HCANYS
Home Care Association of New York State

August 28, 2025

U.S. Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1828-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: File Code CMS-1828-P, Medicare Program; Home Health Calendar Year (CY) 2026 Prospective Payment System Rate Update & Wage Index Update

To CMS Officials:

The Home Care Association of New York State (HCANYS) is a statewide not-for-profit organization representing approximately 150 home care and hospice providers, allied organizations, managed care providers and individuals committed to the advancement of quality home health and hospice care services in New York State.

On behalf of our certified home health agency (CHHA) members that serve many of the approximately 151,000 Medicare home health beneficiaries annually in New York, we appreciate the opportunity to provide comments on the U.S. Centers for Medicare and Medicaid Services (CMS) Medicare Program Home Health CY 2026 Prospective Payment System (PPS) Rate Update and Wage Index Update.

General Overview of CMS's CY 2026 Proposed Rule

CMS's proposed rule updates the Medicare home health payment rates for CHHAs serving Medicare beneficiaries in CY 2026.

In addition to the payment updates, the rule contains numerous proposed changes and updates that HCA is interested in providing comments and in some cases recommendations. These include the following:

- A -4.059% budget neutrality permanent adjustment to account for the one-half of the remaining adjustment from CY 2025 (-1.975%) plus the additional 2024 data year adjustment of -2.087%.
- An additional -5% budget neutrality temporary payment adjustment to recoup approximately $786 million of the $5.3 billion in alleged overpayments from 2020-2024.
- An updated CY 2026 Wage Index.
- A market-basket increase of 2.4 percent based on an annual inflation update of 3.2 percent, reduced by a 0.8 percent productivity adjustment.

- A proposal to change who may conduct the Face-To-Face (F2F) encounter policy.

- Updates the Home Health Quality Reporting Program (HHQRP) by removing COVID-19 and several assessment items.

- A new Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey beginning April 2026.

- Includes an update to the Home Health Value Based Purchasing Program (HHVBP) to reflect the new HHCAPHS survey and proposes four new measures.

- Medicare provider enrollment revisions.

HCANYS Strongly Opposes CMS's Proposed Rate Cuts in the CY 2026 Proposed Rule

HCANYS writes in serious opposition to the CY 2026 Proposed Rule and respectfully requests that CMS not finalize proposals to impose permanent and temporary adjustments. The estimated total impact of the Proposed Rule is a **$1.135 billion decrease** in funding to Medicare-certified home health agencies (CHHAs) compared to 2025.

The proposed reductions come in the wake of nearly 9% in funding cuts imposed by CMS from 2023 to 2025 that have already caused beneficiaries to lose access to home health care as CHHAs substantially reduce service areas or close altogether. According to CMS's own data, since 2019, 20 CHHAs have closed and approximately 188,000 Medicare enrollees needed but did not receive home health care between 2020-2023 here in New York. Simply put, the New York CHHA delivery system cannot sustain the reductions set forth in the Proposed Rule.

If finalized, the proposed cumulative weight reductions will devastate the delivery system, leaving beneficiaries with essentially no viable option to receive skilled care in their homes and communities, and forcing them into higher-cost, higher-risk institutional settings at greater cost to the Medicare program.

For these reasons, we urge CMS to not finalize the proposed permanent and temporary adjustments in the Proposed Rule. Further, HCANYS implores CMS to refine its methodologies to make them consistent with Congressional intent. CMS's methodology contains critical flaws that overstate the permanent and temporary payment adjustments, incorrectly attributing them to provider behavior, when they are largely the result of unrelated policy changes and technical errors. In fact, the only behavioral changes of note that affect Medicare spending are:

- An increased level of Low Utilization Payment Adjustments (LUPAs) that are significantly higher than CMS estimated, which decreases overall Medicare home health spending.

- An increased functional domain scoring which is unknown as to the distribution of real versus nominal changes which increases Medicare home health spending.

- Reduction in therapy visits triggered by changes in financial incentives under PDGM in contrast to the HHPPS incentives with therapy thresholds. We believe that CMS should not use CY 2020 through 2024 therapy utilization data to determine budget neutrality.

Simply put, CMS has overcorrected for any plausible behavior change as a result of the 30-day unit of payment and new case-mix adjustment methodology implemented on January 1, 2020, and should issue a positive permanent adjustment instead of a negative one.

HCANYS believes that Medicare payments should be accurate, predictable, and support access to high quality home healthcare. However, based on the data and serious concerns presented in this comment letter, we believe that CMS policies result in a home health benefit that is failing patients, providers, and the Medicare program.

CY 2026 would be the fourth consecutive year that CMS applies a permanent adjustment to significantly reduce payments to HHAs. In addition, CMS now proposes to apply for the first time in CY 2026, a temporary adjustment to further reduce payments resulting in a one-year net reduction of 6.4% or $1.135 billion in payments compared to 2025. This is tantamount to a 9% rate cut less than the statutory market basket increase. These rate cuts are not sustainable and will cause significant harm to the home health care delivery system and beneficiaries it serves, in Medicare fee-for-service, Medicare Advantage, and under CMS's innovation models that promote use of home care.

Concerns with CMS's Budget Neutrality Methodology

HCANYS and our colleagues at The National Alliance for Care at Home (The Alliance) have previously commented on the flaws in CMS's methodology for determining permanent and temporary adjustments to CHHA payment rates. We continue to have significant technical concerns with CMS's approach that relies on a simulation of payments under the pre-PDGM payment system to establish a budget neutrality target that effectively places an artificial limit on current PDGM payments.

CMS's approach is explicitly intended to replicate what payments would have been had the agency not implemented PDGM and the 30-day unit of payment. However, the approach fails to accurately do that but rather establishes an arbitrarily low limit on current payments. Critically, CMS fails to update aspects of its model to reflect routine changes that would have been made to the pre-PDGM payment system such as recalibration of the case mix weights and updates to LUPA thresholds. CMS continues to rely on case-mix-weights (CMWs) and thresholds developed prior to 2020 using 2017 data. Other concerns relating to use of the data and the misalignment between the pre-PDGM simulation model and actual PDGM payments result in bias and estimation error that are compounded year after year as these adjustments are applied.

HCANYS Recommendation

CMS's methodology contains critical flaws that overstate the PDGM permanent and temporary payment

adjustments and incorrectly attribute them to provider behavior, when they are largely the result of unrelated policy and economic changes, fraud, and technical errors. We strongly recommend that CMS not finalize the proposed -4.06% permanent adjustment for CY 2026, recalculate the total permanent adjustments determined for CYs 2020 – 2024 correcting for the methodological flaws identified in this comment letter, and finalize a positive permanent increase to the 30-day payment rate in 2026.

We also strongly recommend that CMS not finalize the proposed -5% temporary adjustment in CY 2026, recalculate the total temporary adjustments dollar amounts for CYs 2020-2024, taking into account home health expenditure decreases that already occurred due to excess permanent adjustments applied in prior years and to account for shrinking fee-for-service (FFS) Medicare enrollment and payment offsets occurring through lower MA benchmarks, which likely result in positive temporary adjustments. If CMS determines that negative temporary adjustments may still be warranted, the agency should use CMS's "time and manner" authority pause any temporary adjustment for CY 2026 while the agency evaluates an appropriate schedule for implementing any future permanent adjustments that does not jeopardize the ability of Medicare beneficiaries to access quality, legitimate home health care.

Lastly, CMS should also consider the impact home health had on reduced hospitalizations in Medicare and the overall savings to the Medicare program because of the Home Health Value Based Purchasing (HHVBP) program.

Proposed CY 2026 Home Health Wage Index Update

Background

As part of the CY 2023 Home Health final rule, CMS established a permanent approach to smooth year-to-year changes in providers' wage indexes by placing a 5 percent cap on all wage index decreases in future years, regardless of the reason for the decrease. Under this change, a geographic area's wage index would not be less than 95 percent of its wage index calculated in the prior FY.

CMS also finalized that if a geographic area's prior CY 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 prior CY. The 5 percent cap will be implemented in a budget neutral manner and would be applied after the application of the hospice wage index floor. If there is a 5 percent decrease from the previous FY's wage index value after the application of the hospice wage index floor, then the 5 percent cap on wage index decreases would also be applied. CMS will be analyzing the effects of this policy on an ongoing basis in the future in order to assess its appropriateness.

For CY 2026, the proposed home health wage index would be based on the Fiscal Year (FY) 2026 hospital pre-floor, pre-reclassified wage index for hospital cost reporting periods beginning on or after October 1, 2021, and before October 1, 2022 (FY 2022 cost report data).

HCANYS Comments & Concerns

While HCANYS supports a cap on losses in wage index values, we believe that the CMS should consider lowering the cap to 2% in order to protect CHHAs who are already operating with negative or razor-thin operating margins and are still experiencing multiple negative consequences due to the COVID pandemic, such has increased costs and loss of staff.

Although CMS has repeatedly dismissed HCANYS's longstanding request for wholesale revision and reform of the home health and hospice wage index, we also reiterate our support for more far-reaching reforms to the wage index methodology used under Medicare FFS programs.

We believe the pre-floor, pre-reclassified hospital wage index is wholly inadequate for adjusting home health costs, particularly in states like New York, which has among the nation's highest labor costs and continues to increase.

Yet another ongoing concern for CHHAs is the need for parity with other health care providers (i.e., hospitals, nursing homes, etc.) that draw from the same labor pool. While the same data is used to establish the basic wage index values applicable to most provider types, hospitals receive special consideration in a number of ways, including that they are permitted to seek geographic reclassification from their assigned geographic area (thereby receiving higher wage adjustments to their payments).

This situation has come to fruition specifically in New York's Albany-Schenectady- Troy Wage Index (CBSA 10580), where inpatient hospital facilities in this area have successfully appealed its wage index and CMS has implemented a FFY 2026 Wage Index of over 1.20 for these providers, whereas home health and hospice providers in the very same CBSA, are facing a proposed CY 2026 Wage Index of 0.8556. This significant variance in the 10580 CBSA wage index makes it much more difficult for home health and hospice providers to recruit nurses and other professional and para-professional staff when hospitals can offer those same individuals a much higher salary and benefit package due to this large variance in the Wage Index.

HCANYS's Recommendations

The time is long overdue for CMS to develop and implement a wage index model that is consistent across all provider types so that all providers have a level playing field from which to compete for personnel. Finally, all providers should be guaranteed that their wage index value does not drop below the rural wage index value applicable in the state of operation.

CMS should consider the negative and disruptive financial impacts of its proposed wage index changes on care access as it finalizes the 2026 payment rates and any systemic reforms.

Proposed 2.4% CY 2026 Home Health Market Basket Update

By statute CMS is required to utilize the inpatient hospital market basket update (currently projected at 3.2% for CY 2026) less a productivity adjustment (currently estimated to be 0.8 percentage point for CY

2026) to arrive at the annual payment update for home health services. As a result, CMS projects the home health market basket update percentage for CY 2026 to be 2.4%.

This value may change if more recent data becomes available prior to publication of a final CY 2025 home health payment rule. The 2.4% update is generally in keeping with update values over the last 10 years, which have trended between 2.4% and 3.0%. While we understand that CMS has limited discretion relative to calculation of the annual payment update, we are deeply concerned that the projected payment update for home health (as well as hospice) provider members will be inadequate to address the accelerating financial demands that home health has been facing over the course of the last three years. HCANYS' CHHA members have voiced numerous issues that are creating these financial strains, including:

- Severe workforce shortages caused by caregiver burnout and higher pay in other healthcare sectors.

- Increased costs related to management fees, outsourcing, recruitment, staff retention.

- Raising prices and other inflationary pressures such as the increased costs for supplies, drugs, personal protective equipment (PPE) and other items essential to the delivery of high-quality home health care.

- Resumption of the 2% Medicare Sequestration cut.

HCANYS Comments & Recommendations

We are very concerned that the market basket update factors are not sufficiently sensitive to appropriately reflect the rapid financial changes and challenges that home health and hospice providers have experienced over the past 4-5 years. While we understand that CMS has limited flexibility relative to the inputs it uses to calculate the market basket update, we strongly encourage you to explore all options available to address the financial strains that providers are undergoing, including the following:

- Examine trends relative to HIS Global's forecasts to determine whether more recently available data than used for the final CY 2026 rule would result in a higher market basket update and determine whether additional updates could be made during the course of CY 2026 to provide additional support to home health and other providers.

- Direct various divisions of CMS to examine potential options for home health regulatory relief, with a particular focus on policies that could help to address issues that contribute to the existing workforce crisis, including reductions in paperwork and more appropriate utilization of various clinical personnel.

Proposed Regulation Change to Face-to-Face (F2F) Encounter

CMS proposes to codify into regulation changes to who may conduct the home health face-to-face (F2F) encounter, as required by Section 3708 of the Coronavirus Aid, Relief, and Economic Security Act of 2020 (CARES Act).

HCANYS supports the proposed regulatory changes to the home health F2F encounter. We believe these changes will significantly reduce the administrative burden on home health agencies (HHAs) and practitioners, particularly in cases where more than one practitioner is involved in the care of a beneficiary.

HCANYS Comments

- CMS should provide guidance on how HHAs and practitioners can demonstrate that the F2F encounter is conducted by a practitioner who is "most knowledgeable and has firsthand information" about the patient's condition, particularly in complex care settings where multiple practitioners are involved.

- We encourage CMS to maintain flexibility for HHAs and practitioners to determine, based on clinical judgment and care team structure, which practitioner is best positioned to perform the F2F encounter while still meeting eligibility and certification requirements.

Home Health Quality Reporting Program (HHQRP)

General Comments on Revisions to the HHQRP

HCANYS is concerned about the frequency that CMS has modified the OASIS data set over the last several years.

Since the implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, CMS has made revisions to the OASIS data set to accommodate the development of standardized assessment items and cross setting measures as required by the IMPACT Act. CHHAs have had to adapt to significant OASIS updates and instruction changes in 2019, 2020, and 2023. The last revision related to the IMPACT Act requirements took effect in 2023 (OASIS E). However, CMS continued to implement additional changes to the HHQRP requiring another revision to the OASIS data set, OASIS E1, effective January 1, 2025. Now, yet another version—OASIS E2—has been issued that will go into effect April 1, 2026, further adding to the cumulative burden on CHHAs.

Changes to the OASIS data set and instructions, even small changes, increase resource use for agencies in terms of staff training, coordination with vendors, and altered productivity associated with the learning curve required for collecting new material. The burden is magnified by increased rate cuts and a protracted workforce shortage. Also, the addition of assessment items without modifications to reduce the data set could result in a very lengthy assessment tool.

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HCANYS Comments & Recommendation

HCANYS encourages CMS to extend the OASIS revision cycle in alignment with the administration's goal of reducing regulatory burdens on providers, allowing CHHAs to focus on delivering care rather than repeatedly retooling operations to meet shifting reporting requirements.

We also respectfully urge CMS to extend the OASIS revision cycle to no more than once every four years to allow adequate time for implementation, staff training, and operational integration.

Proposed Removal of Quality Measures and Assessment Items

CMS proposes to remove the ''COVID–19 Vaccine: Percent of Patients Who Are Up to Date'' quality measure, along with the corresponding Outcome and Assessment Information Set (OASIS) data element. In addition, CMS is proposing to eliminate four assessment items: one Living Situation item, two Food items, and one Utilities item.

HCANYS supports the removal of the COVID-19 vaccination measure and its associated OASIS data item. Given the current status of the COVID-19 pandemic, this measure is no longer as relevant or actionable as it was when originally implemented.

We also support the removal of the social determinants of health (SDOH) items from the OASIS assessment. CHHAs agencies routinely assess SDOH as part of comprehensive care planning. While these factors are essential for the effective delivery of care to community-dwelling patients, they are already documented in the patient's medical record. Accordingly, including these items in the OASIS assessment tool results in unnecessary duplication and contributes to administrative burden. We appreciate CMS's continued efforts to balance the need for meaningful data collection with the imperative to reduce burden on home health agencies. Removing these items represents a thoughtful step in streamlining data requirements while maintaining a focus on patient-centered care.

HCANYS Recommendations:

CMS should:

- Remove the COVID-19 assessment item from the OASIS and the associated measure from the HHQRP.

- Remove the SDOH assessment items from the OASIS and explore alternative mechanisms to collect SDOH data outside of the OASIS instrument that does not duplicate clinical documentation or impose undue burden.

Amending the Data Non-Compliance Reconsideration Request Policy and Process

CMS proposes to amend the HHQRP non-compliance reconsideration request policy at § 484.245(d) to permit a CHHA to request, and CMS to grant, an extension to file a request for reconsideration of a noncompliance determination in situations where the agency was affected by an extraordinary circumstance beyond its control during the 30-day reconsideration period, as set forth in § 484.245(d). CMS also proposed specific conditions and time frames permitted to submit the request.

We appreciate CMS's proposal to codify this flexibility and allow agencies additional time to request reconsideration, particularly given the increasing threats from natural and man-made disasters. It is important to note that CHHAs are often less resourced in contending with these events relative to larger higher-cost providers, and this proposal would provide CHHAs a clear defined pathway to seek more time to contest a HHQRP non-compliance determination when unexpected events outside their control prevent timely filing.

HCANYS supports amending the regulations at § 484.245 to codify the extension process for requesting reconsideration of a non-compliance determination as proposed.

Proposed Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Survey Updates

CMS has revised the HHCAHPS survey by adding new questions that better reflect issues important to patients and removing several questions that are either less meaningful to patients or not used for public reporting. The revised survey is shorter by seven questions compared to the previous version. CMS plans to begin administering the updated survey with the April 2026 sample month.

Because the revised HHCAHPS survey significantly changes the composition of the composite measures used for public reporting, CMS proposes to delay posting the new measures on Care Compare until October 2027, after four quarters of data are collected.

The revised survey will also change the measures used for public reporting, Star Ratings, and the Home Health Value-Based Purchasing (HHVBP) Model. By focusing on questions that reflect patients' priorities and eliminating items of limited value, the updated survey will yield results that are more impactful to patients while reducing the time and effort required for completion.

HCANYS Comments

HCANYS supports and appreciates CMS's efforts to revise the HHCAHPS survey that strengthens its relevance to patients while also reducing respondent burden.

Home Health Value Based Purchasing Model: Proposed Changes to the Expanded HHVBP Model's Applicable Measure Set Measures Removed

CMS is proposing to remove three measures from the current applicable measure set and add four measures starting in CY 2026. The removal of the three measures is necessary due to revisions to the HHCAHPS Survey that are proposed beginning with the April 2026 sample. While CMS could revise the HHCAHPS measures to use the proposed HHCAHPS Survey instrument changes, a full year of data with the revised HHCAHPS measures will not be available until CY 2027. Data from multiple quarters will be needed to establish benchmarks and achievement thresholds for the revised HHCAHPS Survey-based measures.

CMS will require 1 year of data to establish appropriate benchmarks and achievement thresholds for measuring HHAs' level of performance on the revised HHCAHPS. By contrast, CMS will require 2 years of data to measure improvement over time and establish improvement thresholds. Therefore, CMS seeks public comments on the possibility of initially measuring HHA performance on the future HHCAHPS Survey-based measures based solely on achievement, rather than both achievement and improvement. A central theme consistently raised by the home health industry is frustration with the ongoing changes to the HHVBP model measure set and the associated burden of having to frequently adjust quality improvement strategies in order to remain successful under the program.

HCANYS Recommendation

If CMS intends to include measures from the revised HHCAHPS survey in the HHVBP model, we recommend that both achievement and improvement measures be incorporated simultaneously to avoid additional disruption and to support a consistent and meaningful quality performance program.

Medicare Provider Enrollment

CMS has issued changes to several provider enrollment regulations. These changes include enhanced protections for the Medicare program by addressing areas that have been identified as potentially vulnerable to fraud and abuse.

HCANYS supports CMS's efforts to strengthen provider enrollment processes and enhance program integrity. However, we are concerned about the proposed expansion of CMS's deactivation authority under § 424.547, which would apply to physicians and nonphysician practitioners who order, certify, or refer Medicare services but have not appeared on a Medicare Part A or B claim within the past 12 consecutive months. CHHAs and hospices are among several Medicare providers that will be directly affected if this proposal is finalized.

Deactivation of the certifying or ordering provider will prevent CHHAs and hospices from billing Medicare for any claims that include a deactivated practitioner. Specific to hospices, there are often physicians employed by and working only for the hospice and not in a position that they would routinely or even occasionally certify a patient such as those covering some on-call hours or covering the vacations/absences of other hospice physicians. In these instances, the on-call/covering physician may not have certified a hospice patient and, therefore, not be listed on a claim in a 12-month period.

CHHAs and hospices routinely verify provider eligibility through available databases to ensure that all practitioners certifying patients for home health services are authorized to do so; therefore, the accuracy and timeliness of these databases are critical to their operations.

Moreover, because these ordering and certifying practitioners typically do not bill Medicare directly for services, they may be unaware of their deactivation status and unable to address or correct it promptly. This lack of awareness can lead to unexpected claim denials and disruptions in patient care.

HCANYS Recommendations: CMS should:

- Ensure up-to-date and accurate provider enrollment databases that CHHAs and other Medicare providers rely on to verify ordering and certifying practitioner eligibility.

- Exercise thoughtful discretion in determining deactivations with consideration given to physicians employed only by hospices.

- Provide targeted education and outreach to CHHAs and hospices and ordering/certifying practitioners about the deactivation policy.

- Ensure the reactivation process is efficient and minimizes any delays in restoring ordering and certifying privileges for those practitioners that have been deemed eligible to certify /order home health services or hospice services.

Other Provider Enrollment Issues: Delays in processing provider enrollment applications and changes in information

HCANYS has heard from some of our CHHA members that the time frames for Medicare Administrative Contractors (MACs) to process enrollment applications, changes in ownership, and other updates to provider information have become increasingly lengthy. In some cases, MACs take many months to complete these transactions. Additionally, it is not unusual for MACs to request documentation that has already been submitted by the agency, creating unnecessary duplication and further delaying processing.

HCANYS Recommendations: CMS should:

- Work with MACs to establish clear and reasonable processing timeframes for provider enrollment and change of ownership requests, with transparent tracking of progress.

- Require MACs to implement systems that prevent duplicate document requests and ensure that information already submitted is appropriately retained and applied to the pending file. This would reduce the administrative burden on CHHAs, minimize operational disruption, and help ensure that beneficiaries have uninterrupted access to care.

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Conclusion

HCANYS thanks CMS for this opportunity to submit comments and respectfully request CMS's consideration of our concerns and recommendations. I would be pleased to answer any questions or assist CMS staff in any way going forward and can be contacted at pconole@hcanys.org or (518) 810-0661.

Sincerely,



Patrick Conole, MHA
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Home Care Association of New York State, Inc.