



August 27, 2026

Dr. Mehmet Oz, Administrator
Center for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Subject: **(CMS-1844-P)** Medicare Program; (CY) 2027 Home Health Prospective Payment System Proposed Rule

Electronically via: <http://www.regulations.gov>

Dear Administrator Oz,

- **Trinity Health at Home (THAH) urges CMS to protect the Home Health benefit for Medicare beneficiaries by significantly increasing the percentage update to account for the real expenses experienced by Home Health providers. The proposed update will result in a negative margin.**
- **We urge CMS to reevaluate the methodology of temporary recoupment adjustments, consider the cumulative impact of multiple years of reductions on patient access, and closely monitor agency closures and geographic disparities resulting from multiple years of payment reductions.**
- **THAH recommends that CMS continue to enhance transparency around the methodology and operational impacts associated with future PDGM Case-Mix Weight recalibrations considering the impact to financial sustainability and the needs of medically complex populations.**
- **THAH recommends that CMS issue clear sub-regulatory guidance for palliative care in the Home Health benefit, establishing covered services, provider expectations, and a reimbursement framework that considers the realities of the palliative care patient with reasonable and consistent quality measures specific to the population.**
- **THAH disagrees that Advanced Care Planning should be included as a future quality measure for Home Health.**
- **Trinity Health recommends CMS revise the Provider Enrollment Proposals to ensure enrollment sanctions remain tied to objective evidence of provider misconduct and are supported by appropriate procedural safeguards.**

Trinity Health at Home, a National Health Ministry of Trinity Health, is a not-for-profit, faith-based organization that provides Home Health Care to patients in twelve states; our average daily census is approximately 11,000 patients. We appreciate the opportunity to



comment on CMS-1844-P, the CY 2027, Home Health Prospective Payment System Update.

Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 133,000 colleagues and 30,000 physicians and clinicians caring for diverse communities across 23 states. Nationally recognized for care excellence and patient experience, the Trinity Health system includes 91 hospitals, 101 continuing care locations, and the second largest PACE program in the country (a total cost of care program). Trinity Health has 15 medical groups with 8,900 medical group physicians and providers. With headquarters based in Livonia, Michigan, its annual operating revenue is \$25.4 billion with \$2.9 billion returned to its communities annually in the form of charity care and other community benefit and community impact programs.

Trinity Health has 12 Clinically Integrated Networks (CINs) that are accountable for 2 million lives across the country through alternative payment models. Our health care system participates in 12 markets with Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs), which includes 10 markets partnering in one national MSSP Enhanced Track ACO, Trinity Health Integrated Care. All of these markets participated in the “enhanced track,” which qualifies as an advanced alternative payment model (AAPM). Two of the 12 markets also participate in the Comprehensive Primary Care Plus Model. In addition, we participated for many years in the Bundled Payments for Care Improvement Advanced (BPCIA) initiative and the Comprehensive Care for Joint Replacement (CJR) program across 37 hospitals. Our work—and experience in value-based contracting—also extends beyond Medicare as illustrated by our participation in 123 non-CMS APM contracts.

Our comments and recommendations reflect a strong interest in public policies that support better health, better care, and lower costs to ensure affordable, high quality, and people-centered care for all. In addition, the comments below are recommendations on modifications to the Medicare fee-for-service payment system. Many of these issues would be lessened, or in some cases eliminated, if CMS gave non-profit health systems, such as Trinity Health, more accountability in total cost of care payment and delivery arrangements.

Our comments on the proposed rules for Home Health are provided with a sense of responsibility to Medicare beneficiaries who wish to remain in their home to receive skilled nursing care, therapy, social work, and aide services. It is crucial that CMS consider and adjust rate changes to ensure this benefit remains financially sustainable, is able to adequately address staffing shortages, and

continues to serve the most vulnerable patient populations. We urge CMS to adjust the percentage update to account for the real expenses experienced by Home Health providers. The accumulating impact of years of inadequate rate changes, coupled with underpayment from commercial insurance, Medicare Advantage Plans and Medicaid will lead to significant access challenges for those requiring care in the home and lengthen the need to board patients in hospitals and skilled nursing facilities.

The population is aging, and more people have chronic conditions that require care. The cost of delivering this care is growing. Home Health Care is the setting people prefer to receive care and is a less expensive option than inpatient or institutional care.

HOME HEALTH CARE SAVES MEDICARE DOLLARS. Home Health (HH) is the solution to the increasing numbers of patients requiring therapy and nursing services. Sustaining those providers who put the patient at the center of the care delivery experience, like Trinity Health at Home, must be the goal of CMS to allow for access to this Medicare benefit. CMS has acknowledged that bad actors who are for-profit have tarnished the reputation of the Home Health industry. As a not-for-profit, faith-based provider, CMS should look to THAH as a resource for defining expectations and accountabilities related to care of the Medicare beneficiary in the home setting. We are eager to work with the agency on improving and sustaining the Home Health benefit.

Our Comments are as follows:

CY 2027 Proposed Payment Rate:

We appreciate CMS's proposal to increase aggregate Medicare payments to home health agencies by approximately 2.4 percent in CY 2027, representing an estimated increase of \$420 million nationally. However, we remain concerned that the proposed payment update does not fully account for the cumulative inflationary pressures facing providers, including workforce shortages, wage increases, transportation costs, technology investments, and compliance requirements.

Home health agencies continue to operate in an environment marked by significant labor challenges and increasing patient acuity. While the proposed update provides important support, additional payment stability is necessary to ensure continued access to care, particularly in rural and underserved communities where home health capacity is already strained.

To illustrate the impact of multiple facets of this proposed rule including wage index changes, our analysis confirms that we would realize a 2.8% increase in CY27, *prior to*

budgeted and necessary wage increases for staff. The results are depicted in the chart below:

	CY2027	CY2027
	Proposed Rule	Estimated Medicare
State	Rate Change	Rate Impact
PA	1.29%	705,938
IL	1.74%	166,474
MI	3.25%	829,362
IA	2.54%	255,367
OH	4.19%	558,248
MD	-0.41%	(17,278)
CT	3.62%	260,566
GA	2.93%	172,734
CA	-1.33%	(56,596)
IN	0.66%	22,930
DE	2.72%	76,822
NY	1.81%	189,000
Total	2.84%	3,163,567

However, Home Health Agencies (HHAs) continue to struggle with recruitment and retention of qualified Home Health staff. THAH has budgeted a 3.6% wage increase for FY27 that translates to an annual cost of \$7.8 million. The results of the proposed increase with budgeted wage increase is a negative margin of 1.8% as illustrated in this chart:

Annualized Impact	\$3,163,567
Wage Increase 3.59%	7,783,232
Net Impact	(\$4,619,665)

This inadequate proposed payment update would inhibit our ability to reward and retain staff. This creates a substantial barrier to access as workforce challenges continue to impact the industry. It will negatively influence our ability to hire and train the number of skilled clinicians to deliver high-quality care to the most vulnerable. We must continue to offer our clinicians annual merit-based pay increases if we want to attract and retain the best and the brightest. Our agencies in rural and underserved areas will continue to be the hardest hit as they already have fewer health care resources available to them.

THAH is troubled that the data CMS uses to predict real inflation and cost of labor does not reflect the current landscape and will result in a seventh consecutive year where the payment update is not reflective of the actual cost increases HHAs are experiencing. THAH believes increased labor costs are not transitory. The cost to adequately staff an agency with skilled workers is not going down. Many positions remain in short supply and competition for home health workers is only growing. The time it takes THAH to fill vacant positions is already lengthy. For nursing positions, it is taking on average 68 days to fill and for physical therapists, 72 days. This problem is not improving, and rate adjustments that do not reflect the actual staffing costs for home health agencies only adds to this alarming trend.

Although CMS does not have oversight of commercial payors, it is important that the Agency understands the challenge they pose. Commercial payors do not cover the cost of providing Home Health care, yet they are making record profits. Our choices are clear: we go out-of-network with these payors and further limit access for patients or agree to dismal terms that put their profits over fair payment. Equally infuriating, commercial payors have adopted the unconscionable practice of denying payment after care has been provided.

We urge CMS to significantly increase the percentage update to account for the real expenses experienced by Home Health providers.

PDGM Behavioral Adjustments and Temporary Payment Reduction: We appreciate CMS's recognition that utilization changes observed in more recent years may be attributable to factors beyond implementation of the Patient-Driven Groupings Model (PDGM), including ongoing case-mix recalibrations, OASIS-E implementation, and prior rate reductions. We therefore support CMS's decision not to propose an additional permanent behavioral adjustment for CY 2027.

However, we have significant concerns regarding the proposed continuation of the 3% temporary adjustment intended to recoup retrospective overpayments associated with PDGM implementation. CMS acknowledges that various confounding factors affect utilization patterns and that recent behavioral changes may not be directly attributable to PDGM. Given this uncertainty, continued reductions create additional financial pressure on providers already managing thin operating margins. **We urge CMS to eliminate the 3% proposed temporary adjustment, re-evaluate the methodology of temporary recoupment adjustments, consider the cumulative impact of multiple years of reductions on patient access, and closely monitor agency closures and geographic disparities resulting from multiple years of payment reductions.**

THAH recognizes that statutory constraints may limit the actions CMS may take and therefore, we urge CMS to use your “time and manner” discretion authority from the Bipartisan Budget Act of 2018 to pause the implementation of any additional budget neutrality and behavioral adjustments. As CMS has done in the past with historic disruptions to providers, we urge CMS to use its discretion to ensure reimbursement predictability so that HHAs can continue to care for patients.

Recalibration of PDGM Case-Mix Weights: We support CMS's efforts to maintain accurate reimbursement through appropriate recalibration of PDGM case-mix weights, functional levels, comorbidity adjustments, and LUPA thresholds using the most current utilization data available.

At the same time, we encourage CMS to carefully evaluate whether annual recalibrations are necessary and appropriate and recognize they can lead to unintended volatility in reimbursement. Frequent changes may make financial planning challenging for providers and could disproportionately affect agencies serving medically complex populations. The data can be skewed if agencies cherry pick or serve a specific diagnosis. In addition, this can risk lowering of the PDGM Case-Mix weights and change the LUPA thresholds, resulting in potential for increased re-hospitalizations as only LUPA thresholds are authorized. **THAH recommends that CMS continue to enhance transparency around the methodology and operational impacts associated with future recalibrations considering the impact to financial sustainability and the needs of medically complex populations.**

Home Health Wage Index RFI: We appreciate CMS's request for information regarding development of a home health-specific wage index. Current wage index methodologies do not always reflect the labor market realities faced by home health agencies, particularly those competing for clinical staff across multiple care settings.

We recommend that CMS establish a **Home Health Rural Travel Adjustment** that incorporates factors such as population density, average clinician drive time, geographic dispersion of patients, and county-level rurality. The current wage index adjusts for labor costs but does not account for the additional staffing resources required when clinicians spend considerable portions of their workday traveling between homes rather than providing billable patient care.

We also encourage CMS to evaluate the use of **Home Health-specific Labor Market Data**, rather than relying primarily on hospital wage data, which does not accurately reflect the workforce challenges facing home health providers. Home health agencies compete for the same nurses and therapists as hospitals while operating in fundamentally different care delivery environments. CMS already recognizes the significance of county-level and CBSA wage index variations in Home Health PPS



payment policy, and further refinement is warranted to better capture the realities of home-based care delivery. CMS must implement payment methodologies that recognize both labor costs and workforce access challenges. Without such adjustments, reimbursement will continue to understate the true cost of delivering Medicare home health services and may jeopardize access to care for beneficiaries living in rural and underserved areas.

We encourage CMS to thoroughly evaluate whether alternative data sources, including Bureau of Labor Statistics data, could provide a more accurate representation of home health workforce costs. Any future transition should be transparent, budget-neutral where appropriate, and accompanied by adequate transition protections for affected providers.

CMS is proposing changes to better align the HH Quality Reporting Program (QRP) and the HH Value Based Purchasing Model (VBP), including revisions to the data submission and correction period. THAH appreciates CMS's efforts to improve the timeliness of publicly reported quality data and support the objective of providing beneficiaries and stakeholders with more current information regarding home health agency performance. However, we are concerned that reducing the OASIS assessment submission and correction period from approximately 4.5 months to 45 days will create operational challenges that could adversely affect data accuracy and reliability.

Home health agencies routinely rely on documentation and clarification from hospitals, physicians, and other external healthcare providers to ensure the accuracy of OASIS assessments. In addition, agencies require sufficient time to conduct internal quality assurance reviews, identify coding or assessment discrepancies, and implement appropriate corrections. A substantially shortened correction window may limit the ability of agencies to complete these essential validation activities before quality measures are calculated and publicly reported.

While CMS's analysis indicates that most OASIS assessments are submitted within 45 days, timely submission should not be equated with the completion of comprehensive data validation and quality review processes. We are concerned that the proposed change may inadvertently increase the risk of uncorrected assessment errors, thereby affecting the accuracy of quality measure results and publicly reported performance information.

THAH recommends that CMS consider maintaining the proposed 45-day submission requirement while preserving an extended correction period that would allow agencies adequate time to perform necessary quality assurance activities. Such an approach would advance CMS's objective of more timely public reporting while ensuring that quality data remain accurate, reliable, and reflective of

patient outcomes and provider performance. Additionally, we recommend a phase-in approach to this change, to allow agencies, software vendors, and quality review teams to redesign workflows gradually instead of facing an immediate 67% reduction in review time.

Timeliness and accuracy are equally important components of a meaningful quality reporting program. We encourage CMS to adopt a balanced approach that supports both goals without placing undue operational burden on home health agencies or limiting their ability to validate and correct clinically significant OASIS data.

Home Health Palliative Care: Studies support the fact that the majority of people with palliative care needs live in the community or in their homes, making home-based palliative care crucial for patients and their families.¹ We strongly support CMS's acknowledgment of the important role that home health agencies can play in the delivery of community-based palliative care. The proposed rule appropriately recognizes that home health services can serve as one valuable component of the care continuum for patients with serious, chronic, or progressive illnesses. However, it is vital that CMS establishes the covered benefits under palliative care and a reimbursement model that covers specific, expanded services. Currently home health treats patients who need a skilled service, such as nursing or therapy and quality measures are aligned with functional improvement and rehabilitation outcomes. In contrast, many palliative care patients require specialty trained physicians and APP's providing skilled clinical oversight focused on symptom management, prevention of avoidable complications, medication optimization, caregiver education, care coordination, and maintenance of function rather than functional improvement. As a result, quality measures based primarily on rehabilitation outcomes may not accurately reflect the quality of care delivered to this population. Although CMS has acknowledged that improvement is not required when skilled services are needed to maintain a patient's condition or prevent decline, additional guidance is needed to ensure that palliative care services are appropriately recognized and supported.

We recommend CMS add language stating:

Skilled palliative care provided by specialty trained physicians and APP's should include symptom assessment and management; management of symptom-focused medications; monitoring medication effectiveness and side effects; management of pain, dyspnea, nausea, anxiety, delirium, and other distressing symptoms; prevention of crises that may

¹ Lin, C. P., & Chu, W. M. (2025). Home-Based Palliative Care: Benefits, Challenges, Opportunities and Future Directions in a Super-Aged Society. *Journal of hospice and palliative care*, 28(3), 81–88. <https://doi.org/10.14475/jhpc.2025.28.3.81>

lead to hospitalization; caregiver education; coordination with treating practitioners; and support for complex decision-making and advance care planning.

CMS should establish quality measures specific to palliative care. Current home health quality measures (HH QRP) are heavily focused on functional improvement. These measures are appropriate for rehabilitation-oriented patients but may not reflect the goals of palliative care, where the objective is often symptom management, comfort, maintenance of function, caregiver support, and goal-concordant care rather than improvement. This misalignment disadvantages agencies for caring for a high proportion of palliative patients. CMS has acknowledged that home health eligibility does not require potential for improvement and that skilled services may be necessary to maintain condition or prevent deterioration. We recommend consideration of a palliative-sensitive HH QRP approach that could include measures such as:

- *Pain assessment and management*
- *Dyspnea assessment and management*
- *Comprehensive symptom burden assessment and management, including pain, nausea, anxiety, delirium, fatigue, and other distressing symptoms.*

Goal-Concordant Care:

- *Advance care planning discussions and documentation*
- *Goals-of-care discussions and documentation*
- *Ongoing decision regarding disease management, interventions, and disease progression*
- *Caregiver preparedness and support*
- *Patient-reported quality of life*
- *Patient and caregiver experience measures*

Utilization and Safety Outcomes:

- *Avoidance of burdensome or unwanted interventions*
- *Reduction in avoidable emergency department visits*
- *Reduction in potentially preventable hospitalizations*

- *Goal-Concordant hospitalization rates*
- *Hospice Utilization*
- *Advanced Directives completions*

This approach would better reflect the realities of palliative care while preserving accountability for quality and safety. It would also encourage more agencies to accept complex palliative patients rather than avoiding them because of concerns about quality scores. This addition would allow beneficiaries greater access to palliative services and would align policy with modern palliative care practice.

Eligibility and Access

In addition, many seriously ill patients would benefit from palliative care but are not technically "homebound." Because the homebound standard is fundamental to the existing Medicare home health benefit structure, CMS should consider testing alternative eligibility pathways for community-based palliative care through demonstration projects, waiver authority, or future payment models.

We recommend CMS add language stating:

CMS should evaluate alternative pathways that allow beneficiaries with advanced chronic illness or serious progressive disease to receive home-based palliative care services when a physician or qualified practitioner determines that such services are clinically appropriate, even when the beneficiary does not meet the traditional homebound.

Such an approach would better support beneficiaries with cancer, heart failure, COPD, ALS, dementia, and other serious illnesses, allow beneficiaries earlier access to symptom management, and reduce avoidable emergency department utilization.

Clarifying the Distinction Between Hospice and Palliative Care

CMS should further clarify the distinction between hospice care and palliative care delivered concurrently with disease-directed treatment. Many patients delay supportive care because they mistakenly believe palliative care requires giving up disease-modifying treatment.

We recommend CMS add language stating:

Home health agencies may provide palliative care services through specialty trained physicians and APP's to beneficiaries with serious illness when skilled clinical

management is required to alleviate symptoms, support quality of life, assist with complex treatment decisions, coordinate care, or prevent avoidable complications. Eligibility for these services should not be based solely on rehabilitative potential, prognosis, or restoration of function. Palliative care may be provided concurrently with disease-directed treatment.

This language would reinforce the distinction between palliative care and hospice. CMS describes hospice as comfort-focused care for terminally ill patients who elect the hospice benefit, while palliative care may be appropriate much earlier in the disease trajectory and may accompany ongoing disease-directed treatment.

Interdisciplinary Care and Payment Reform

Palliative care programs are typically led by interdisciplinary teams that may include specialty trained physicians, advanced practice providers (APPs), nurses, social workers, chaplains, and other professionals working collaboratively to address physical, psychosocial, emotional, and spiritual needs.

Covered palliative care services should include skilled social work interventions addressing caregiver burden, psychosocial distress, advanced care planning, resource coordination, and support for complex decision-making.

Furthermore, the current Home Health Prospective Payment System is designed primarily around short episodes of post-acute and restorative care. Patients receiving palliative care often require longitudinal symptom management, intermittent skilled oversight, caregiver support, and coordination across multiple providers over an extended period. Under the current reimbursement structure, sustaining comprehensive palliative care services beyond a traditional home health episode may not be financially feasible. CMS should evaluate alternative reimbursement methodologies that recognize the ongoing needs of patients with serious illness and adequately support agencies delivering community-based palliative care services.

Expanded access to palliative care services has the potential to improve quality of life, reduce avoidable hospitalizations, and better align care delivery with patient goals and preferences. **THAH recommends that CMS issue clear sub-regulatory guidance establishing covered palliative care services, a distinct palliative care eligibility pathway, clearly defined interdisciplinary provider expectations, palliative-specific quality measures, and reimbursement models that reflect the realities of caring for patients with serious illness.**

THAH strongly supports CMS's efforts to expand access to community-based palliative care and encourages the agency to develop demonstration projects and

payment models that improve outcomes for beneficiaries with serious illness. THAH would welcome the opportunity to participate in future pilots and model-testing initiatives aimed at advancing community-based palliative care through the Medicare program.

Include Additional Examples of Skilled Home Health Services for Beneficiaries with Serious Illness and Palliative Care Needs:

Although the Medicare Benefit Policy Manual states that home health skilled services may be covered when needed to maintain a patient's condition or prevent deterioration, current guidance contains limited examples that clearly illustrate the skilled needs of patients receiving palliative care.

As a result, providers may hesitate to admit patients with serious illness whose primary goals are symptom management, quality of life, and avoidance of unnecessary hospitalization rather than rehabilitation or functional improvement.

Additional examples would improve consistency in coverage determinations and clarify that palliative care services can be delivered under the existing home health benefit when medical necessity criteria are met. We recommend that CMS revise Chapter 7 of the Medicare Benefit Policy Manual to include a dedicated subsection titled:

Examples of Skilled Home Health Services for Beneficiaries with Serious Illness and Palliative Care Needs

Examples should emphasize the clinical judgment, assessment, care planning, and skilled interventions required to manage complex symptoms and support patients with advanced disease.

CMS should clarify that the following activities may constitute skilled nursing services when medically necessary:

Complex Pain Management:

- *Assessment of uncontrolled cancer pain.*
- *Evaluation of opioid effectiveness and side effects.*
- *Monitoring for oversedation, delirium, constipation, or respiratory depression.*
- *Titration and reassessment of pain management plans.*
- *Education of patients and caregivers regarding medication administration and safety.*

Example case:

A patient with metastatic cancer experiences escalating pain despite multiple medication changes. Skilled nursing visits are required to assess response to treatment, monitor adverse effects, coordinate with the physician, and educate family caregivers regarding symptom management.

Management of Dyspnea and Respiratory Distress:

- *Assessment of worsening shortness of breath.*
- *Oxygen management.*
- *Monitoring of respiratory symptoms.*
- *Non-pharmacologic symptom management.*
- *Caregiver education regarding symptom escalation.*

Example case:

A beneficiary with advanced COPD experiences recurrent episodes of dyspnea requiring ongoing symptom assessment and coordination of treatment adjustments to prevent emergency department utilization.

Medication Management for Serious Illness:

- *Reconciliation of complex medication regimens.*
- *Assessment of medication effectiveness.*
- *Monitoring for adverse reactions.*
- *Coordination among multiple specialists.*
- *Education regarding new symptom-management medications.*

Example case:

A patient with advanced heart failure receives medications from several specialists and requires skilled nursing oversight to monitor effectiveness, identify interactions, and adjust management plans in collaboration with treating practitioners.

Assessment and Management of Progressive Decline:

- *Monitoring functional deterioration.*

- *Assessment of nutritional decline.*
- *Evaluation of falls risk.*
- *Monitoring cognitive changes.*
- *Development of strategies to maintain safety and quality of life.*

Example case:

A beneficiary with advanced dementia demonstrates ongoing decline requiring skilled assessment, caregiver education, and implementation of interventions to maintain comfort and safety.

These changes would encourage community-based palliative care services under the Medicare Home Health benefit by providing agencies clarify as to how existing Medicare home health coverage criteria apply to patients with serious illness. By giving concrete examples, CMS could reduce variation in interpretation, encourage appropriate admissions, and make it easier for home health agencies to serve palliative care patients while remaining compliant with Medicare coverage requirements.

Advanced Care Planning RFI: CMS is requesting information (RFI) and soliciting public comments on whether to consider advanced care planning as a future quality measure for home health providers. Although THAH strongly supports advanced care planning and believes it is an important step in understanding and conducting the wishes of each individual, there are barriers to including this as a future quality measure under Home Health. The patient relationship in Home Health is often brief and intermittent and focused on improving functional outcomes. We believe Advanced Care Planning should be the responsibility of the Primary Care Physician who would have a longer-term relationship with the patient and broader view of the patient's condition. **THAH disagrees that Advanced Care Planning should be included as a future quality measure for Home Health.**

Provider Enrollment: Trinity Health appreciate CMS's continued efforts to safeguard the Medicare program and protect beneficiaries and taxpayers from fraud, waste, and abuse. We share CMS's commitment to program integrity and support targeted enforcement measures directed at individuals and entities that engage in fraudulent or abusive conduct, including those that knowingly violate material provisions of the provider enrollment requirements. However, several of the enrollment proposals included in the CY 2027 Home Health Prospective Payment System (PPS) Proposed Rule (the

“Proposal”) represent a significant expansion of CMS's denial and revocation authority and raise concerns regarding fairness, due process, and regulatory predictability.

A common theme throughout the Proposal is the expansion of denial and revocation authority based not on demonstrable misconduct by the affected provider or supplier (collectively referred to herein as “providers”), but on generalized risk factors, geographic considerations, affiliation-based concerns, or conduct attributable to third parties. As drafted, several provisions would permit Medicare enrollment actions that are disconnected from the provider's own conduct and would authorize severe sanctions based on highly discretionary standards. **Trinity Health recommends CMS revise these proposals to ensure enrollment sanctions remain tied to objective evidence of provider misconduct and are supported by appropriate procedural safeguards.**

1. Retroactive Effective Date for All Enrollment Revocations - 42 C.F.R. § 424.535(g)

Proposed Change

CMS proposes revising 42 C.F.R. § 424.535(g) to make all enrollment revocations effective retroactively, rather than permitting certain revocations to become effective prospectively. CMS explains that a uniform retroactive effective date would improve program integrity and facilitate recovery of Medicare payments made to providers that CMS later determines were noncompliant.

While we support CMS's efforts to combat fraud and protect the Medicare Trust Fund, the proposed amendment to § 424.535(g) should be updated to distinguish between intentional misconduct and technical enrollment noncompliance, with retroactive revocation being reserved for the former.

Trinity Health recommends retroactive revocation be limited to circumstances involving:

- Fraud.
- Intentional concealment of material information.
- Knowing or reckless misrepresentations; or
- Other egregious conduct demonstrating a substantial program integrity risk.

For technical enrollment deficiencies, reporting errors, or other administrative noncompliance, CMS should retain prospective revocation authority or permit corrective action plans and other remedial measures before imposing retroactive revocation.

2. Expansion of False or Misleading Information Revocation Authority - 42 C.F.R. § 424.535(a)(4)

Proposed Change

CMS proposes expanding its revocation authority under 42 C.F.R. § 424.535(a)(4) to encompass false or misleading information contained not only in enrollment applications, but also in enrollment-related forms, supporting documentation, and other materials submitted in connection with Medicare enrollment. We agree that intentional falsification should remain grounds for revocation. However, we recommend the proposed expansion, if adopted, be updated to include certain safeguards.

Enrollment submissions often involve large amounts of information generated by multiple individuals, contractors, attorneys, accountants, consultants, and third-party entities. Despite exercising reasonable diligence, providers may unknowingly submit information that later proves inaccurate, incomplete, or subject to differing interpretations.

Moreover, and due to the operational realities of many providers, certain information may itself be made effective retroactively, like appointing members to serve on a board of directors. If taken to its extreme, the proposed expansion of 42 C.F.R. § 424.535(a)(4) could result in a provider's enrollment being revoked because a board member was retroactively appointed to a reportable director position – a change otherwise promptly reported by the provider once made final. Such a situation can happen, for example, if the board or nominating committee selected the individual, but the formal board resolution, written consent, or meeting minutes were not finalized until a later date due to scheduling or administrative delays – or if a vacancy occurs due to unexpected resignation, death, or incapacity.

Trinity Health recommends the proposal be updated to include a definition of “false and misleading information” to mean “information that is materially false, materially incomplete, or materially misleading, that influences CMS's enrollment determination and that cannot be corrected by updating the information submitted.” Trinity Health also recommends CMS direct its Medicare Administrative Contractors (“MACs”) to allow providers no less than thirty (30) days to correct errors that are not “false or misleading,” as defined above, before revocation is imposed.

3. Expansion of "Abuse of Billing Privileges" Revocation Authority - 42 C.F.R. § 424.535(a)(8)

Proposed Change

CMS proposes revising 42 C.F.R. § 424.535(a)(8) by removing the existing regulatory factors used to evaluate whether a provider or supplier has engaged in a pattern or practice of abusive billing. CMS explains that removing these factors would provide greater flexibility in identifying problematic billing conduct.

Trinity Health believes the existing framework should be maintained as it provides objective criteria that assists providers in understanding the conduct that may trigger revocation. Eliminating those factors risks replacing a structured analysis with subjective decision-making that may vary among MACs, regions, or reviewers. At minimum, Trinity Health recommends the framework be maintained in Chapter 10 of the Medicare Program Integrity Manual to ensure that MACs have clear guidance on application of 42 C.F.R. § 424.535(a)(8).

4. Revocation Based on "High-Risk" Geographic Areas – 424.535(a)(24)

Proposed Change

CMS proposes a new basis for enrollment revocation when it determines that a provider's location presents a heightened risk of fraud, waste, or abuse because the provider operates in a geographic area that CMS has determined contains an excessive concentration of providers.

As CMS is aware, providers cannot control where other entities choose to operate. Nor can they control whether unrelated individuals engage in fraudulent activity within a particular market. Yet the proposal would authorize revocation based on characteristics of the surrounding environment rather than the provider's own actions. As revocation is one of the most severe actions CMS can take with respect to a provider's Medicare enrollment, Trinity Health believes it should be reserved for cases in which the provider has engaged in substantial and direct misconduct, rather than circumstances arising from factors outside the provider's control.

Instead of adopting its proposed update at 42 C.F.R. §424.535(A)(24), Trinity Health recommends CMS use enhanced screening, monitoring, and oversight tools to investigate and remediate geographic risk concerns. However, Trinity Health believes that if CMS adopts this change, either as proposed or as may be modified, sanctions resulting therefrom should be imposed by CMS directly and not the MACs, as this would help ensure consistent application of this otherwise extraordinary basis for revocation. In addition, CMS should clarify that affected providers are able, on an individual basis, to fully avail themselves of all appeal rights at 42 CFR Part 498.

5. Expansion of Program or License Suspension Grounds to Owners and Managers - 42 C.F.R. § 424.530(a)(14)(i)

Proposed Change

CMS proposes expanding existing authorities under 42 C.F.R. § 424.530(a)(14)(i) to permit denial based on license suspensions, program suspensions, or similar actions involving owners, managing employees, or managing organizations.

While CMS has a legitimate interest in preventing individuals with problematic compliance histories from facilitating fraud, the proposal is overly broad because it does not sufficiently distinguish among varying levels of involvement and responsibility.

A provider may have numerous owners, executives, managers, investors, or affiliated entities. If made final, the proposal will permit significant sanctions based on conduct attributable to a single individual even where the provider itself has maintained full compliance with Medicare regulations.

Trinity Health recommends the proposed expansion to 42 C.F.R. §§ 424.530(a)(14)(i) be updated to require a substantial nexus between the individual's conduct and the provider's Medicare operations. Trinity Health also recommends the provider be given an opportunity to remove the individual before denial occurs.

6. Expansion of Medicare Debt-Based Denial Authority to Managing Employees, Managing Organizations, and Other Business Relationships - 42 C.F.R. § 424.530(a)(6)

Proposed Change

CMS proposes to expand its ability to revoke a provider's enrollment under 42 C.F.R. § 424.530(a)(6) to include managing employees, managing organizations, and individuals and entities that maintain other business or financial relationships with the provider or supplier.

Trinity Health has significant concerns with this proposed change because it extends enrollment sanctions far beyond the provider and reaches individuals and entities that may have no ownership interest, operational control, or responsibility over or for the provider. Providers routinely engage with many management personnel, affiliated entities, joint venture participants, contractors, physician leaders, and vendors. The



existence of a business or financial relationship does not establish responsibility for a separate entity's Medicare liabilities or even knowledge of those liabilities.

Trinity Health believes CMS should maintain 42 C.F.R. § 424.530(a)(6) as is, as it is appropriately tailored to account for those that have an ownership interest or operational control over the enrolled provider. At a minimum, Trinity Health strongly recommends 42 C.F.R. § 424.530(a)(6) not be extended to those with which the provider has only a “business or financial relationship.”

7. Revocation or Denial Based on Shared Suite or Co-Located Office Space – 42 CFR § 424.530(a)(19)

Proposed Change

CMS proposes a new enrollment denial ground at 42 CFR § 424.530(a)(19) based on the provider having its practice location in the same suite or office as another provider whose Medicare enrollment has been revoked or denied.

It is common for medical complex buildings to house numerous providers within the same building or suite. Trinity Health believes compliant providers should not face enrollment consequences solely because the enrollment of another tenant in one of these buildings is denied or revoked. Providers cannot reasonably control who leases nearby space now or in the future or the ownership structure or compliance history of neighboring tenants.

If finalized, Trinity Health recommends that denial under 42 CFR § 424.530(a)(19) require evidence of common ownership, common control, commingled operations, or coordinated conduct.

8. Expansion of Enrollment Actions Subject to Moratoria - 42 CFR § 424.570(a)(1)(i)(A) through (E)

Proposed Change

CMS proposes updating 42 CFR § 424.570(a)(1)(i)(A) to include additional enrollment activities that would be subject to a temporary moratorium, including reactivating applications, including those from voluntarily providers who had previously voluntarily terminated their enrollment.

CMS should maintain the current scope of moratoria or at a minimum decline to extend moratorium application to reactivation applications, including those providers who

previously terminated their enrollment voluntarily. These applicants are distinguishable from new entrants to the Medicare program. Reactivation applicants have already undergone Medicare screening and enrollment review and are often seeking to restore billing privileges that were deactivated for administrative reasons unrelated to fraud or abuse.

Extending moratoria to these categories would provide limited additional program integrity benefit while potentially restricting beneficiary access to care, delaying the return of qualified providers to the program, and increasing administrative burdens for both CMS and providers.

9. Expansion of the Definition of Managing Employee - 42 CFR § 424.502

Proposed Change

CMS proposes to update the definition of managing employee to include the following persons: medical directors (not only those at SNFs and hospices); clinical directors; departmental heads (for example, a hospital's chief of cardiology); supervising physicians (not simply those at IDTFs); nursing directors; alternate administrators; and all other clinical personnel that meet the “managing employee” definition.

While CMS's program integrity objectives are understandable, Trinity Health believes the proposed expansion would provide limited additional value because much of the information regarding these individuals is already disclosed to CMS through existing certification, accreditation, and operational oversight processes. For example, providers routinely report organizational structure, key leadership personnel, medical directors, supervising physicians, and other responsible officials through state licensure requirements, survey processes, and other regulatory mechanisms. As a result, the proposal may create duplicative reporting obligations.

In addition, the proposal would be difficult to administer for large health systems, integrated delivery networks, academic medical centers, and multi-facility organizations. These providers often employ numerous medical directors, service line leaders, departmental chiefs, nursing directors, supervising physicians, and other clinical personnel whose responsibilities may change frequently or vary across facilities, departments, and locations. Determining which individuals qualify as “managing employees” under the expanded definition could require continuous monitoring and reporting of personnel changes, creating significant administrative burden and increasing the risk of inadvertent reporting errors. The proposal could create a perpetual cycle of

Medicare enrollment updates, with new changes becoming reportable before previously submitted changes have completed review and processing.

Accordingly, CMS should either retain the current definition of managing employee or, at a minimum, limit the expansion to individuals who exercise direct operational or managerial control over the provider's Medicare participation and billing activities. CMS should also avoid requiring disclosure of individuals whose information is already available through existing regulatory reporting mechanisms.

10. Mandatory Posting of CMS Signage - 42 CFR § 424.510(f)

Proposed Change

CMS proposes to expand the signage requirements at 424.57(c)(7)(i)(D) and 410.33(g)(14)(ii) to all Medicare providers, codified at new 424.510(f). The proposal would require all providers whose place of business is located in a building complex to post a sign at the main entrance of the building that includes the provider's or supplier's normal business hours.

Trinity Health believes helping beneficiaries and site visit personnel better locate provider locations is an appropriate objective. However, CMS's proposal is not operationally feasible for many providers located in large medical office buildings, hospital campuses, and health system facilities that may house dozens of separately enrolled entities.

In many cases, individual providers and suppliers cannot independently install signage due to space limitations, building management policies, landlord restrictions, or centralized campus wayfinding systems. Requiring separate signage for every enrolled provider and supplier would create significant administrative burden without materially improving beneficiary access or program integrity. In addition, frequent updates would be necessary, which are already made via provider websites, appointment communications, online directories, patient portals, suite directories, and other office-specific signage.

If finalized, Trinity Health recommends the proposed modification be updated as follows:

- Treating the requirement as satisfied where the provider or supplier is identifiable through a building directory, electronic directory, website, patient portal, or other publicly accessible location-identification tool.
- Permitting shared or centralized signage for providers and suppliers located within multi-tenant buildings, health system campuses, or other facilities with common wayfinding systems.



- Clarifying that temporary signage lapses resulting from maintenance, construction, weather, vandalism, or circumstances outside the provider's control will not result in denial, revocation, deactivation, or other adverse enrollment action.
- CMS should also limit enforcement to corrective action. Any provider found to be out of compliance should receive notice and a reasonable opportunity to cure before CMS pursues enrollment-related consequences. Because signage deficiencies are administrative in nature and generally do not implicate patient safety or program integrity, they should not serve as an independent basis for adverse enrollment action absent a failure to correct the issue after notice.

We strongly support CMS's efforts to combat fraud, waste, and abuse. However, enrollment denial and revocation are among the most severe enforcement tools available to the agency and therefore should remain closely tied to demonstrable misconduct by the provider whose Medicare participation is at issue.

Accordingly, CMS should revise these provisions and adopt a more tailored framework that:

- Requires a direct nexus between the provider's conduct and any sanction.
- Limits revocation based on third-party actions absent evidence of provider involvement or control.
- Establishes objective and clearly defined standards.
- Incorporates materiality requirements for disclosure-related violations.
- Preserves corrective action opportunities for technical violations.
- Restricts retroactive revocation to cases involving fraud or intentional misconduct; and
- Avoids geographic or affiliation-based sanctions unsupported by provider-specific evidence.

Hospice Medical Directors and Administrators: CMS proposes to permit denial of a hospice's enrollment application if any of the following apply:

1. The enrolling hospice's medical director is:
 - a. The medical director of multiple other hospices.

- b. The practice location is an unrealistic distance to perform all medical director functions.
- 2. The enrolling hospice's administrator is:
 - a. The administrator of multiple other hospices.
 - b. Located a distance that is unrealistic to perform administrative duties.
- 3. The hospice's medical director does not have an active physician medical license in the state in which they are practicing.

THAH supports CMS's goals to eliminate fraudulent activity in the hospice industry. However, CMS must also consider the inadequate labor pool of physicians who wish to work in hospice. Therefore, THAH recommends that CMS clearly define a maximum number of hospice agencies per Medical Director. We recommend no more than 2 hospice agencies per Medical Director but expanded to 3 or 4 in rural areas where the need is greater.

The second proposed rule is unrealistic from a staffing perspective. THAH is a national provider of hospice services. In some geographic areas it makes sense to have one director overseeing 2 or 3 programs. THAH recommends CMS consider the geographic area and clearly define the distance that would realistically be considered too far.

THAH supports the third proposed rule and agrees that the Medical Director should not be practicing in a state where they are not licensed.

As CMS reviews regulatory burdens on providers, it would be prudent for the Agency to consider the impact of some regulations on the patient and family. Today's network of post-acute care is difficult to navigate. Seniors who are transitioning between levels of care oftentimes do not clearly understand the maze of care levels including why they are transitioning, what the requirements are, and what Medicare and/or Medicaid will pay for if anything. It is a regulatory maze of rules and guidelines that often differ by state and provide little to no guidance for families dealing with the needs of a loved one. Trinity Health encourages CMS to establish a work group of post-acute providers to define and ultimately produce guidance for people, both patient and families, who are navigating the post-acute care continuum. Trinity Health Continuing Care would be honored to assist CMS in this task.

THAH appreciates the opportunity to comment on the proposed Home Health Payment Update. Home Health has been proven to save Medicare dollars and is the solution to the increasing numbers of patients requiring therapy, nursing services, and returning the patient to an optimal level of health for that individual. Striving to provide Medicare beneficiaries with the high-quality care in the home they are entitled to should be the goal of CMS. Proposing rate adjustments that do not sustain the agency does not support this goal.



THAH urges CMS to significantly increase the percentage update to accurately reflect the current workforce and inflationary environment.

If you have any questions, please feel free to contact Donna Wilhelm, Vice President of Advocacy for Trinity Health Continuing Care at donnaw@trinity-health.org.

Sincerely,

/s/

Benjamin Petersen, Chief Operating Officer
Trinity Health at Home