out the payment effects of the case-mix weights recalibration budget neutrality factor, the 2027 wage index update, the 2027 update percentage, the FDL update, and the temporary adjustment. Proprietary free-standing HH facilities (about 84 percent of all facilities) would experience an average increase of payments of 2.3 percent. Voluntary/non-profit HHAs would experience a 2.8 percent increase. Government-based facilities would experience a 3.4 percent increase. The aggregate impact of the proposed temporary payment adjustment equals zero percent because both the 2026 and 2027 payments rates would include a 3.0 percent temporary adjustment (thus, no change from prior year). The overall impact of the case-mix recalibration and the wage index is also zero percent, due to maintaining budget neutrality.

CMS considered other alternatives including implementing a permanent adjustment to the 2027 30-day base payment rate of -1.024 percent. CMS states, however, that it continues to believe that implementing a permanent adjustment would not be appropriate because its analysis suggests that the majority of the behavior change related to the implementation of the PDGM occurred in 2020 through 2022 and that the behavior change observed in 2023 through 2025 is related to factors other than the implementation of the PDGM. CMS also considered not applying a temporary adjustment, as in prior rules, or recouping the temporary adjustment dollar amount, to date, of $4.9 billion. It states, however, due to the growing temporary adjustment calculated from 2020 through 2025, delaying the implementation of a temporary adjustment would lead to many years of reductions to the payment rate to reach budget neutrality. Thus, CMS believes it is prudent to begin collecting a portion of this temporary adjustment dollar amount as postponing the collection of this 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.

Table 36: Proposed 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%

Table 36: Proposed 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
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%
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.