HOME CARE ALLIANCE of MASSACHUSETTS

August 21, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1828-P
7500 Security Boulevard
Baltimore, MD 21244–1850

**RE: CMS-1828-P, Medicare Program; CY 2026 Home Health Prospective Payment System Rate and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program Updates**

Dear Administrator Oz:

On behalf of the Home Care Alliance of Massachusetts (HCA) and its over 200-provider home health, home care, and hospice providers, we appreciate the opportunity to provide comments on the Calendar Year (CY) 2026 Home Health Prospective Payment System (HH PPS) Proposed Rule. HCA represents more than 100 Medicare-certified home health agencies across the Commonwealth, serving more than 110,000 Medicare patients in urban, suburban, and rural communities.

Our members provide critical, skilled, and compassionate care to individuals of all ages, helping patients recover safely at home, manage chronic conditions, and avoid unnecessary hospitalization or institutional care. The policies outlined in this proposed rule have direct and significant implications for patient access, agency operations, workforce stability, and overall quality of care across Massachusetts.

These comments address both financial and payment-related concerns, as well as policy, regulatory, and quality program proposals. Together, they reflect the experiences and priorities of home health agencies across Massachusetts and their shared commitment to advancing high-quality, equitable, and patient-centered care in the home.

We thank CMS for engaging stakeholders in this process and welcome the opportunity to provide the following detailed comments.

1. **Overview**

   HCA writes with fierce opposition to the Proposed Rule and recommends that CMS not finalize the proposals to implement additional permanent and temporary adjustments. The proposed rule would result in a $1.135 billion decrease in funding to Medicare Certified Home Health Agencies (HHAs) compared to CY2025.

From 2023 to 2025, CMS implemented nearly 9% in funding cuts. In Massachusetts, this is exacerbating a health care system under strain, and leaves thousands of our residents without access to home health care. In turn, additional HHAs will close, service areas will shrink, and community and hospital referrals will be denied, which will challenge our hospital system capacity or leave beneficiaries with no viable option to receive skilled care in their homes. This forces people into higher-cost settings such as Long-Term Care (LTC) facilities. As has been reported repeatedly over the years, the number one place people prefer to receive care is in their home. Care-at-home services result in better outcomes, fostering independence and enabling people to remain engaged and connected with their communities. Any further reduction to the Medicare Home Health payments will further delay the opportunity to fully realize a patient-centered health care system rooted in where people live.

**Access Issues:**

Demand for home health care services is higher than ever. But with a dwindling provider-pool, shrinking service areas, and a workforce crisis because of inadequate reimbursement across all payers, hundreds of Massachusetts residents are without access to home health care.

According to a monthly Massachusetts Health and Hospital Association (MHA) throughput survey: in May 2025, there were 1,844 patients awaiting discharge from Massachusetts Hospitals – 597 of whom were awaiting discharge to home health. Widely published data shows that when referrals are unsuccessful, beneficiaries are at much higher risk for readmission, nursing homes, and death. Furthermore, it results in costlier post-acute care episodes.

HCA also encourages CMS to consider the overall impact the Proposed Rule will have on the broader health care system. In Massachusetts, Medicaid Home Health reimbursement is wholly insufficient. Our State Waiver Home and Community-Based Services (HCBS) programs are underfunded and are incurring waitlists. Private pay non-medical home care services are largely unaffordable to most residents. Combined, we have a system reliant on facility-based and hospital Emergency Department usage, or unpaid family caregivers when available. And when a family member or friend is unavailable to a patient, the patient is at increased risk for falls or complications from chronic disease, leading to avoidable hospital admissions.

**Workforce Issues**

The United States is amid a labor shortage across various sectors. In home health care, there are several factors that have exacerbated the issue.

a. Reimbursement
   Inadequate reimbursement across all home health and HCBS programs has hampered providers' ability to attract and retain a workforce to meet demand.
b. Competition

Massachusetts has a world-class health care system. The health care labor market is extremely competitive in our state, making it difficult for home health providers to compete against facility-based compensation. In addition, we have seen a migration of nursing staff to opportunities away from the bedside, such as opportunities to work remotely for an insurance entity conducting prior authorization reviews. For non-medical professionals (home health aides), increases to the State's minimum wage presented new opportunities in retail or hospitality industries, which compensated above what reimbursement for home health care could support.

c. Regulatory

The evolving regulatory landscape for home health services has undoubtedly harmed workforce recruitment and retention. Once seen as a flexible career affording schedule autonomy, it has steadily become stigmatized by productivity and documentation pressures.

**Margins**

As HCA and our partner association, the National Alliance for Care at Home, have disputed for many years – CMS continues to rely on MedPAC's fee-for-service margin estimates. These estimates only consider Medicare Home Health Payment, and not Medicare Advantage or Medicaid reimbursement. This creates a fundamentally flawed basis for analysis. The CMS Office of the Actuary estimates that by 2027, 44% of home health providers will have negative total margins. By 2040, 56% of providers will have negative total margins. These figures raise the question of whether CMS' goal is to increase these percentages at an accelerated rate with this Proposed Rule.

HHAs are not 'Medicare Certified Fee-for-Service Providers', they care for a diverse population of patients with varying insurances. Thus, CMS' analysis should assess the health of HHAs across all payers, not only Medicare. **We recommend that CMS conduct a deeper analysis of the home health agency provider network which incorporates all payers, while discarding suspicious billing outliers. It is not unusual for health care providers to utilize reimbursement from certain payers to subsidize inadequate reimbursement by other payers, such as Medicare Advantage and Medicaid – these factors must be considered in payment analysis and determination.**

## 2. Proposed CY 2026 Reductions and Other Changes to CY 2026 Payments

**Overview**

If implemented, the CY 2026 proposed payment adjustments would mark the fourth consecutive year in which CMS applies a permanent payment adjustment. This year, CMS is also

proposing to apply (for the first time) a temporary adjustment, which will result in a one-year net-reduction of 6.4% ($1.135 billion) compared to 2025. Cumulatively, this results in a nearly 9% rate cut less than the market basket increase. As stated above, HCA cannot overstate how devastating this will be to home health agencies and patients across Massachusetts.

**HCA urges CMS to reconsider the payment reductions outlined in the Proposed Rule based on concerns with CMS' methodology in arriving at these proposals.** In addition, the continued degradation of the Medicare Home Health benefit runs contrary to public sentiment and desire for care at home services, as well as the significant value proposition that home health care provides to State and Federal health care expenditures. HCA would also note that we fully support our partner national association, the National Alliance for Care at Home, and the extensive comments they will submit on this proposed rule.

**Permanent and Temporary Adjustments**

a. *Flaws in Methodology*

As HCA and the National Alliance for Care at Home have commented repeatedly, the industry has significant concerns about the flaws in CMS' methodology for determining permanent and temporary adjustments to HHA payment rates. CMS' decision to rely on a simulation of payments under the pre-Patient Driven Groupings Model (PDGM) payment system in establishing budget-neutrality is fundamentally flawed. This approach artificially illustrates a low limit on current payments. Above all, CMS has not updated aspects of the model to reflect regular changes that would have been made to the pre-PDGM payment system (recalibration of case-mix weights, updated LUPA thresholds, etc.). Lastly, the inclusion of suspicious billing or fraudulent data is undoubtedly skewing the data, which in turn prescribes significant payment reductions.

Simply simulating payments under a pre-PDGM system, which had different incentives, coding and billing requirements, and episodes, is not an appropriate approach to comparing the current payment system to the prior and using such a simulation to determine future payment adjustments.

**HCA urges CMS to refrain from implementing additional permanent and temporary adjustments through this Proposed Rule until the agency reapproaches its methodology in meeting budget neutrality requirements.**

**HCA also urges CMS to consider the National Alliance for Care at Home's extensive comments regarding the industry's legal and policy concerns with respect to CMS' methodology.**

b. *Inclusion of Outlier Claims with Suspicious/Fraudulent Billing*

It is evident that CMS' inclusion of suspicious and fraudulent billing patterns within the dataset is impacting CMS' annual rate setting. This outlier data is skewing the recalibration of case-mix weights, fixed-dollar loss ratios, and the calculation of permanent and temporary adjustments. Again, HCA directs CMS to the National Alliance for Care at Home's comments on this topic, which identify concerning outlier data from Los Angeles County agencies, which is skewing national data that CMS is relying on.

**HCA urges CMS to assess its dataset and exclude claims data from potentially fraudulent HHAs when calculating payment adjustments.** This data is disproportionately punishing compliant HHAs across the country, threatening provider sustainability and beneficiary access to care.

c. *Clinical Group Assignments*

HCA raises concerns that CMS' simulation combines consecutive 30-day periods into a single 60-day episode. However, in the pre-PDGM payment system, mid-episode changes were permitted when updated assessments illustrated different patient needs. But in CMS' current simulation methodology, the primary and secondary diagnoses from the first 30-day episode are applied to the entire 60-day episode. This runs the risk that the simulation is not capturing whether the second 30-day episode has higher-acuity conditions or increased resource needs for the patient.

**HCA urges CMS to consider the impact of combining consecutive 30-day episodes into a single 60-day episode in its simulation and the potential for excluding common instances where patient needs change in the 31-60 day time of the episode.**

d. *OASIS Instrument Assumptions*

As CMS acknowledged in the CY2025 proposed rule, before January 2023 when the OASIS-E instrument was implemented, HHAs were using a 153-group system (OASIS-D). Due to changes (which CMS acknowledges) in 13 data points, which are now collected in OASIS-E at the start-of-care (SOC) or resumption of care (ROC) and not at follow-up. CMS has also created a crosswalk to map these changes back to OASIS-D equivalents. But this leaves CMS' simulations open the possibility of bias in the counterfactual 60-day payment estimates. It may misclassify case-mix groups or understate patient severity since these assessments would have been classified under OASIS-D, but are no longer captured in follow-ups under OASIS-E.

**HCA raises concern to CMS regarding its OASIS assumptions in determining payment, as the current OASIS mapping methodology to pre-PDGM payments exposes the process to unintentional bias or inaccuracy.**

*e. Temporary Payment Adjustments*

HCA is concerned with and disputes CMS' proposed temporary payment adjustments (-5% proposed in CY 2026). The basis for this temporary adjustment does not fully consider the declining number of Medicare FFS home health users, growth in Medicare Advantage, and a significant decline in billing HHAs across the country. Furthermore, as stated above, the inclusion of California HHAs with one Medicare FFS claim skews the data pool on which these proposals are predicated.

**HCA supports the National Alliance for Care at Home's recommendation that CMS adjust the total temporary adjustments downward by 11.3% to reflect the shrinking pool of service-eligible Medicare beneficiaries.**

*f. Overall Recommendations*

As stated, HCA has significant concerns with CMS' methodology which is overstating calls for PDGM permanent and temporary adjustments. We urge CMS to not finalize the proposed -4.06% permanent adjustment for CY2026 and instead recalculate the CY2020-2024 permanent adjustments and finalize a positive permanent increase to the 30-day payment rate in CY 2026.

HCA also urges CMS to not finalize the proposed 5% temporary adjustment in CY 2026 and instead recalculate the total dollar amounts resulting from temporary adjustments for CY 2020-2024 to account for significant reductions in home health expenditures and shrinking fee-for-service enrollments.

**3. Proposed CY 2026 Home Health Low Utilization Payment Adjustment (LUPA) Thresholds, Functional Impairment Levels, Comorbidity Subgroups, and Case Mix Weights**

HCA supports CMS' intent to recalibrate case-mix weights using updated 2024 data, but we raise concerns to CMS that potentially fraudulent or suspicious billing actors included is skewing payment variances. **HCA urges CMS to remove this data and not apply the permanent and temporary adjustments that are errantly prescribed by including this data. HCA also invites CMS to explore a new approach in accounting for patient acuity in the case-mix adjustment methodology. As care delivery has shifted across the entire system, admissions to home health are sourced in various ways that is not comparable to pre-PDGM care delivery.**

4. **Proposed CY2026 Home Health Payment Rate Updates**

a. *Update Factor*

HCA is supportive of CMS' proposal and application of the CY 2026 annual payment update. In the Proposed Rule, CMS calls for an annual net payment update of +2.4% (3.2% market basket increase minus .8% productivity adjustment). Regular adjustments to reflect the changing environment of home health care delivery are necessary to keep pace with increases in costs. Most provider costs are labor. However, as stated, for the fourth year in a row these adjustments are offset by the permanent and temporary payment cuts. In sum, the overall payment system does not account for increases in cost of care and is misaligned with price trends outlined in various Bureau of Labor Statistics (BLS) data.

b. *Forecast Error in the Market Basket*

Once again, HCA is commenting regarding CMS' forecast errors to the market basket. The industry believes that CMS has incurred a forecasting error of -5.89% when compounded year over year since 2021. This is an underestimation of price growth in home health care delivery.

**HCA urges CMS to finalize a forecast error correction to increase the base payment rate 9.6% to account for these forecasting errors from CY 2021 to CY 2024. In addition, we encourage CMS to reexamine its methodology in assessing the market basket and forecasting approach.**

c. *Productivity Adjustment*

HCA supports concerns raised by the National Alliance for Care at Home with respect to CMS' approach in applying a productivity adjustment. As we have commented previously, productivity gains in home health care delivery is limited and often offset by new and burdensome regulatory requirements.

d. *Home Health Wage Index*

HCA is supportive of the annual update to the wage index. However, we continue to harbor concerns about HHAs ability to compete with hospitals in the same labor pool of clinicians, aides, and administrative staff. Although HCA supports capping wage index decreases at -5%, a decrease to the wage index is an additional reduction in payment on top of the temporary and permanent adjustments proposed.

e. *Outlier FDL and Fraud Impact on Outliers*

As stated above, HCA is concerned by the inclusion of claims from suspicious/fraudulent billing patterns or HHAs. HCA directs CMS to the National Alliance for Care at Home's comprehensive review on this topic in its comments. But in sum, inclusion of fraudulent/suspicious data triggers these proposals for reductions in payment for compliant and good-acting HHAs.

**HCA urges CMS to reconsider implementing the proposed increase to the FDL ratio until it recalibrates its analysis by excluding suspicious claims data.**

f. *Payment for Telecommunication Technologies*

Since the COVID-19 pandemic, telehealth utilization has been adopted by most HHAs in one form or another. CMS initially issued Section 1135 waivers during the pandemic, permitting use of telecommunications in care delivery and later made these flexibilities permanent in the CY 2021 Home Health Final Rule. In 2023, CMS began collecting data on the use of telecommunications using three G-Codes on home health claims. However, recent research illustrates that many HHAs have discontinued use of telecommunication technology – citing high costs and lack of reimbursement. CMS outlines in the CY 2026 proposed rule that only 2% of claims include one of these G-codes.

**HCA urges CMS to consider utilizing the data it is collecting from HHAs and include it in the rate-setting methodology to incorporate telecommunication and remote patient monitoring technology. This will yield more accurate payment settings in future years to reflect more current care-delivery strategies.**

**Other Comments to the Proposed Rule:**

**Face-to-Face (F2F) Encounter**

CMS' proposal to codify changes to who may conduct the home health face-to-face (F2F) encounter is a positive step that will help reduce administrative burden for both home health agencies (HHAs) and practitioners. These changes, authorized under Section 3708 of the CARES Act, are especially valuable in cases where multiple clinicians are involved in a patient's care. At the same time, we urge CMS to recognize that F2F documentation remains one of the most common reasons for home health claim denials. In our members' experience, denials are rarely due to a failure to meet the F2F requirement itself, but rather because the documentation obtained from the certifying physician is judged insufficient during audit. This discrepancy underscores the need for consistent, practical guidance.

**Recommendations:**

- CMS should issue clear instructions to Medicare Administrative Contractors (MACs) regarding the updated F2F requirements to ensure uniform interpretation and application during medical review.
- Written guidance and education should also be made available to HHAs and physicians outlining exactly what documentation is expected to demonstrate compliance at audit.
- CMS should maintain flexibility so that the practitioner best positioned to perform the F2F—based on clinical judgment and care team structure—may do so, without introducing new layers of administrative burden.

  By pairing this regulatory change with clear, consistent education and documentation guidance, CMS can ensure that the F2F requirement fulfills its original intent—supporting patient eligibility determinations—without creating unnecessary barriers to access.

**Removal of OASIS Item O0350 and Retirement of the COVID-19 Vaccine Measure**

The Home Care Alliance of Massachusetts supports CMS' proposal to remove the Patient/Resident COVID-19 Vaccination is Up to Date item (O0350) from OASIS and retire the associated quality measure.

We agree with CMS that the end of the public health emergency, combined with evolving CDC guidance, has reduced the clinical relevance of tracking COVID-19 vaccination status as a standalone measure. Retiring this item also meaningfully reduces administrative burden for agencies, particularly as it is no longer tied to public reporting or payment incentives.

**Recommendations:**

- Allow HHAs to submit any valid response (0, 1, or dash) for O0350 until April 2026, with no impact on quality measures.
- Issue clear guidance to HHAs and vendors, including updates to iQIES documentation, to prevent data validation errors during the transition.

**Removal of SDOH OASIS Items**

HCA also supports CMS' proposal to eliminate the four standardized social determinants of health (SDOH) OASIS data elements—Living Situation (R0310), Food (R0320A/B), and Utilities (R0330)—effective April 1, 2026. While we recognize the importance of SDOH in patient care, the current items add documentation burden without influencing case-mix or directly contributing to quality or payment models. Their removal is a reasonable step, especially given ongoing workforce and resource constraints.

At the same time, we request clarification on how the removal of these items may impact future approaches to patient acuity assessment and risk adjustment. If CMS intends to explore the use of SDOH data in future models, we urge the agency to:

- Engage providers and other stakeholders early in the design process.
- Clearly identify whether SDOH data would be collected through claims or other sources.
- Ensure that any future SDOH data collection has a direct and transparent connection to quality measurement or payment.
- Recognize that home health agencies were not included in federal funding for interoperability, leaving most HHAs unable to connect directly with hospital or physician EHR systems.

**Revisions to the HH QRP Reconsideration Process**

CMS' proposal to codify and clarify the Home Health Quality Reporting Program (HH QRP) reconsideration process is a welcome step toward greater transparency and fairness. The ability for agencies to request extensions under the Extraordinary Circumstance Exception policy, and the clear articulation of reconsideration criteria, will help ensure the process is applied consistently.

To further strengthen this policy, we recommend that CMS:

- Provide technical assistance and practical examples of acceptable supporting documentation, especially for smaller agencies that may lack compliance resources.
- Align reconsideration policies across all post-acute programs to create consistency and reduce confusion for providers participating in multiple settings.

**Revisions to OASIS Terminology in the Conditions of Participation**

CMS' proposal to replace "beneficiary" with "patient" in the Conditions of Participation (CoPs) is a straightforward edit to align regulatory language with the finalized all-payer OASIS submission requirement. We agree that the CoPs should be updated for consistency. However, while the terminology change itself is technical, the broader all-payer OASIS mandate has created significant operational and administrative challenges for home health agencies. The requirement to submit OASIS assessments for all skilled patients—regardless of payer source—has led to confusion across the field, as reflected both in the volume of member inquiries we receive and in the frequency of CMS' own clarifying Q&As. Agencies continue to raise questions around which patients require assessments, the timing of assessments, and how this data will ultimately be used.

We are particularly concerned that the expansion beyond Medicare and Medicaid significantly increases documentation burden, particularly for smaller agencies without advanced IT infrastructure, while the purpose and future application of the data remain unclear. Providers need reassurance that the additional information being collected will be used in a transparent and meaningful way.

**Recommendations:**

- Provide detailed, written guidance on the purpose of all-payer OASIS data and how it may be used in reporting or future policy.
- Continue issuing clear instructions on timing, assessment types, and expectations for non-Medicare/Medicaid patients.
- Consider limited flexibility or phased implementation, particularly for short-stay or private-pay patients.
- Engage providers in direct dialogue before expanding the use of this data in any reporting or payment program.

**HHCAHPS Survey Updates**

CMS' proposal to revise the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey represents a meaningful step toward making the instrument more patient-centered and less burdensome. By removing lower-impact questions and adding new items that reflect patient priorities, the updated survey should improve both response rates and the usefulness of the results. We agree that a shorter, more focused instrument has the potential to provide a clearer picture of patient experience in home health care. Importantly, HHCAHPS remains a critical way for patients' voices to be reflected in quality reporting and the Value-Based Purchasing model.

At the same time, successful implementation depends on vendor readiness and provider support. With the April 2026 launch date approaching, agencies need sufficient lead time and technical guidance to ensure a smooth transition.

**Recommendations:**

- Confirm HHCAHPS vendor readiness and allow time for testing before rollout.
- Provide technical specifications, training, and updated protocols well in advance of implementation.
- Monitor the transition to avoid disruptions in data collection and protect agencies from inadvertent non-compliance.

**HHCAHPS Survey Impact on Public Reporting and Star Ratings**

We support CMS' proposal to treat the revised HHCAHPS measures as new measures and delay their inclusion in Star Ratings until four full quarters of data have been collected. This approach provides stability during the transition and allows providers time to adjust.

To promote transparency, CMS should clearly explain how the revised survey impacts scores and provide HHAs with guidance on how to communicate these changes to referral sources and the public. We also urge CMS to monitor any shifts in Star Ratings during the transition to ensure they reflect real performance differences rather than artifacts of survey redesign.

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**Proposed HHCAHPS Case-Mix and Mode Adjustments**

We support CMS' plan to maintain case-mix adjustments and incorporate mode adjustments to ensure fairness across patient populations and survey administration methods. However, we are concerned about the proposed removal of case-mix adjustment for patients with schizophrenia or dementia. These populations face unique challenges that can influence survey participation and responses, and the absence of an adjustment may lead to unintended disparities.

**Recommendations:**

- Monitor the impact of removing diagnosis-based case-mix adjustments and reinstate them if disparities emerge.
- Develop plain-language tools to help providers and stakeholders understand how case-mix and mode adjustments influence Star Ratings and reported scores.

**RFI – Future HH QRP Measure Concepts**

HCA appreciates the opportunity to provide input on CMS' Request for Information regarding future quality measure concepts. We value CMS' commitment to strengthening the HH QRP framework with measures that reflect a more patient-centered and holistic view of care. At the same time, new measures must be feasible, actionable, and realistic for home health agencies to implement. We offer the following feedback on the four concepts

1. **Interoperability**
   Improving interoperability is a worthwhile goal, but one that must recognize the significant barriers HHAs face. Unlike hospitals and physician practices, home health agencies were excluded from prior federal funding programs to support EHR adoption and interoperability. As a result, most agencies lack the resources to invest in advanced IT systems. Any interoperability measure should begin as a process measure, paired with funding or technical support, before advancing to performance-based metrics.

2. **Cognitive Function**
   Cognitive disorders are often chronic and progressive, with limited potential for observable improvement during a typical home health episode. Holding agencies accountable for changes in cognitive status is not realistic or appropriate. If CMS wishes to pursue this concept, measures should instead focus on areas within an HHA's control—such as caregiver education, preparedness, and timely referral processes—rather than patient outcomes that are not attributable to home health care.

3. **Well-Being**
   We support CMS' interest in person-centered, holistic care and agree that well-being is an important concept. However, defining and measuring "well-being" in a way that is valid, risk-adjusted, and appropriate for the home health setting is challenging. We

recommend CMS engage providers and stakeholders to identify which elements are most relevant and ensure any tool is validated for use with older, homebound patients.

4. **Nutrition**
   Nutrition is a critical element of overall health, but home health agencies typically assess nutritional risk rather than provide in-depth counseling or intervention, as dietitians are rarely part of the reimbursed plan of care. A feasible nutrition measure should therefore be structured as a process measure—focusing on screening, risk identification, and referral—rather than outcomes or interventions that fall outside the scope of home health services.

**Cross-Cutting Considerations**
Across all domains, CMS should prioritize feasibility, minimize administrative burden, and pilot-test new measures in real-world home health settings before formal adoption.

**Recommendation**
HCA urges CMS not to proceed with a cognition measure concept in its current form. If CMS chooses to move forward, the measure should be limited to realistic, actionable aspects of home health, such as caregiver support and referral practices, rather than outcomes beyond agency control.

**RFI – HH QRP Data Submission Deadline**
HCA agrees that timelier data can improve the usefulness of public reporting. However, reducing the OASIS submission deadline from the current 4.5 months to just 45 days following the reporting period would represent a major operational shift for agencies. Such a compressed timeline risks undermining data quality, as agencies rely on the current window to conduct QA reviews, resolve coding errors, and manage delays related to staffing or vendor system issues. Smaller agencies, in particular, may be disproportionately affected.

Before advancing a permanent change, CMS should provide additional data on current submission patterns, including how often corrections are made beyond 45 or 60 days. Without that information, it is difficult to determine whether the proposed reduction would meaningfully improve timeliness without creating unintended strain.

**Recommendations:**
- Pilot-test any revised submission deadline to assess operational impacts before full implementation.
- Consider a phased approach (e.g., beginning with a 90-day deadline).
- Provide clear training, technical assistance, and sufficient notice prior to rollout.
- Ensure that data quality and provider capacity are not compromised in the pursuit of timeliness.

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**RFI – Digital Quality Measurement in the HH QRP**

HCA supports CMS' long-term goal of advancing digital quality measurement (dQM) and increasing use of FHIR®-based data exchange to strengthen quality reporting, care coordination, and transparency. At the same time, it is essential to recognize the structural and financial barriers that home health agencies face in making this transition. Unlike hospitals and physician practices, HHAs were excluded from federal incentive programs that subsidized certified electronic health record (EHR) adoption, leaving most agencies without the resources to implement or maintain interoperable, ONC-certified systems.

Even where agencies use EHRs, system capabilities vary widely, and many vendors serving the home health field are not yet equipped to support CEHRT or FHIR®-based exchange. Agencies also contend with workforce training needs, vendor-driven implementation costs, and practical challenges such as inconsistent internet access in patient homes. Without targeted support, mandating interoperability or digital reporting risks placing additional burden on providers rather than enhancing quality.

**Recommendations:**

- Partner with vendors to assess readiness and ensure system capabilities before setting national requirements.
- Establish incentives or funding support to help agencies upgrade or transition systems.
- Pilot-test FHIR®-based OASIS submission before requiring it nationally.
- Maintain flexibility in submission pathways to prevent penalizing agencies that are not yet technologically equipped.
- Ensure equity and feasibility remain central in the transition, particularly for small, rural, and resource-constrained providers.

**HCA urges CMS to pace this transition carefully to avoid widening disparities between providers and to ensure that all agencies, regardless of size or resources, can participate fully in digital quality reporting.**

**Expanded Home Health Value-Based Purchasing (HHVBP) Model**

The proposed updates to the HHVBP Model reflect CMS' effort to refine quality measurement, but several of the changes raise significant concerns for home health agencies.

**Proposed Removal and Addition of Measures**

We understand CMS' plan to remove certain HHCAHPS measures due to survey revisions and agree that updated measures should not be introduced until sufficient data is collected to establish both achievement and improvement benchmarks. We urge CMS to ensure that patient experience continues to have strong weight in the HHVBP model, even as survey-based measures are temporarily reduced.

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**Proposed Addition of MSPB-PAC**

HCA does not support the addition of the Medicare Spending per Beneficiary – Post-Acute Care (MSPB-PAC) measure to HHVBP at this time. Post-discharge spending is largely outside of an HHA's control and may unfairly penalize agencies serving medically complex or underserved populations. Without careful risk adjustment, this measure risks disincentivizing care for the very patients who need home health the most.

We also note that many agencies are unfamiliar with MSPB-PAC methodology. Transparent training, feedback reports, and clear explanations of how scores are calculated will be critical if this measure moves forward. Until then, we believe its inclusion would introduce more risk than value.

**Recommendations on MSPB-PAC**

- Withdraw or delay implementation until a full impact analysis is conducted.
- Provide transparent, timely reports and ensure exclusions for patients with high post-discharge needs.
- Balance spending measures with continued emphasis on quality and patient experience to maintain equity.

**Proposed Addition of OASIS-Based Functional Measures**

We support the addition of functional status measures based on OASIS data, as these are meaningful, actionable, and directly reflect the care provided. Adjusting measure weights to account for HHCAHPS revisions is reasonable, but CMS must ensure that the patient voice remains central to the HHVBP model.

**HHVBP – RFI on Future Measure Concepts**

HCA appreciates CMS' openness to stakeholder input and offers the following feedback on measured concepts under consideration:

- **Falls With Major Injury:** A hybrid OASIS/claims measure may improve accuracy but must exclude events beyond agency control. Risk adjustment and provider education are essential.
- **Achievement-Only Scoring for New HHCAHPS Items:** This approach may disadvantage small agencies. CMS should outline a clear plan and timeline for transitioning to achievement + improvement scoring.
- **Single-Item Measures:** These should be carefully pilot-tested for reliability and impact on survey burden before inclusion in payment.

**General Recommendations:**

- Prioritize feasibility for small and mid-sized agencies.
- Pilot-test and publicly report new measures before tying them to payment.
- Focus on outcomes that are actionable, patient-centered, and within the scope of home health care.

**HCA urges CMS to refine the HHVBP model in ways that strengthen quality improvement without exacerbating disparities or creating unintended disincentives for serving high-need populations.**

**Conclusion**

The Home Care Alliance of Massachusetts writes in urgent and intense opposition to the proposed cuts in the CY 2026 Home Health PPS Rule. An estimated $1.135 billion reduction in 2026—on top of nearly 9% in cuts already imposed from 2023–2025—would devastate the overall health care delivery system.

These reductions are not abstract figures: they translate directly into fewer agencies, smaller service areas, and patients left without needed care at home. CMS' own data confirms the damage that more than 1,000 home health agencies have closed since 2020, and MedPAC has documented an 8% decline in Medicare home health utilization over the same period. The system cannot sustain further reductions without widespread loss of access for vulnerable beneficiaries.

At the same time, we recognize and support CMS' efforts to modernize quality reporting, streamline OASIS, improve the HHCAHPS survey, and strengthen the HHVBP model. Our detailed comments highlight the importance of aligning these initiatives with clarity, feasibility, and equity so that providers can focus on delivering patient-centered care. But no quality framework, however well-designed, can succeed if the payment system undermines the stability of the provider network.

For these reasons, we respectfully urge CMS to withdraw the proposed payment cuts and work collaboratively with providers to build a payment and quality structure that preserves access, promotes equity, and sustains high-quality care at home. We stand ready to partner with CMS to ensure home health remains a reliable and accessible option for the patients who depend on it.

Sincerely,

Jake Krilovich
Executive Director
Home Care Alliance of Massachusetts