UnityPoint at Home

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August 31, 2026

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services
Attention: CMS–1844-P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: CMS–1844-P - Medicare and Medicaid Programs; 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; published at Vol. 91, No. 127 Federal Register 41216-41327 on July 6, 2026.

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

Dear Administrator Oz,

UnityPoint at Home is pleased to provide the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed Home Health rules for calendar year 2027. UnityPoint at Home is the Home Health Agency (HHA) affiliated with UnityPoint Health, one of the nation's most integrated healthcare systems. UnityPoint at Home offers a diverse set of programs: traditional home health, durable medical equipment, infusion pharmacy, specialty pharmacy, palliative care, and hospice care. In 2025, UnityPoint at Home provided 221,600+ home care visits and 203,700+ home medical equipment orders. In addition, UnityPoint at Home is committed to payment reform and is actively engaged in numerous initiatives which support population health and value-based care. Among these initiatives, UnityPoint at Home was an ACO Participant in the Next Generation ACO and Medicare Shared Savings Program models, an initial participant in the Home Health Value-Based Purchasing (HHVBP) Model in Iowa, and a CMMI Medicare Care Choices Model awardee in three Iowa regions. The CMS Innovation Center found both HHVBP and MCCM reduced total Medicare expenditures, consistent with UnityPoint at Home's performance.

UnityPoint at Home appreciates the time and effort spent by CMS in developing these proposed Home Health regulations. **As a member of the National Alliance for Care at Home (Alliance) and the Iowa Health Care Association, we generally support the comments submitted by these organizations to this rule.** In addition, UnityPoint at Home respectfully offers the following comments to the proposed regulatory framework.

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (HH PPS)

CMS proposes a 2.4% aggregate rate increase for CY 2027 – a $420 million increase from CY 2026. This rate includes a proposed update of 2.1% combined with a -0.3% adjustment decrease for the updated fixed dollar loss ratio. To recoup approximately $500 million of the $4.9 billion in alleged overpayments from 2020-2025, CMS proposes a -3% temporary payment adjustment. CMS also proposes to recalibrate the case-mix weights and LUPA thresholds using CY 2025 data.

Comment: Home Health is a community-based, low-cost setting of care that is preferred by patients. As more healthcare services are being pushed to the community and patients have expressed a desire for more home-based services, HHA payment rates forecast decisions to open/close HHAs, increase/reduce geographic service areas, and/or expand/decrease overall services, which ultimately equates to the number of patients being served and strength of population health outcomes. From 2020 to 2025, Medicare home health utilization is in decline (Table 1). Demand has not declined, but HHA capacity has.

Table 1. Medicare Home Health Utilization is Declining

	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	TREND
30-day Periods of Care	8,423,688	9,269,971	8,593,266	8,319,064	8,275,089	7,719,966	-20% over 4 years
Unique Beneficiaries	2,850,916	3,017,464	2,502,044	2,715,010	2,657,261	2,502,044	-21% over 4 years
Avg. Visits per 30-day Period	8.59	8.25	8.06	8.00	7.87	7.77	-11% over 5 years
Percent LUPAs	8.7%	7.9%	7.8%	6.9%	6.9%	6.6%	-32% over 5 years

By supporting a robust Home Health benefit, Medicare has the opportunity to reduce costs and improve outcomes. In a 30-day period, it is possible for a chronically ill patient with a progressive disease state to have two or more hospital stays or alternatively a less-costly Home Health episode with or without an initial hospital stay. In-home care is an opportunity to enhance the patient experience and meets the patient where they are. This is the difference that Home Health can drive if reimbursement and guidelines appropriately incentivize these services.

Rate Update: After seven years of rate reductions, **UnityPoint at Home commends the modest 2.4% increase in the home health 30-day payment rate.** This rate appropriately excludes any permanent behavioral adjustment to the base rate – a recognition that multiple headwinds impact utilization and spending trends outside PDGM. Over time, the permanent behavioral adjustments eroded home health reimbursement by $1.5 billion – an impact projected to take a decade for the industry to recover from. So, while the overall rate increase is directionally current, its magnitude does not reflect the actual cost of providing high-quality care in the home nor is it sufficient to make ongoing home health investments.

Temporary PDGM Adjustment: We are extremely disappointed that CMS has once again proposed a 3.0% temporary payment adjustment to recoup an estimated $4.9 billion in alleged overpayments. We remain concerned that CMS' methodology cannot fully isolate the effects of the Patient-Driven Groupings Model (PDGM) from the numerous policy, market, and operational changes that have simultaneously reshaped the home health landscape since 2020. During this period, HHAs have navigated a sustained period of transformation, including implementation of OASIS-E, annual case-mix recalibrations, expansion of the Home Health Value-Based Purchasing Model, significant growth in Medicare Advantage enrollment and related utilization management requirements, workforce shortages, inflationary cost pressures, and multiple Medicare payment reductions. Collectively, these changes have influenced patient mix, service

delivery patterns, operational costs, documentation practices, and reimbursement in ways that make it difficult to attribute changes in aggregate spending solely to provider behavioral responses under PDGM.

Given the complexity and cumulative effect of these concurrent changes, we question whether the analysis supporting the proposed recoupment accurately reflects the current HHA operating environment. Imposing an additional 3.0% reduction based on assumptions that remain highly uncertain risks further destabilizing providers at a time when they continue to face significant financial and operational challenges while serving an increasingly complex and medically fragile patient population.

Patient Acuity, Case-Mix Methodology, and Payment Accuracy: We continue to believe that the case-mix and payment methodologies do not reflect patient acuity and the changing nature of the patients being served versus those who are eligible for the Home Health benefit, and several CY 2027 proposals appear to support this belief. Most notably, wound care remains one of the most challenging and resource-intensive clinical groupings served under the Medicare home health benefit, yet CMS proposes a -2.9% case-weighted payment shift for the Wound clinical grouping. This reduction is difficult to reconcile with the realities of caring for patients who often require specialized supplies, frequent skilled nursing visits, extensive care coordination, prolonged episodes of care, and heightened compliance and documentation requirements. These patients are not lower-cost beneficiaries, nor are they easier to serve. In fact, wound care patients frequently present some of the highest operational, financial, and denial-management challenges facing HHAs today.

Similarly, significant proposed changes to comorbidity adjustment methodology raise additional questions regarding the stability and accuracy of payment classifications. CMS proposes modifications involving approximately 100 different diagnosis interactions within the high comorbidity subgroup, while also reversing a prior policy decision by restoring Endocrine 3-Type 1, Type 2, and Other Specified Diabetes to the low comorbidity subgroup after previously removing it for 2026. These ongoing recalibrations illustrate the complexity and evolving nature of the PDGM classification system and reinforce our concern that payment changes are often driven by coding and classification adjustments rather than a clear understanding of underlying patient acuity and resource utilization.

The same concern applies to CMS' proposed updates to the OASIS functional scoring methodology. From a provider perspective, the proposed point reallocations appear to reduce payment recognition in circumstances where greater functional impairment is observed and documented. As the home health population continues to become more clinically complex, HHAs are caring for beneficiaries with higher levels of dependency, mobility limitations, cognitive impairment, and chronic disease burden. Yet the proposed refinements seem to move functional impairment scoring in a direction that does not fully recognize the increased resources required to care for these patients safely in the home.

Taken together, the proposed reductions to the Wound clinical grouping, continued modifications to comorbidity subgroup interactions, shifting diagnosis classifications, and changes to functional impairment point allocations create a cumulative effect that appears disconnected from the realities facing providers. These policies assume a level of precision in case-mix adjustment that does not adequately account for the increasing acuity of patients who are able to access home health services. As workforce shortages and reimbursement pressures constrain capacity, HHAs are increasingly serving only

the most medically complex patients. We therefore urge CMS to evaluate whether current case-mix methodologies accurately reflect the intensity of services provided, the costs incurred, and the growing gap between patients referred to home health and those who are ultimately able to receive care.

HHA Cost Pressures: Home health is a labor-intensive service, and our industry inputs are particularly sensitive to the market fluctuations. Labor, supplies, and mileage costs have outpaced reimbursement updates, resulting in financial strain.

- Labor: With a limited labor supply, the Home Health workforce is particularly sensitive to overall wage increases due to market conditions and the use of contracted labor. Capacity to provide Home Health services is in many cases restricted by staffing. In an attempt to recruit and retain team members, UnityPoint at Home has increased salaries and benefits 5% annually for 5 years, yet we still struggle with persistent vacancies and staff turnover.
- Supplies: The costs of non-routine supplies (i.e., those outside the episodic payment) have not kept up with inflation. As for routine supplies (i.e., those covered in the episodic payment), CMS keeps expanding the list of included supplies without corresponding reimbursement attributable to the episode.
- Mileage: For Home Health, particularly in rural areas, this reimbursement component is crucial. From a staff standpoint, team members in rural areas sometimes travel upwards of 600 miles per week for patient visits in addition to actual time and efforts spent on visits and documentation duties. Currently, mileage reimbursement is based on Internal Revenue Service rates[1], and rates are established after the HHA budget is determined. Vehicle wear and tear and insurance are other vehicle costs being absorbed by our personnel or the HHA and, as vehicle prices rise and gas prices skyrocket, mileage reimbursement does not cover costs and equates to a wage decrease.

These pressures are not recognized within Medicare reimbursement.

Rural Add-On Payment: We encourage CMS to reinstate a 3% rural add-on payment to encourage access to patients in rural and remote geographies. The elimination of the rural add-on payment in 2024 is not aligned with other prospective payment systems – hospital inpatient, hospital outpatient, and physician fee schedule – which provide payment add-ons or even special designations to support the increased cost of access in rural areas. Dating back to 2000, the Home Health rural add-on was 10% and decreased over time to 5%, 3%, 4%, 2% and eventually 1% in CY 2023.

REQUEST FOR INFORMATION (RFI): HOME HEALTH-SPECIFIC WAGE INDEX

For CY 2027, CMS proposes to continue to use the concurrent pre-floor, pre-reclassified IPPS hospital wage index as the basis for the HH PPS wage index. CMS seeks stakeholder input on the appropriateness of developing a home health-specific wage index from an alternative data source (e.g., Bureau of Labor Statistics and home health Medicare cost reports) consistent with CMS' statutory authority and regulatory requirements.

[1] For 2026, fuel prices dictated a mid-year increase in the standard business mileage rate from 72.5 cents/mile (January–June) to 76 cents/mile (July–December) - https://www.irs.gov/tax-professionals/standard-mileage-rates

Comment: UnityPoint at Home appreciates CMS' efforts to evaluate whether a home health-specific wage index could better reflect the labor market realities faced by HHAs. However, we do not currently have the resources necessary to independently analyze potential alternative data sources or assess their implications. Without the benefit of CMS' underlying analyses, it is difficult to determine how a home health-specific wage index derived from sources such as Bureau of Labor Statistics data or Medicare cost reports would compare to the current concurrent pre-floor, pre-reclassified IPPS hospital wage index or what impacts such a change could have on providers, services, and beneficiaries.

As part of an integrated health system serving predominantly rural communities, UnityPoint at Home competes for the same workforce as hospitals, physician practices, long-term care providers, and other healthcare settings. Consequently, the hospital wage index reflects labor market dynamics that directly influence our ability to recruit and retain clinical staff. The current hospital wage index is also a well-established, audited, and transparent methodology that providers understand and have relied upon for many years.

Should CMS continue to explore the development of a home health-specific wage index, we encourage the agency to maintain a transparent and collaborative process that includes ongoing stakeholder engagement and robust impact analyses. In particular, CMS should share modeling assumptions, methodological considerations, and agency-specific impact estimates so stakeholders can meaningfully evaluate how potential alternatives would affect reimbursement, workforce stability, beneficiary access, and rural providers. We appreciate the opportunity to provide input and look forward to reviewing additional analyses as CMS' exploration of a home health-specific wage index progresses.

PALLIATIVE CARE SERVICES AS HOME HEALTH SERVICES

CMS is seeking to advance its broader goal of promoting access to and utilization of palliative care services, with a particular focus on expanding opportunities for community-based palliative care services. Specifically, CMS plans to include additional palliative care examples of skilled care to the Medicare Benefit Policy Manual following the publication of the CY 2027 HH PPS final rule and seeks stakeholder input.

Comment: CMS has expressed a desire to expand access to community-based palliative care and, in this proposed rule, clarifies that palliative care services may qualify as skilled services under the Medicare home health benefit. We generally agree with CMS that "the Medicare home health benefit can be an important step in the care continuum when a patient needs palliative care, either during episodes of serious illness or near end of life, before choosing hospice care." We appreciate CMS' intent to provide additional examples of palliative care services in Chapter 7 of the Medicare Benefit Policy Manual (BPM). However, we do not believe that additional guidance alone will meaningfully increase the provision of palliative care through HHAs, as most HHAs already recognize that palliative care can be furnished as a skilled service.

Instead, we believe that the primary barriers to expanding access to palliative care under the Home Health Benefit are misaligned quality incentives and inadequate reimbursement.

- Misaligned incentives: Although CMS has clarified that palliative care may be furnished as a skilled home health service, both the Home Health Value-Based Purchasing (HHVBP) Model and the Home Health Quality Reporting Program (HH QRP) continue to emphasize measures that

reward functional improvement. HHVBP includes measures such as the Discharge Function Score, Improvement in Bathing, Improvement in Upper Body Dressing, and Improvement in Lower Body Dressing. Similarly, HH QRP includes the Discharge Function Score as well as measures assessing improvement in ambulation/locomotion, bathing, and bed transferring.

For many patients receiving palliative care, the clinical objective is not functional improvement but rather symptom management, maintenance of function, avoidance of unnecessary hospitalizations, and support for patient goals and preferences. These beneficiaries often have progressive, serious illnesses for which stabilization represents a successful outcome. As a result, HHAs may face both operational and financial disincentives to admit and manage palliative care patients whose outcomes may adversely affect performance on quality measures that prioritize functional gains. To better align quality programs with the goals of palliative care, CMS should consider establishing a mechanism within OASIS to identify palliative care patients and exclude those beneficiaries from the denominators of HHVBP and HH QRP outcome measures focused on functional improvement.

- Appropriate reimbursement: The continuum of home-based care evolves from restoration to stabilization to comfort. Traditional home health services are designed to restore function and independence; palliative care focuses on symptom management, care coordination, and maintaining quality of life; and hospice care prioritizes comfort and honoring patient preferences at the end of life. As patients move across this continuum, the resources, disciplines, and intensity of services required also change.

  CMS acknowledges that palliative care differs from traditional home health services by proposing additional examples in the BPM. We believe those examples will further demonstrate that palliative care patients often require more resource-intensive interventions, including complex symptom management, extensive care coordination, advanced care planning, and caregiver support. Despite these additional demands, the current payment methodology does not provide differentiated reimbursement for palliative care services delivered under the Home Health Benefit.

  To meaningfully improve access to home-based palliative care, CMS should consider convening HHAs with experience delivering palliative care services to explore the development of a dedicated PDGM category for palliative care. A separate payment category could support a more appropriate 30-day payment structure, facilitate accurate identification of palliative care beneficiaries, and better align payment and quality policies with the goals of symptom management, maintenance of function, and patient-centered care. Such an approach would also provide a more appropriate framework for excluding palliative care patients from outcome measures that are predicated on functional improvement and may not accurately reflect the quality of care delivered to this population.

HOME HEALTH QUALITY REPORTING PROGRAM (HHQRP)

CMS proposes to (1) reduce the OASIS assessment data submission and correction timeframe, (2) transition both the OASIS and CAHPS Annual Payment Update (APU) reporting periods to a calendar-year basis, and

(3) revise methods for transmission of quality noncompliance and reconsiderations to digital platforms.

Comment: Consistent with our comments from the CY2026 HH PPS proposed rule, **UnityPoint at Home supports reducing the deadline for OASIS assessments from 135 days to 45 days and we already comply with this timeline**. We agree that public reporting on Home Health Compare is valuable for patients and families and should be timelier**.**

Additionally, the transition of the OASIS and CAHPS APU reporting periods to a calendar year is a win for the industry. Thank You! Aligning reporting periods to the same period will simplify interpretation and streamline compliance.

REQUEST FOR INFORMATION: HHQRP QUALITY MEASURE CONCEPTS UNDER CONSIDERATION FOR FUTURE YEARS

CMS seeks input on advance care planning as a future measure concept for the home health setting.

Comment: As an integrated health system, **UnityPoint Health (including UnityPoint at Home) supports meaningful advance care planning (ACP) as an essential component of patient-centered care**. We appreciate that CMS recognizes the importance of advance care planning, acknowledges that ACP adoption rates are low, and is soliciting stakeholder feedback across 2026 Medicare annual payment rules targeting most if not all provider types. In the CMS List of Measures Under Consideration (MUC) issued in December 2025, 15 CMS Quality Reporting and Value Based Programs[2] were identified for potential inclusion of MUC2025-020 (Advance Care Planning). We respectfully suggest that ACP will benefit from clear and targeted provider responsibility. The adoption of process measures across 15 varied CMS programs obfuscates ACP responsibility, increases administrative burden, and duplicates efforts resulting in patient confusion and dissatisfaction, instead of patient trust and confidence.

Meaningful ACP involves identifying patient needs, reinforcing preferences, supporting patients and caregivers, and coordinating follow-up. Ideally, providers with longitudinal patient relationships are best suited to be responsible for ACP as evidence by scope of practice, access to clinical information, duration of involvement, and ability to influence the outcome. While HHAs have long played a key role in identifying, documenting, and honoring patient preferences regarding advanced directives through Medicare's Conditions of Participation, **HHAs should not be primarily responsible ACP and the addition of an ACP measure to the HH QRP measure set would not enhance the quality of home health services**. A home health episode is generally time limited, and not every patient receiving home health services has an established or continuing relationship with the agency. Home health clinicians may identify a need for a more comprehensive goals-of-care discussion but may not have the clinical authority, longitudinal knowledge, or access to the full medical record necessary to address complex decisions regarding

[2] Ambulatory Surgical Center Quality Reporting Program; End-Stage Renal Disease Quality Incentive Program; Home Health Quality Reporting Program; Hospital Inpatient Quality Reporting Program; Hospital Outpatient Quality Reporting Program; Hospital Value-Based Purchasing Program; Inpatient Psychiatric Facility Quality Reporting Program; Inpatient Rehabilitation Facility Quality Reporting Program; Long-Term Care Hospital Quality Reporting Program; Medicare Promoting Interoperability Program; Merit-based Incentive Payment System; Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program; Rural Emergency Hospital Quality Reporting Program; Skilled Nursing Facility Quality Reporting Program; Skilled Nursing Facility Value-Based Purchasing Program

prognosis and treatment options. In many cases, these conversations require the participation of the patient's physician or other practitioner who understands the patient's diagnoses, anticipated disease trajectory, and available treatment alternatives.

DMEPOS ENCOUNTER REQUIREMENTS FOR IDENTICAL REPLACEMENT ITEMS

CMS clarifies that while an order would continue to be required for replacement DMEPOS items, a new face-to-face encounter would not need to occur to support payment for these DMEPOS items.

Comment: Thank you for embedding common sense into these requirements. UnityPoint at Home supports this clarification, which eliminates an unnecessary visit along with its expense and burden to the patient.

DME BENEFIT EXPANSION FOR INFUSION PUMPS AND DRUGS

CMS proposes to implement provisions from Consolidated Appropriations Act of 2026 regarding the home infusion DME benefit to provide that certain external infusion pumps, associated home infusion drugs, and related supplies will be treated as meeting the ''appropriate for use in the home'' requirement when certain criteria are met. Currently, only one drug meets this is expected to qualify for Medicare coverage under the revised external infusion pump criteria.

Comment: For context, CMS pays home infusion therapy (HIT) suppliers for professional services furnished for each infusion drug administration calendar day under the Medicare HIT benefit. In its most recent HIT Monitoring Report covering 10 quarters of HIT utilization from Q1 of 2023 through Q2 of 2025[3], CMS found:

- HIT service visits fluctuated with an average of 6,991 quarterly visits;
- Utilization of HIT drugs declined in home setting, as well as in physician offices and outpatient settings; and
- Market for HIT service visits is concentrated with 7 of 73 HIT suppliers organizations providing 54% of HIT service visits.

These statistics represent an anemic Medicate HIT benefit that is vastly underperforming in an area for which there was and is exciting potential.

UnityPoint at Home fields requests for HIT services weekly. Across payers, our UnityPoint at Home infusion intake team performs between 50-60 HIT benefit checks weekly. On average, roughly 15% of benefit checks are declined due to lack of Medicare coverage – 92% for IV antibiotics, and 3% for hydration/fluids. To put a face on this issue, the HIT Benefit Patient Dilemma scenario on the next page represents a typical HIT benefit tradeoff between affordability and access to clinically appropriate, patient-centered care. In this instance, financial hardship hits this family's limited income and is pitted against patient and caregiver quality of life during a recovery period.

UnityPoint at Home continues to advocate for expanding home infusion therapy (HIT) services. This proposal includes "external infusion pump" within the definition of DME. CMS anticipates this change will

[3] https://www.cms.gov/files/document/hit-monitoring-report-feb-2026.pdf

impact only one drug. Unfortunately, **the limited scope of this benefit expansion will not help close the HIT access gap that exists between commercially insured patients and traditional Medicare beneficiaries.**

HIT Benefit Patient Dilemma

An older adult in their 80s developed a serious infection following knee replacement surgery and required 6 weeks of 3 times daily intravenous (IV) antibiotic therapy. Due to significant mobility limitations, travel was challenging and physically taxing. Patient lives with spouse 30 minutes from hospital.

Consideration	Outpatient Infusion Center	Home Infusion
Treatment Setting	Daily visits to hospital-based infusion center	Therapy administered in the patient's home
Travel Requirements	30-minute trip each way, every day for 6 weeks	No daily travel required
Mobility Impact	Significant burden due to limited mobility following knee replacement infection	Eliminates transportation challenges during recovery
Treatment Administration	Continuous infusion pump required, with medication delivered every 8 hours	Brief 3-to-5-minute infusions every 8 hours
Infusion Pump Use	Connected to pump 24/7 for 6 weeks	No continuous pump required
Patient Comfort	Reduced flexibility and mobility because of continuous pump use	Greater comfort, flexibility, and independence
Caregiver Burden	Daily transportation and scheduling demands on spouse/caregiver	Significantly reduced transportation and logistical burden
Out-of-Pocket Cost	Lower direct cost to patient	Approximately $75/day ($3,150 total)
Financial Impact	More affordable option	Significant financial burden for patient and spouse
Quality of Life	Long daily travel and continuous pump use may disrupt daily activities	Allows patient to remain at home and maintain greater independence
Patient Decision Factors	Lower cost but substantial transportation and treatment burden	Higher cost but better aligned with patient needs and recovery goals

As a member of Premier, Inc., we echo Premier's observation that "*Immune globulin, biologics and other infused medications continue to be directed to hospital outpatient departments and skilled nursing facilities despite home infusion often being the clinically appropriate, lower-cost, and patient-preferred setting. This proposal to modify the criteria for the use of an infusion pump should not be viewed as a solution to the broader access challenges facing Medicare beneficiaries who could safely receive infusion therapy at home*." This proposal's approach is overly restrictive and hampers patient access to the HIT benefit because:

- Self-administered infusion drugs are excluded. The HIT benefit should enable self-administered

infusion drugs. Common examples are IV antibiotics and IV fluids which are easily administered by the patient or caregiver. Today and unchanged by this proposal, patients must still go to a hospital outpatient department (HOPD), physician office, or ambulatory infusion center (AIC) EACH DAY for drugs which can be self-administered or alternatively pay a private pay daily rate to receive an infusion in the home setting. These patients are often the most vulnerable population at increased risk of falls and infections, and Medicare requires them to travel daily (or at prescribed intervals) to receive infusions rather than enabling infusions in the comfort of their homes.

- DME equipment/supply definitions are severely limited. The HIT benefit excludes home infused drugs that do not require a pump or may be infused with a disposable pump. These safe infusion delivery methods represent service enhancements, are often less cumbersome than DME pumps, and are less frustrating for patients to learn to use and troubleshoot.
- HIT administration requirements exceed health care professional scope of practice. The HIT proposal requires a registered nurse, clinical nurse specialist, nurse practitioner, physician assistant, or physician to administer HIT or supervise HIT administration. While registered nurses are required to administer infusion specialty drugs, registered nurses are not required to administer fluids and antibiotics which are the most common medication classes our home infusion pharmacy services. By exceeding scope of practice requirements, the HIT benefit creates operational inefficiencies and exacerbates workforce shortages.
- Infusion administration frequency is arbitrarily set. The proposal restricts the HIT benefit to home infusion drugs that are to be infused at least 12 times annually. When factoring in other HIT requirements, this represents only 3.7% of nurse-administered drugs that UnityPoint at Home dispenses and significantly limits the HIT Benefit to the determent of Medicare beneficiaries.

While not directly addressed in this proposal, we also reiterate Premier's recommendation for CMS to revise its existing definition of "infusion drug administration calendar day" to be consistent with Congressional intent and to allow for reimbursement of home infusion professional services each day that an infusion drug physically enters the patient's body, irrespective of whether a skilled professional is in the individual's home.

DMEPOS COMPETITIVE BIDDING PROGRAM—COUNTRY OF ORIGIN

CMS proposes to revise Form C (reporting form for DMEPOS CBP contract suppliers) to include the country of origin for each lead item.

Comment: UnityPoint at Home does not oppose inclusion of this data point for each lead item in Form C, but we caution that this information may be difficult to capture, and should CMS impose penalties for fields that are inaccurate or blank, this may further exacerbate DME supply chain access and costs. The DME industry has been the subject of a lot of unexpected supply chain issues, which may require frequent changes to the country-of-origin field based on supply availability. In addition, all UnityPoint at Home DME suppliers are US-based; however, as a function of the market, the products often originate from Mexico or Asia.

MEDICARE PROVIDER ENROLLMENT

CMS proposes numerous provisions related to Medicare provider enrollment, including provisions that apply to all Medicare providers and suppliers.

Comment: UnityPoint Health appreciates CMS' ongoing efforts to strengthen program integrity, protect Medicare beneficiaries, and safeguard the Medicare Trust Funds. We support CMS' commitment to preventing fraud, waste, and abuse and recognize the important role provider enrollment requirements play in ensuring accountability across the Medicare program. That said, these provisions represent a significant expansion of CMS discretion, revocation authority, and enrollment-related obligations, and include substantial changes to Medicare provider enrollment authorities that would apply not only to HHAs but to ALL providers and suppliers enrolled in Medicare. Because only a subset of providers and suppliers provide home health services, it is likely a majority of impacted regulated entities are not aware of the scope of this proposed rule and have not offered input. **We reiterate the recommendation of the American Hospital Association and urge CMS to issue this Medicare enrollment changes through standalone rulemaking** - "I*ssuing a separate proposed rule, rather than incorporating program-wide enrollment changes into a home health payment regulation, would be more consistent with CMS' longstanding commitment to transparency, and would provide all affected stakeholders a meaningful opportunity to comment."*

General Tenets: As CMS revisits program integrity framework for Medicare provider enrollment, UnityPoint at Home encourages CMS to consider several overarching principles that should guide the finalization and implementation of any expanded enrollment authorities.

- Maintain Transparency, Consistency, and Objective Standards.
- Distinguish Intentional Misconduct from Good-Faith Errors.
- Provide Opportunities for Corrective Action and Reasonable Implementation Timeframes.
- Institute Flexibilities that Recognize Operational and Administrative Realities.
- Ensure Proportionate and Risk-Based Enforcement.
- Protect Beneficiary Access to Care.

The following comments reflect these overarching principles and provide recommendations on specific enrollment provisions included in the proposed rule.

Definitional Changes

Affiliation: The definition of "affiliation" is proposed to include broad categories such as marketing, business, fulfillment, financial, managerial, and beneficiary relationships. Additionally, the 5-year lookback period has been removed for reporting. These changes combined make it difficult for providers and suppliers operating in good faith to determine what relationships must be disclosed and how far their due diligence obligations extend. We are particularly concerned about implications for "managing employees." In many cases, a managing employee may not know whether a former employer, contractor, or affiliated organization has ever experienced a disclosable event, nor would they necessarily have access to that information. As a result, providers and suppliers could inadvertently provide false or misleading

information despite making a good-faith effort to comply. **We request that CMS limit enforcement to situations where there is evidence that the individual knew, reasonably should have known, or was directly involved in the disclosable event or affiliation presenting the program integrity concern**. This would help ensure that the affiliation requirements remain effective while avoiding undue burden on providers and suppliers attempting to comply with increasingly expansive disclosure obligations.

We encourage CMS to provide clear guidance regarding what affiliations must be disclosed, the criteria used to evaluate those affiliations, and the steps providers and suppliers should take to conduct appropriate due diligence ultimately reducing the administrative burden on CMS as well. Clear disclosure requirements would help providers and suppliers identify and address potential risks before entering into employment or contractual relationships and reduce uncertainty regarding what constitutes a reportable affiliation.

Final Adverse Action: The definition is proposed to include a "misdemeanor conviction," which relates to sexual assault or financial misconduct within a 10-year lookback window tied to enrollment, revalidation, or reenrollment. This impacts decisions on screening levels; FCA denials and revocations; revocations for improper prescribing, debt, billing noncompliance, and abusive ordering; reenrollment bars; and extension of revocation. **This definitional look-back window creates compliance challenges** for providers and suppliers, particularly in situations when the conviction occurred prior to the effective date of this requirement. **If finalized, CMS should institute a reasonable implementation period, preferable two years of non-enforcement, to enable providers and suppliers to evaluate applicable individuals, obtain updated disclosures, and take corrective action where necessary.**

Managing Employee: We understand the importance of identifying individuals who exercise meaningful operational control over providers and suppliers. However, ambiguity in the current definition of "managing employee" has led to varying interpretations of CMS reporting requirements and uncertainty regarding which individuals must be disclosed. CMS is exacerbating this situation by adding categories such as "all other clinical personnel" that will significantly increase the administrative burden of maintaining enrollment information, particularly for large organizations with frequent leadership and supervisory changes. Large health systems may have dozens of service line leaders, assistant directors, nurse managers, clinical coordinators, and supervisory personnel whose responsibilities do not extend to day-to-day organizational operations or Medicare participation. For example, not all employees with managerial or clinical oversight responsibilities have direct or indirect control over the provider's day-to-day operations or Medicare participation. **We encourage CMS to provide clear criteria and limit reporting requirements to individuals with substantial authority over operations based on the individual's job description, area of functions, or Medicare-related activities.** This would promote consistency while reducing unnecessary enrollment updates and administrative burden.

To balance program integrity with operational flexibility, we recommend that CMS:

- Clarify that reporting is limited to individuals who exercise significant decision-making authority over organizational operations, regulatory compliance, billing, reimbursement, or strategic management. Clear thresholds would improve consistency and reduce unnecessary enrollment updates resulting from routine personnel changes.

- Recognize a provider's documented attempt to report a change as timely compliance when PECOS limitations, contractor instructions, or a pending application prevents formal submission. Submission tools (PECOS) should be evaluated to better support the supplier or provider to ensure seamless updates. Examples of recommended enhancements can be found throughout our comments below.
- Establish a reasonable correction period for late-reported changes that do not affect ownership, control, payment destination, qualifications, or beneficiary safety.

Revised Enrollment Revocation Grounds

False or Misleading Information (§ 424.535(a)(4)): The revocation category relates to written and electronic documents. We encourage CMS to consider these further revisions:

- Establish clear, objective standards for when revocation is considered "justified and necessary." Enrollment processes often rely on information and documentation provided by third parties that the provider or supplier does not control (e.g., insurance agencies, financial institutions, etc.), and inadvertent errors can occur despite good-faith efforts to ensure accuracy.
- Distinguish intentional misrepresentations from clerical errors, third-party inaccuracies, and other good-faith mistakes, and allow providers an opportunity to correct errors before revocation is imposed.
- Clarify that claims corrected through routine adjustments, self-audits, or voluntary refunds will not independently be treated as evidence of providing false or misleading information.

Given the significant financial and operational consequences of revocation, clear criteria, consistent contractor applications, and timely enrollment processing are critical.

Abuse of Billing Privileges (§ 424.535(a)(8)(ii)): CMS proposes to remove the considerations used to evaluate a "pattern or practice" of noncompliant billing, creating a more subjective standard that could lead to inconsistent application and diminished transparency regarding revocation decisions. Providers and suppliers benefit from detailed guidance regarding the factors, frequency, severity, or duration of claim errors that may support revocation. **We urge CMS to reinstate this list or replace it with other considerations that inform this determination**. If CMS believes the current list of factors constrains their efforts, CMS could and should simply insert the word "may" – "*In making this determination, CMS may consider, as appropriate or applicable, the following:*" We appreciate that CMS has chosen to use factors lists for 9 other revocation categories and to inform determinations for reenrollment bars, revocation extensions to other Medicare enrollments, and voluntary terminations. Factor lists are valuable tools for transparency and accountability.

In the spirit of transparency, we also encourage CMS to add further guidance to distinguish between intentional or reckless billing practices and operational or educational errors that can occur in complex billing environments. For example, a series of claims submitted with an incorrect code due to employee training deficiencies, human errors, or lack of vague guidance from CMS and/or the Medicare Administrative Contractor (MAC) on what is required for a valid claim may establish a pattern of billing

mistakes but does not necessarily indicate fraud or abuse. In these circumstances, corrective action and provider education may be more effective than revocation. The existence of the Targeted Probe and Education (TPE) audit program reflects CMS' recognition that patterns of claim denials frequently stem from correctable billing and documentation errors and are often more appropriately addressed through provider education and corrective action than through revocation. Moreover, revocation based on billing errors that do not reflect fraudulent or abusive conduct may have the unintended consequence of disrupting beneficiary access to care, particularly in areas with limited provider options, ultimately harming the patients CMS seeks to protect.

Affiliation that Poses Undue Risk (§ 424.535(a)(19)): Consistent with our earlier comments, the expanded definition of managing employee raises operational concerns for providers and suppliers performing due diligence without further guidance from CMS.

Additional Enrollment Revocation Grounds

Misdemeanor Conviction (§ 424.535(a)(16)): We encourage CMS to consider several important modifications.

First, **CMS should limit this authority to misdemeanor convictions that present a demonstrable program integrity risk**. Revocation should require a clear nexus between the underlying offense and the individual's duties, particularly their ability to influence patient care, billing, financial operations, or other Medicare program activities. Given the broad definition of a "managing employee," individuals may hold management responsibilities that have little or no connection to reimbursement, compliance, or beneficiary care. A misdemeanor conviction involving such an individual may not present the same level of risk as one involving a person with direct authority over billing, finances, or clinical operations.

Second, **CMS should provide providers and suppliers an opportunity to take corrective action** before imposing revocation. In many cases, legitimate program integrity concerns can be effectively addressed by removing the individual from the applicable role or implementing other corrective measures. Allowing corrective action would enable CMS to mitigate risk while avoiding unnecessary disruption to provider operations and beneficiary access to care.

Third, **enrollment actions should be based on current program integrity risk** and not merely the historical occurrence of a misdemeanor offense. CMS should consider whether the underlying conduct has already been reviewed by the appropriate state licensing or regulatory authority. State boards frequently investigate misconduct, impose corrective actions, and determine whether an individual may continue to practice. Where an individual remains licensed, authorized to practice, and in good standing subject to state oversight, CMS should consider those facts as part of its risk assessment rather than relying solely on the existence of a misdemeanor conviction.

Finally, we are concerned that the proposal places significant responsibility on providers and suppliers to identify potentially disqualifying misdemeanor convictions without providing a corresponding mechanism to obtain that information. Providers already conduct required sanction screenings, exclusion checks, and abuse registry reviews, yet may have no reasonable way to identify historical convictions that are not otherwise disclosed. **CMS should develop more effective processes and tools for identifying and**

communicating potentially disqualifying convictions and should consider whether the provider knew, or reasonably could have known, of the conviction before imposing revocation. Where a conviction was not identified through required screening processes, revocation may be neither appropriate nor proportionate.

High-Risk Based on Excess Providers in Area (§ 424.535(a)(24)): This new revocation category raises several questions. First, **this category introduces broad concepts such as "high risk," "limited geographic area," and "excessive number" without clear standards for how these determinations will be made**. This creates uncertainty for providers operating in good faith and may subject them to increased scrutiny based solely on location. Second, **we highly recommend that CMS base revocation on objective evidence supporting fraud, abuse, or other program integrity concerns**. Specifically, geographic concentration should be a trigger for additional review or audit, not a basis for revocation, absent objective evidence. Likewise, potential involvement in a fraud scheme should be supported by evidence, including claims data proving an aberrant referral or procedure, rather than proximity to other providers. Third, **as an alternative, CMS could consider targeting states or areas where a high number of the same provider types are located**. We disagree that providing thresholds would necessarily lead to circumvention. CMS could provide example thresholds or factors that inform its decision-making without creating bright-line standards. Doing so would help providers better understand CMS expectations while still allowing the agency to account for evolving community needs, demographic shifts, and population growth.

We also recommend that CMS coordinate with state agencies to provide greater visibility into provider need and market saturation considerations before providers establish operations. Clearer guidance regarding the factors used to assess enrollment risk would promote transparency, support informed investment decisions, and help ensure that compliant providers are not disadvantaged by the misconduct of unrelated organizations operating in the same market.

Enrollment Revocation Process

Effective Date of Enrollment Revocation (§ 424.535(g)): CMS proposes to make all revocation grounds effective retroactive to the date on which the provider's non-adherence to Medicare requirements commenced. We recognize CMS' desire for Medicare funds to be paid only to legitimate, compliant providers. However, this proposal represents a significant expansion of CMS enforcement authority that fails to distinguish between intentional misconduct and correctable administrative noncompliance, exposing providers to substantial financial liability based on subjective retroactive determinations while discouraging remediation and potentially undermining beneficiary access to care.

As proposed, the universal retroactive revocation policy has inherent risks.

- *Disproportionate Penalties for Technical or Administrative Errors*. The proposal does not adequately distinguish between intentional misconduct and inadvertent administrative errors. Fraud, materially false enrollment disclosures, and deliberate efforts to conceal information present fundamentally different risks than technical reporting deficiencies, documentation errors, or other compliance issues that may be promptly corrected once identified.
- *Significant Retroactive Financial Liability.* Retroactive revocation functions not only as an

enrollment sanction but also as a significant payment recoupment mechanism. Providers may face substantial repayment obligations for medically necessary services furnished to eligible beneficiaries, even where the underlying deficiency was administrative in nature and unrelated to the quality of care provided.

- *Subjective Determinations of When Noncompliance Began.* The proposal substitutes verifiable events with subjective determinations based on hindsight and creating uncertainty and increasing the risk of inconsistent enforcement.
- *Reduced Incentives for Self-Disclosure and Corrective Action*. Expanding retroactive revocation across all revocation grounds may reduce incentives for self-disclosure and prompt remediation if providers perceive that good-faith efforts to correct deficiencies will not meaningfully reduce their exposure to substantial retroactive liability.
- *Threats to Beneficiary Access to Care*. Enrollment sanctions intended to protect the Medicare program may inadvertently reduce patient access to medically necessary services if compliant providers are unable to absorb the financial impact.

While CMS notes that revocation remains discretionary and that the agency is not required to revoke a provider in every instance of noncompliance, the proposal contains little assurance that corrective action, remediation, or opportunities to cure deficiencies will be available or meaningfully considered before retroactive revocation is imposed. As written, the proposal would significantly expand CMS' authority to apply retroactive effective dates while providing providers and suppliers with limited visibility into the circumstances under which discretion may be exercised in favor of corrective action rather than revocation. Absent clear standards, providers may reasonably conclude that even inadvertent or technical violations could expose them to substantial retroactive repayment liability despite efforts to promptly identify, report, and correct deficiencies.

Below are examples of some inadvertent or technical violations that may occur should retroactive revocation be implemented without guardrails. **For each revocation grounds below, CMS should clarify that retroactive revocations will be reserved for circumstances involving clear program integrity concerns rather than technical, administrative, or reporting deficiencies, and further CMS should affirmatively state its intent to make processes to cure or correct errors available as appropriate, including to address inadvertent errors and mistakes that occur despite good faith efforts**.

- **False Information (§ 424.535(g)(iv))**: The existing effective date is retroactive to date the application's certification statement was signed and is proposed to also include the date the false or misleading information was submitted. This is an area that is subject to inadvertent errors and for which good faith efforts should be given deference. Enrollment forms often rely on information and documentation provided by third parties that the provider or supplier does not control (e.g., insurance agencies, financial institutions, etc.), and inadvertent errors can occur despite good-faith efforts to ensure accuracy. **CMS should target retroactive remedies to material or willful and intentional mistakes**.
- **Failure To Satisfy Enrollment Requirements (§ 424.535(g)(1)(vi)):** The effective date is proposed

to change from a prospective revocation to retroactive revocation (i.e., the date on which CMS or its contractor determines that the provider or supplier should be revoked under paragraph (a)(5)). This is an area that is subject to inadvertent errors and for which good faith efforts should be given deference. Using a date determined by CMS or its contractor to be appropriate is a vague standard and may lead to inconsistent application. We have encountered enrollment reviews where contractors requested information or applied standards that were not relevant to the provider type, reflecting the subjectivity that can occur in these determinations. **CMS should also consider implementing a more objective and uniform effective date tied to the enrollment process to promote consistency, predictability, and equitable enforcement.**

- **Application Fee Payment (§ 424.535(g)(1)(vii)):** The effective date is proposed to change from a prospective revocation to retroactive revocation (i.e., the date on which CMS or its contractor determines that the provider or supplier should be revoked under paragraph (a)(6). This is an area that is subject to inadvertent errors and for which good faith efforts should be given deference. We have experienced instances where PECOS failed to link a payment to the appropriate NPI, resulting in the payment incorrectly appearing as unpaid. **We recommend that CMS (1) provide written notice and a reasonable opportunity to cure application fee deficiencies before revocation, particularly when payment issues result from banking, contractor, or technical errors rather than intentional nonpayment, and (2) clarify how providers may document timely payment attempts**.

- **Reporting Enrollment Data Changes (§ 424.535(g)(1)(vi)):** The effective date is proposed to change from a prospective revocation to retroactive revocation (i.e., the day following the date by which the provider or supplier was required to report the applicable change, addition, or deletion). This is an area that is subject to inadvertent errors and for which good faith efforts should be given deference. While we support CMS' expectation that enrollment information be maintained accurately and updated in a timely manner, providers and suppliers often face operational challenges, including employee absences, honest mistakes, or PECOS system challenges when reporting enrollment changes, particularly when multiple changes occur during an active revalidation or while a previously submitted change request is still under review. In these situations, providers may have limited ability to submit additional updates through PECOS and may be required to rely on paper submissions, which can be difficult to track and may create confusion when multiple enrollment changes are occurring simultaneously. Given these practical challenges, expanding retroactive revocation authority for all reporting deficiencies may disproportionately impact providers that are making good-faith efforts to comply with enrollment requirements.

  In addition to overall clarifications related to program integrity intent, **we encourage CMS to implement operational enhancements to proactively support compliance while reducing the likelihood of revocations resulting from administrative and system-related limitations rather than intentional noncompliance**. These enhancements include (1) allowing multiple concurrent change requests through PECOS, (2) providing a mechanism to request extensions when a pending application prevents timely submission of additional updates, and (3) implementing

automated notifications for expiring licenses, insurance, accreditation, and other enrollment-related information. Automated notification processes are used by some Medicaid programs and have proven effective in promoting timely updates and maintaining enrollment accuracy.

- **Failure To Document or Furnish Documentation (§ 424.535(g)(1)(x)):** The effective date is proposed to change from a prospective revocation to retroactive revocation (i.e. for record retention, the date on which CMS or the CMS contractor determines that the provider or supplier has not complied with this retention requirement; for failure to furnish, the day after the date by which the provider or supplier was required to furnish access). This is an area that is subject to inadvertent errors and for which good faith efforts should be given deference. We have also seen administrative errors such as staff mistakenly selecting the wrong patient record or system-related issues that cause incorrect documentation to be submitted despite the good faith effort to comply with the request. In most instances, missing documentation is isolated rather than indicative of a broader compliance failure. Providers may occasionally be unable to produce specific records despite having compliant record retention policies, established processes, and evidence demonstrating a good-faith effort to meet Medicare requirements. It is unclear how CMS will consider the scope and nature of the documentation deficiency, the provider's overall compliance history, and any evidence supporting adherence to record retention requirements before pursuing revocation. In cases involving limited documentation gaps, recoupment of associated claim payments and corrective action may be more appropriate than revocation, particularly when there is no established pattern of missing records or intentional misconduct. The absence of guidance from CMS for revocation on these grounds has implications for CMS' concurrent proposals to expand retroactive revocation and to revoke related enrollments and extends isolated documentation deficiencies to potentially significant operational consequences far beyond the affected claims. **It is imperative that CMS retain flexibility to consider mitigating circumstances and provide providers and suppliers an opportunity to demonstrate compliance and implement corrective actions before revocation is imposed**.

- **Other Program Termination (§ 424.535(g)(1)(xii)):** The existing effective date is retroactive revocation to the date of termination. This proposal includes retroactive revocation to the date of revocation or bar in reference to existing law. **We are pleased that CMS has retained the list of revocation factors in §424.535(a)(12) to be used in its revocation determination to prevent revocations based on certain administrative enrollment actions.** The reason for termination from a State Medicaid program does not always result from fraud, abuse, or other compliance concerns. In some states, providers and suppliers may be terminated for administrative reasons, such as prolonged inactivity or a lack of recent claims submission. This is particularly relevant for providers and suppliers that maintain enrollment in neighboring states to ensure timely access to care for patients residing near state borders. In these situations, enrollment may be maintained for occasional patient needs, even when claims are submitted infrequently. Distinguishing administrative enrollment actions from those involving program integrity concerns will help ensure enforcement efforts remain appropriately targeted while preserving

beneficiary access to care.

Additionally, **if CMS revokes a provider or supplier based on a State Medicaid revocation, termination, or bar and the State subsequently reverses or overturns that action, CMS should be required to reverse its corresponding Medicare revocation**. Because the Medicare revocation was predicated on the State's determination, fairness and due process support restoring Medicare enrollment when the underlying State action no longer exists.

- **False Claims Act (FCA) (§ 424.535(g)(1)(xv)):** The effective date is proposed to change from a prospective revocation to retroactive revocation (i.e., the date of the judgment). **We are pleased that CMS has retained the list of revocation factors in §424.535(a)(15) to be used in its revocation determination**. Given the significant consequences of retroactive revocation, CMS should ensure that revocation decisions are based on a thorough evaluation of the circumstances surrounding the FCA judgment and the factors already set forth in §424.535(a)(15).

- **Debts Referred to Treasury (§ 424.535(g)(1)(xvii)):** The effective date is proposed to change from a prospective revocation to retroactive revocation (i.e., the date on which CMS referred the debt to the Department of Treasury). **We are pleased that CMS has retained the list of revocation factors in §424.535(a)(17) to be used in its revocation determination.** Given the significant consequences of retroactive revocation, CMS should (1) not impose revocation when the provider or supplier is actively disputing/appealing the amount, complying with an approved repayment arrangement, or did not receive timely notice of the debt before referral to Treasury, (2) provide a final notice and reasonable cure period before revocation and confirm that the debt is legally enforceable, accurately attributed to the provider or supplier, and not subject to a pending reopening, appeal, reconciliation, cost report settlement, or bankruptcy-related protection, and (3) give deference to compliance with an approved repayment plan and not consider the associated debt as evidence that the provider or supplier is unwilling to satisfy its Medicare obligations.

- **Revoked Under Different Name or Identity (§ 424.535(g)(1)(xviii)):** The effective date is proposed to change from a prospective revocation to retroactive revocation (i.e., the effective date of the provider's or supplier's current enrollment). **We are pleased that CMS has retained the list of revocation factors in §424.535(a)(18) to be used in its revocation determination.** Given the significant consequences of retroactive revocation, CMS should evaluate the totality of the circumstances and ensure there is sufficient evidence that the provider or supplier intentionally sought to circumvent an existing revocation and reenrollment bar.

- **Affiliation that Poses an Undue Risk (§ 424.535(g)(1)(xix)):** The effective date is proposed to change from a prospective revocation to retroactive revocation (i.e., the date on which CMS or its contractor determines that the provider or supplier should be revoked under this paragraph). This is an area in which good faith efforts should be given deference. CMS has proposed significant changes to §424.535(a)(19) via the addition of "any of its owning or managing employees or organizations." The proposed effective date for revocations based on undue risk

affiliations may lead to inconsistent application because of the broad and subjective nature of the underlying determination. **Without clear guidance regarding how CMS will evaluate affiliations and assess "undue risk," providers and suppliers may have difficulty understanding their compliance obligations and the circumstances that could result in revocation**. Our concerns are detailed under our comments related to the definitions of "affiliation" and "managing employee."

As proposed, there is significant risk that providers and suppliers will be subject to revocations for affiliations they may not have reasonably known would be considered an undue risk. If CMS expects providers and suppliers to conduct screening or monitoring beyond currently established requirements, such as sanction checks, background checks, exclusion screenings, abuse registry checks, policies and surveys on conflict of interest disclosures, etc., CMS should (1) clearly identify those expectations within an interim final rule (or other public notice and comment opportunity) that allows providers and suppliers an opportunity to further comment prior to implementation and (2) incorporate a delayed implementation date or otherwise delay enforcement to provide a reasonable implementation period. CMS should also consider incorporating specific affiliation-related questions with clear criteria/instructions within the CMS-855 enrollment applications that allow providers and suppliers to proactively disclose potentially relevant affiliations.

- **Billing From Non-Compliant Location (§ 424.535(g)(1)(xx)):** The effective date is proposed to change from a prospective revocation to retroactive revocation (i.e., the earliest date on the claims for the non-compliant location that are triggering the revocation). **We are pleased that CMS has retained the list of revocation factors in §424.535(a)(20) to be used in its revocation determination.** Given the significant consequences of retroactive revocation, CMS should evaluate the totality of the circumstances and have transparency regarding how location-related noncompliance will be evaluated. CMS determinations should (1) target intentional and willful noncompliance when considering whether a provider or supplier "knew or should have known", (2) distinguish substantive location noncompliance from minor administrative discrepancies, such as suite-number errors, delayed processing of a timely submitted location update, or temporary operational changes, and (3) refrain from using retroactive revocation when a provider attempted to report the location, relied on contractor guidance, or corrected the issue promptly after discovery.

- **Patient Harm (§ 424.535(g)(1)(xxii)): Retroactive revocation to the date of the underlying conduct may create unintended access-to-care concerns**. This is an area for which good faith efforts should be given deference. Providers and suppliers often remain fully licensed and authorized to furnish services while a state investigation is pending, which may last months or years. If enrollment is ultimately revoked under §424.535(a)(22), retroactive application could require repayment for services furnished during a period when the provider remained licensed and reasonably relied on the expectation that no adverse licensing action would occur. Additionally, the perceived risk of substantial retroactive liability may incentivize providers to discontinue services before a final **S**tate determination is made (which may not end in

revocation), potentially reducing beneficiary access to care.

Overall, we recommend that CMS maintain flexibility to distinguish between intentional misconduct and good-faith compliance errors. Retroactive revocation should be reserved primarily for circumstances involving fraud, intentional misrepresentation, concealment of material information, repeated noncompliance after education or corrective action opportunities, failure to comply following specific guidance from CMS or the Medicare Administrative Contractor (MAC), or other demonstrated program integrity concerns. For administrative, technical, or otherwise remediable deficiencies, CMS should prioritize corrective action plans, prospective enforcement, and other proportionate remedies.

Claims Submissions Upon Enrollment Revocation (§ 424.535(h)): CMS is proposing to reduce the claims submission window from 60 to 15 calendar days. This short timeframe may increase the risk of administrative and billing errors as organizations work to identify, prepare, and submit all outstanding claims within a compressed period. Providers and suppliers may need to obtain final documentation, complete coding and charge reconciliation, resolve edits, coordinate with employed and independent practitioners, and identify claims across multiple facilities and billing systems. While CMS' concerns regarding program integrity are understandable, **we recommend that providers acting in good faith should have a reasonable opportunity to submit claims for services appropriately rendered prior to revocation.**

To promote greater clarity, predictability, and fairness in the enrollment and claims submission process, we encourage CMS to provide additional guidance and operational safeguards in the following areas:

- **Clarify how rejected claims submitted within the allowable timeframe will be treated** and whether providers will retain the ability to correct and resubmit such claims under existing claims processing rules.
- **Establish a minimum claims submission period** rather than applying retroactive revocations that may vary significantly in duration. A lengthy retroactive revocation period could result in substantial repayment obligations and eliminate the provider's opportunity to bill for services already rendered, whereas a prospective or standardized timeframe would provide greater predictability and a more reasonable opportunity to complete necessary billing activities.
- **Implement delivery practices for notice that ensure providers and suppliers receive the full response period contemplated by regulation and have a meaningful opportunity to respond within prescribed timeframes**. We recommend that letters be emailed on the same day they are dated. This will avoid situations where Stay of Enrollment notices were effective as of the letter date, yet the notice was not emailed until several days later, effectively shortening the response period. And CMS should clarify how notices are delivered when regulatory timeframes are measured in calendar days, as enrollment functions are generally managed during standard business hours (Monday through Friday). For example, we have received notices dated several days before email notification, notices emailed on Sundays, and notices sent after normal business hours on Fridays, all of which reduce the practical time available to review and respond.

Extension of Enrollment Revocation (§ 424.535(i)): Although we support CMS' goal of preventing bad actors from leveraging multiple Medicare enrollments to continue fraudulent or abusive conduct, we are concerned that using an enrollment denial as a potential basis for reviewing or revoking other Medicare enrollments may be overly broad. While CMS cites an egregious example to support this proposal, such scenarios may not be representative of all denial circumstances.

It is our experience that many providers and suppliers operating under a single TIN maintain multiple PTANs with distinct locations, service lines, operational structures, and compliance histories. A denial associated with one enrollment application does not necessarily indicate deficiencies across all related enrollments. We therefore appreciate CMS' clarification that a denial would not automatically trigger revocation of existing enrollments.

Rather than broadly extending revocation authority based on a denial, **CMS should adopt a more targeted, risk-based approach. If concerns arise from a denied application, CMS could conduct a focused review, audit, or site visit of related enrollments to determine whether those concerns are isolated or reflect broader compliance issues.** Such an approach would more effectively identify systemic problems while minimizing unnecessary disruption for compliant providers, suppliers, and the patients they serve.

We also request that CMS clarify the retroactive implications of this proposal. First, CMS should establish clear and objective standards for determining when noncompliance began, particularly where a condition developed gradually or where the available evidence does not support a definitive start date. In such situations, CMS should use the date the deficiency was identified or verified rather than assigning an estimated retroactive effective date. Second, CMS should distinguish between a provider's enrollment status and the validity of services furnished to beneficiaries. When medically necessary, covered services were provided by qualified personnel to eligible beneficiaries, retroactive revocation should not automatically invalidate previously paid claims absent a separate determination that the claims themselves failed to meet Medicare payment requirements. Such distinctions are important to ensure that enforcement actions remain proportionate to the underlying risk and do not create unwarranted repayment obligations for otherwise appropriate care.

Revised Enrollment Denial Grounds

False or Misleading Data (§ 424.530(a)(4)): Consistent with our earlier comments, we recommend CMS distinguish intentional misrepresentations from clerical errors, third-party inaccuracies, and other good-faith mistakes, and allow providers an opportunity to correct non-material errors before revocation is imposed.

Medicare Debt (§ 424.530(a)(6)): Consistent with our earlier comments, the expanded definition of managing employee raises operational concerns for providers and suppliers performing due diligence without further guidance from CMS.

Affiliation that Poses Undue Risk (§ 424.530(a)(13)): Consistent with our earlier comments, the expanded definition of managing employee raises operational concerns for providers and suppliers performing due diligence without further guidance from CMS.

Program Terminations/Suspensions (§ 424.530(a)(14)): We encourage CMS to recognize that a voluntary

surrender of a license in lieu of further disciplinary action does not necessarily indicate fraud, abuse, or an ongoing risk to Medicare or its beneficiaries. In some cases, the individual may no longer practice in the affected capacity, may have satisfied all repayment or penalty obligations, and may no longer be in a position to repeat the conduct that led to the licensure action. We therefore recommend that CMS evaluate the specific circumstances and level of risk presented rather than treating all voluntary surrenders similarly. At a minimum, CMS should consider allowing providers and suppliers an opportunity to take corrective action, such as removing the individual from an ownership or management role, before denying enrollment. This approach would address legitimate program integrity concerns while avoiding unnecessary enrollment denials where the identified risk can be effectively mitigated.

Additional Enrollment Denial Grounds

Misdemeanor Convictions (§ 424.530(a)(16)): Consistent with our earlier comments, we encourage CMS to clearly demonstrate how a misdemeanor conviction relates to an individual's role and ability to influence patient care, billing, or other program activities before pursuing revocation.

Denial for misdemeanor convictions also includes a definition “final adverse action.” We are concerned that adding misdemeanor convictions for sexual assault or financial misconduct to the definition of a "final adverse action" could create compliance challenges for providers and suppliers, particularly where the conviction occurred before this requirement existed. If finalized, CMS should provide a reasonable implementation period for providers and suppliers to evaluate applicable individuals against clear CMS criteria, obtain updated disclosures, and take corrective action where necessary.

We also recommend that CMS allow providers and suppliers to self-disclose and remove affected individuals from applicable ownership or leadership roles within a defined cure period before revocation is imposed. Revocation would be inappropriate where the provider was unaware of the conviction and could promptly remedy the issue.

Same Suite (§ 424.530(a)(19)): To balance program integrity and operational flexibility, we recommend that CMS:

- Use a shared suite or office address as a screening indicator rather than an independent basis for denial. Medical office buildings, hospital campuses, co-location arrangements, incubator spaces, and shared clinical facilities frequently house unrelated providers that have no ownership, management, financial, or operational connection.
- Before denying enrollment, CMS should establish a meaningful relationship between the applicant and the denied or revoked provider, such as common ownership, shared management, shared bank accounts, common billing operations, common personnel, or evidence that the applicant is attempting to continue the prior provider’s operations, before denying enrollment.
- Allow the applicant to demonstrate that the entities are operationally and financially independent.

Hospice Medical Director and Administrator (§ 424.530(a)(20)): We appreciate CMS' continued focus on safeguarding hospice program integrity. Hospice medical directors and administrators should be able to

effectively oversee the organizations they serve, and when their responsibilities extend across an unusually large number of hospices, the potential for quality, compliance, and patient care risks may increase. However, we encourage CMS to recognize that technological advancements have enhanced the ability of medical directors and administrators to effectively fulfill their responsibilities and comply with the Hospice Conditions of Participation across broader geographic areas, including across state lines. **Geographic distance alone should not be presumed to indicate inadequate oversight or heightened program integrity risk**. Instead, we recommend that CMS provide hospices with an opportunity to demonstrate how oversight functions are performed and how compliance with applicable requirements is maintained before concluding that a medical director's or administrator's physical location presents a concern.

Enrollment Denial Process

Reapplication Bar After Enrollment Denial (§ 424.530(f)): **We request CMS to reinstate the list of factors used to determine the length of the reapplication bar.** While we understand that a single set of factors may not neatly apply to every denial, this does not justify removing them entirely. The existing factors provide important structure, transparency, and consistency in determining whether a reapplication bar is appropriate and, if so, its duration. In particular, the factor addressing whether there is evidence that the provider or supplier intentionally furnished false or misleading information or deliberately withheld information remains highly relevant across many denial scenarios and helps distinguish intentional misconduct from administrative error or misunderstanding. Moreover, the existing catch-all provision allowing CMS to consider "any other information CMS deems relevant" already provides sufficient flexibility to address denial reasons outside the current factors.

Additionally, since administrative errors are inevitably going to occur when relying on human processing, we encourage CMS to allow for a correction period if/when these administrative errors occur.

Other Enrollment Changes

Signage (§ 424.510(f)): As a requirement of Medicare enrollment, CMS proposes a new signage requirement. **We generally support reasonable signage requirements that assist beneficiaries and site-visit personnel.** To balance program integrity against operational practice and regulatory burden, **we request that CMS include additional flexibilities** – (1) health system campuses, hospitals, medical office buildings, and multi-department locations may satisfy the requirement through building directories, campus signage, suite signage, electronic directories, or other wayfinding systems; and (2) temporary exceptions are permitted during construction, relocation, rebranding, or local sign-permitting delays when the provider can demonstrate that patients and site-visit personnel can readily locate the provider.

Maintaining and Providing Access to Documentation (§ 424.516): As a requirement to enroll and maintain active Medicare enrollment status, CMS proposes to require that written orders, certifications, referrals, prescriptions, and requests for payments for Part A or B services, items or drugs be “accurate, complete, and compliant with all CMS requirements.” **We support this expectation; however, despite protocols, safeguards and technology aids, isolated documents may contain deficiencies, clerical errors, signature omissions, date discrepancies, or conflicting information that do not impact medical**

necessity, beneficiary eligibility, or the service actually furnished. To balance program integrity with meaningful compliance, we request that CMS:

- Clarify that isolated documentation errors, technical defects, or minor record inconsistencies, standing alone, do not constitute a failure to comply with § 424.516(f).
- Distinguish between documentation deficiencies that materially affect the ability to validate a claim and those that may be corrected through established documentation correction processes.
- Enable an opportunity for providers to cure and obtain missing signatures, correct scrivener's errors, and submit clarifying documentation before such deficiencies are used as a basis for enrollment action.

Fingerprinting (§ 424.518(c)): When screening individuals with high categorical risk, CMS proposes to require the use of a "CMS-designated fingerprinting contractor." While we appreciate efforts to standardize fingerprinting processes, we caution against creating bottlenecks to timely fingerprinting, especially in rural and underserved areas. **We encourage CMS to streamline contractor vetting to enable the use of local police departments to perform this function.** Additionally, CMS should provide flexibility for good faith compliance efforts when delays are caused by contractor scheduling limitations, processing timelines, and/or geographic access barriers.

Temporary Moratoria (§ 424.570): We are limiting our input to inclusion of "reactivation applications" for moratoriums on new enrollment providers. Many deactivations occur for administrative reasons, such as not submitting claims for six months or failing to timely report enrollment changes, rather than conduct suggesting fraud, waste, abuse, or other program integrity concerns. CMS should evaluate reactivations on a case-by-case basis and distinguish between administrative deactivations and those involving actual program integrity risks. **Applying moratoria to all reactivations may unnecessarily restrict providers and suppliers whose deactivation was unrelated to any concern regarding beneficiary safety or program integrity and adversely impact patient access to care.**

Miscellaneous Impacted Provisions

Preclusion List (42 CFR 422.2 and 423.100): Consistent with our earlier comments, the expanded definition of managing employee raises operational concerns for providers and suppliers performing due diligence without further guidance from CMS.

Corrective Action Plans (CAPs), Rebuttals, and Appeals

- *CAPs (§ 405.809)*: We support CMS' continued recognition of corrective action plans as a mechanism to achieve compliance without unnecessary disruption to beneficiaries. **We encourage CMS to consider expanding the availability of corrective action plans beyond §424.530(a)(1) and §424.535(a)(1) in situations involving administrative, technical, or operational deficiencies that are readily correctable and do not involve fraud, abuse, beneficiary harm, identity misuse, or other significant program integrity concerns**. Corrective action frequently achieves CMS' compliance objectives while preserving beneficiary access to care and avoiding the administrative burden associated with denial and revocation actions.

- *Notification of Determinations*: **We support and appreciate the use of email to provide these notices.** CMS should implement notice delivery practices that ensure providers and suppliers receive the full response period contemplated by regulation and have a meaningful opportunity to respond within prescribed timeframes. We recommend that letters be emailed on the same day they are dated. This will avoid situations where Stay of Enrollment notices were effective as of the letter date, yet the notice was not emailed until several days later, effectively shortening the response period. CMS should consider how notices are delivered when regulatory timeframes are measured in calendar days, as enrollment functions are generally managed during standard business hours (Monday through Friday). For example, in 2026 we received multiple notices dated several days before email notification, notices emailed on Sundays, and notices sent after normal business hours on Fridays, all of which reduce the practical time available to review and respond.

  We recommend that CMS transmit the notice to all designated contacts listed under the enrollment contact information section (historically, only one contact has been chosen at random) and make the notice available in PECOS as proof of correspondence.

ADDITIONAL INPUT – AT HOME CARE DELIVERY AND PAYMENTS

In November 2020, CMS announced the Acute Hospital Care at Home waiver, building upon the Hospital Without Walls program. Acute Hospital Care at Home is for beneficiaries with defined acute conditions who require an acute inpatient admission to a hospital and at least daily rounding by a physician and a medical team monitoring their care needs on an ongoing basis. In order to gather more data, Congress extended this waiver program in the short term.

Comment: UnityPoint at Home applauds Congress for its long-term extension of the platform to assess the Acute Hospital Care at Home services until September 30, 2030. It is now time to consider program permanency. Under the leadership of UnityPoint at Home, UnityPoint Health (our parent organization) was one of the first six health systems with extensive experience providing acute hospital care at home approved for the Hospital at Home waiver. UnityPoint Health was the first to enroll a patient as well as to bill and be reimbursed under this Medicare waiver. As of July 24, 2026, 136 health systems with 364 CCNs in 37 states have applied and been approved to participate in this waiver.[4] **Starting in 2023, UnityPoint Health began offering At Home services in some of our commercial health plan contracts and we currently provide these services with 3 health plans**. We attribute our expansion to commercial plans as a direct result of being able to demonstrate proof of concept via the Medicare waiver program. Permanency would support long-term program investment and promote scaling of home-based services.

ADDITIONAL INPUT – DISPROPORTIONATE SHARE PAYMENT FOR HIGH-NEED HHAs

The current home health payment system does not adequately distinguish between freestanding, for-profit HHAs, and health system- or hospital-based HHAs.

Comment: As background, for-profit HHAs can pick and choose their patients, selectively admitting higher-margin patients with a specific focus on payers that can provide opportunity for higher margins and avoiding patients that require resource-intensive care and/or receive Medicaid benefits.

[4] https://qualitynet.cms.gov/acute-hospital-care-at-home/resources

Furthermore, freestanding for-profit HHAs, which tend to serve higher-margin, lower-acuity patients, reported an average Medicare profit margin of 21.2% in 2024 according to MedPAC's 2026 report to Congress[5]. Because of the large-scale consolidation of these organizations, MedPAC's view of HHA margins continues to be heavily weighted by freestanding, for-profit HHAs and inaccurately reflects the reality of most nonprofit health system- and hospital-based HHAs across the country.

UnityPoint at Home is a nonprofit health-system-based HHA serving a broad, largely rural, geographic area. Nonprofit HHAs — many of which serve as safety-net providers for medically complex and underserved populations—operate generally at negative or low margins. UnityPoint at Home has implemented several budget modifications to conserve resources and work to ensure that patients can continue to receive the care they need. According to available claims data, the majority of freestanding HHAs in Iowa served less than 11 Medicaid patients in 2023. For that same period, UnityPoint at Home served approximately 2,700 Medicaid patients. UnityPoint at Home services the patients that are at highest risk of poor clinical outcomes and/or readmission without additional support after hospital discharge, regardless of payer source. We are very concerned that the long-term economics of providing home health care in our region may become unsustainable when considered alongside the broader financial pressures facing health system- and hospital-based HHAs.

To address this structural imbalance, **we urge CMS to work with Congress to establish a Disproportionate Share Home Health (DSH-HH) payment, modeled after the existing DSH program for hospitals.** Targeted adjustment for HHAs should include HHAs that serve high proportions of Medicaid beneficiaries, medically complex patients, patients in medically underserved areas, or communities with limited alternative home health capacity. A 2023 JAMA Health Forum article[6] found that targeted DSH payments significantly improved outcomes for low-income patients in hospital settings. Extending this logic to the home health sector will help correct misaligned incentives, stabilize safety-net providers, and promote access for patients most in need.

ADDITIONAL INPUT – DEREGULATION

CMS seeks public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other stakeholders participating in the Medicare program.

Comment: UnityPoint at Home suggests the following:

- Exempt Medicare Prior Authorization of Home Health Services Demonstration (CMS–10599) from Post-Payment Review. While CMS has "paused" this demonstration, if reinstituted CMS should exempt participating HHAs from duplicative, post-payment review processes that delay payment. CMS used this approach in the Home Health Review Choice Demonstration (RCD). In RCD, HHAs were able to choose one of three review options to minimize burden – pre-claim review, post-

[5] March 2026 Report to the Congress: Medicare Payment Policy, Chapter 8: Home health care services, page 267 accessed at https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch8_MedPAC_Report_To_Congress_SEC.pdf

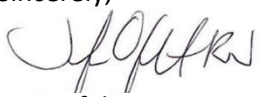
[6] Chatterjee P, Schpero WL. Realigning Reality with Intent in Funding Safety-Net Hospitals. JAMA Health Forum. 2023 Jul 7;4(7):e232000. doi: 10.1001/jamahealthforum.2023.2000. PMID: 37477924.

payment review, or minimal review with payment reduction. Eliminating redundant oversight would not only reduce administrative burden for HHAs, but also for Medicare Administrative Contractors (MACs).

- Recalibrate disciplinary actions for technical and/or single instance errors in coordination with other healthcare service lines. Currently one minor error on a consent or Notice of Election cancels reimbursement, requires days of care to be written off, and requires the beneficiary to be "readmitted."
- Include benefit enhancements for post-discharge home visits in risk-bearing bundled payment models and total cost of care programs: UnityPoint Health encourages CMS to embed benefit enhancements within Transforming Episode Accountability Model (TEAM) and the Medicare Shared Savings Program (MSSP) to promote operational flexibilities. TEAM includes episodes of care categories that target a reduction in post-acute care costs, and MSSP is a total cost of care model in which providers are held accountable for the quality, cost, and experience of care of an assigned Medicare fee-for-service (FFS) beneficiary population. Medicare ACO models housed in CMMI and dating back to the Next Generation ACO Model have tested Post-Discharge Home Visits. UnityPoint Accountable Care has tested and utilized this benefit enhancement to improve quality outcomes in the Next Generation and Global and Professional Direct Contracting (GPDC) models. **TEAM and ENHANCED Track MSSP Participants should have the option to provide Post-Discharge Home Visits like those currently available to REACH ACO Participants and proposed for LEAD and CJR-X Model Participants**.
- Add flexibility to Durable Medical Equipment benefit:
    - Eliminate the face-to-face requirement to promote timely access or authorize a telemedicine visit to meet this requirement;
    - Remove health system- or hospital-based DME operations from the competitive bidding process; and
    - Reduce administrative requirements, such as administrative elements unrelated to medical/clinical necessity.

We are pleased to provide input on this proposed rule and its impact on our patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Cathy Simmons, Government & External Affairs at Cathy.Simmons@unitypoint.org or 319-361-2336.

Sincerely,



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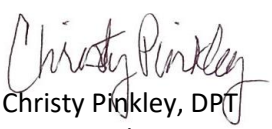

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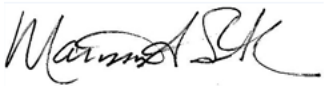

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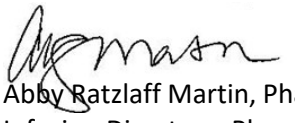

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