HCAF
Home Care Association of Florida
RESOURCES • EDUCATION • ADVOCACY

August 28, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Calendar Year 2027 Home Health Prospective Payment System Proposed Rule; Centers for Medicare & Medicaid Services Proposed Rule CMS-1844-P; Regulation Identifier Number (RIN) 0938-AV80

Dear Administrator Oz:

The Home Care Association of Florida (HCAF) respectfully submits these comments on the proposed Calendar Year (CY) 2027 Home Health Prospective Payment System (HH PPS) rule. HCAF is Florida's leading voice for home health care. Since 1989, HCAF has represented for-profit and not-for-profit providers furnishing Medicare-, Medicaid-, and privately funded care and has worked to advance high-quality, cost-effective services in the home.

We appreciate the Centers for Medicare & Medicaid Services' (CMS) decision not to propose an additional permanent behavioral adjustment for 2027, the proposed payment update, the outlier policy improvement, and CMS's recognition that palliative care may be furnished through the Medicare home health benefit. We also share CMS's obligation to protect beneficiaries and the Medicare Trust Funds from fraud, waste, and abuse. Those constructive features do not resolve the central access threats in the proposal: the continued 3.0% temporary reduction, sharp Florida wage index losses, and enrollment authorities that can impose the program's most severe consequences without a sufficiently objective finding of provider misconduct.

Our comments are grounded in a simple principle: Medicare should distinguish legitimate providers from bad actors through evidence, materiality, intent, due process, and proportionate remedies. Payment cuts and location- or association-based sanctions strain compliant agencies while failing to target the entities that exploit the program. In Florida, that distinction is indispensable to protecting access.

Executive Summary of HCAF Recommendations

1. Finalize the 2.1% annual payment update and the proposed fixed-dollar loss ratio change, and do not finalize the 3.0% negative temporary adjustment.
2. Preserve the decision not to impose an additional permanent behavioral adjustment and reevaluate prior and future behavioral calculations using data that exclude anomalous and fraudulent utilization and isolate changes actually attributable to the Patient-Driven Groupings Model (PDGM).
3. Recognize that the 2.4% national aggregate estimate is not a 2.4% increase for every agency. Publish provider- and county-level impact files and adopt immediate mitigation for Florida labor markets facing significant losses.
4. Retain the permanent 5.0% wage index cap and use a multi-year, non-budget-neutral transition if CMS adopts a home health agency-specific wage index.

5. Develop a home health agency-specific wage index only after transparent modeling, data validation, occupation-specific weighting, and safeguards for rural travel, cross market competition, contract labor, and disaster readiness.
6. Withdraw or substantially narrow the proposed retroactive revocation, high-risk geography, same-suite, associated-party, affiliation, and managing-employee provisions. Enforcement should require provider-specific evidence and written findings.
7. Retain the existing abuse-of-billing factors, preserve the 60-day post-revocation claim submission period, and permit corrective action for good-faith administrative and reporting errors.
8. Limit retroactive enrollment revocation to final, material events that legally foreclosed billing, or to adjudicated fraud or knowing misconduct. A long-running billing interpretation dispute should not retroactively erase payment for covered care.
9. Finalize clear palliative care examples, while creating a workable payment and staffing model, protecting hospice choice, recognizing spiritual care needs, clarifying homebound status, and excluding palliative periods from value-based purchasing until appropriate measures and risk adjustment exist.
10. Do not impose an advance care planning performance expectation without defined roles, competency standards, beneficiary consent, adequate payment, and protection against measuring the existence of a document rather than goal-concordant care.
11. For quality reporting, retain disaster and extraordinary circumstance relief, maintain multi-channel notice, and allow correction of good-faith errors beyond 45 days when patient care, declared emergencies, or system outages interfere.
12. Establish Florida-specific access monitoring, including referral acceptance, start of care delay, county-level service loss, hospital discharge delay, and agency closures, and commit to corrective action if access deteriorates.

I. Florida's Medicare Beneficiaries Need a Stable Home Health Infrastructure

Florida is not an average Medicare market. The state had an estimated 23.46 million residents in 2025, an 8.9% increase from 2020, and 21.8% of Floridians are age 65 or older. Florida's Community Health Assessment Resource Tool Set (CHARTS) reports that 31.4% of non-institutionalized Floridians age 65 or older have a disability and 19.7% have an ambulatory disability. These figures describe a large and growing population for whom skilled nursing, therapy, medication management, caregiver education, and safe transitions at home are not optional conveniences. They are the difference between recovery at home and avoidable hospital or institutional care.

The Florida-specific materials supplied for this comment estimate that 903 Medicare-certified home health agencies serve approximately 277,093 Medicare home health patients annually. Florida providers serve dense metropolitan markets, the Panhandle, inland rural counties, the Florida Keys, coastal and barrier island communities, and fast-growing retirement destinations. Of Floridians age five or older, 30.6% speak a language other than English at home, adding an important need for culturally and linguistically appropriate education and care coordination.

Florida agencies also shoulder an emergency readiness obligation that is unusually concrete. Florida law requires every licensed home health agency to maintain an annually updated comprehensive emergency management plan, prioritize patients who need continued services, coordinate with county and local emergency officials, and plan for continuity at special needs shelters. Hurricanes, flooding, fuel constraints, power and communications outages, evacuation, impassable roads, and patient displacement increase staffing, travel, technology, and coordination costs. The national payment methodology does not adequately recognize that readiness burden.

Access losses do not remain within the home health sector. They delay hospital discharge, increase boarding, force transitions to higher-cost institutional settings, disrupt chronic disease management, and impose new burdens on family caregivers. National analyses cited in the submitted materials associate failure to receive ordered post-hospital home health with materially worse readmission, mortality, emergency department, and Medicare spending outcomes. A peer-

reviewed national study likewise found that more than one-third of hospital discharges referred to home health never received it.[8] Florida cannot absorb further capacity loss without increasing the risk of home health care deserts.

II. Payment Policy Must Protect Actual, Not Merely Aggregate, Access

A. The 2.4% Aggregate Estimate Does Not Describe the Experience of Florida Agencies

CMS estimates that proposed policies would increase aggregate Medicare home health payments by 2.4%, or $420 million, compared with 2026. That estimate combines a 2.1% payment update with an estimated 0.3% outlier effect. HCAF appreciates the movement in the right direction. The number must not be presented as an across-the-board agency increase. An aggregate national result masks regional wage index changes, case-mix recalibration, low-utilization payment adjustments, outlier distribution, quality reporting penalties, and the expanded Home Health Value-Based Purchasing (HHVBP) Model.

HCAF's preliminary provider-level review indicates that some Florida agencies may experience total payment reductions approaching 6.0% after geographic wage index and other policy effects are applied. An agency cannot recruit a nurse, therapist, aide, or social worker with a national aggregate. It must pay the labor market in which the patient lives, finance travel between homes, and maintain 24-hour clinical and emergency capacity. CMS should therefore publish and respond to the distribution of impacts, not rely on the average.

B. CMS Should Not Finalize the 3.0% Temporary Adjustment

The proposed national standardized 30-day payment amount is $2,092.27 with the temporary adjustment and $2,156.98 without it. Thus, even in a year with a positive update, the temporary adjustment removes 3.0% from the rate that otherwise would apply. It follows years of permanent reductions, including 3.925% for 2023, 2.890% for 2024, 1.975% for 2025, and 1.023% for 2026. A positive update applied to a repeatedly reduced base does not restore the resources removed from care.

CMS itself recognizes that later behavior changes may not be attributable to PDGM because of confounding factors, including case-mix recalibration, the Outcome and Assessment Information Set Version E2 (OASIS-E2) transition, and prior payment reductions. The same attribution problem undermines the retrospective temporary calculation. Further, anomalous growth by bad actors can contaminate utilization data and distort any inference that legitimate agencies were overpaid. CMS should not recoup a nationwide amount from compliant providers until it can demonstrate that the calculation excludes aberrant providers and isolates the effect Congress directed CMS to measure.

HCAF therefore asks CMS to withdraw the 3.0% temporary adjustment. At minimum, CMS should suspend the adjustment, publish reproducible provider- and county-level analyses, exclude providers identified through credible program integrity screens, and conduct an access impact test before any future recoupment. CMS should also explain how it will avoid using the same suspect utilization once to reduce rates and again to justify broad enrollment sanctions.

C. Florida Wage Index Losses Erase the Apparent Update for Many Communities

The 2027 proposed wage index file shows that 22 of Florida's 25 urban labor markets would receive a lower wage index than in 2026. The statewide rural index also declines. Six Florida markets are at approximately the full 5.0% annual cap: Gainesville; Orlando-Kissimmee-Sanford; Port St. Lucie; Sebastian-Vero Beach-West Vero Corridor; Sebring; and Wildwood-The Villages. The affected counties include Alachua, Gilchrist, Levy, Lake, Orange, Osceola, Seminole, Martin, St. Lucie, Indian River, Highlands, and Sumter.

Other significant declines affect Lee County; Polk County; Palm Beach County; Miami-Dade County; Hernando, Hillsborough, and Pasco Counties; Bay and Washington Counties; Charlotte County; Collier County; Citrus County; and Escambia and Santa Rosa Counties. These are not isolated rural adjustments. They reach large urban, coastal, inland, high-growth, and retirement markets across the state.

HCAF supports retaining the permanent 5.0% cap, but the cap merely limits the wage index change. It does not guarantee a positive agency payment result. CMS should add a provider-level transition so that combined 2027 payment policy

changes cannot reduce an agency's Medicare home health revenue by more than 1.0%, absent case-mix or volume changes, and should finance that protection outside budget neutrality.

D. Provider and Patient Consequences of Inadequate Payment

- Reduced referral acceptance and longer start of care delays, especially for patients needing high-frequency nursing, wound care, complex medication management, or long travel.
- Expansion of home health care deserts in the Panhandle, inland rural communities, the Keys, and areas where urban employers draw workers across county lines.
- Forced use of hospitals, skilled nursing facilities, emergency departments, or other higher-cost settings when care at home would be clinically appropriate.
- Disproportionate harm to older adults with disabilities, people living alone, dually eligible beneficiaries, patients with cognitive impairment, and people facing language, transportation, or caregiver barriers.
- Agency closures, reduced service areas, fewer disciplines offered, delayed investment in quality and cybersecurity, and loss of emergency response resilience.
- Greater difficulty recruiting and retaining registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech-language pathologists, medical social workers, and home health aides while competing with hospitals and other settings.
- Increased strain on compliant agencies that accept complex referrals, while broad payment reductions do not identify or remove fraudulent operators.

CMS should evaluate these outcomes through a formal beneficiary access standard. The final rule should identify trigger points for corrective action, such as county-level agency loss, referral rejection, start of care delay, hospital discharge delay, and disproportionate impact on rural or disabled beneficiaries.

III. Request for Information on a Home Health Agency-Specific Wage Index

HCAF agrees that the hospital wage index is an imperfect proxy for home health labor costs. Home health agencies do not operate hospital campuses. Clinicians travel to individual residences, absorb unproductive drive time, mileage and vehicle costs, traffic and tolls, weather disruption, and safety and communications burdens. Rural agencies often must match urban wages because clinicians can commute across labor market boundaries. Florida's rapid population growth and emergency readiness duties add pressure that hospital cost reports do not measure.

HCAF supports development of a home health agency-specific methodology in principle, but not immediate adoption of an untested index. CMS should follow these design requirements:

- Use occupation-level Bureau of Labor Statistics (BLS) data for the disciplines actually furnishing home health, with transparent weights updated regularly.
- Use home health Medicare cost reports only after standardizing reporting, auditing data quality, capturing contract labor, and excluding aberrant or incomplete reporters. A small or suspect data pool must not set payment for an entire region.
- Recognize travel time, mileage, supervisory capacity, after-hours coverage, interpreter needs, and emergency preparedness as home health labor resources, even when they are not separately billable visits.
- Model at the county level and test commuting patterns across core-based statistical areas so rural agencies that compete with nearby urban employers are not assigned artificially low labor costs.
- Use at least three years of data, appropriate smoothing, minimum sample sizes, and statistical trimming. Publish all assumptions, occupational weights, and Florida county results before implementation.
- Retain a permanent 5.0% cap and add a hold-harmless transition of at least three years. The transition should not be financed by reducing rates for other home health agencies.

- Test the interaction with PDGM case mix, low-utilization payment adjustments, outliers, rural add-ons, and the HHVBP Model, rather than evaluating the wage index in isolation.
- Convene a technical expert panel with meaningful representation from Florida, small and rural agencies, nonprofit and proprietary agencies, clinicians, beneficiaries, and cost report experts.

IV. Provider Enrollment Proposals Require Objective Standards and Proportionate Remedies

HCAF strongly supports removing fraudulent, unqualified, and unsafe providers from Medicare. HCAF's code of ethics requires integrity and high standards from its members. Effective program integrity uses targeted screening, site visits, claims analytics, ownership transparency, payment suspension where legally justified, and prompt enforcement against proven misconduct. It does not presume wrongdoing from a street address, a vendor relationship, or an ordinary billing denial.

The concern is especially acute in Florida because the proposed rule itself identifies south Florida as a historically high-risk geography.[12] A vague geographic revocation standard is therefore likely to expose legitimate Florida agencies to disproportionate uncertainty. Enforcement history cannot substitute for provider-specific proof.

A. Retroactive Revocation Can Turn a Good-Faith Billing Issue Into an Existential Penalty

CMS proposes to make all revocation grounds retroactive, generally to the date CMS or its contractor determines noncompliance began. CMS also proposes to remove the existing factors used to determine whether a provider has a pattern or practice of claims that fail to meet Medicare requirements. Together, these changes create an unfair and draconian result.

Consider a long-running documentation or billing interpretation that an agency and its Medicare contractor reasonably understood one way, but that is later resolved against the agency. Claims may have been denied for technical reasons even though beneficiaries were eligible, care was ordered, and skilled services were delivered. If several such claims can establish a pattern and revocation can reach back to the first alleged error, years of otherwise payable claims may be placed at risk. The agency may lose enrollment, face recoupment for covered care, and become unable to serve current patients before the underlying claims dispute completes the appeals process.

A state license revocation is different when the provider legally lacked authority to furnish care. Even there, CMS should act only on a final, operative licensure action and use the effective date fixed by the state. The rule should not extend a state action against an owner, manager, or related entity to a separate enrolled provider without a material nexus, control, knowledge, finality, and an opportunity to respond.

HCAF recommends that CMS:

- Retain prospective revocation as the default. Permit retroactivity only for a period in which the provider was legally unlicensed, excluded, terminated from the program, or engaged in fraud or knowing material misrepresentation established through a final determination.
- For billing-based revocations, require a final denial rate that is material in both number and percentage, exhaustion or finality of the relevant claim appeals, consideration of the provider's history and facts, and a finding that lesser remedies are inadequate.
- Retain the factors now in 42 Code of Federal Regulations (C.F.R.) 424.535(a)(8)(ii), add an intent or reckless disregard standard for severe sanctions, and exclude isolated, immaterial, corrected, or good-faith errors.
- Protect payment for medically necessary, covered services actually furnished to eligible beneficiaries unless payment was legally prohibited or procured through fraud.
- Provide written notice identifying the precise conduct, claims, effective date, legal standard, and evidence; toll recoupment and patient-disrupting effects during timely appeal unless an immediate patient safety threat exists.
- Offer a corrective action plan for curable administrative, enrollment, reporting, and billing deficiencies.

B. The 15-Day Post-Revocation Claims Period is Unworkable

CMS proposes to reduce the post-revocation claim submission period from 60 days to 15 calendar days measured from the revocation letter. Fifteen days is too short for a home health agency to complete assessments, obtain signed orders and certifications, reconcile visit documentation, resolve electronic edits, and submit accurate final claims while simultaneously protecting patients, transferring care, notifying staff, and pursuing appeal. The proposal invites hurried and incomplete billing — the opposite of program integrity.

CMS should retain 60 days. At a minimum, it should allow 45 business days, toll the period during system outages and declared disasters, permit submission of claims held for missing third-party documentation, and prohibit a shortened deadline from overriding the otherwise applicable timely filing rule when a revocation is reversed.

C. Geography and Same-Suite Location Are Not Evidence of Misconduct

Proposed 42 C.F.R. 424.535(a)(24) would permit revocation based on a high risk of fraud, waste, or abuse arising from location in a limited geographic area with an excessive number of providers. CMS proposes no numerical thresholds, no mandatory factors, and no requirement for an actual finding of wrongdoing. A separate same-suite proposal would permit denial because a new provider occupies the same suite or office as a denied or revoked provider.

Florida's rapid population growth, large older population, shared medical office buildings, subleases, incubator spaces, and normal tenant turnover make address-based inference particularly unreliable. A legitimate agency cannot investigate every past occupant or control which unrelated providers lease nearby space. Nor should a compliant agency be revoked because other agencies later locate in its neighborhood. The rules would chill entry into underserved markets while the national enrollment moratorium already limits new capacity.

CMS should withdraw both proposals. If CMS proceeds, geography should trigger heightened screening only — not denial or revocation — unless CMS finds provider-specific indicia such as common ownership or control, shared staff or records, coordinated billing or referral conduct, sham operations, or knowing participation in a scheme. CMS should define geographic terms, publish factors, provide notice and an opportunity to rebut, and protect an innocent successor tenant with a documented arm's-length lease.

D. Associated Party, Affiliation, Debt, and Payment Suspension Proposals Are Overbroad

The proposed expansion to any person or entity with any form of business or financial relationship could sweep in landlords, billing companies, software vendors, staffing firms, answering services, consultants, medical suppliers, lenders, and other vendors. Agencies cannot reliably discover confidential Medicare debts, payment suspensions, or historic relationships of independent counterparties. Unlimited affiliation lookback compounds the impossibility, especially when records are no longer legally or operationally available.

HCAF recommends that CMS:

- Define an associated party narrowly to include persons with ownership, control, operational authority, or a direct and material role in Medicare billing, referrals, or beneficiary solicitation.
- Exclude ordinary course vendors, landlords, lenders, software platforms, staffing firms, and professional advisers absent actual knowledge and a material nexus to the conduct at issue.
- Retain the five-year affiliation lookback. Any older relationship should be requested only upon particularized evidence and should not support strict liability.
- Use only final, non-appealable Medicare debt or payment suspension determinations, provide notice and an opportunity to repay or rebut, and require that the enrolling provider knew or reasonably should have known of the issue.
- Publish a safe harbor due diligence checklist so a compliant agency can determine prospectively what inquiry is sufficient.

E. Managing Employee Reporting Should Follow Actual Authority, Not Titles

CMS proposes to identify medical directors, clinical directors, department heads, supervising physicians, nursing directors, alternate administrators, and other clinical personnel as categories potentially within the managing-employee definition. HCAF agrees that people who actually conduct day-to-day operations should be reported. Job title alone, however, does not establish operational or managerial control. Multi-site organizations may use titles consistently even where local personnel have limited authority. Contract clinicians may lead care standards without controlling enrollment, billing, finance, or corporate operations.

CMS should retain a functional control test; state that the listed titles are not automatic; provide prospective education and at least 90 days to update records; and prohibit revocation for an immaterial, good-faith delay. The provider should not bear strict enrollment liability for a manager's remote personal history unless the history is reportable, final, material to Medicare, reasonably discoverable, and connected to the person's current authority.

F. Reapplication Bars and Ownership Rules Require Proportionality

CMS proposes to permit a reapplication bar of up to 10 years following any denial reason and to remove factors CMS currently must consider. A decade-long bar is quasi-punitive. It should not follow an unpaid application fee, a clerical omission, a disputed location issue, or another curable defect. CMS should limit bars to knowing, material misconduct or repeated noncompliance; retain objective factors; require written findings; and scale the bar to severity.

Likewise, enforcement of the 36-month change-in-majority-ownership (CHOW) rule should distinguish deliberate evasion from a good-faith transaction or reporting error. CMS should offer pre-transaction guidance, a cure period for nonmaterial defects, and expedited review when a transaction preserves care in a market facing closure or access loss.

G. A More Effective Program Integrity Alternative

CMS can protect Medicare more effectively by concentrating resources on conduct that predicts fraud while preserving beneficiary access. HCAF recommends enhanced screening in demonstrably high-risk markets; unannounced site visits; verification of patient need and referral sources; ownership network analytics; bank and electronic funds transfer validation; targeted pre-payment review; rapid action against stolen identities and sham locations; collaboration with the Florida Agency for Health Care Administration (AHCA); and transparent referrals to law enforcement. These tools focus on behavior. They do not punish an ethical agency because of its neighbors.

V. Palliative Care Under the Medicare Home Health Benefit

A. HCAF Supports Coverage Clarity and Additional Examples

HCAF supports CMS's clarification that palliative care is a method of care delivery that can be furnished under the existing home health benefit when the beneficiary satisfies home health eligibility requirements and an allowed practitioner orders reasonable and necessary skilled services. Palliative care should not require a terminal prognosis, abandonment of disease-directed treatment, or improvement potential. Skilled nursing, therapy, medical social services, medication management, symptom management, caregiver teaching, and advance care planning can all serve palliative goals.

CMS should add detailed examples to the Medicare Benefit Policy Manual involving heart failure, chronic obstructive pulmonary disease, cancer, dementia, neurologic disease, frailty, multiple comorbidities, complex medications, caregiver distress, and transition discussions. Examples should describe the skilled need, documentation, visit pattern, reassessment, and relationship to the plan of care without creating a new mandatory template or checklist.

B. The Staffing and Payment Model Must Precede Expansion

Florida providers advise that expanding advance care planning beyond the practitioners who commonly perform it will require substantial clinician education, competency assessment, supervision, documentation standards, and time for sensitive conversations with patients and families. CMS should permit appropriately trained home health registered nurses, medical social workers, and therapists to facilitate or furnish team-based advance care planning within their

professional scope, with practitioner coordination and beneficiary consent. It should not assume that every visiting clinician is prepared to do so without training.

HCAF recommends separate, identifiable payment outside the PDGM payment for the 30-day period when a qualified home health clinician performs substantive advance care planning. If CMS concludes that separate payment is not available under current law, CMS should identify the legal constraint, adjust the base or case-mix methodology to recognize the resource, and refrain from imposing a measure or documentation expectation until adequate funding exists. Advance care planning cannot become another unfunded task inside a rate already subject to reductions.

CMS should not mandate a medical social worker or chaplain for every palliative case when both are in short supply. The model should be needs-based and interdisciplinary, permit network or contracted support, and allow remote participation where clinically appropriate without substituting technology for necessary in-person care.

C. Recognize Spiritual Care Without Creating an Unfunded Mandate

CMS's definition of palliative care includes spiritual needs, yet the covered home health disciplines do not expressly identify chaplains. CMS should recognize a qualified chaplain or spiritual care professional as an optional interdisciplinary team participant and clarify how agencies may document, coordinate, and report that role. CMS should also clarify whether related costs are allowable on the Medicare cost report. If adding chaplain services as a separately covered discipline requires legislation, CMS should say so and recommend the needed statutory change rather than leaving agencies with an expectation they cannot finance.

D. Clarify Homebound Status for Serious Illness

CMS should confirm that the existing homebound standard accommodates patients whose symptoms, functional decline, cognitive impairment, treatment burden, infection risk, or need for assistance makes leaving home a considerable and taxing effort. A palliative patient need not be bedbound, and infrequent medical, religious, therapeutic, or family outings should not automatically defeat eligibility. Clear examples would reduce inappropriate denials while preserving the statutory standard.

E. Protect Hospice Choice and Avoid Unintended Diversion

Palliative home health and hospice are complementary but distinct. Providers are concerned that referral sources may route hospice-appropriate patients to palliative home health because the word palliative appears less final or because hospice election requires a different benefit choice. CMS guidance should prohibit marketing palliative home health as a substitute for hospice, preserve informed beneficiary choice, and include clinical prompts for timely hospice education when prognosis and goals make hospice appropriate. CMS should monitor whether the policy changes hospice referral timing, length of stay, live discharge, or late hospice election.

F. Exclude Palliative Periods From Value-Based Purchasing Until Measures Fit the Goals of Care

Palliative patients may appropriately prioritize comfort, symptom control, caregiver confidence, and remaining at home over functional improvement or utilization outcomes developed for a general home health population. HCAF asks CMS to exclude clearly identified palliative periods from the HHVBP Model until CMS develops validated, goal-concordant measures and adequate risk adjustment. If CMS does not adopt an exclusion, it should at minimum stratify performance, apply robust clinical and social risk adjustment, and prevent palliative case acceptance from lowering an agency's score.

VI. Quality Reporting, Advance Care Planning, and Notice

A. Shorter Data Deadlines Need Florida Disaster Safeguards

CMS proposes to shorten the OASIS submission and correction window from approximately four and one-half months to about 45 days and to align OASIS and the Home Health Consumer Assessment of Healthcare Providers and Systems (CAHPS®) reporting periods to the calendar year. CMS reports that 99.27% of OASIS assessments are already submitted within 45 days. HCAF supports calendar alignment and timely reporting, but initial submission is not the same as a meaningful correction opportunity.

The final rule should preserve automatic extensions for hurricanes, declared disasters, widespread power or communications loss, CMS or vendor outages, cyber incidents, and other extraordinary circumstances. It should permit correction of good-faith errors that do not manipulate performance and should not impose a 2.0% annual payment update penalty for an immaterial timing defect when the data were otherwise complete and accurate.

B. Do Not Rely on a Portal as the Only Notice Channel

CMS proposes to send quality reporting noncompliance notices and reconsideration decisions through the designated data submission system rather than by mail or email. Small agencies can miss a portal notice because of staff turnover, account access problems, system outages, or an emergency. Because a missed notice can lead to a significant payment reduction, CMS should retain redundant email notice to at least two designated contacts, provide delivery confirmation and reminder alerts, and begin the appeal period only after the notice is available and the provider is electronically alerted.

C. Advance Care Planning Should Measure Meaningful Care, Not Paperwork

CMS seeks input on a future advance care planning measure concept. HCAF supports voluntary, person-centered conversations that respect culture, language, cognition, family roles, and changing preferences. HCAF does not support a measure that rewards the mere presence of a form, pressures a beneficiary to complete a directive, or penalizes an agency when a patient declines.

Before proposing a measure, CMS should:

- Define the eligible population, exclusions, responsible team members, timing, reassessment, and valid documentation through notice and comment rulemaking.
- Require informed, voluntary participation and record a patient's decision to decline as a valid outcome.
- Test for disparities affecting people with cognitive impairment, limited English proficiency, low health literacy, cultural concerns, or absent caregivers.
- Avoid duplicating hospital, physician, hospice, or other post-acute documentation and support interoperable transfer of patient preferences.
- Pay for the clinician time and training required, and align the measure with palliative care and hospice guidance.
- Prefer outcomes such as communication quality, documented preferences available across settings, caregiver understanding, and goal-concordant care rather than a binary document-completion rate.

VII. Conclusion

Florida's Medicare beneficiaries need CMS to protect both program integrity and care capacity. HCAF welcomes the positive payment update, the absence of a new permanent behavioral adjustment, the proposed outlier change, and clearer recognition of palliative care. We urge CMS to complete the work by withdrawing the 3.0% temporary adjustment, mitigating Florida wage index losses, replacing vague enrollment sanctions with targeted evidence-based enforcement, and ensuring that palliative and quality initiatives are appropriately staffed, measured, and paid.

These changes will better protect the Medicare Trust Funds because they focus enforcement on misconduct while preserving the legitimate providers who prevent hospitalization, support recovery and chronic care management, respond during disasters, and keep vulnerable Floridians safely at home. HCAF and its members stand ready to work with CMS and to provide Florida-specific operational data as the agency finalizes the rule.

Respectfully submitted,

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