Advancing High Performance Health

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August 31, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-1844-P; 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

Dear Administrator Oz:

On behalf of AMGA and its members, I appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) Home Health Prospective Payment System proposed rule for Calendar Year (CY) 2027. AMGA represents multispecialty medical groups and integrated delivery systems, with more than 177,000 physicians who collectively care for one in three Americans.

AMGA's comments focus on two distinct areas of the proposed rule that are particularly relevant to our members: CMS' Request for Information (RFI) on expanding access to palliative care services under the Medicare home health benefit and CMS' proposed changes to Medicare provider enrollment and program integrity requirements. While these policy areas address different aspects of the Medicare program, both raise important questions about how CMS can improve beneficiary access and program integrity without creating unnecessary administrative barriers for providers delivering coordinated, high-quality care.

In summary, AMGA urges CMS to:

- **Palliative Care:** Clarify and expand access to palliative care under the home health benefit while preserving a clear distinction from hospice; support interdisciplinary care, advance care planning, caregiver engagement, and non-visit-based care coordination; avoid new documentation and certification burdens; and continue developing complementary value-based and Innovation Center pathways for beneficiaries who need serious illness care but do not qualify for home health.

- **Provider Enrollment and Program Integrity:** Use targeted, risk-based enforcement rather than broad, one-size-fits-all requirements; reserve severe remedies such as

retroactive revocation for material program integrity violations; establish clear and objective standards for geographic concentration and other risk indicators; provide meaningful notice, opportunities to cure, and appeal rights; and ensure consistent implementation across CMS and its contractors.

Our detailed comments follow.

Expanding Access to Palliative Care Under the Medicare Home Health Benefit

AMGA is particularly well-positioned to provide feedback on this RFI, given its longstanding work on value-based and patient-centered care delivery transformation. Through its MACRA and Value-Based Care Task Force, AMGA developed recommendations focused on improving end-of-life and advanced illness care, including advancing care coordination, aligning incentives for longitudinal patient-centered care, supporting advance care planning, and improving access to palliative care services.[1] These efforts reflect AMGA members' extensive operational experience integrating palliative and supportive care into broader value-based care strategies and reinforce the importance of developing sustainable Medicare policies that support community-based palliative care outside of the traditional hospice benefit.

AMGA supports CMS' clarification that palliative care may be furnished under the existing Medicare home health benefit when a beneficiary otherwise meets applicable eligibility requirements and requires reasonable and necessary skilled services. We particularly appreciate CMS' recognition that palliative care is not limited to beneficiaries who are terminally ill, does not require patients to forgo life-prolonging treatment, and may be appropriate even when restoration or clinical improvement is not expected. These clarifications are important to reducing persistent confusion among beneficiaries and providers regarding the distinction between palliative care and hospice.

At the same time, AMGA encourages CMS to ensure that efforts to expand palliative care through home health do not unintentionally restrict access by tying palliative care too closely to existing home health eligibility requirements. Beneficiaries with serious illness may have substantial symptom-management, care-coordination, caregiver-support, and goals-of-care needs while remaining sufficiently mobile, so that they do not satisfy the homebound standard. As CMS considers how the home health benefit can support palliative care, the agency should continue evaluating complementary payment and delivery pathways that can reach beneficiaries who would benefit from community-based palliative care but do not qualify for home health.

Clarify the Scope of Covered Palliative Care Services

AMGA supports CMS' recognition that existing home health services can address many core elements of palliative care, including advanced symptom management, medication management, patient and caregiver education, psychosocial support, advance care planning, and therapies designed to preserve functional independence and quality of life.

CMS should provide additional guidance clearly illustrating how these services may be furnished

[1] AMGA, "Protect Patient Dignity at End of Life," available at: https://www.amga.org/advocacy/key-issues/improving-macra/protect-patient-dignity-at-end-of-life.

and documented as part of a palliative care plan. We support CMS' plan to add palliative care examples to Chapter 7 of the Medicare Benefit Policy Manual and encourage the agency to include a range of clinical scenarios reflecting different stages of serious illness, including patients receiving disease-directed treatment, patients with progressive chronic illness, and patients approaching but not yet electing hospice.

Such examples should emphasize that skilled care may be reasonable and necessary when its purpose is to manage symptoms, prevent deterioration, preserve current capabilities, educate caregivers, or support safe care in the home. Clear guidance would help reduce variation in coverage determinations and mitigate provider concern that palliative services may be denied simply because improvement is not expected.

Support Interdisciplinary Palliative Care

High-quality palliative care is inherently interdisciplinary. CMS appropriately recognizes the roles of skilled nursing, medical social services, physical therapy, occupational therapy, and speech-language pathology in addressing the needs of beneficiaries with serious illness.

AMGA encourages CMS to preserve flexibility for interdisciplinary care teams and avoid policies that narrowly define palliative care as a discrete set of nursing services. Depending on the patient, effective palliative care may require coordination among physicians and advanced practice clinicians, nurses, social workers, therapists, pharmacists, behavioral health professionals, care managers, and other members of the care team.

CMS also should examine whether current payment methodologies adequately support the non-visit-based work required to deliver high-quality palliative care, including interdisciplinary case conferences, coordination with treating clinicians, medication reconciliation, caregiver communication, advance care planning, and transitions between home health, hospice, hospital, and ambulatory settings. These activities are central to effective serious illness care but can be difficult to support under payment structures primarily oriented around discrete visits or episodes of service.

Avoid Creating Additional Documentation and Administrative Burden

AMGA strongly supports CMS' goal of expanding access to palliative care but cautions against creating new certification, documentation, or reporting requirements specifically for palliative care furnished through home health.

Existing home health documentation requirements are already substantial. Any additional requirements should be narrowly tailored to information necessary to demonstrate the beneficiary's need for skilled services and the goals of the plan of care. CMS should avoid establishing separate palliative care eligibility criteria, duplicative assessments, or additional documentation standards that could discourage providers from furnishing these services.

The examples CMS plans to add to the Medicare Benefit Policy Manual should provide practical guidance on sufficient documentation, rather than create a de facto checklist or new coverage standard. CMS should also encourage consistent interpretation of these policies by Medicare Administrative Contractors (MACs) to reduce regional variation and uncertainty.

Strengthen Advance Care Planning and Goals-of-Care Support

Advance care planning and goals-of-care conversations are foundational elements of high-quality palliative care. AMGA continues to encourage CMS to improve reimbursement and operational support for these services and to ensure that home health agencies and treating practitioners can coordinate effectively around patient preferences and treatment goals.

CMS should support workflows that allow advance care planning information to follow the patient across care settings and be available to all members of the care team. This is especially important during transitions among hospital, ambulatory, home health, hospice, and post-acute care settings. CMS should also recognize that goals-of-care discussions are not one-time events. Preferences may change as illness progresses, and serious illness care often requires repeated conversations with patients and caregivers. Medicare policy should support longitudinal rather than episodic approaches to these discussions.

Expand Support for Caregivers

Family and unpaid caregivers are frequently essential to enabling beneficiaries with serious illness to remain safely at home. AMGA therefore supports CMS' recognition that caregiver education and assessment may be integral to home-based palliative care.

CMS should encourage home health agencies to incorporate caregiver capacity, burden, and support needs into the plan of care where relevant. Policies should facilitate caregiver education regarding symptom management, medications, equipment, warning signs, and when to seek additional clinical support.

More broadly, CMS should continue exploring models that directly support caregivers of beneficiaries with serious illness, including through Innovation Center demonstrations and value-based care arrangements, such as the Guiding an Improved Dementia Experience model. Caregiver support can improve patient experience, reduce avoidable utilization, and make home-based care more sustainable.

Improve Alignment Across Medicare Programs and Value-Based Care Models

Palliative care should not operate as an isolated service. CMS should strengthen alignment among home health, hospice, physician services, accountable care organizations, Medicare Advantage, and Innovation Center models so beneficiaries can move smoothly between levels of supportive care as their needs change.

AMGA encourages CMS to coordinate its home health palliative care efforts with existing and emerging Innovation Center initiatives, including the GUIDE Model, accountable care initiatives, and home-based care demonstrations. CMS should also consider testing serious-illness models that provide greater flexibility to interdisciplinary teams and hold participating organizations accountable for quality, patient experience, and total cost of care. These models could help address some of the limitations of relying exclusively on the traditional home health benefit, particularly for patients who need longitudinal palliative services but do not consistently satisfy home health eligibility requirements.

Preserve a Clear Distinction Between Palliative Care and Hospice

Finally, AMGA encourages CMS to continue clearly distinguishing palliative care from the

Medicare hospice benefit. Palliative care should be available throughout the course of serious illness and alongside curative or life-prolonging treatment. Hospice remains a distinct benefit for beneficiaries who meet hospice eligibility requirements and elect hospice care.

Expanding palliative care under home health can help beneficiaries receive appropriate symptom management and supportive care earlier in the course of illness and may facilitate more informed transitions to hospice when hospice becomes consistent with the patient's desires and clinical circumstances. However, palliative care should not become a substitute for the comprehensive interdisciplinary services available under the hospice benefit, nor should beneficiaries be required to be hospice-eligible to receive meaningful palliative support.

Medicare Provider Enrollment and Program Integrity

AMGA supports CMS' continued efforts to strengthen Medicare program integrity and prevent fraud, waste, and abuse. As AMGA emphasized in its recent comments on CMS' Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) RFI; however, program integrity policies should be carefully targeted toward demonstrably high-risk actors and activities rather than imposing broad new compliance burdens or payment risks on providers operating in good faith. AMGA encourages CMS to ensure that the provider enrollment proposals included in the CY 2027 Home Health PPS proposed rule reflect this risk-based and proportionate approach.

The proposed rule would significantly expand CMS' enrollment and enforcement authorities, including by making revocations retroactive to the date CMS determines noncompliance began; expanding the circumstances under which enrollment may be denied or revoked based on ownership, managing-employee, licensing, or other program actions; and establishing new authority related to excessive concentrations of providers in geographic areas associated with heightened fraud, waste, and abuse concerns. AMGA recognizes the need for CMS to act decisively where there is evidence of fraudulent conduct or serious program-integrity risk. At the same time, these authorities could have substantial consequences for compliant providers if applied without sufficiently clear standards and appropriate procedural safeguards.

AMGA urges CMS to distinguish serious program-integrity violations from technical or readily correctable enrollment deficiencies. Retroactive revocation is particularly consequential because it can expose a provider to substantial recoupment for services that were otherwise properly furnished to Medicare beneficiaries. CMS therefore should reserve retroactive revocation for circumstances involving willful and knowing fraud, material misrepresentation, serious patient-safety concerns, or similarly significant violations. Technical enrollment errors or administrative deficiencies that do not affect a provider's underlying qualifications to participate in Medicare should generally be subject to notice and an opportunity to correct the deficiency before revocation or recoupment occurs.

CMS should also clearly identify the factual and legal basis for any proposed retroactive revocation, including the date on which CMS believes noncompliance began. Providers should have a meaningful opportunity to challenge both the basis for the action and the proposed effective date before substantial payment recoupments occur. Where a provider appeals a revocation or other adverse enrollment action in a timely manner, CMS should consider safeguards that prevent irreversible financial consequences before meaningful administrative review has occurred.

AMGA also encourages CMS to adopt objective and transparent criteria before exercising its proposed authority to deny or revoke enrollment based on excessive provider concentration or geographic indicators of heightened fraud risk. Geographic concentration may warrant additional scrutiny, but it should function as a risk indicator rather than a substitute for evidence of misconduct by an individual provider. Legitimate market characteristics—including integrated delivery systems, population growth, local access needs, service-area configurations, and established provider networks—can result in concentrations of providers that are unrelated to fraud or abuse. CMS should provide clear criteria, consider relevant local and organizational context, and allow providers an opportunity to demonstrate legitimate reasons for the identified enrollment pattern before taking adverse action.

Similarly, unusual patterns involving ordering, certifying, referring, or prescribing should serve as triggers for further review, rather than automatically establishing abusive behavior. Clinical practice patterns may vary based on patient acuity, specialization, referral relationships, organizational structure, and the populations served. Consistent with AMGA's broader recommendation that CMS use advanced analytics to identify potentially high-risk conduct, data should help CMS focus its investigative resources but should not replace clinically informed, individualized review before adverse action is taken. AMGA has similarly urged CMS to ensure that technology and analytics used for program integrity support—not replace—appropriate human judgment and that providers can clearly see the basis for adverse determinations.

These considerations are particularly important for multispecialty medical groups and integrated systems of care. Modern health systems frequently rely on shared infrastructure, centralized administrative functions, complex ownership structures, and team-based clinical models. Enrollment policies should account for these legitimate organizational arrangements and should not treat structural complexity itself as evidence of increased program-integrity risk. CMS should ensure that definitions relating to ownership, managing employees, and managing organizations are sufficiently precise to capture individuals and entities exercising meaningful operational control without unnecessarily sweeping routine administrative personnel or shared-service arrangements into heightened enrollment requirements.

Finally, AMGA encourages CMS to promote greater consistency and transparency in the implementation of these policies across CMS and its contractors. AMGA members operating in multiple jurisdictions continue to encounter differences in enrollment, documentation, and review expectations among MACs. AMGA previously urged CMS to standardize medical review policies and audit expectations across contractors, and the same principle should apply to expanded enrollment authorities. Clear national standards, reliable notice, meaningful opportunities to cure correctable deficiencies, and timely review of adverse actions will strengthen program integrity while reducing unnecessary disruption for compliant providers and their patients.

AMGA shares CMS' goal of protecting Medicare beneficiaries and taxpayer resources from fraudulent actors. We encourage CMS to finalize provider enrollment policies that are targeted, data-driven, transparent, and proportionate to the underlying risk, while preserving appropriate due process and avoiding unnecessary administrative burden on providers that have demonstrated a record of compliant participation in the Medicare program.

Conclusion

AMGA looks forward to working with CMS on both sets of policies and to advancing approaches that support high-quality, coordinated care while safeguarding the integrity of the Medicare program.

We appreciate your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

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