August 28, 2025

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-1828-P)** Medicare Program; (CY) 2026 Home Health Prospective Payment System Proposed Rule

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

Dear Administrator Oz,

- **Trinity Health at Home (THAH) is urging CMS to adjust the percent update and not finalize the punishing Medicare rate cuts proposed in this rule that will result in a $11 million dollar loss in revenue and a (-1.2) margin.**
- **We urge 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.**
- **We implore CMS to evaluate the inclusion of telehealth visits and establish add-on payments for remote patient monitoring.**
- **And THAH encourages CMS to ensure up-to-date and accurate provider enrollment databases and implement thoughtful discretion in determining deactivations with consideration given to physicians employed only by hospices.**

Trinity Health at Home, a National Health Ministry of Trinity Health, is a faith-based organization that provides Home Health Care to patients in eleven states; our average daily census is approximately 9,000 patients. We appreciate the opportunity to comment on CMS-1828-P, the CY 2026, Home Health Prospective Payment System Update. Trinity Health is one of the largest not-for-profit, faith-based health care systems in the nation. It is a family of 127,000 colleagues and over 38,000 physicians and clinicians caring for diverse communities across twenty-six states. Nationally recognized for care and experience, the Trinity Health system includes 93 hospitals, 107 continuing care locations, the second largest PACE program in the country (a total cost of care program),142 urgent care locations and many other health and well-being services. In fiscal year 2024, the Livonia, Michigan-based health system invested $1.3 billion in its communities in the form of charity care and other community benefit programs. 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 looming crisis as the proposed cuts would significantly affect our ability to remain financially sustainable, address staffing shortages, and continue to serve the most vulnerable patient populations. Likewise, the proposed cuts would negatively affect other sectors of the health care delivery system by forcing patients to board in hospitals and skilled nursing facilities as they wait for Home Health admission. We implore you to make changes. **Most importantly, we urge CMS to adjust the percentage update to account for the real expenses experienced by Home Health providers**. If not, these proposed 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.

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 AND MEDICAID DOLLARS. Home Health (HH) is the solution to the increasing numbers of patients requiring therapy and nursing services, yet the proposed rule would push more people into high-cost care options by eliminating access to home health.

Our Comments are as follows:

CY 2026 Proposed Payment Rate:

The proposed CY 2026 updated rates include the proposed CY 2026 HH payment update of 2.4% ($425 million increase); an estimated 3.7% decrease that reflects the net impact of the proposed permanent behavior adjustment, required by statute, ($655 million decrease); an estimated 4.6% decrease that reflects the net impact of the proposed temporary adjustment ($815 million decrease); and an estimated 0.5% decrease that reflects the effects of a proposed update to the wage adjusted Fixed Dollar Loss (FDL) ratio ($90 million decrease).

The impact of these proposed cuts to THAH is dire. After modeling the numbers, accounting for the impact of multiple facets of this proposed rule including wage index changes, our analysis confirms that we would suffer a reduction in our Medicare reimbursement of $11 million in CY 26. The results are depicted in the chart below:

State	CY26 Impact	Rule Impact
PA	($4,126,182)	**-7.54%**
MI	($2,251,150)	**-7.62%**
OH	($920,644)	**-6.91%**
IA	($653,259)	**-6.22%**
IL	($590,314)	**-6.17%**
CT	($533,197)	**-6.63%**
GA	($481,651)	**-8.17%**
CA	($416,602)	**-9.79%**
MD	($316,059)	**-7.50%**
IN	($279,330)	**-8.04%**
DE	($176,805)	**-6.26%**
	($10,745,193)	**-7.34%**

In addition to the proposed cuts, Home Health Agencies (HHAs) continue to struggle with recruitment and retention of qualified Home Health staff. We have budgeted a 3.5% wage increase for FY26 that translates to an annual cost of $5.4 million. This proposed cut would severely inhibit our ability to reward and retain staff. This creates a substantial barrier to access as workforce challenges continue to impact the industry. THAH tracks the number of referrals we are unable to take due to open positions. From July 1, 2024-June 30, 2025, THAH did not admit 4,500 patients to service due to open positions. That is 5% of our total referrals. A cut like this will only exacerbate the staffing problem and increase the number of referrals we will have to deny service. 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 sixth 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.

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.

THAH recognizes that statutory constraints may limit the actions CMS may take and therefore, we urge CMS to continue to monitor the PDGM payment model and make no negative adjustments for CY 2026. 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.

THAH wishes to clearly make the point that further erosion of our reimbursement in Medicare is unsustainable. The projections with this proposed cut would reduce our operating margin to a ***negative -1.2%. No going concern can sustain that. This action will seriously threaten the long-term viability of many of our agencies.***

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

Payment for Telecommunications Technology:

From September 1, 2024-June 30, 2025, THAH served 9,787 patients with Remote Patient Monitoring (RPM). For both the 30-day and 60-day hospital readmission rate, those served with RPM saw a 3% decrease over those who did not have RPM. THAH believes in the value of this service and the peace-of-mind it can add to the patient experience. THAH spent $3,257,000 for FY25 for total cost of equipment and dedicated staff for this same period delivering this service. ***Yet, it remains unreimbursed.***

Collecting data on services furnished via telecommunications technology on claims allows CMS to analyze the characteristics of patients using services provided remotely. Correspondingly, HHAs report, in aggregate, the costs of telecommunication technology are allowable administrative and general costs on Medicare cost reports. However, such services are not adequately or explicitly paid for under the Medicare home health benefit. CMS should support effective use of telehealth and remote patient monitoring in home health not just by collecting data on its use, but by considering options for paying appropriately for virtual services.

THAH urges CMS to evaluate the inclusion of telehealth visits in the visit counts when updating the case-mix weights and consider establishing add-on payments for remote patient monitoring. In addition, CMS should ensure that telecommunications technology costs are adequately captured on Medicare cost reports in a way that enables accurate rate setting.

Proposed Changes to the Face-To-Face Encounter Policy:

CMS is proposing to change the face-to face regulation to allow Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs), to perform the face-to-face encounter regardless of whether they are the certifying practitioner or whether they cared for the patient in the acute or post-acute facility from which the patient was directly admitted to home health and who is different from the certifying practitioner. **THAH agrees with this proposed rule change as it allows for improved needed flexibility.**

Home Health (HH) Quality Reporting Program (QRP):

CMS is proposing to remove the COVID-19 Vaccine: Percentage of Patients Who Are Up to Date Measure and the corresponding Outcome and Assessment Information Set (OASIS) data element. CMS is also proposing the removal of four assessment items in the standardized patient assessment. As the pandemic is now in the past, the tracking of Covid vaccines is an overly burdensome task that is not an efficient use of the clinician's time. **THAH does agree with this proposed rule change.**

HHVBP Quality Measures: CMS is also proposing the addition of four measures to the applicable measure set. This includes three OASIS-based measures related to bathing and dressing, and one claims-based measure, the Medicare Spending per Beneficiary for the Post-Acute Care (PAC) setting measure. THAH has concerns about the measure, Medicare Spending per Beneficiary. This is not a quality metric and therefore should not be included in the OASIS measure set. If included it will put emphasis on reducing costs, not patient care and could be viewed as cost versus quality. It has the potential to impact decision-making of agencies whether-or-not to admit complicated, high-cost patients. This could potentially leave those patients without Home Health services, or they would all be directed to those agencies that make decisions based on Mission, leaving those providers even more vulnerable to unsustainable rates. **THAH disagrees with including Medicare Spending per Beneficiary in the HHVBP measures.**

Medicare Provider Enrollment: CMS is proposing several new and revised provider enrollment provisions. Retroactive Revocations and Adding Bases for Revocation or Deactivation are used to battle fraud within the provider community. THAH supports CMS's efforts to strengthen provider enrollment processes and enhance program integrity. However, we are concerned about the proposed expansion of CMS's deactivation authority, which would apply to physicians and nonphysician practitioners who order, certify, or refer Medicare services but have not appeared on a Medicare Part A or B claim within the past twelve consecutive months. Home Health and hospice agencies are among several Medicare providers that will be directly affected if this proposal is finalized.

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

THAH routinely verifies provider eligibility through available databases to ensure that all practitioners certifying patients for home health services are authorized to do so; therefore, the accuracy and timeliness of these databases are critical to their operations. Because these ordering and certifying practitioners typically do not bill Medicare directly for services, they may be unaware of their deactivation status and unable to address or correct it promptly. This lack of awareness can lead to unexpected claim denials and disruptions in patient care.

THAH encourages CMS to ensure up-to-date and accurate provider enrollment databases that Home Health Agencies and other Medicare providers rely on to verify ordering and certifying practitioner eligibility. They should implement thoughtful discretion in determining deactivations with consideration given to physicians employed only by hospices. And CMS should ensure the reactivation process is efficient and minimizes any delays in restoring ordering and certifying privileges for those practitioners that have been deemed eligible to certify /order home health services or hospice services.

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.

Trinity Health
At Home

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. Drastically reducing reimbursement 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/

Ruth Martynowicz, Chief Operating Officer
Trinity Health at Home