National Rural Health Association

August 31, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244

RE: CMS-1844-P; Calendar Year (CY) 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 Proposed Rule.

Submitted electronically via regulations.gov.

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to offer comments on the proposed 2027 Home Health Prospective Payment System rule. We appreciate the Centers for Medicare and Medicaid Services' (CMS) continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

I. Expanding the definition of "Managing Employee" (proposed 42 CFR §424.502)

NRHA appreciates CMS' efforts to streamline efforts in identifying and reporting employees who have a significant impact on the operations of a provider organization but are not currently reported as managing employees. However, this change would impact all provider types including skilled nursing facilities (SNFs), home health, and hospice, which are vital facilities that provide long-term care to the rural aging population. From 2008 to 2018, 472 nursing homes in 400 rural counties closed.[1] Between 2017 and 2022, nursing home closures were more common in small or isolated rural towns (10.3 percent) than in urban areas (8.5 percent). Rural SNFs face distinct challenges, including geographic isolation, healthcare provider shortages, and high staff turnover.[2] Long-term care services in many rural areas are scarce, and many

[1] Hari Sharma, et al., Trends in Nursing Home Closures in Nonmetropolitan and Metropolitan Counties in the United States, 2008-2018, RUPRI Center for Health Policy Analysis, Feb. 2021. https://rupri.publichealth.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf.
[2] Rural Long-Term Care Facilities Overview - Rural Health Information Hub. Accessed September 2, 2024. https://www.ruralhealthinfo.org/topics/long-term-care

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residents do not have timely access to adequate services.[3] These facilities often struggle with recruiting and maintaining staff, staff shortages leading to inability to accept patients, and increased use of expensive contract and travel nursing staff as current limitations in providing care.[4] About fifty-nine percent of nursing homes and 30 percent of assisted living communities characterized their staffing situation as "severe".[5] This proposed expanded definition and expanded revocation and denial reasons based on managing employees may impose a significant burden on an already struggling rural long-term care workforce.

CMS further proposes that a provider could be revoked or denied if a managing employee has unpaid Medicare debt, financial misconduct, has been terminated or suspended from another Federal health care program, has a felony conviction, has previous payment suspensions, or has a previous civil judgment under the False Claims Act. Pairing this expanded roster of reportable employees with an expanded set of disqualifying conduct compounds the risk to rural providers in workforce constrained rural communities, where qualified clinical and administrative staff and already scarce. In these settings a single disqualifying event affecting one newly reportable manager could jeopardize an entire facility's enrollment, with little realistic prospect of finding a timely replacement.

NRHA raises concerns over proposals that impose additional administrative burdens on rural healthcare providers. Rural facilities already face difficulty in recruiting and retaining rural providers; among the 23,664 Health Professional Shortage Areas (HPSAs) in September 2023, about 56.67 percent were in rural areas.[6] Since 2018, administrative burden, particularly clerical and documentation demands, has been the top contributor to physician burnout.[7] While provider documentation may be appropriate in some circumstances, requiring confirmation from a limited set of practitioners could substantially increase administrative burden for rural providers, who already care for disproportionately large Medicaid and Medicare populations.

II. Expanding the definition of "Affiliations" (proposed 42 CFR § 424.519)

NRHA appreciates CMS' efforts to decrease fraud, waste, and abuse risk. However, NRHA is concerned that the proposed expanded definition and expanded revocation and denial reasons based on affiliations may pose a significant burden to rural home health providers. Since 2020, there have been multiple rural health providers and suppliers of rural health clinics that have been revoked from the Medicare program due to failure to report within 30-day timeframes for actions such change in practice location or managing employees.[8] Rural providers are especially vulnerable because many operate with thin administrative

[3] Sharma H, Bin Abdul Baten R, Ullrich F, MacKinney AC, Mueller KJ. Nursing home closures and access to post-acute care and long-term care services in rural areas. The Journal of Rural Health. n/a(n/a). doi:10.1111/jrh.12822

[4] Mehboob G, Sharma H, Ullrich F, Mueller K. *Changes in Staffing, Resident Health, Closure, and Financial Performance of Rural Nursing Homes from 2017 to 2022.* RUPRI Center for Rural Health Policy Analysis; May 2026. Changes in Staffing, Resident Health, Closure, and Financial Performance of Rural Nursing Homes from 2017 to 2022

[5] Muoio, Dave. (2021). Staffing Shortages Force Long-term Care Facilities to Limit Admissions, Hire Agency Workers. https://www.fiercehealthcare.com/hospitals/staffing-shortages-force-long-termcare-facilities-to-limit-admissions-hire-agency

[6] Health Resources and Services Administration. Health Professional Shortage Areas Dashboard. Updated September 2023. Accessed November 22, 2024. https://data.hrsa.gov/topics/health-workforce/shortage-areas

[7] Rios Partners. Administrative Burden in U.S. Healthcare: A Focus on Rural Systems and Workforce Sustainability - Health of Health Index. Health of Health Index -. Published May 13, 2025. https://www.healthofhealth.org/health-of-health-2024-administrative-burden-in-u-s-healthcare-a-focus-on-rural-systems-and-workforce-sustainability

[8] Centers for Medicare & Medicaid Services. Revoked Medicare Providers and Suppliers. CMS Data; updated 2026. Accessed August 20, 2026.

staffing, making it easier to miss deadlines or overlook PECOS updates. Revocation means a facility is no longer able to bill for Medicare services performed and will therefore not be reimbursed for these services. This impacts both provider payments and financial stability of these rural facilities. As a result, this can often lead to closure of rural facilities, which impacts access to care, as well as health outcomes, for rural populations.

CMS's proposal to remove the five-year affiliation lookback period compounds this risk further. Providers would be required to report affiliations regardless of how long ago they occurred or ended, and the definition of a reportable affiliation would expand to include any marketing, business, fulfillment, financial, managerial, or beneficiary relationship, not merely ownership or control. Critical access hospitals (CAHs) and rural health clinics (RHCs) have been continuously enrolled in Medicare for decades. Requiring these long-tenured providers to reconstruct a lifetime accounting of every affiliated vendor, contractor, and referral relationship is not administratively feasible and would divert scarce staff time away from patient care.

III. Home Health Quality Reporting Program (HH QRP)

CMS proposes a new authority to revoke a provider's or supplier's Medicare enrollment where CMS determines the enrollment presents a high risk of fraud, waste, or abuse based on the provider's or supplier's location within a limited geographic area that has an "excessive number" of enrolled providers or suppliers. Under this proposal, the affected providers need not be the same provider type, there is no stated limit on the distance or number of providers considered, and CMS would not need to make an actual finding of fraud, waste, or abuse by the provider itself or by any other provider located in the same area. CMS also proposes a related revocation and denial ground based solely on a provider having its practice location in the same suite or office as another provider whose Medicare enrollment has been revoked or denied.

NRHA is concerned that these provisions, while framed as fraud-prevention tools, would disproportionately burden rural providers. In many rural communities, health care infrastructure is concentrated by necessity rather than by design. CAHs often serve as the anchor for co-located RHCs, hospital-based home health and hospice agencies, and skilled nursing and swing-bed services, all operating from a single campus because it is the only viable clinical space within the community. Small towns frequently have only one medical office building or one commercial corridor capable of supporting health care use, leaving providers with little practical choice but to co-locate. Sharing space in these communities is often what keeps care available at all, not an indicator of fraud, waste or abuse. Under the proposed rule, this same practical necessity could increase revocation and denial risk for providers with no connection to, or knowledge of, any wrongdoing by a co-located neighbor.

NRHA urges CMS not to finalize the high-risk and same-suite revocation and denial authorities as proposed. At minimum, CMS should require a documented, individualized finding connecting the enrollment at issue to fraud, waste, or abuse, rather than relying on geographic proximity or a shared address alone. Further CMS should establish a safe harbor for providers that can demonstrate a legitimate, documented clinical or business rationale for co-location, such as hospital campus affiliation or the lack of alternative commercial space in the community.

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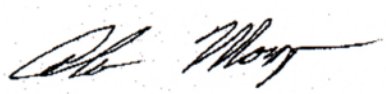
IV. For Hospice Members: New Denial Reason for Hospice Medical Directors and Administrators (proposed 42 CFR §424.530(a)(20))

Hospice care is vital in supporting age-friendly care for rural aging adults. The concept of "aging in place" is an important component of age-friendly care, as the majority (77 percent) of adults 50 and older say they would prefer to remain in their homes as they age.[9] In 2020, the older adult population reached 55.8 million or 16.8 percent, with more than 20 percent of individuals 65 and older residing in a nonmetro area.[10] Rural hospices are significant in providing palliative and end-of-life-care to older adults. Rural areas already experience a shortage of hospice and palliative medicine providers due to limited geographic barriers and access issues, limited economic support, regulatory hindrances, and difficulty training and retaining palliative care staff.[11] NRHA is concerned over CMS' proposed new denial authority for hospice enrollment. This denial reason will significantly impact rural areas where it is increasingly difficult to identify physicians appropriately trained to act as hospice medical directors. This proposal would also impact rural hospices operating under multiple CMS certification numbers (CCNs) that rely on a single medical director or administrator to provide consistent leadership and continuity of care across their service areas, an arrangement rural hospices often use precisely because qualified candidates are so scarce. Rather than improving care, this denial reason would have a chilling effect on rural hospices' ability to attract and retain the very clinicians their communities depend on.

NRHA thanks CMS for the opportunity to provide comments on this proposed rule. If you have any questions or would like any further information, please contact NRHA's Senior Government Affairs and Policy Coordinator, Marguerite Peterseim at mpeterseim@ruralhealth.us.

Sincerely,



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National Rural Health Association

[9] Davis MR. 77 Percent of Older Adults Want to Remain in Their Homes as They Age. AARP. Published June 2, 2025. Accessed October 6, 2025. https://www.aarp.org/home-living/home-and-community-preferences-survey2021/?utm

[10] U.S. Census Bureau. U.S. older population grew from 2010 to 2020 at fastest rate since 1880 to 1890. Published May 25, 2023. https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-populationgrew.html

[11] Anwar A, Amin MK, Anwar S, Shahzad M. Bridge the Gap: Addressing Rural End-of-Life Care Disparities and Access to Hospice Services. *Journal of Pain and Symptom Management.* 2024;68(4):e280-e286. doi:10.1016/j.jpainsymman.2024.07.001.