MEDPAC | Medicare Payment Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • www.medpac.gov

Amol S. Navathe, M.D., Ph.D., Chair
Gregory P. Poulsen, M.B.A., Vice Chair
Paul B. Masi, M.P.P., Executive Director

August 27, 2026

Mehmet Oz, M.B.A., M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1844

Attention: CMS-1844-P

Dear Dr. Oz:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Provider Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies," *Federal Register*, vol. 91, no. 127, p. 41216 (July 6, 2026). We appreciate your staff's efforts to administer and improve the Medicare program for beneficiaries, taxpayers, and providers, particularly given the considerable demands on the agency.

Our comments focus on the following CMS proposals:

- Proposed calendar year (CY) 2027 home health payment update and permanent and temporary budget-neutrality adjustments
- Request for information on the construction of a home health–specific wage index
- Durable medical equipment and provider enrollment provisions

Home health prospective payment system: Proposed CY 2027 payment update and permanent and temporary budget-neutrality adjustments

CMS estimates that aggregate Medicare payments to home health agencies (HHAs) will increase by 2.4 percent in CY 2027. This reflects a 2.1 percent increase in the home health base payment rate and a 0.3 percent increase in projected outlier payments.

The 2.1 percent increase in the CY 2027 base payment rate reflects four adjustments: a 3.1 percent market basket increase, which is offset by a 1.0 percent productivity adjustment; a 3.093 percent increase to remove the temporary behavioral adjustment

incorporated into the CY 2026 base rate; and a new 3.0 percent temporary behavioral adjustment for CY 2027.

The proposed 3.0 percent temporary behavioral adjustment for CY 2027 reflects CMS's updated analysis of the remaining amount that must be recovered under the spending limits set by the Bipartisan Budget Act of 2018 (BBA of 2018).[1] After accounting for temporary adjustments already applied and expected recoveries through CY 2026, CMS estimates that approximately $4.9 billion in excess payments remains to be recovered. CMS estimates that the proposed 3.0 percent temporary behavioral adjustment would recover approximately $500 million in CY 2027, with additional temporary adjustments expected in future years until the remaining balance has been reconciled.

Comment

The Commission supports CMS's efforts to better align Medicare payments with HHA costs. Although the proposed payment update is larger than the Commission's recommendation for CY 2027, the proposed temporary behavioral adjustment would further align Medicare payments with providers' costs. We do not expect the proposed policy to adversely affect fee-for-service (FFS) beneficiaries' access to home health care.

In its March 2026 report to the Congress, the Commission recommended reducing the CY 2027 home health base payment rate by 7 percent because Medicare payments continue to substantially exceed providers' costs. The Commission found that beneficiary access to care and quality of care remained adequate and that Medicare payments exceeded the estimated cost of furnishing care and noted that FFS Medicare margins for freestanding HHAs were 21.2 percent in 2024. CMS's analysis in the proposed rule similarly indicates that Medicare payments in 2025 exceeded the estimated cost of a typical 30-day home health period by approximately 34 percent. Although CMS's proposed policies result in a smaller reduction than the Commission recommended, the proposed policy would better align Medicare's payments with HHAs' costs. Smaller increases in home health payments safeguard Medicare's finances and also reduce growth in the Part B premium paid by Medicare beneficiaries.

The Commission's recommendation to reduce the CY 2027 home health base payment rate by 7 percent suggests that CMS should consider a larger temporary behavioral adjustment to recover a greater share of the remaining budget-neutrality balance, which would reduce the pressure on program resources and beneficiary premiums. The Commission's payment adequacy findings indicate that a larger temporary adjustment could be implemented without adversely affecting beneficiary access to care.

The Commission's recent evaluation of the Patient-Driven Groupings Model (PDGM) provides additional support for this conclusion.[2] As part of its congressionally mandated evaluation of PDGM, the Commission found that the implementation of the new payment

---

[1] The Bipartisan Budget Act of 2018 required CMS to revise the home health prospective payment system by eliminating therapy visits as a payment factor and adopting a 30-day unit of payment. It also required these changes to be implemented in a budget-neutral manner by adjusting payment rates whenever actual FFS Medicare home health spending deviated from the amount that would been spent in the absence of these two changes.

[2] Medicare Payment Advisory Commission. 2026. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

system was not associated with a statistically significant change in aggregate FFS Medicare margins. Despite the substantial redesign of the payment methodology, Medicare margins remained above 20 percent across nearly all provider categories, indicating that payments continued to exceed providers' costs after PDGM was implemented. These findings also suggest that the agency could make a larger adjustment for retrospective overpayments while maintaining beneficiaries' access to care.

Construction of a home health–specific wage index

For CY 2027, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index"). The proposed rule also solicits comments on whether CMS should consider using alternative data sources to construct a home health–specific wage index for potential use in future years, citing MedPAC's 2023 recommendation for the Secretary to phase in new Medicare wage index systems. CMS seeks feedback to better understand the potential advantages and limitations of using alternative data sources, such as Bureau of Labor Statistics (BLS) data and HHA cost reports, as well as other methodologies that stakeholders believe could appropriately reflect the geographic variation in labor costs for HHAs.

Comment

The Commission has long been concerned with flaws in the wage indexes Medicare uses to adjust provider payments to reflect geographic differences in labor costs.[3] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to, HHAs), wage indexes should be less manipulable and more accurately reflect geographic differences in market-wide labor costs, and should limit how much wage index values can differ among providers that are competing for the same pool of labor within a given market. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in a new Medicare wage index system for hospitals and other types of providers that:

- Uses all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type,
- Reflects local area level differences in wages between and within metropolitan statistical areas and statewide rural areas, and
- Smooths wage index differences across adjacent local areas.[4]

The Commission supports CMS's initial steps toward constructing a home health–specific wage index for potential use in future years. The use of BLS Occupational Employment and Wage Statistics (OEWS) data for core-based statistical area– and occupation-level wage estimates has numerous advantages: This data source is publicly available, recent, and

---

[3] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC.
[4] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

includes all-employer mean wage data. These features would reduce CMS administrative burden, reflect more recent data than the current cost report data that is the basis of the unadjusted hospital wage index, acknowledge that employers in a market compete for similar types of workers, and decrease current circularity that causes deviation between the labor costs reported by hospitals and broader labor market wages.[5]

A revised home health wage index would provide an opportunity to use home health–specific data to develop the occupational weights, which should better reflect the home health workforce than the current approach of relying on the hospital occupational mix. There are several possible sources for home health–specific occupational wage data. For some services, including skilled nursing, therapy, and other covered home health services, HHAs report occupational-mix information on Medicare claims and cost reports, providing a readily available source of occupation-specific staffing data. Alternatively, CMS could revise home health cost reports to collect occupation-specific wages and full-time equivalent staffing for occupations not currently reported, or it could conduct a periodic occupational-mix survey similar to the one used for IPPS hospitals. A third option would be to use BLS industry-level data as a proxy for the occupational mix within the home health sector. Each of these approaches has advantages and limitations, but any would likely provide a more relevant measure of the home health occupational mix than the current methodology that is based on hospital data.

Regardless of the alternative wage index data sources used, we urge CMS also to consider the two other parts of our June 2023 wage index recommendation: to account for differences in wages within metropolitan statistical areas (for example, by using data from the Census Bureau's American Community Survey), and to smooth wage index differences across adjacent local areas (such as county lines). We also encourage the agency to estimate the magnitude of changes under an improved wage index and contemplate phasing in larger changes over a period of time.

Durable medical equipment and provider enrollment provisions

The rule also includes several provisions intended to strengthen Medicare's provider enrollment safeguards for HHAs and other providers. CMS proposes to broaden its existing authority to deny or revoke enrollment and establish new grounds for taking such actions. These proposals would allow CMS to address potential fraud risks associated with concentrations of providers operating in a small geographic area, certain fraud-related activities, and violations of Medicare enrollment requirements. The rule also includes provisions related to changes in majority ownership for HHAs, hospices, and DMEPOS suppliers. Together, the proposals would expand the circumstances in which CMS could deny or revoke a provider's Medicare enrollment.

CMS also proposes to make all Medicare enrollment revocations effective retroactively to the date a provider's noncompliance began, rather than prospectively for certain

[5] The current process for setting the wage index for hospitals is based on data they submit. As a result, it embeds individual hospitals' historic advantages and disadvantages (such as market power) and choices about the mix of occupations they employ and how they employ them, instead of just geographic differences in relative wages. This circularity risk can be a particular problem in market areas with few hospitals or hospitals under common ownership.

revocation grounds. Under the proposal, providers would no longer be eligible for Medicare payment for services furnished during periods in which they did not meet Medicare enrollment requirements, allowing CMS to recover payments made during those periods.

Comment

The Commission appreciates that CMS is taking steps to strengthen the Medicare provider enrollment process to safeguard the Medicare program and its beneficiaries against program integrity concerns. In our March 2026 report to Congress, we noted that aberrant patterns of home health spending suggested the need for greater scrutiny, and the proposed changes recognize the need to address the vulnerabilities of the Medicare program.

Our March 2026 report noted that the Review Choice Demonstration (RCD) was a policy CMS has implemented to address program integrity concerns in home health care. Under the RCD, HHAs are subject to a review of their claims and can select either prepayment or postpayment review. Agencies that maintain high compliance can transition to less frequent reviews. The RCD currently applies to HHAs operating in Florida, Illinois, North Carolina, Ohio, Oklahoma, and Texas through 2029. Given the current concerns about program integrity, CMS could consider if expanded use of RCD would complement other efforts to address program integrity.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Amol S. Navathe, M.D., Ph.D.
Chair