August 29, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Subject: CMS-1828-P Medicare and Medicaid Programs; Calendar Year 2026 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the HH Value-Based Purchasing Expanded Model; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Updates; DMEPOS Accreditation Requirements; Provider Enrollment; and Other Medicare and Medicaid Policies

Submitted electronically via https://www.regulations.gov

Dear Administrator Oz:

LeadingAge New York represents more than 350 not-for-profit aging services providers and other mission-driven organizations encompassing the entire continuum of aging services, including Medicare-certified home health agencies (HHAs), skilled nursing facilities (SNFs), assisted living, memory care, affordable housing, retirement communities, adult day programs, community-based services, and hospice. On behalf of our members, LeadingAge New York appreciates the opportunity to offer the following comments in response to the Calendar Year (CY) 2026 Home Health Prospective Payment System Proposed Rule.

We support and echo the comments of our national LeadingAge association and urge the Trump administration to reverse the proposed cuts in home health rates set forth in the proposed payment rule. The proposed rule would result in a 9% reduction in home health payments. This cut would be in addition to cuts imposed over the last three consecutive rulemaking cycles, amounting to an 8.8% permanent cut to the home health base payment rate in the aggregate.

We urge the Centers for Medicare and Medicaid Services (CMS) and the Trump administration to reverse this disastrous trend in home health reimbursement and use all authorities available to provide a reprieve to HHAs.

Impact on Providers and Access to Care

LeadingAge New York is seriously concerned with the deterioration of the home health rate associated with the Patient-Driven Groupings Model (PDGM). These cuts are coming at a time when our members'

costs and demand for home health services are rising. Continuing to implement these cuts will have a disastrous effect on older adults who rely on these services. The combined impact of the proposed payment changes and current workforce and inflationary pressures will lead to more closures of HHAs and the inability of providers that remain to take on new referrals.

In New York, over 14 HHAs have shut down since 2019, with 5 closures in just the last year directly impacting 6,237 patients and disrupting care in 16 upstate counties in the state. Too many of our members have already shut down their agencies, and others are considering closure. Other members share that they are already reducing services or service areas, laying off staff, or closing branches. Even our largest members are impacted by Medicare cuts, both fee-for-service (FFS) and Medicare Advantage, and are forced to reduce the cases they accept, leaving hospitals and nursing homes with fewer discharge options for care. State statistics from 2023 show that more than 90,580 home health patients have already lost access to home health since 2019, and 40% of patients referred to home health following a hospitalization never received it due to agency capacity constraints or workforce shortages.

The decline in the number of HHAs is an increasing concern with mounting evidence. While the metric of access the Medicare Payment Advisory Commission (MedPAC) uses still identifies access as being high (nearly 98% of beneficiaries living in a ZIP code with at least two agencies), there is growing concern that this is an outdated and harmful definition of access. This definition was first established in 2003. Between 2019 and 2023, the number of skilled HHAs that treated more than 10 FFS patients annually decreased or remained the same in 94.1% of U.S. counties.[1] Half of U.S. counties have 5 or fewer HHAs per 1,000 square miles, with many rural areas having access to only 1 agency or no agencies serving more than 10 patients.

Other recent research highlights growing access issues that are not taken into consideration as part of MedPAC's definition of access:

- Over a third of patients referred to home health care after hospitalization never receive it despite clear medical need.[2]
- According to the same research, for those who are able to access care, delays in access have increased a full day since 2019, and 10% of referrals are currently waiting at least 5 days to receive a visit, with longer wait times more likely in rural areas.
- The lack of access increases the likelihood of readmissions by 35%, emergency department use by 16%, mortality rates by 43%, and overall total health care spending by 5.4%.

[1] Trella Health. (2024, December). *Home health accessibility among Medicare fee-for-service (FFS) beneficiaries* (Special Report).
[2] https://carejourney.com/wp-content/uploads/2025/06/Home-Health-Access_2024-Q3-_2025.02.pdf

Home health reduces costs following a hospital discharge, it is more affordable, and it is where patients want to receive care whenever possible. Cutting home health drives up overall system costs, resulting in increased readmissions, emergency department use, and mortality, and forces patients into high-cost settings.

The rule's proposed payment cuts will coincide with the second year of payment adjustments resulting from the Home Health Value-Based Purchasing (HH VBP) Model, a flawed model that results in payment reductions for our members inconsistent with its intent. This mix of cuts from varying payment policies only creates more access issues for vulnerable Medicare beneficiaries, which is the opposite of what people say they want: high-quality care at home. Moreover, constrictions in access to home health care are likely to result in utilization of more expensive post-acute care – such as SNFs – or expensive rehospitalizations.

Reductions in access will hit rural communities hardest, and these regions already face long wait times for care and provider shortages. With the deepening financial instability of rural HHAs, these regions are already becoming home health deserts.

The impact on larger metropolitan areas is significant as well. A large not-for-profit HHA in the New York City metropolitan area could admit only 50% of referrals in 2023, down from 66% in 2020. They had to turn away nearly 18,000 patients in 2023 due to workforce shortages. To increase access, they raised nurse wages 15% over 2 years, plus implemented financial incentives for working in areas with low home health access. We believe steps like this to increase access will be infeasible if rates continue to plummet as proposed in the payment rule.

Impact on the Broader Health Care System

As LeadingAge has expressed, the narrative of health care often pits post-acute care providers against each other, but the reality is these providers together create a fragile ecosystem of collaborative support for older adults. From LeadingAge's unique vantage point as the only association representing the continuum of not-for-profit and mission-driven aging services providers including home health and skilled nursing, we can see how critical each setting is to the well-being of older adults. Multiple studies have shown that coordinated discharge from skilled nursing to home health care reduces risk of readmission.[3]

Our providers are not in competition; they are partners in supporting older adults, and the loss of access to one hurts the entire system, whether it is a SNF or an HHA. In New York, we are seeing gridlock in hospitals and long emergency department wait times associated with the reductions in post-acute care capacity. Hospitals lack available beds to admit patients from the emergency department because they

[3] Weerahandi H, Bao H, Herrin J, Dharmarajan K, Ross JS, Jones S, Horwitz LI. Home Health Care After Skilled Nursing Facility Discharge Following Heart Failure Hospitalization. J Am Geriatr Soc. 2020 Jan;68(1):96-102. doi: 10.1111/jgs.16179. Epub 2019 Oct 11. PMID: 31603248; PMCID: PMC6964248.

cannot discharge stabilized patients who need post-acute care. There is no safe way to discharge these patients because HHAs do not have the capacity to admit them, and SNFs do not have available beds. Similarly, SNFs are unable to discharge patients who would be suitable for home health care because of the shortage of home health services.

When hospitals cannot admit new patients and discharge stable ones, patients and families suffer. Hospital bottom lines decline due to reduced through-put, and Medicare spending rises as a result of prolonged hospital and nursing home stays.

Proposed CY 2026 Home Health Payment Rate Updates

LeadingAge remains gravely concerned with the proposed decreases associated with PDGM. In the CY 2026 Home Health Proposed Rule, CMS is proposing to apply an additional -4.059% permanent adjustment in addition to a -5% temporary adjustment.

For the past 3 years of rulemaking cycles, we have conveyed concerns to CMS regarding the impact of permanent behavior adjustments – which currently total -8.8% since CY 2023 – on the entire home health sector and the FFS beneficiaries served.

While we support the development of a payment methodology based on clinical characteristics, the accompanying legislated requirements regarding budget neutrality raise significant concerns with the sustainability of home health services. The previous administration first implemented permanent and temporary adjustments to provider payments, and we strongly believe the interpretation of the adjustments was incorrect.

We ask that your staff review the previous administration's interpretation of the required adjustments and use your statutory authority to avoid permanent and temporary adjustments under the budget neutrality clause for CY 2026.

Negative Operating Margins

CMS has been unwaveringly clear in their discussion of margins, consistently citing section 1861(v)(1)(A) of the Social Security Act, which states "under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs." In other words, other payers should not be relied on to cover the costs incurred by HHAs in serving Medicare beneficiaries, just as Medicare reimbursement should not be a source of funds for the care of patients who are not Medicare beneficiaries.

With this statutory charge in mind, we ask CMS to look at HHA overall financial condition as a metric to analyze whether Medicare rates are sufficient to cover the cost of home health care for Medicare beneficiaries, without relying on revenues from other payers. Moreover, CMS should examine the financial viability of the sector prior to imposing new rate cuts and delay them if necessary to preserve access to services.

In New York, approximately 57.7% of surveyed Certified Home Health Agencies (CHHAs) have negative operating margins, with the overall average margin being -2.06% in 2023. Under these pressures, providers will simply be unable to remain financially sustainable to deliver Medicare home health care to individuals who are entitled to receive it.

Similarly, according to CMS' own Office of the Actuary (Appendix C of the *2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*): "Over the long range, however, the simulations suggest that absent other modifications, significant financial pressures will arise for providers, increasing the possibility of access and quality of care issues for Medicare beneficiaries." This is a clear indication that the Trustees of the Medicare Trust Fund, along with the CMS Office of the Actuary, feel it is their obligation to look at the overall financial pressures faced by providers as it relates to potential effects on FFS Medicare beneficiaries' access and quality of care.

The government needs to work on ensuring rate adequacy across all payers before disrupting overall access to care through further cuts to FFS Medicare. CMS must seek additional congressional authority to evaluate payment adequacy across all payers under federal jurisdiction.

Not-for-Profit Providers

Since 2019, over 1,000 HHAs have closed, and many more have needed to reduce services or service areas. Not-for-profit providers have decreased from 11% of the home health sector to only 7% of the sector in that 6-year period. The mission of not-for-profit agencies is different from the majority of the home health sector, which is dominated by for-profit operators. Not-for-profits are often faith-based and invest any surplus revenues back into their operations and in their communities, a crucial difference that results in quality care and collaboration among the continuum of care. They invest in their staff, their growth, and they provide significant charity care in the sector.

Not-for-profit providers tend to be smaller operators with limited ability to leverage operational economies of scale. Their patient mix generally includes beneficiaries with more complex needs whose care needs are more acute. Both characteristics increase the cost of providing care. For those reasons, not-for-profits' margins tend to be thinner, on average, compared to the sector's overall margins. The loss of almost 10% in traditional CY 2026 Medicare payment for services provided will further diminish a revenue stream that has been shrinking since CY 2023. It could be the final blow to not-for-profit, mission-based home health.

Conclusion

We ask CMS to abandon the temporary and permanent adjustments. We urge you to review and revise the flawed and damaging payment proposal with specific attention to inaccuracies, including an egregious mistake of apparently including data from fraudulent providers in the HH VBP formula, and 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 until the flaws of the previous administration can be fixed.

The home health care sector is critical to the broader delivery of health care and post-acute care in New York and across the country. We thank you for your consideration of our comments.

Sincerely,

Meg Everett
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