AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

August 28, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: 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 [CMS-1844-P]

Dear Administrator Oz:

On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment in response to the Calendar Year (CY) 2027 Home Health (HH) proposed rule referenced above. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine (HPM). Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding population of patients facing serious illness as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality palliative and hospice care.

Summary of Key Messages and Recommendations

AAHPM offers the following key messages and recommendations, which are further detailed in our comments below.

Palliative Care Services as HH Services

- AAHPM appreciates CMS calling attention to the use of HH as an avenue for accessing palliative care and encouraging its use. At the same time, we highlight limitations of the use of HH to deliver comprehensive palliative care, which contributes to fragmentation. We underscore that the fragmentation across HH and palliative care is evidence of a payment gap that we believe could be better addressed through dedicated payments for palliative care services, and we summarize what such payments could entail. Until such time as new palliative care payment codes are established and appropriately reimbursed, however, AAHPM would welcome improvements to HH services to improve support for patients with serious illness.

HH Measure Concepts Under Consideration For Future Years – Request for Information (RFI)

- AAHPM supports efforts to promote advanced care planning discussions and appreciates CMS seeking input on a potential quality measure related to ACP in the HH Quality Reporting Program (QRP). As CMS designs an ACP measure for the HH QRP, AAHPM urges CMS to consider several core principles.

Provider Enrollment

- AAHPM supports several of CMS' proposed changes to Medicare provider enrollment regulations, including proposed changes to:
    - Deny or revoke enrollment if CMS determines that a HHA, hospice, or DMEPOS supplier failed to comply with 36-month rule requirements for changes in majority ownership
    - Require hospices to obtain an initial state survey/accreditation before they can be reactivated
    - Update regulations regarding provider enrollment moratoria
    - Modify CMS' authority to extend revocation when another enrollment is denied
    - Establish a new revocation reason and a new denial reason based on an applicable sexual assault or financial misconduct misdemeanor conviction
    - Establish a new denial reason for misuse of identity/enrollment under another party's identity
- AAHPM has grave concerns that many of the proposals would be overly burdensome for providers and suppliers currently participating in the Medicare program, as well as prospective participants. We are particularly concerned about CMS' proposals to expand the scope of individuals and entities that CMS could consider when assessing for potential denial or revocation, including under the following proposals:
    - To expand the definition of "managing employee"
    - To update regulations regarding reporting of affiliations
    - To expand the applicability of its denial authority for Medicare debt
    - To expand the applicability of its denial authority for payment suspension
    - To expand the applicability of its denial authority for program terminations/suspensions to managing employees
    - To modify criteria for adding providers and prescribers to the Preclusion List
- AAHPM also has concerns with CMS expanding its authorities to deny or revoke enrollment without any clear guidance on how CMS should exercise such authorities, including under the following proposals:
    - To modify CMS revocation authority for abuse of billing privileges
    - To establish a new revocation reason for high-risk enrollments
    - To establish a new denial reason for revocation or denial in the same suite
    - To allow imposition of a discretionary reapplication bar to all denial reasons

- For CMS' proposed denial reason regarding hospice medical directors and hospice administrators, AAHPM appreciates that CMS is not applying the denial reason in an absolute manner, but rather as a discretionary tool for keeping high-risk hospices out of the Medicare program. At the same time, we request that CMS clarify what process it will use when determining whether to deny enrollment based on this authority, including what data CMS will consider and what criteria CMS will apply. AAHPM also recommends that CMS clarify that hospice medical directors must have an active physician medical license in the state(s) in which the hospice is operating and that CMS will deny hospice enrollment applications if that requirement is not met. Finally, AAHPM recommends that CMS implement new requirements regarding minimum training and expertise that physicians must demonstrate in hospice and/or palliative care in order to serve in the hospice medical director role.
- For CMS' proposal to extend retroactive revocation to all revocation reasons, AAHPM recommends that CMS retain the flexibility to apply revocation on a prospective basis and only apply revocation retroactively in clear cases of knowing and willful fraud or abuse. We also request clarification on how retroactive revocations would be effectuated while still providing meaningful opportunity for providers and suppliers to appeal revocation determinations, including revocations for general non-compliance.
- For CMS' proposal to expand its denial authority for Medicare debt, AAHPM recommends that CMS limit the applicability of this denial reason by specifying that the denial authority would only apply when debt is significant and maintained over a prolonged period, after a final determination is made specifying payment due.
- For CMS' proposal to establish a new denial reason for revocation or denial in the same suite, we also recommend that CMS include a reasonable lookback timeframe for which CMS will review for previous revocation or denial.
- Regarding CMS' proposed changes to the definition of "operational," AAHPM requests that CMS clarify that programs like home hospice programs that serve patients in their homes would not be expected to meet all of the applicable criteria, for example having a location that is fully accessible to all patients or having business hours that are sufficient to regularly serve patients.

Palliative Care Services as HH Services

In this year's proposed rule, CMS discusses its belief that the Medicare HH benefit can be an important step in the care continuum when a patient needs palliative care and details how palliative care can be furnished under the HH benefit. AAHPM recognizes that there is a significant unmet need for palliative care for patients with serious illness and that current coverage and payment rules can create barriers that prevent patients from accessing comprehensive palliative care when they are needed. ***AAHPM therefore appreciates CMS calling attention to the use of HH as an avenue for accessing palliative care and encouraging its use***.

Our members are well aware of the ability to leverage HH services to furnish palliative care, and they report that referral to HH is common when a patient needs palliative care concurrently with curative or life-sustaining care. Indeed, many elements of HH can support patients' palliative care needs, including the availability of home aide services and provision of therapy services. ***At the same time, we highlight limitations of the use of HH to deliver comprehensive palliative care.***

To begin, many patients with serious illness may not qualify for HH care, for example if the patient is not homebound. Additionally, the requirement for HH recertification to be conducted every 60 days creates

uncertainty and distress, as patients must repeatedly face the risk that HH services might no longer be available. We also note that HH staff do not typically have the kind of specialized palliative care training that is necessary to furnish high-quality palliative care, nor do they include the full range of disciplines that are required to furnish a core set of palliative care services, thereby raising concerns about the comprehensiveness of palliative care they furnish. Moreover, there are not mechanisms in place to ensure HH agency (HHA) accountability for the delivery of high-quality palliative care.

We acknowledge that palliative care teams may be relying on HHAs to support delivery of medically appropriate palliative care. However, we note that such arrangements can create fragmentation: the palliative care team manages goals of care, symptom management, and psychosocial support, while the home health agency provides skilled services under a separate plan of care, separate documentation, and separate clinical oversight. The patient experiences two teams, two sets of visits, and two care plans that may or may not communicate effectively.

AAHPM underscores that this fragmentation across HH and palliative care is evidence of a payment gap that we believe could be better addressed through dedicated payments for palliative care services. As we have previously noted, CMS could develop codes for comprehensive palliative care services furnished by an interdisciplinary care team across facility and non-facility settings. This could include a code for an initial comprehensive palliative care assessment and care plan development, which would require multidisciplinary assessment across physical, psychological, social, and spiritual domains, along with a resulting care plan that addresses patients' needs and goals across the domains. CMS could also develop additional codes that would allow for ongoing delivery of palliative care services pursuant to the care plan under a monthly case rate that would cover comprehensive palliative care furnished in a manner consistent with NCP Guidelines. Eligibility for these payments should require palliative care teams to meet interdisciplinary staffing and quality standards consistent with the NCP Guidelines. Additionally, the monthly case rate codes should account for progressive levels of patient acuity, with tiered case rates that would cover services based on patient need, including initial comprehensive assessments, ongoing patient education, development of care plans and goals of care, communication with other providers and coordination of related services, 24/7 availability to respond to requests for information or assistance, in-person and telehealth visits, symptom management, and more.

AAHPM is providing more detailed comments in response to the RFI in the CY 2027 Medicare Physician Fee Schedule proposed rule on what these codes should entail.

Until such time as new palliative care payment codes are established and appropriately reimbursed, AAHPM would welcome improvements to HH services to improve support for patients with serious illness. For example, we believe it could be beneficial to distinguish between traditional home health patients and those who are receiving home health care as part of a palliative care plan by placing the palliative care patients in a separate "palliative track." Patients in this track should have a written "coordination agreement" between a palliative care physician or APP and the home health agency. CMS could also assess home health agencies on different quality measures that are more relevant to their care. This could include, for example, the proportion of patients with a symptom assessment, a psychosocial assessment, and a spiritual assessment; patient's experience of feeling heard and understood (see MIPS measure #495); or improvement of distress burden.

AAHPM would be pleased to work with CMS to effectuate these and other improvements in the use of HH services to furnish palliative care, as well as to develop appropriate coding and payment for comprehensive community-based palliative care services under the Physician Fee Schedule.

HH Measure Concepts Under Consideration for Future Years - RFI

CMS seeks input on a quality measure concept related to advanced care planning (ACP) for the HH QRP, including its importance, relevance, appropriateness, and applicability.

AAHPM supports efforts to promote ACP discussions and appreciates CMS seeking input on a potential quality measure related to ACP in the HH QRP. ACP is an important component of high-quality serious illness care. We consider ACP as a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.[1] Studies show that timely, meaningful advance care planning can improve patient and family satisfaction, decrease hospitalization and intensity of treatment near the end of life, increase hospice use and the likelihood of patients dying in their preferred place, and reduce stress, anxiety, and depression in surviving caregivers.[2, 3, 4, 5]

Adopting an ACP-related measure in the HH QRP could help ensure that HH beneficiaries receive care aligned with their values, preferences, and goals, while minimizing the risk of burdensome care transitions. However, thoughtful implementation is essential. ***As CMS designs an ACP measure for the HH QRP, AAHPM urges CMS to consider the following core principles***:

- ***Capture role of health care agents and surrogate medical decision-makers.*** A critical component of effective ACP is ensuring that patients clearly identify a health care agent or, among patients who do not have capacity to engage in ACP discussions, surrogate medical decision-makers, in accordance with state laws. Identification of such agents or surrogates should be a priority for patients. In designing the ACP measure, CMS should ensure that any measure only gives credit to rightful health care agents or surrogates. For example, any measure should explicitly exclude temporary health care surrogate designations (e.g., those captured on temporary advance directive forms used at admission) from qualifying as valid surrogate decision-makers. Identification of a patient's surrogate decision-maker should be performed by an appropriate

[1] Sudore RL, Lum HD, You JJ, Hanson LC, Meier DE, Pantilat SZ, Matlock DD, Rietjens JAC, Korfage IJ, Ritchie CS, Kutner JS, Teno JM, Thomas J, McMahan RD, Heyland DK. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. J Pain Symptom Manage. 2017 May;53(5):821-832.e1. doi: 10.1016/j.jpainsymman.2016.12.331. Epub 2017 Jan 3. PMID: 28062339; PMCID: PMC5728651.

[2] Schichtel M, Wee B, Perera R, Onakpoya I. The Effect of Advance Care Planning on Heart Failure: a Systematic Review and Meta-analysis. J Gen Intern Med. 2020 Mar;35(3):874-884. doi: 10.1007/s11606-019-05482-w. Epub 2019 Nov 12. PMID: 31720968; PMCID: PMC7080664.

[3] Weissman JS, Reich AJ, Prigerson HG, et al. Association of Advance Care Planning Visits With Intensity of Health Care for Medicare Beneficiaries With Serious Illness at the End of Life. JAMA Health Forum. 2021;2(7):e211829. doi:10.1001/jamahealthforum.2021.1829

[4] Scott I, Reymond L, Sansome X, Carter H. Association of advance care planning with hospital use and costs at the end of life: a population-based retrospective cohort study. BMJ Open. 2024 Nov 7;14(11):e082766. doi: 10.1136/bmjopen-2023-082766. PMID: 39510772; PMCID: PMC11552563.

[5] Scott I, Reymond L, Sansome X, Carter H. Association of advance care planning with hospital use and costs at the end of life: a population-based retrospective cohort study. BMJ Open. 2024 Nov 7;14(11):e082766. doi: 10.1136/bmjopen-2023-082766. PMID: 39510772; PMCID: PMC11552563.

clinical member of the care team, and this process should include a clear discussion with the patient and the surrogate to ensure an accurate understanding of the decision-maker's role and responsibilities. CMS should also consider excluding patients who are unrepresented from the denominator to avoid inadvertently penalizing facilities that serve a higher proportion of such patients.

- *Ensure measure reflects meaningful ACP, not a checkbox exercise.* Medical decision-making is not a single event but an ongoing process that evolves across different stages of illness and care, and any ACP measure should reflect this reality. Meaningful ACP must be more than a static entry in the patient's record.[6] CMS should consider approaches, such as requiring structured questions integrated into clinical workflows, that prompt teams to assess what is currently documented in the patient's chart and whether it remains relevant. In specifying an ACP measure, CMS must ensure that the measure cannot be satisfied by the presence of an advance directive completed decades earlier, without any assessment of whether it is still representative of the patient's preferences or applicable to their current condition. Incorporating a requirement to confirm whether existing ACP documentation is up to date and reflective of the patient's current preferences would support informed, patient-centered decision-making.

- *Incentivize high-quality, well-timed ACP discussions.* Equally important is the quality and appropriateness of ACP discussions themselves. A measure that captures only the occurrence of a conversation, without regard to how or when it took place, risks incentivizing discussions conducted at inappropriate moments or by insufficiently trained clinicians. CMS should consider ways to incentivize high-quality, well-timed ACP discussions and should engage stakeholders in assessing the feasibility of quality-based approaches applicable to HH care.

  In response to AAHPM's comments on the adoption of the eCQM in the IQR Program, CMS encouraged hospitals to ensure that staff have appropriate training and "to support their health care providers in discussing with the patient, or their surrogate, whether existing documentation accurately reflects the patient's current advance care planning preferences and to implement the measure consistent with professional standards." While we appreciate this acknowledgement, we remain concerned that it does not go far enough to ensure the measure drives high quality, appropriate ACP discussions. We again urge CMS to work with stakeholders to explore ways to strengthen the eCQM so that it functions as more than a "check-the-box" process measure.

- *Ensure reporting flexibility in light of challenges with electronic health record adoption.* While AAHPM appreciates CMS' broader interest in transitioning to digital quality measurement, which could enable greater care coordination and information sharing, we caution against moving too quickly, particularly given the unintended consequences that rapid transitions may create for post-acute care providers with limited health information technology infrastructure. Fully transitioning to digital quality measurement will demand investments in technology, infrastructure, and workforce training, posing challenges for many organizations; this is particularly true for post-acute care providers like HHAs that did not benefit from federal incentives to adopt certified electronic health record technology. Notably, as part of the Fiscal Year 2027 Inpatient Prospective Payment System (IPPS), CMS finalized adoption of an electronic

[6] McMahan RD, Hickman SE, Sudore RL. What Clinicians and Researchers Should Know About the Evolving Field of Advance Care Planning: a Narrative Review. J Gen Intern Med. 2024 Mar;39(4):652-660. doi: 10.1007/s11606-023-08579-5. Epub 2024 Jan 2. PMID: 38169025; PMCID: PMC10973287.

clinical quality measure (eCQM) related to ACP; however, the HH care presents distinct challenges compared to acute care hospitals, and ACP-related data may be less readily captured through electronic systems in these environments. As a result, we urge CMS to specify a measure that accounts for these challenges by maintaining flexibility for different reporting approaches. CMS should also explore integration of the ACP measure into existing OASIS reporting systems.

AAHPM applauds CMS' consideration of adopting an ACP measure into the HH QPR and urges CMS to incorporate these design principles as it continues to work with stakeholders to specify a measure that promotes high-quality, patient-centered care. AAHPM would be pleased to serve as a resource to help guide this work.

Provider Enrollment

CMS proposes numerous changes to its Medicare provider enrollment regulations to enhance its ability to address fraud, waste, and abuse. While AAHPM recognizes the risk that fraud, waste, and abuse pose to Medicare beneficiaries and the Medicare Trust Funds, and we support several of the proposed changes, we have grave concerns that many of the proposals would be overly burdensome for providers and suppliers currently participating in the Medicare program, as well as for prospective participants. We are particularly concerned about CMS' proposals to expand the scope of individuals/entities that CMS could consider when assessing for potential denial or revocation – including as a result of CMS' proposals to update specific denial or revocation reasons as well as CMS' proposals to update the definitions of "managing employee" and "affiliation." We also disagree that CMS should expand its authorities to deny or revoke enrollment without any clear guidance on how CMS would exercise such authorities. ***We therefore urge CMS to consider our comments and work with the stakeholder community to identify and implement policies that offer a more balanced approach, while still protecting the program from unscrupulous actors.***

Provisions that Directly Implicate Hospices

While most of the provider enrollment proposals apply across-the-board to all providers and suppliers, several specifically reference or apply to hospices.

AAHPM recognizes that program integrity risks associated with hospice care have increased over the past several years, resulting in harm to beneficiaries and their loved ones, millions of lost dollars, and erosion in trust for hospice care. However, we underscore that the fundamental value of hospice care remains and that Medicare beneficiaries nearing the end-of-life need – and deserve – all of the important services that good hospice delivers.

AAHPM appreciates that the high rates of fraud and abuse undermine efforts to expand availability and utilization of hospice services for terminally ill Medicare beneficiaries. We therefore stand ready to partner with CMS and other policymakers to ensure that the benefit delivers on its promise and that Medicare beneficiaries are able to access the end-of-life care and supports they deserve and need. To that end, we offer feedback on CMS' proposals that specifically apply to hospices, including CMS' proposals to:

- Deny or revoke enrollment if CMS determines that a HHA, hospice, or DMEPOS supplier failed to comply with 36-month rule requirements for changes in majority ownership (CIMOs).
- Require hospices to obtain an initial state survey/accreditation before they can be reactivated.

- Update regulations related to provider enrollment moratoria.
- Establish a new denial reason associated with characteristics of hospice medical directors and administrators, as further discussed below.

AAHPM is supportive of CMS' proposals regarding CIMOs, survey/accreditation before hospice reactivation, and enrollment moratoria. We believe these proposals balance provider burden with program integrity interests, and that they put in place reasonable safeguards that could prevent new, re-established, or ongoing Medicare participation by high-risk hospice providers.

For the new denial reason, CMS proposes to permit denial of a hospice's enrollment application if any of the following apply:

- The enrolling hospice's medical director is a medical director of multiple other hospices or practices at such a distance from the enrolling hospice that the medical director cannot realistically perform all medical director functions required in Medicare hospice regulations;
- The enrolling hospice's administrator is the administrator of multiple other hospices or located at such a distance from the enrolling hospice that the administrator cannot realistically perform all administrator functions required in Medicare hospice regulations; or
- The hospice medical director does not have an active physician medical license in the state in which they are practicing.

CMS clarifies that this provision would not formally prohibit medical directors and administrators from serving at more than one hospice or change hospice conditions of participation or other hospice policies.

While AAHPM appreciates that serving as a medical director or hospice administrator of multiple hospices may serve as an indicator of fraudulent activity, we highlight that there are also reasonable explanations for why a physician may legitimately serve as medical director for two or more hospice programs, including to enable operations in rural or underserved areas; to support multiple small hospices; or to support multiple hospices operating under the same parent organization. The same is true for medical directors and hospice administrators practicing at a distance from the hospice location seeking to participate in the Medicare program. Notably, telehealth and virtual capabilities have enabled physicians to manage hospices and deliver care across state lines, particularly when metropolitan areas are located at state borders. Furthermore, when large multi-state hospice organizations operate, it is common for hospice medical directors to oversee hospices from a distance. ***For all of these reasons, we appreciate that CMS is not applying this denial reason in an absolute manner, but rather as a discretionary tool for keeping high-risk hospices out of the Medicare program. At the same time, we request that CMS clarify what process it will use when determining whether to deny enrollment based on this authority, including what data CMS will consider and what criteria CMS will apply.*** Such transparency will be helpful in providing assurances to stakeholders on the appropriate use of this denial authority.

With respect to physician licensure, we believe it is critical that hospice physicians be licensed in the state(s) in which the hospice operates. Hospice physicians are routinely involved in day-to-day care delivery for hospice patients, including to diagnose complications and prescribe medications and other treatments. While many physicians are obtaining licensure across multiple states given the availability of telehealth, if a physician is not licensed in the hospice's state, they would not be eligible to perform these functions for patients in that state, leaving patients at risk when changes in care needs arise. ***AAHPM therefore recommends that CMS clarify that hospice medical directors must have an active physician medical license in the state(s) in which the hospice is operating and that CMS will deny hospice enrollment applications if that requirement is not met.***

Finally, we call to CMS' attention the risk that unqualified hospice medical directors pose. If a hospice medical director does not have sufficient training or expertise in hospice and palliative care, patients may suffer from poor pain and symptom control, inappropriate medication decisions, ineffective crisis management, unnecessary emergency department visits or hospitalizations, and more. Unfortunately, it is far too common for hospices to hire or contract with hospice medical directors without necessary training and expertise, including for part-time or moonlighting roles. To protect patients and support high-quality hospice care, ***AAHPM recommends that CMS implement new requirements regarding minimum training and expertise in hospice and/or palliative care that physicians must demonstrate in order to serve in the hospice medical director role.***

Managing Employee Definition

CMS proposes to expand the list of persons added to the "managing employee" definition to include:

- Medical directors (not merely those at skilled nursing facilities, or SNFs, and hospices)
- Clinical directors
- Departmental heads (for example, a hospital's chief of cardiology)
- Supervising physicians (not simply those at independent diagnostic testing facilities)
- Nursing directors
- Alternate administrators
- All other clinical personnel that meet the "managing employee" definition.

CMS notes that these categories apply to all provider and supplier types, including SNFs and hospices. CMS also notes that it believes the persons in these categories already qualify as "managing employees" and should have always been reported. CMS also notes that these bulleted categories do not establish any minimum threshold for disclosure.

AAHPM has significant concerns with this proposal, which we believe will result in excessive administrative burden for Medicare providers and suppliers. If CMS finalizes this proposal, we are concerned that large institutions, including large hospices and hospitals, may need to update enrollment records as frequently as every month as clinical directors, department heads, supervising physicians, nursing directors and more cycle through employment. We also disagree with CMS' characterization that most of these individuals exercise operational or managerial control over the day-to-day operation of the provider, and that they should have always been reported as managing employees. We believe that "managing employee" should refer to individuals who have broad oversight over the entire entity, not small sub-units within the entity, and we highlight that CMS' previous enumeration of specified individuals/roles suggested that the term was limited to those roles.

We also believe that this policy will result in significant operational challenges and compliance risks, which will be compounded by CMS' proposal to apply revocations on a retroactive basis. If CMS finalizes that these individuals should have been reported all along, every provider or supplier who has not reported these individuals on their enrollment forms risks being subject to revocation based on false or misleading information. Even if they scramble to report these individuals prospectively, CMS will have established the framework for designating these providers and suppliers as non-compliant on a retrospective basis. We do not believe such a change is tenable or appropriate, particularly given lack of clarity in previous regulations regarding who must be reported.

For all of these reasons, ***AAHPM opposes this proposal and urges CMS to retain the current definition of "managing employee."***

Affiliations

Under current regulations, an initially enrolling or revalidating provider or supplier must disclose any and all affiliations that it or any of its owning or managing employees or organizations has or, within the previous 5 years, had with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider that has a disclosable event. CMS proposes to update these regulations to:

- Remove the 5-year lookback period. With this change, affiliations would have to be reported regardless of how long ago they occurred or ended.
- Add a new paragraph to the "affiliation" definition to include any marketing, business, fulfillment, financial, managerial, or beneficiary relationship.
- Add that affiliations include interests in which "owning or managing employees or organizations" of an individual or entity exercise operational control over (not just interests in which the individual or entity exercises operational control over).

AAHPM again disagrees with this proposal, which would place unreasonable demands on enrolling and revalidating providers and suppliers and again result in excessive administrative burden and compliance risk. To begin, it is not clear how providers or suppliers would be expected to know if any of their many marketing, business, fulfillment, financial, managerial, or beneficiary relationships were parties to a disclosable event at any point in time, much less 10, 15, or 20 years ago. While this would be particularly challenging for large institutions, even small physician practices rely on a host of third parties to support their operations that would fall under the proposed definition of affiliation; having to report affiliations under the proposed definition would strain resources and take away from patient care. Further, we note that these entities involved in these relationships could undergo changes in ownership over time that may make tracking of previous disclosable events extremely difficult, if not altogether impossible.

While we recognize CMS' interest in expanding its arsenal to keep out bad actors, we believe new requirements should be proportionate to the risks that they are intended to prevent. Requiring tracking and disclosure of affiliations for the expansive set of relationships included in the proposal – the majority of which would not likely pose Medicare program integrity risks – does not pass that test.

For all of these reasons, ***AAHPM opposes CMS' proposed changes to affiliation requirements and urges CMS to retain its current policies.***

Revocations and Denials of Enrollment

Modifications of Current Revocation Provisions

Abuse of Billing Privileges

CMS proposes to remove four enumerated factors from regulation that it must currently consider before making a determination to revoke based on abuse of billing privileges. CMS indicates that greater flexibility is needed to address potential abuse. AAHPM is concerned that the removal of the four enumerated factors leaves too much discretion to CMS, and ***we recommend that CMS retain transparent guidelines for how it determines whether billing privileges have been abused for the purposes of revoking enrollment.***

Additionally, ***while CMS proposes to remove claims denial rate as a factor when considering abuse of billing privileges, we recommend that CMS instead clarify this policy to focus on final adjudication status of claims rather than initial denial rates.*** AAHPM is concerned that a focus on initial denial rates could – for example – lead to hospices denying enrollment of Medicare beneficiaries who are rightfully eligible for hospice, but for whom prognoses may be subject to greater interpretation, which could ultimately result in initial claim denial.

Expansion of Retroactive Revocation Grounds

CMS proposes to extend retroactive revocation to all revocation reasons that do not currently have retroactive revocation dates. While AAHPM agrees that retroactive revocation is important when providers or suppliers have knowingly and willfully engaged in fraud or other abusive misconduct, we are concerned about the potential financial liabilities that retroactive enrollment could pose on providers and suppliers who may be subject to revocation for administrative oversights – for example by failing to report a change in a managing employee or by misplacing documentation. We highlight that many of the proposals included in the proposed rule would further magnify the potential risk that these providers or suppliers would face as the proposals would expand reporting requirements and increase potential liability. ***We therefore recommend that CMS retain the flexibility to apply revocation on a prospective basis and only apply revocation retroactively in clear cases of knowing and willful fraud or abuse.***

Additionally, ***we request clarification on how retroactive revocations would be effectuated while still providing meaningful opportunity for providers and suppliers to appeal revocation determinations, including revocations for general non-compliance***. We believe that providers and suppliers should be provided advance notification of any concerns and given the opportunity to respond and rectify, but we are unclear if CMS' proposals will accommodate such action.

Extension of Revocation

CMS proposes to specify that it could revoke a provider's other enrollments if a provider has a triggering enrollment that is denied. CMS can already revoke a provider's other enrollments if a provider has another enrollment that is revoked. ***AAHPM supports this proposal and recommends that CMS finalize the policy as proposed.***

New Revocation Reasons

High-Risk Enrollments. CMS proposes to establish new revocation authority for high-risk enrollments based on a provider's or supplier's location within a limited geographic area that has an excessive number of providers or suppliers. While we appreciate that CMS has identified high risk of fraud or abuse in such circumstances, we note that there are numerous incidences when several hospices and other provider types are legitimately furnishing services in close proximity to each other, and we are concerned that compliant providers acting in good faith could be inappropriately revoked from the Medicare program under this authority. ***We therefore recommend that CMS articulate the factors it will consider and standards it will apply before making a determination to revoke a provide under its proposed high-risk enrollments revocation authority.***

Certain Misdemeanor Convictions. CMS proposes to establish a new revocation reason for convictions for a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.

AAHPM generally supports CMS's authority to revoke enrollment when the provider or supplier – or any owner, managing employee or organization, officer, or director thereof – has an applicable sexual assault or financial misconduct misdemeanor conviction. However, as noted above, we disagree that CMS should expand the definition of "managing employee" as proposed.

Revised and New Denial Reasons

Changes to Existing Denial Reasons

Debt. CMS proposes to specify that it may deny enrollment if a managing employee, managing organization, or individuals and entities with any other form of business or financial relationship with the provider (collectively referred to as "associated party") has an existing Medicare debt or was an associated party of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was terminated or revoked.

AAHPM has significant concerns with this proposal, which we believe would cast too broad a net. Hospices are responsible for virtually all of their enrolled beneficiaries' care, which means that they must enter into financial relationships with a number of entities that support patient care, including, but not limited to, nursing facilities, HHAs, DMEPOS suppliers, and pharmacies. Denying a hospice enrollment based on one of their contracted HHA's Medicare debt, for example, would be overly punitive, particularly when the hospices' finances and incentives are not dependent on the HHA. We are also concerned with CMS' proposal to include managing employees under this provision, and we would be particularly concerned if CMS finalizes its proposal to expand the definition of managing employee. We disagree that a hospice program, for example, should be denied enrollment if one of its nursing directors held Medicare debt. Finally, we note that this requirement would increase providers' administrative burden associated with monitoring for associated parties' debts. ***AAHPM therefore urges CMS not to finalize this proposal.***

AAHPM is also concerned that this provision could be overly broad and punitive for potentially enrollment providers and suppliers. ***AAHPM recommends that CMS limit the applicability of this denial reason by specifying that this denial authority would only apply when debt is significant and maintained over a prolonged period, after a final determination is made specifying payment due.***

Payment Suspension. CMS proposes that it may deny enrollment if any individual or any entity with any form of business or financial relationship with the enrolling provider is currently under a Medicare or Medicaid payment suspension. As with CMS' proposal to expand denial based on debt, we again believe this proposal is excessive and would create undue administrative burden. ***AAHPM therefore urges CMS not to finalize this proposal to expand denial authority based on payment suspension.***

Program Terminations/Suspensions. CMS proposes to expand its denial authority for program terminations and suspensions to allow for denial if a provider's owners, managing employees, and managing organizations are terminated or suspended. Again, AAHPM is concerned with CMS' proposal to include managing employees under this authority, and we would be particularly concerned if CMS finalizes its proposal to expand the definition of managing employee. We also highlight that this provision would place unreasonable requirements on providers and suppliers to track program terminations and suspensions of their staff when they may have limited visibility into their activities outside of the immediate work environment. ***We therefore caution against expanding the definition of managing employee and including it under this denial authority.***

New Denial Reasons

Misdemeanor Convictions. CMS proposes to duplicate as a denial reason its proposed changes that would allow for revocation based on misdemeanor convictions related to sexual assault or financial misconduct. ***AAHPM reiterates our overall support for this proposal, but our opposition to CMS' proposed expansion of the definition of "managing employee."***

Revocation or Denial in Same Suite. CMS proposes that it may deny enrollment based on the provider having its practice location in the same suite or office as another provider whose Medicare enrollment has been revoked or denied. As with CMS' proposal to revoke based on high-risk enrollments, we note that there are numerous incidences when several hospices and other provider types are legitimately furnishing services in the same office as one whose enrollment was revoked or denied, and we are concerned that compliant providers acting in good faith could be inappropriately denied from the Medicare program under this authority. ***We therefore recommend that CMS articulate the factors it will consider and standards it will apply before making a determination to deny a provide under its proposed revocation or denial in same suite authority. We also recommend that CMS include a reasonable lookback timeframe for which CMS will review for previous revocation or denial*** as we worry that providers or suppliers newly moving into a suite could be denied enrollment for actions that occurred well in the past.

Misuse of Identity. CMS proposes that it can deny enrollment if the prospective provider or supplier is attempting to enroll under another party's identity. ***AAHPM supports this proposal and recommends that CMS finalize the policy as proposed.***

Reapplication Bar

CMS proposes to allow imposition of a discretionary reapplication bar for up to 10 years based on any of the denial reasons included under 42 CFR 424.530(a). CMS can currently apply a reapplication bar only based on denial of false or misleading information. CMS also proposes to delete factors specified in regulation text that CMS currently must consider in determining whether to impose a reapplication bar, and the length thereof.

AAHPM disagrees that CMS should expand its authority for imposing a reapplication bar while at the same time decreasing transparency and accountability for how decisions for applying such a reapplication bar would be made. ***We therefore recommend that CMS retain transparent guidelines for how it determines whether a reapplication bar should be applied, including what data it would consider and what criteria it would apply.***

Preclusion List

The Preclusion List is a compilation of providers and prescribers who are prohibited from receiving payment for furnished, ordered, or prescribed MA items/services and Part D drugs. Among other reasons, a party may be placed on the Preclusion List if, regardless of whether the provider/prescriber is or was enrolled in Medicare, they have been convicted of a felony under Federal or State law within the previous 10 years that CMS deems detrimental to the Medicare program's best interests. CMS proposes to expand this category to include felony convictions against the provider/prescriber's owner, managing employee, managing organization, corporate director, or corporate officer.

Consistent with comments above, AAHPM is concerned with CMS' proposal to include managing employees under this provision, and we would be particularly concerned if CMS finalizes its proposal to expand the definition of managing employee. We highlight the increased administrative burden this proposal would impose on providers and suppliers to monitoring employees' activities outside of the immediate work environment. We also question what would happen to a provider on the Preclusion List by virtue of their managing employee's felony conviction if the provider terminated employment. For these reasons, ***we recommend that CMS exclude managing employees from its proposed changes to Preclusion List qualifying criteria.***

Definition of "Operational"

CMS proposes to expand the definition of "operational" that providers or suppliers must meet in order to obtain Medicare billing privileges, including to clarify requirements around having a physical practice location and being open and accessible to the public. While AAHPM appreciates the added clarity and agrees the proposed changes are reasonable for providers and suppliers that furnish care on site, ***we request that CMS clarify that programs like home hospice programs that serve patients in their homes would not be expected to meet all of the applicable criteria, for example having a location that is fully accessible to all patients or having business hours that are sufficient to regularly serve patients.*** While we believe proposed language specifying that the requirements are "as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered" addresses our concerns, we believe it would be helpful to clearly articulate types of programs for which the general "operational" requirements would not apply.

* * * * *

Thank you again for the opportunity to provide feedback on the important issues addressed in this proposed rule. AAHPM would be pleased to work with CMS to address our recommendations above. Please direct questions or requests for additional information to Wendy Chill, Senior Director of Health Policy and Government Relations, at wchill@aahpm.org.

Sincerely,

Kimberly Curseen, MD, FAAHPM
President, American Academy of Hospice and Palliative Medicine