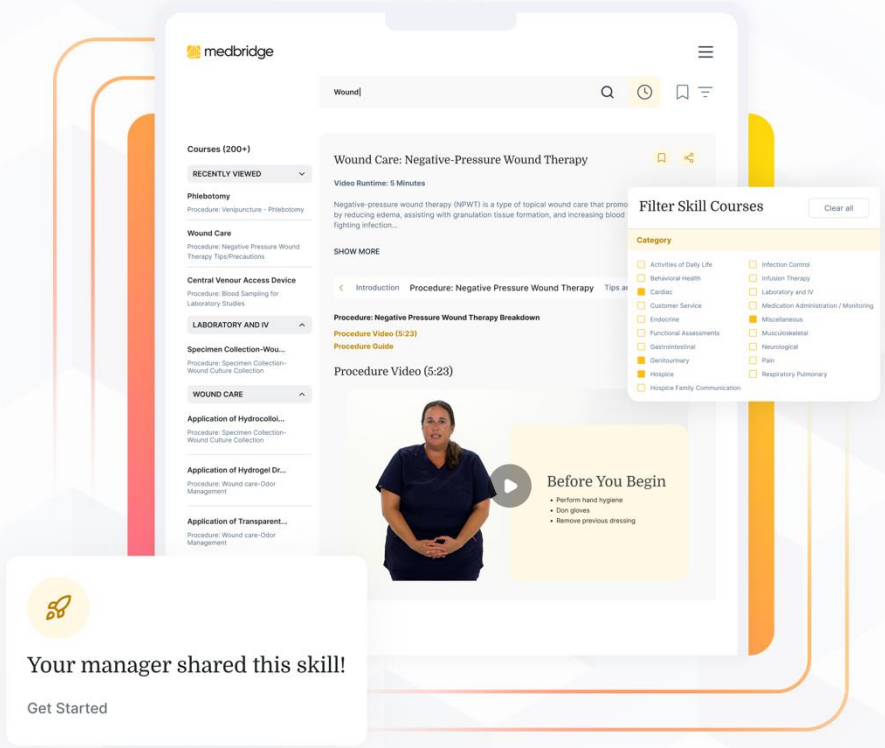
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Home Health Final Rule 2027

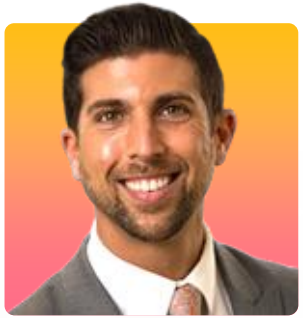
Overview and Impact

11/12/2026

Today's Speakers



Mike Simione
Vice President, Post Acute Data Analytics



John Rabbia, PT, DPT, MS MBA
Director, Operations Consulting



Anna Zimmerman
MSW, Sr. Program Manager, Home Health & Hospice

Home Health Final Rule Summary

- Global spending increase of 2.4% ($415 million)
- Behavioral rate adjustment includes only temporary adjustment, no permanent adjustment
- Updates on CMS fraud and abuse approach
- Commenters in favor of palliative care inclusion, but concerns raised on its alignment with home health
- HHQRP/HHCAHPS measures proposed timelines
- No major VBP changes
- RFIs on Advance Care Planning and HH wage index

Reimbursement Update

Temporary Adjustment: CMS Analysis

- **3.0% temporary adjustment** factored into proposed CY 2027 rate setting would account for an estimated $500M of this total recoupment pool
- **This does not include temporary adjustment impact from CY 2026**, as Centers for Medicare & Medicaid Services (CMS) notes they do not yet have enough data to calculate this

Claims Analysis Year	Estimated Payments in Excess
CY 2020	-$873,073,121
CY 2021	-$1,211,002,953
CY 2022	-$1,405,447,290
CY 2023	- $836,208,180
CY 2024	- $430,435,218
CY 2025: This final rule	-$155,101,861
CY 2026	TBD
Total	**-$4,911,268,623**

Source: CMS Final Rule Table 5: SUMMARY OF TEMPORARY ADJUSTMENTS DOLLAR AMOUNTS FOR CYs 2020 – 2026

Base Rate Change: Proposed and Final

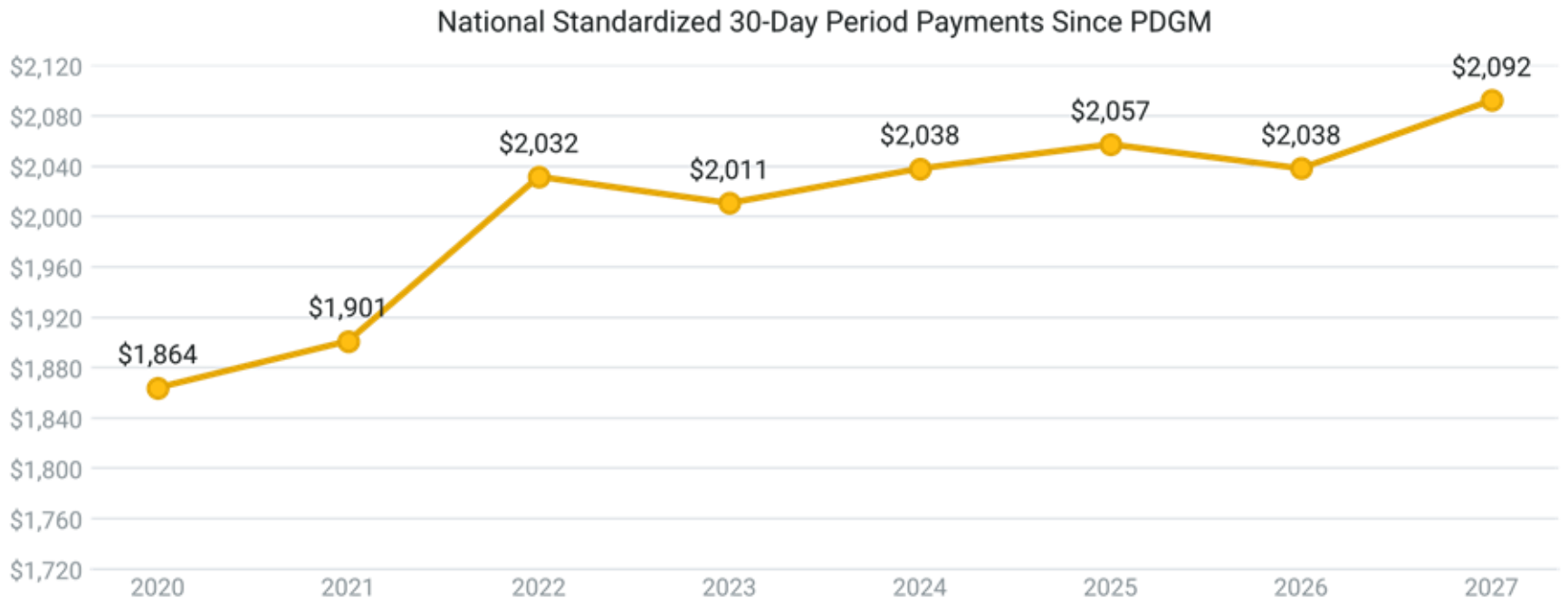
Proposed National Standard Base Rate Change: **+2.67%**

Proposed vs. Final	2026 National Standardized 30-Day Period Payment	Permanent Adj. Factor	2027 CMW Recalibration Neutrality Factor	2027 Wage Index Budget Neutrality Factor	2027 HH Payment Update Factor	2027 National Standardized 30-Day Period Payment (w/o Temp. Adj.)	Temporary Adjustment Factor	2027 National Standardized 30-Day Period Payment (w/ Temp. Adj.)
Proposed	**$2,038.22**	1.03093	1.0047	1.0009	1.0210	$2,157.41	0.9700	**$2,092.69**

* Rates provided above are based upon HHA submitting required quality data, otherwise subject to a penalty of -2.0%

Source: CMS Final Rule TABLE B12: CY 2026 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT (WITHOUT TEMPORARY ADJUSTMENT) & TABLE B13: FINAL CY 2027 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

Home Health Payment Rates Trending



CY 2026 National Per-Visit Rates

HH Discipline	CY 2026 Per-Visit Payment Amount	CY 2027 Wage Index Budget Neutrality Factor	CY 2027 HH Payment Update Factor	CY 2027 Per-Visit Payment Amount
Home Health Aide	$80.12	0.9999	1.021	$81.79
Medical Social Services	$283.64	0.9999	1.021	$289.57
Occupational Therapy	$194.74	0.9999	1.021	$198.81
Physical Therapy	$193.42	0.9999	1.021	$197.46
Skilled Nursing	$176.96	0.9999	1.021	$180.66
Speech-Language Pathology	$210.25	0.9999	1.021	$214.64

Source: CMS Final Rule TABLE 15: FINAL CY 2027 NATIONAL PER-VISIT PAYMENT AMOUNTS

Additional Rate Updates

Wage index changes

- Urban average change: -0.30%
- Rural average change: -0.15%
- 246 urban and 34 rural Core-Based Statistical Areas (CBSAs) decrease or no change in wage index
  - 57 urban and 13 rural incurring max capped 5% reduction
- 172 urban and 25 rural CBSAs increase in wage index
- Includes 0 new CBSAs and 9 transitional CBSAs for 2027 and 12 transitional CBSAs no longer used from 2026

Fixed dollar loss decreased from 0.37 to 0.29

- Outlier payments as percentage of estimated total payments not to exceed 2.5%

Penalty for failing to submit quality data at -2.0%

Wage Index Update

Wage Index Change	Count of CBSA Codes	% of CBSA Codes
Equal to -5%	70	15%
Between -5% and -3%	57	12%
Between -3% and -1%	103	22%
Between -1% and 0%	50	10%
Between 0% and +1%	53	11%
Between +1% and +3%	67	14%
Between +3% and +5%	34	7%
Greater than +5%	43	9%
Total CBSA Codes	**477**	

Source: Home Health PPS Wage Index

Rural Wage Index Update

Wage Index Change	Count of Rural CBSA Codes	% of CBSA Codes
Equal to -5%	13	22%
Between -5% and -3%	2	3%
Between -3% and -1%	11	19%
Between -1% and 0%	8	14%
Between 0% and +1%	5	8%
Between +1% and +3%	8	14%
Between +3% and +5%	7	12%
Greater than +5%	5	8%
Total CBSA Codes	**59**	

Included transitional rural CBSA codes used in both 2026 and 2027

Source: Home Health PPS Wage Index

Top Wage Index Changes: Proposed to Final

County	Proposed	Final	% Difference
Wausau, WI	0.8918	0.8567	-3.51%
Burlington, NC	0.9261	0.8830	-4.31%
Lewiston, ID-WA	0.9480	0.8964	-5.16%
Burlington-South Burlington, VT	1.1508	1.0486	-10.22%
Salisbury, MD	1.0493	0.9407	-10.86%

Source: Home Health PPS Wage Index

Lowest and Highest Urban Wage Index Changes

Highest % Change

County	% Change
Kingston, NY	+16.80%
Greenville, NC	+14.74%
Salisbury, MD	+13.08%
Wheeling, WV - OH	+12.82%
Decatur, IL	+11.26%

Lowest % Change

County	% Change
Youngstown-Warren, OH	-5.00%
Laredo, TX	-5.00%
Fargo, ND-MN	-5.00%
Gainesville, FL	-5.00%
Albany, GA	-5.00%

This does not include transitional urban CBSA codes used in both 2026 and 2027.

There is one transitional urban CBSA code in 2027 which has a -5.00% reduction in wage index.

Source: Home Health PPS Wage Index

Lowest and Highest Rural Wage Index Changes

Highest % Change

County	% Change
Washington Rural	+14.73%
Hawaii Rural	+7.92%
West Virginia Rural	+7.84%
Minnesota Rural	+6.09%
North Carolina Rural	+5.41%

Lowest % Change

County	% Change
Puerto Rico Rural	-5.00%
Virgin Islands Rural	-5.00%
Delaware Rural	-5.00%
Montana Rural	-5.00%
Nevada Rural	-5.00%

This does not include transitional rural CBSA codes used in both 2026 and 2027.

There are eight transitional rural CBSA codes in 2027, seven of which have a -5.00% reduction in wage index.

Source: Home Health PPS Wage Index

Wage Index Update Example: Lafayette, LA

Discipline	2026 FY Rate*	2027 FY Rate*	% Change
Standard Rate	$1,756.25	$1,739.24	-0.97%
Skilled Nursing	$152.48	$150.15	-1.53%
Physical Therapy	$166.66	$164.11	-1.53%
Occupational Therapy	$167.80	$165.23	-1.53%
Speech Therapy	$181.16	$178.39	-1.53%
Medical Social Work	$244.40	$240.66	-1.53%
Home Health Aide	$69.04	$67.98	-1.54%

CBSA: 29180 Lafayette, LA- Wage Index Change -5.00% from 2026 to 2027 (from 0.8153 to 0.7745)

*Wage Adjusted Payment

Source: Home Health PPS Wage Index

Wage Index Update Example: Dallas, TX

Discipline	2026 FY Rate*	2027 FY Rate*	% Change
Standard Rate	$1,983.11	$2,036.26	+2.68%
Skilled Nursing	$172.18	$175.79	+2.10%
Physical Therapy	$188.19	$192.14	+2.10%
Occupational Therapy	$189.47	$193.45	+2.10%
Speech Therapy	$204.57	$208.85	+2.10%
Medical Social Work	$275.97	$281.76	+2.10%
Home Health Aide	$77.95	$79.58	+2.09%

CBSA: 19124 Dallas-Plano-Irving, TX Wage Index Change +0.01% from 2026 to 2027 (from 0.9639 to 0.9640)

*Wage Adjusted Payment

Source: Home Health PPS Wage Index

Wage Index Update Example: Green Bay, WI

Discipline	2026 FY Rate*	2027 FY Rate*	% Change
Standard Rate	$1,874.87	$2,007.58	+7.08%
Skilled Nursing	$162.78	$173.31	+6.47%
Physical Therapy	$177.92	$189.43	+6.47%
Occupational Therapy	$179.13	$190.72	+6.47%
Speech Therapy	$193.40	$205.91	+6.47%
Medical Social Work	$260.91	$277.79	+6.47%
Home Health Aide	$73.70	$78.46	+6.46%

CBSA: 24580 Green Bay, WI - Wage Index Change +5.90% from 2026 to 2027 (from 0.8930 to 0.9457)

*Wage Adjusted Payment

Source: Home Health PPS Wage Index

PDGM Recalibrations

Clinical Groupings

Clinical Grouping	CY 2026 Avg. CMW	CY 2027 Avg. CMW	% Difference	2025 % Distribution
MMTA - Endocrine	1.335	1.347	0.85%	7.3%
Musculoskeletal Rehabilitation	1.129	1.138	0.73%	21.6%
MMTA - Cardiac/Circulatory	1.085	1.090	0.48%	16.8%
MMTA - GI/GU	1.083	1.086	0.20%	5.2%
MMTA - Other	1.094	1.094	0.03%	3.9%
MMTA - Respiratory	1.097	1.096	-0.04%	6.6%
Neuro/Stroke Rehabilitation	1.234	1.232	-0.10%	10.8%
MMTA - Infectious Disease	1.112	1.109	-0.26%	4.8%
Complex Nursing Interventions	1.066	1.062	-0.40%	3.1%
Behavioral Health Care	1.071	1.063	-0.70%	2.2%
MMTA - Surgical Aftercare	1.109	1.101	-0.76%	3.5%
Wound	1.523	1.481	-2.75%	14.2%

Final Comorbidity Adjustments

Low Comorbidity

Addition of 22 low comorbidities

- Circulatory 7 (PVD, hypotension)
- Endocrine 3 (Type 1 and 2 DM)
- Renal 3 (CKD)
- Resp 10 (COVID-19)

High Comorbidity

Total of 103 high comorbidities

Added

- Stroke sequelae + malnutrition (Cerebral 4 + Endocrine 4)
- Hereditary anemias + motor neuron disease (Circulatory 1 + Neuro 5)
- Aplastic and other anemias + breast cancer (Circulatory 2 + Neoplasms 9)
- Malnutrition + motor neuron disease (Endocrine 4 + Neuro 5)
- *C. diff*/MRSA/*E. coli* + non-pressure chronic ulcers (Infectious 1 + Skin 3)
- Other kidney disorders + non-pressure chronic ulcers (Renal 3 + Skin 3)

Comorbidity Distribution

Comorbidity Adjustment	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
None	55.6%	52.0%	49.1%	49.6%	37.3%	30.7%	29.1%	24.1%
Low	35.3%	38.0%	36.9%	36.9%	47.8%	52.6%	55.4%	58.3%
High	9.2%	10.0%	14.0%	13.5%	14.9%	16.7%	15.4%	17.6%

Comorbidity Impact	CY 2026	CY 2027	% Difference
None	1.076	1.070	-0.6%
Low	1.133	1.127	-0.6%
High	1.275	1.278	0.3%

Source CMS Proposed Rule: Table 7: Distribution of 30-Day Periods of Care by Comorbidity Adjustment Category for 30-Day Periods, CYs 2018-2025

Functional Points

OASIS Item	Responses	Points (2026)	Points (2027)	Percent of Periods With This Response
M1800: Grooming	0 or 1	0	0	21.5%
	2 or 3	3	3	78.5%
M1810: Dress Upper Body	0 or 1	0	0	15.9%
	2 or 3	5	5	84.1%
M1820: Dress Lower Body	0 or 1	0	0	7.7%
	2	4	4	63.5%
	3	12	**11**	**28.8%**
M1830: Bathing	0 or 1	0	0	2.0%
	2	2	2	8.6%
	3 or 4	10	**8**	**48.0%**
	5 or 6	17	**16**	**41.3%**

Source: CMS Final Rule TABLE 6: FINAL OASIS POINTS TABLE FOR CY 2027

Functional Points (cont.)

OASIS Item	Responses	Points (2026)	Points (2027)	2025 Periods With This Response
M1840: Toilet Transferring	0 or 1	0	0	58.3%
	2, 3, or 4	6	6	41.7%
M1850: Transferring	0	0	0	1.0%
	1	1	**3**	**16.4%**
	2, 3, 4 or 5	4	**5**	**82.6%**
M1860: Ambulation/Locomotion	0 or 1	0	0	2.7%
	2	5	**4**	**13.3%**
	3	1	**0**	**66.2%**
	4, 5 or 6	20	**19**	**17.8%**
M1033: Risk of Hospitalization	Three or fewer items marked (excluding responses 8, 9 or 10)	0	0	52.9%
	Four or more items marked (excluding responses 8, 9 or 10)	12	**11**	**47.1%**

Source: CMS Final Rule TABLE 6: FINAL OASIS POINTS TABLE FOR CY 2027

Functional Threshold Comparison

Group	Impairment	2026	2027
MMTA - Other	Low	0–30	0–30
	Medium	31–45	**31–42**
	High	46+	**43+**
Behavioral Health	Low	0–31	0–31
	Medium	32–46	32–44
	High	47+	**45+**
Complex Nursing Interventions	Low	0–31	0–31
	Medium	32–54	**32–55**
	High	55+	**56+**

Group	Impairment	2026	2027
MS Rehab	Low	0–31	0–31
	Medium	32–45	**32–44**
	High	46+	**45+**
MMTA - Cardiac and Circulatory	Low	0–34	**0–33**
	Medium	35–52	**34–50**
	High	53+	**51+**
MMTA - Endocrine	Low	0–33	**0–32**
	Medium	34–52	**33–50**
	High	53+	**51+**

Source CMS Proposed Rule: Table 20: Proposed Thresholds for Functional Levels by Clinical Grouping, for CY 2027

Functional Threshold Comparison (cont.)

Group	Impairment	2026	2027
MMT - Surgical Aftercare	Low	0-30	0-30
	Medium	31-42	31-42
	High	43+	43+
MMTA - Cardiac and Circulatory	Low	0-28	**0-29**
	Medium	29-43	**30-42**
	High	44+	**43+**
MMTA - Endocrine	Low	0-27	0-27
	Medium	28-41	**28-42**
	High	42+	**43+**

Group	Impairment	2026	2027
MMTA - GI/GU	Low	0–34	**0–33**
	Medium	35–48	**34–46**
	High	49+	**47+**
MMTA - Infectious Disease	Low	0–32	**0–31**
	Medium	33–46	**32–44**
	High	47+	**45+**
MMTA - Respiratory	Low	0–33	**0–32**
	Medium	34–46	**33–44**
	High	47+	**45+**

Source CMS Proposed Rule: Table 20: Proposed Thresholds for Functional Levels by Clinical Grouping, for CY 2027

Functional Distribution

Functional Impairment Level	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Low	33.90%	31.90%	25.70%	23.30%	28.10%	29.80%	30.40%	29.30%
Medium	34.90%	35.50%	32.70%	32.60%	33.10%	31.80%	31.80%	32.70%
High	31.20%	32.60%	41.70%	44.20%	38.80%	38.40%	37.80%	38.00%

Functional Impact	CY 2026	CY 2027	% Difference
Low	1.062	1.063	0.1%
Medium	1.160	1.156	-0.3%
High	1.263	1.255	-0.6%

LUPA Trending

	CY 2018 (Sim.)	CY 2019 (Sim.)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Total LUPA %	**6.7%**	**6.8%**	**8.7%**	**7.9%**	**7.8%**	**6.9%**	**6.9%**	**6.6%**

- LUPA % continues to trend downwards over the past few years
- Final rule does not break this out, but providers should analyze their LUPAs by period timing when developing strategic action plans to achieve industry averages

Source CMS Proposed Rule: Table 4: The Proportion Of 30-Day Periods Of Care That Are LUPAs And The Average Number Of Visits by Home Health Discipline For LUPA Home Health Periods, CYs 2018 - 2025

Changes in LUPA Thresholds

CMS recalculates LUPA thresholds at 10th percentile of visits per period

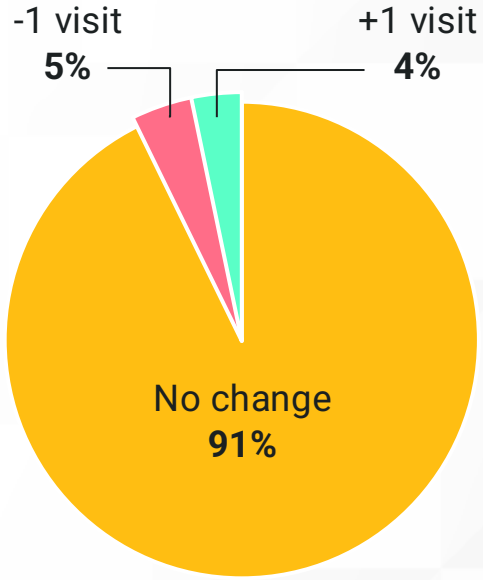
- 394 HIPPS have no change
- 23 HIPPS decrease by 1 visit
- 15 HIPPS increase by 1 visit

LUPA Threshold increase

- = fewer LUPAs
- = more full payment care periods

LUPA Threshold decrease

- = increased LUPAs



LUPA Threshold Changes by Clinical Grouping

Clinical Grouping	-1 Visit	+1 Visit
Behavioral Health	3	1
Complex Nursing Interventions	1	1
MMTA – Cardiac and Circulatory	1	2
MMTA – Endocrine	0	2
MMTA – GI/GU	3	2
MMTA – Infectious Disease	0	1
MMTA – Other	0	3
MMTA – Respiratory	4	1
MMTA – Surgical Aftercare	4	2
MS Rehab	1	0
Neuro Rehab	4	0
Wounds	2	0
TOTAL	**23**	**15**

Overall Utilization of HH Services

Volume of Periods and Number of Beneficiaries	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
30-Day Periods of Care	9,336,898	8,744,171	8,423,688	9,269,971	8,593,266	8,319,064	8,118,120	7,719,986
Unique Beneficiaries	2,980,385	2,802,560	2,850,916	3,017,464	2,831,138	2,715,010	2,620,520	2,501,044
Average Number of 30-Day Periods per Unique Beneficiary	3.13	3.12	2.95	3.07	3.04	3.06	3.11	3.09

Source CMS Proposed Rule: Table 2: Overall Utilization of Home Health Services, CYs 2018-2025

Utilization by Discipline

Discipline	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Skilled Nursing	4.53	4.49	4.35	4.05	3.90	3.87	3.84	3.81
Physical Therapy	3.30	3.33	2.70	2.74	2.77	2.77	2.73	2.71
Occupational Therapy	1.02	1.07	0.79	0.78	0.77	0.76	0.73	0.71
Speech Therapy	0.21	0.21	0.16	0.15	0.14	0.14	0.13	0.13
Home Health Aide	0.72	0.67	0.54	0.48	0.43	0.42	0.39	0.37
Social Work	0.08	0.08	0.06	0.05	0.05	0.05	0.04	0.04
Total (All Disciplines)	**9.86**	**9.85**	**8.59**	**8.25**	**8.06**	**8.00**	**7.87**	**7.77**

Source CMS Proposed Rule: Table 3: Utilization of Visits Per 30 – Day Periods of Care by Home Health Discipline, CYs 2018-2025

Clinical Grouping Distribution

Clinical Grouping	CY 2018 (Simulated)	CY 2019 (Simulated)	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025
Behavioral Health	1.7%	1.5%	2.3%	2.4%	2.3%	2.2%	2.1%	2.2%
Complex Nursing	2.6%	2.5%	3.5%	3.3%	3.2%	3.1%	3.1%	3.1%
MMTA – Cardiac	16.5%	16.1%	18.9%	18.5%	17.9%	17.5%	17.1%	16.8%
MMTA – Endocrine	17.3%	17.4%	7.2%	6.9%	6.8%	7.0%	7.1%	7.3%
MMTA – GI/GU	2.2%	2.3%	4.7%	4.7%	4.9%	5.0%	5.2%	5.2%
MMTA – Infectious	2.9%	2.7%	4.8%	4.6%	4.6%	4.7%	4.8%	4.8%
MMTA – Other	4.7%	4.7%	3.1%	3.6%	3.5%	3.7%	3.8%	3.9%
MMTA – Respiratory	4.3%	4.1%	7.8%	8.0%	7.8%	7.2%	7.0%	6.6%
MMTA – Surg. Aftercare	1.8%	1.8%	3.6%	3.4%	3.4%	3.5%	3.5%	3.5%
MS Rehab	17.1%	17.3%	19.4%	19.8%	20.8%	21.2%	21.4%	21.5%
Neuro Rehab	14.4%	14.5%	10.5%	10.9%	11.0%	10.9%	10.8%	10.8%
Wounds	14.5%	15.1%	14.2%	13.9%	13.7%	14.0%	14.0%	14.2%

Source CMS Proposed Rule: Table 6: Distribution of 30-Day Periods of Care by the 12 PDGM Clinical Groups, CYs 2018-2025

HHQRP Updates

Final Changes to the HHQRP

Beginning in 2027, HHQRP-agencies will be required to complete the Outcome and Assessment Information Set (OASIS) data submission AND make corrections, when necessary, no later than the 15th calendar day of the second month after the end of the calendar quarter. If this day falls on a Friday, on the weekend, or on a Federal holiday, the deadline will be the next business day.

CY Quarter	Collection Time Frame	Final Data Submission Deadline for CY 2029 Payment Determination
1st Quarter	January 1 – March 31, 2027	May 17, 2027
2nd Quarter	April 1 – June 30, 2027	August 16, 2027
3rd Quarter	July 1 – September 30, 2027	November 15, 2027
4th Quarter	October 1 – December 31, 2027	February 15, 2028

Final OASIS and HHCAHPS APU Timeframe

- CMS finalized revising both the OASIS and the HHCAHPS APU data reporting time frame to a calendar year instead of the current timeframe, which is July 1–June 30. The transition will occur with the 2028 APU.
- CMS finalized that to make this revision, the APU data reporting timeframe used to determine the HHQRP 2028 API will be shortened.
    - **The 2028 APU determination will be based on 6 months of OASIS data (July 1, 2026–Dec 31, 2026)**
    - **The 2029 APU will be the first year the APU timeframe is based on the calendar year**

Final HHCAHPS APU Timeframe

- The 2028 APU determination will be based on nine months of HHCAHPS data (April 1, 2026–December 31, 2026)
- The 2029 HHCAHPS data reporting will be first year that will include an entire year (January 1, 2027–December 31, 2027)

APU Issued	OASIS Data That Counts	HHCAHPS Data That Counts
January 2027 (old pattern)	June 1, 2025 to June 30, 2026	April 1, 2025 to Mar 31, 2026
January 2028 (transition)	July 1 to Dec 31, 2026 (6 months)	April 1 to Dec 31, 2026 (9 months)
January 2029 + later	Jan 1 to Dec 31, 2027 (calendar year)	Jan 1 to Dec 31, 2027 (calendar year)

Palliative Care

Palliative Care

- CMS wants to promote access to palliative care and sees the home as the ideal setting for it during serious illness.
    - This follows a RFI put in the FY 2027 Hospice Wage Index proposed rule asking the public how community based palliative care outside the hospice benefit could be strengthened.
- Must meet HH criteria for admission; may fall into any Patient-Driven Groupings Model (PDGM) category.
- CMS recognizes this is an underserved community.
- The patient does not have to be terminally ill. Restoration potential is not the deciding factor; a patient can need skilled services just to prevent deterioration or preserve current function.
- Must meet all home health criteria: medical necessity, etc.
- Think about outcomes.

Fraud and Abuse

What Affects ALL Medicare Providers?

- CMS wants to make it easier to keep bad actors out of Medicare and faster to remove them from the program
  - Denials
  - Revocation
- Affects all Medicare Providers
- “CMS received about 375 comment sets and finalized almost everything. It refused every request for a delay, a grace period, or minimum thresholds before acting.”

What Affects ALL Medicare Providers?

- **Revocation for sitting in a "fraud cluster"** New § 424.535(a)(24)
  - Could revoke a provider for being located in a small geographic area (building, suite, a few city blocks) that holds an excessive number of providers, when CMS judges the enrollment a high fraud risk, waste or abuse
    - No actual finding of fraud is required (based on assessed risk)
    - The nearby providers DO NOT have to the same vertical as you (mix of hospice, durable medical equipment (DME), etc.)
    - CMS does not define "limited area" or "excessive number"
- **Denial for sharing a suite with a revoked or denied provider** New § 424.530(a)(19)
  - Deny enrollment if the practice is located in the same suite or office as a provider whose Medicare enrollment was revoked or denied.

What Affects ALL Medicare Providers?

- **New criminal trigger: Sexual assault or financial misconduct** New § 424.535(a)(16) revoke or deny
  - CMS could deny or revoke enrollment for a misdemeanor conviction within the past 10 years for sexual assault or financial misconduct. Not just the organization, but any owner, managing employee, officer or director.
    - These were added to the formal “final adverse action” list, which ripples into many other enrollment consequences. (A final adverse action puts the provider in the **high-risk screening category**, which means fingerprinting.)
    - CMS says providers aren’t required to research staff for these convictions, but the exposure still falls on the agency.
- **Abusive billing** New § 424.535(a)(8)(ii)
  - Currently CMS must weigh four factors (such as % of denied claims and the provider’s adverse action history). CMS is proposing to delete all four factors and says a “pattern or practice” might be shown by even a small number of bad claims.

What Affects ALL Medicare Providers?

- **False information expands past the application** New § 424.535(a)(4) and § 424.530(a)(4)
  - Currently just on application. CMS would expand this to any enrollment-related submission (EFT forms, opt-out affidavits, delegated-official letters) and drop the requirement that it was certified or submitted specifically to gain enrollment, since correctness is the key. HHA proof of startup operating funds. Routine claim corrections, self-audits and refunds don't count, because this applies only to enrollment documents.
- **Debt, payment suspension, and license actions reach more people** New § 424.530(a)(6)(7)(14)
  - License and program actions reach more people (§ 424.530(a)(14)). Finalized: A program termination, an out-of-state license action, or a license surrendered to avoid discipline by an owner or managing employee can block enrollment. NOT finalized: The proposed expansion of debt and payment suspension denials to managing employees and business partners.

What Affects ALL Medicare Providers?

- **Broad tools: cross-enrollment, stolen identity, retroactivity, longer bars**
  § 424.535(i), 424.530(a)(21), 424.530(f), 424.519
  - A denial of one enrollment could trigger revocation of your other enrollments.
  - A new denial ground targets applications built on stolen or misappropriated identities.
  - Nearly all revocations become retroactive to when the noncompliance began, not 30 days after the notice. CMS estimates this alone moves about $82 million a year back to Medicare via clawback claims.
  - The reapplication bar (up to 10 years) could apply after any denial reason, not just false information.
  - Affiliation lookback window may be removed, so a problematic relationship from any point in the past could count.

What Affects Hospice?

- **Hospice medical directors and administrators under the microscope** § 424.530(a)(20)
  - CMS could deny a hospice's enrollment if its medical director OR administrator serves as a medical director / administrator of multiple other hospices, practices so far away that they can not realistically perform the role, or (for the medical director) holds an inactive license (currently this is also tied to CoPs).
- **Deactivated hospices must pass a survey before billing resumes** § 424.540(b)(3)(I)
  - A hospice that was deactivated must undergo a state survey or accreditation before it can reactivate its Medicare billing. This extends a requirement that already applies to home health agencies. CMS expects about 226 hospices to be affected.
- **Medical director must hold an active license in the state where the medical director practices.**

What Affects Home Health, Hospice, and DME?

- **Breaking the 36-month ownership rule:** This targets a specific dodge: selling a newly certified home health hospice agency within 36 months while disguising the sale as a “management agreement” until the 36-month clock runs out. CMS could deny or revoke a home health hospice agency or DME supplier that fails to comply with the change in majority ownership rules.
    - Covers sales never reported

What Affects Home Health, Hospice, and DME?

- **National moratorium active and clarified**
  - CMS finalized that a moratorium takes effect the moment the notice is filed for public inspection (not the later Federal Register publication date), to stop a rush of “beat-the-deadline” applications. It also confirms that hospice and DMEPOS ownership changes requiring initial enrollment fall under the moratorium, just like HHAs. CMS now lists exactly which application types count as new for a moratorium.
    - Initial enrollments
    - Ownership changes that require new enrollment
    - Re-enrollment after a revocation or a voluntary termination
    - **Reactivations**

Day-to-Day Compliance Changes

- **Claims after revocation:** 15 days, down from 60. HHAs lose their special timing based on the end of the last payable period, and CMS will issue HHA guidance.
- **Managing employee now includes clinical leaders:** medical directors, clinical directors, nursing directors, alternate administrators.
- **Documentation:** Records must be accurate, complete and compliant (§ 424.516(f)(3)). CMS's examples were missing signatures, certifications signed before the face-to-face, and end dates before start dates.
- **Notices:** Denials and revocations can arrive by email.

Operational, Signage, and Ownership

- **Operational:** The office must be ADA accessible, free of hazards, open a sufficient amount of hours, findable online, staffed by qualified people, and “prepared **and able**” to bill.
- **Signage:** A visible sign with your hours. There’s an exception for providers who treat patients in the patients’ homes, but CMS didn’t say whether it covers an HHA’s office, so post one.
- **Private equity and REIT:** New checkboxes are coming on the 855A to flag private equity or REIT owners and managers, with no exception for minority investors.
- **Fingerprints:** These must go through CMS’s designated contractor.

Leadership Takeaways Specifically Around Fraud

- Map your colocation risk. List every building or suite you share with other agencies, hospices, or DME suppliers, and note anyone revoked or denied.
- Extend background checks to owners, officers, directors, and managing employees, screening for the new sexual assault and financial misconduct triggers.
- Screen owners and managing employees for program terminations, out-of-state license actions, and licenses surrendered to avoid discipline.
- (Hospice) Verify your medical director and administrator are not overextended across facilities, are local enough, and hold active licenses. Tighten pre-bill review. CMS set no minimum number of claims.
- Treat every CMS form as accuracy-critical, not just the 855.
- For any sale or purchase within 36 months of enrollment or last CHOW, get the change-in-majority ownership rules correct.
- Recognize the higher stakes; revocations can now claw back paid claims. Fix issues before they become findings.

Leadership Takeaways Specifically Around Fraud (cont.)

- **Track every 855A change with due dates:** A late report of a new administrator, clinical manager, or bank account can now lead to a revocation dated back to the day after it was due
- **Put clinical leaders on the 855A:** director of nursing or clinical manager, alternate administrator, medical director
- **Prepare for the 15-day window:** Have a plan to get all claims out within 15 days of a revocation, and make sure the email address on file is monitored
- **Check documentation:** Signatures, certification dates, and face-to-face timing are now an enrollment issue, not just a claims issue

How to Prepare

How to Prepare

- Do not let the indication of rate relief reduce the urgency on organizational optimization
- Understand the true financial impact on your organization
- Educate your team on the impact of the rule on operations
- Ensure coding and OASIS accuracy to optimize reimbursement and outcomes; consider a risk analysis audit
- Confirm your organization is prepared for the potential additional regulatory scrutiny in the final rule; additional pre-bill audits to ensure accurate billing
- Explore technology partners that can support operational and financial performance goals/needs
- Perform an organizational assessment to identify both revenue and expense opportunities

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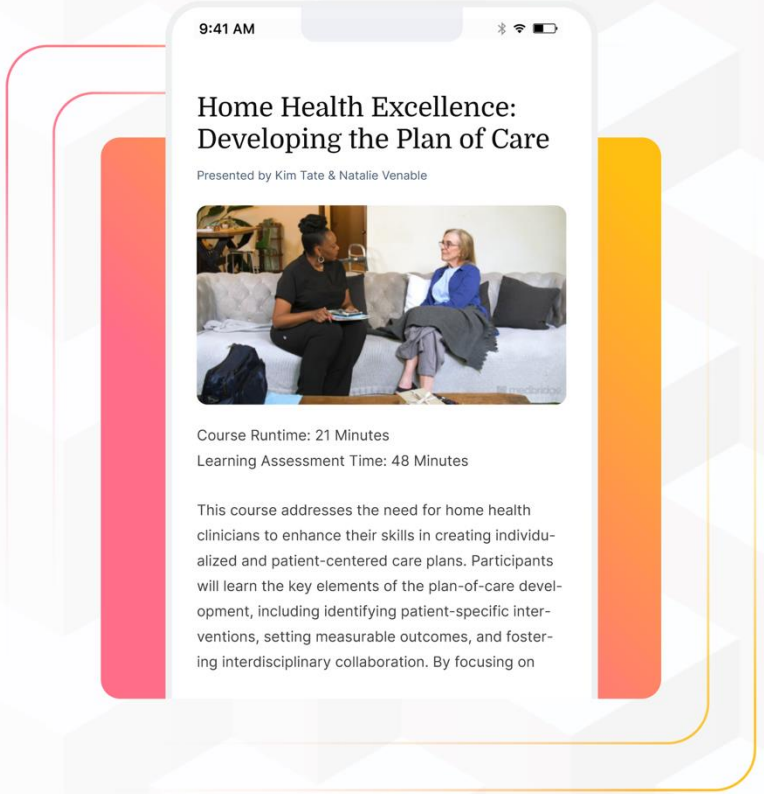
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