AAHOMECARE
American Association for Homecare

Submitted electronically to www.regulations.gov

August 31, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Comments on CMS-1844-P, "Calendar Year 2027 Home Health Prospective Payment System (HH PPS) Rate Update; Requirements for the HH Quality Reporting Program and the Expanded HH Value-Based Purchasing Model; Medicare Program Enrollment, Durable Medical Equipment (DME), and DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies" (91 Fed. Reg. 41216, July 6, 2026) (the "Proposed Rule")

Dear Administrator Oz:

1. Introduction

The American Association for Homecare (AAHomecare) is pleased to submit comments on the Centers for Medicare and Medicaid Services' (CMS's) above-captioned Proposed Rule. AAHomecare members include a cross-section of suppliers, manufacturers, and other industry stakeholders that assist, make, or furnish DMEPOS items that beneficiaries use in their homes. Our members are proud to be part of the continuum of care that assures Medicare beneficiaries receive cost-effective, safe and reliable home care products and services. As such, our comments are focused on the DMEPOS provisions of this Proposed Rule.

As you consider policy and enforcement measures to address bad actors in our industry, we urge that any recommendations be carefully calibrated, so they target fraudulent conduct specifically, rather than imposing broad administrative burdens that inadvertently penalize the legitimate, compliant suppliers who work every day to serve Medicare beneficiaries. We welcome the chance to serve as a resource and partner in this effort, offering our members' front-line expertise to help design solutions that protect program integrity while preserving patient access to essential home-based care.

2. AAHomecare Position on Fraud, Waste, and Abuse

AAHomecare fully supports the eradication of fraud in the Medicare program and would like to work with CMS to ensure that bad actors cannot bilk the Medicare program. The services our members provide are essential in keeping beneficiaries safe in their homes while they are being treated. Most patients prefer to be in their home rather than being treated in an inpatient setting. Every day, our

members are connecting with patients to ensure they are safely using their DMEPOS products to allow them to live healthily and comfortably.

As the leading voice for the DMEPOS community, AAHomecare is committed to being a good steward of the Medicare program and fully supports the Agency's ongoing efforts to eliminate fraudulent activity within the marketplace. We recognize that fraud not only drains critical resources but also creates an unfair "black eye" for the many legitimate, law-abiding suppliers who serve the most vulnerable patient populations. Fraudulent activity is dangerous to patients who may experience delays in life-saving services. AAHomecare has numerous proposed initiatives that would materially improve CMS's ability to prevent fraudulent billing in the DMEPOS program.

3. **Overall Comments**

To ensure any fraud-fighting efforts are successful without inadvertently harming patients and the legitimate DMEPOS supplier community, we urge CMS to adopt a more nuanced and strategic approach that targets at-risk and bad actors while minimizing the administrative burden on ethical suppliers.

While AAHomecare generally supports CMS's program integrity objectives, it is important that expanded enrollment and revocation authorities be narrowly tailored to address intentional fraud and abuse, supported by objective standards, allow for cure periods for non-material deficiencies, and provide suppliers with meaningful appeal rights.

CMS must ensure that revocations and deactivations are warranted. There are many examples where a supplier number is revoked or deactivated in error. Similarly, when a supplier appeals a revocation or deactivation, the revocation or deactivation should not be flagged to other programs until a final determination is made. An appeal signifies that the supplier is actively working to fix the issue in good faith, which is an action that is inconsistent with fraudulent players. Similarly, when a supplier number is reinstated, the update must be communicated consistently and immediately across all government healthcare programs.

4. **Comments on Specific Proposals**

A. DMEPOS Encounter Requirement for Identical Replacement Items (Proposed changes to 42 C.F.R. §410.38)

Proposal

In the Proposed Rule, CMS is proposing to clarify DMEPOS Encounter Requirements for Identical Replacement Items. CMS is proposing that a new face-to-face encounter would not be required for the replacement of a DMEPOS item if the replacement item falls under the same Healthcare Common Procedure Coding System (HCPCS) code as the original. A new order would still be required, but a new encounter would only be necessary if the beneficiary needed a different item (a different HCPCS code) due to a change in medical condition. This proposal would only be applicable to items on the Required Face-to-Face Encounter and Written Orders Prior to Delivery (F2F/WOPD) List.

Position
AAHomecare supports this proposal as it provides needed clarity.

B. Provider Enrollment Proposals; Expansion of Medicare Revocation and Denial Authorities (proposed changes to 42 C.F.R. §424.530 and 42 C.F.R. §424.535)

Proposal
In the Proposed Rule, CMS is proposing to make all revocation reasons retroactive to the date the non-compliance began. For example, revocation could be the date a provider/supplier knowingly sells to or allows another entity to use their billing number; and revocations for failure to report required enrollment changes would be effective retroactively to the day after the reporting deadline. This would include failures to report changes such as new managing employees, a change of ownership (CHOW), banking information updates, and billing agency changes.

Position
It is important for CMS to have its revocation action commensurate with the revocation reason. AAHomecare recommends that CMS review DMEPOS supplier revocation activity over the last few years and analyze the revocations that were subsequently overturned. For example, revocations based upon clerical errors, rather than fraud, are easily corrected and overturned.

Under current law, CMS is prohibited from initiating or continuing recoupment of an alleged Medicare overpayment while a provider or supplier has a timely and valid appeal pending at the redetermination or reconsideration levels.[1] Specifically, when a provider or supplier submits a redetermination request within thirty (30) calendar days of the date of the initial overpayment demand letter, or within 60 days of the subsequent redetermination partial or unfavorable decision, Medicare contractors must suspend recoupment activities until an unfavorable determination is issued at the applicable level of appeal. This statutory protection preserves suppliers' cash flow and ensures that alleged overpayments are not recovered before the provider has had a meaningful opportunity to challenge the determination through the administrative appeals process.

If a redetermination appeal is filed after 30 days but within 120 days, or if a reconsideration appeal is filed after 60 days but within 180 days of the redetermination decision, recoupment will stop upon receipt of the appeal, but any funds already withheld will not be refunded until the appeal is resolved in the supplier's favor.[2]

These limitations on the government's ability to recoup are based upon the due process principle that the supplier be able to pursue its administrative appeal processes and should not be financially penalized until the supplier has had a meaningful opportunity to present its case to challenge the initial determination. CMS should adopt a similar process, particularly when the reason for the revocation is clearly not based upon fraud.

[1] Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and consistent with Section 1893 of the Social Security Act

[2] Medicare Financial Management Manual (100-06) Chapter 3, Section 200

In the interest of fairness, due process, continuity of patient care, and consistency with the protections afforded under Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) with respect to Medicare overpayment disputes, CMS should consider adopting a policy that temporarily suspends overpayment recovery activities associated with a revoked Medicare billing number (PTAN) when the revocation is based upon 42 C.F.R. § 424.535(a)(1) and the provider timely exercises its administrative review rights.

More specifically, CMS should refrain from initiating or continuing overpayment recovery efforts related to a PTAN revoked under 42 C.F.R. § 424.535(a)(1) where the provider or supplier submits a timely and complete Corrective Action Plan (CAP) within thirty-five (35) calendar days of the date of the revocation notice. Under such a policy, overpayment recovery actions would be held in abeyance pending CMS's final determination of the CAP, unless CMS determines and documents that immediate recovery action is necessary to protect Medicare beneficiaries, safeguard the Medicare Trust Funds, or address a credible program integrity concern.

Such a policy would be consistent with the principles embodied in Section 935 of the MMA, which recognizes that suppliers and providers should be afforded meaningful administrative review before being subjected to significant adverse financial consequences. By temporarily suspending overpayment recovery during the CAP review process, CMS would help ensure procedural fairness, reduce the risk of irreparable financial harm resulting from potentially erroneous revocation determinations, preserve access to care for Medicare beneficiaries, and promote confidence in the integrity and fairness of the Medicare enrollment and appeals framework. This will also reduce the administrative burden on the Medicare Administrative Contractors (MACs) involved in re-adjudicating the claims potentially two additional times. Finally, if suppliers fail to submit the CAP in a timely manner, CMS should pursue the overpayment recovery.

CMS should adopt a policy providing that, when a provider or supplier whose Medicare enrollment has been revoked pursuant to 42 C.F.R. § 424.535(a)(1) submits a timely CAP within the period prescribed by applicable regulations, any overpayment recovery actions attributable to the revoked PTAN should remain pending adjudication of the CAP. During such period, CMS and its contractors shall refrain from initiating or continuing recoupment or other collection activities unless CMS makes a written determination that immediate recovery is necessary to protect Medicare beneficiaries, prevent loss to the Medicare Trust Funds, or address significant program integrity risks. This approach would parallel the protections afforded under Section 935 of the MMA and advance the fundamental principles of administrative due process, fairness, and continuity of patient care.

Proposal

CMS could exercise its revocation authority if it determines that a provider or supplier failed to retain all required claims documentation for the required 7-year period. CMS could exercise its revocation authority when a provider/supplier fails to provide access to required claims documentation. The revocation would go into effect the day after the date the provider/supplier was required to give access.

Position

While AAHomecare generally supports this proposal, there need to be considerations for instances when claims documentation has been lost due to natural disasters or other similar events.

Proposal
CMS is proposing to make revocations based on a False Claims Act (FCA) civil judgment effective retroactively to the date of the judgment, rather than prospectively. The proposal would apply when a provider/supplier or certain affiliated individuals (such as an owner, managing employee, officer, director, or organization) has received an FCA civil judgment within the previous 10 years.

Position
AAHomecare supports this proposal.

Proposal
Providers/suppliers who have a debt with CMS and have been referred to the Department of Treasury would be subject to a retroactive revocation back to the date the debt was referred.In addition to the owner, this proposal would apply to managing employees, managing organizations, and individuals and entities with any other form of business or financial relationship with the provider/supplier.

Position
AAHomecare supports this proposal except to urge CMS to apply it only to owners and authorized officials (AOs).

Proposal
CMS is proposing to allow it to impose a reapplication bar of up to 10 years regardless of the specific reason for enrollment denial. Currently, CMS must consider the list of denial reasons under §424.530(f)(2). This proposal would eliminate the current list of reasons that include:

- The materiality of the information in question.
- Whether there is evidence to suggest that the provider or supplier purposely furnished false or misleading information or deliberately withheld information.
- Whether the provider or supplier has any history of final adverse actions or Medicare or Medicaid payment suspensions.

Position
AAHomecare opposes the proposed elimination of the current reasons that provide rational parameters for the government to follow when determining whether to impose a reapplication bar. Eliminating the list of reasons eliminates the ability of suppliers to understand the reasons for the bar and provide information to challenge the reapplication bar. This proposal would be fundamentally unfair and violative of due process; suppliers must be informed of the specific reason for the reapplication bar.

Proposal
For revoked providers/suppliers, any services provided prior to the revocation effective date must be submitted within 15 calendar days. This proposal would change the time frame from 60 to 15 days, within which to submit claims for services provided prior to the effective date of the revocation.

Position
AAHomecare disagrees with CMS's proposal to shorten the 60-day time to 15 days because it often takes a significant amount of time for the notice of the revocation to reach the appropriate individual

within the supplier organization. This is particularly true for larger organizations when the revocation notice is being delivered via U.S. mail (which is typical). The mail address may not be the same address where the company's principal or internal counsel is located, and it may take many days to reach the appropriate individual.

In addition, the proposed "15 days of the revocation notification" is defined as the date that CMS or its contractor mails the notice. It may take 7-10 days for that revocation notice to reach the appropriate individual, providing minimal time to act upon the revocation notice. AAHomecare therefore opposes any reduction in the 60-day time frame. In addition, revocation notices should be sent via certified mail, signature required, or other third-party notice with signature requirements.

C. Modifications to Existing Revocation and Denial Reasons (proposed changes to 42 C.F.R. §424.535)

Proposal
CMS is proposing to remove the specific factors it must consider when determining if a supplier has a "pattern or practice" of improper billing. Currently, 42 C.F.R. §424.535(a)(8)(ii) includes a list of specific rational situations where CMS determines that the provider has a pattern or practice of submitting claims that fail to meet Medicare requirements. These include looking at the percentage of submitted claims that were denied, whether the provider had any history of final adverse actions and the nature of such action and the type of billing non-compliance and the specific facts surrounding that non-compliance.

Position
AAHomecare opposes this proposed change because there is no rational basis to delete these reasons. CMS's explanation that the change is intended to give CMS more flexibility also means that CMS can act in an arbitrary fashion without adherence to a published list of reasons it considered when determining whether there is a "pattern or practice" of improper billing. Removal of published factors would essentially give CMS the ability to decide based simply on a "hunch," amounting to arbitrary governmental action.

Proposal
CMS is proposing to expand its revocation authority when false or misleading information is submitted on any CMS or Medicare enrollment-related form or documentation, not just the initial enrollment application. Revocation could also occur even if the information was not certified as "true" or was not intended to gain or maintain enrollment. This would apply to all enrollment-related forms.

Position
AAHomecare supports.

Proposal
CMS is proposing to allow it to revoke all of a provider's enrollments if a single enrollment application is denied under §424.530(a). Currently, this authority is limited to situations where an existing enrollment has been revoked.

Position
AAHomecare opposes this proposal. Each enrollment should be reviewed individually. Our members' experience is that many revocations are trivial and are overturned. For legitimate DMEPOS suppliers that have multiple locations, just because one location has an issue does not mean the other locations warrant revocation. CMS's policies need to make a clear distinction between suppliers that are engaged in fraudulent activities versus those that are not. CMS policy needs to be based upon objective criteria to distinguish between fraudulent activity and non-fraudulent activity.

Proposal
CMS proposes to broaden its authority to deny an enrollment application if the provider/supplier is under a Medicare or Medicaid payment suspension to include any individuals or entities with any form of business or financial relationship with the enrolling provider/supplier.

Position
AAHomecare opposes this proposal because it fails to distinguish between different reasons for a payment suspension. CMS needs to establish objective criteria to distinguish between fraudulent activity and non-fraudulent activity. This is another example of an overarching policy that would negatively affect suppliers who are not engaged in fraudulent activity.

D. New Revocation and Denial Reasons – Proposed Changes to 42 C.F.R. §424.530

Proposal
CMS is proposing to allow it to revoke a provider/supplier's enrollment if it is in a geographic area with an "excessive" number of providers, presenting a high risk of fraud, waste, or abuse. It appears that CMS is making this proposal based on the recent uncovering of a large number of hospices in the Los Angeles area.

Position
AAHomecare opposes this proposal as it has no rational basis. Each entity itself needs to have a reason to be revoked. CMS needs to determine whether there is a basis for each individual provider/supplier entity to have its enrollment revoked. An arbitrary "assessment" that there are an "excessive" number of providers/suppliers is not reasonable or rational.

Proposal
CMS is proposing to allow it to deny a provider/supplier if its practice location is in the same suite or office as another provider/supplier whose Medicare enrollment has been revoked or denied.

Position
CMS regulations already prohibit DMEPOS suppliers from co-locating with any other provider or supplier; each supplier is required to have its own location with its own postal address (42 C.F.R. §424.57(c)(29)). Therefore, this proposal is duplicative of existing requirements. If there are multiple DMEPOS suppliers in a building, each leases separate office space; then that is consistent with current regulations and should not provide any basis for revocation. Each enrolled provider/supplier itself needs to have a reason to be revoked. Simply being co-located in the same office building provides no rational basis to revoke another provider/supplier's billing privileges. CMS needs to investigate each provider/supplier individually and each provider/supplier's enrollment should be

investigated based on that provider/supplier's fact situation. CMS may consider revising enrollment procedures to identify providers and suppliers who are in the same building but have different suites for closer scrutiny.

Proposal
CMS is proposing that suppliers which fail to comply with the 36-month Change in Majority Ownership (CIMO) rule and related requirements regarding changes in majority ownership would have their numbers revoked.

Position
AAHomecare supports this proposal.

Proposal
CMS proposes a new ground to deny or revoke enrollment if a provider, owner, or managing employee was convicted of a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years.

Position
AAHomecare supports this proposal.

E. Clarification on Moratoriums Proposed change to 42 C.F.R. §424.570

Proposal
CMS proposes to clarify that a moratorium's effective date would be the date the notice is filed with the Office of the Federal Register (OFR). Currently, the effective date of the moratorium is published in the Federal Register.

Position
AAHomecare opposes this proposal. The vast majority of suppliers do not have ready access to pre-publication notices. CMS should adhere to due process protections ensuring affected suppliers can access the official public announcement of the moratorium in the Federal Register.

Notably, broad national moratoriums often have unintended effects of preventing legitimate suppliers from opening new locations to serve beneficiaries. In the case of preparations for competitive bidding Round 2028, the current moratorium is having a material negative impact on the ability of many legitimate DMEPOS suppliers to open new locations needed to qualify to submit bids in the program. There are many examples in the DMEPOS sector of the moratorium impeding legitimate business activity.

Proposal
CMS is proposing to clarify that the moratorium applies to initial enrollment, change of ownership applications, re-entry applications, reactivations, and re-enrollment applications.

Position
AAHomecare urges CMS not to apply moratoriums to (1) any change in majority ownership transactions that are compliant with the 36-month CIMO rules, and (2) reactivations, as these situations involve legitimate non-fraudulent suppliers.

F. Proposed Changes to 42 C.F.R. §424.502 Definitions

Proposal
CMS is proposing to clarify that the definition of "operational" includes having adequate administrative and logistical ability to submit valid claims and maintain written policies for patient care and safety.

Position
AAHomecare supports this proposal but notes that it is likely redundant to accreditation requirements.
Proposal
CMS is proposing to expand the definition of managing employees to include the following clinical staff: medical directors, clinical directors, departmental heads, supervising physicians, nursing directors, alternate administrators, and all other clinical personnel that meet the "managing employee" definition.

Position
AAHomecare opposes this proposal.

Under current regulation (42 C.F.R. §424.502), a managing employee means—

> A general manager, business manager, administrator, director, or other individual that exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W-2 employee of the provider or supplier. For purposes of this definition, this includes, but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.

In the DMEPOS industry, there has been much confusion about the scope of "managing employee." AAHomecare strongly urges CMS to continue to allow individual suppliers to determine who is, and who is not, a "managing employee." A plain reading of the current definition of "managing employee" means those persons or individuals who are controlling the organization and making decisions about how to run it. This would not necessarily include individuals who are simply carrying out the instructions of those in control of the organization. For large organizations, this could mean reporting hundreds of individuals, an administratively burdensome task, and providing the government with little meaningful information to address fraud.

Proposal
CMS is proposing that enrollees must disclose all affiliations, regardless of time. CMS further explains that affiliations would include marketing, business fulfillment, financial, managerial, or

beneficiary relationships. CMS also proposes expanding the disclosure requirements to any of a supplier's owning or managing employees or organizations.

Position
AAHomecare opposes this proposal as it would be an overly broad disclosure requirement, providing CMS with information that has no bearing on potentially fraudulent or abusive activity. Particularly for suppliers that have been in operation for decades, there are potentially hundreds of affiliations that would need to be disclosed. AAHomecare recommends that CMS limit this requirement to affiliations that have a rational relationship to the supplier's servicing of/billing on behalf of Medicare beneficiaries, and maintain the requirement's applicability to the entity, not expand it to owning or managing employees. Otherwise, this would be overly burdensome for suppliers to comply with and would provide the government with little meaningful information to address fraud.

Proposal
CMS is proposing that providers/suppliers must have adequate written policies and records regarding their operations, including patient care and patient safety.

Position
AAHomecare supports this proposal but notes that it is also likely redundant to accreditation requirements.

G. Screening Levels - Proposed changes to 42 C.F.R. §424.518

Proposal
CMS is proposing to clarify that providers and suppliers in the "high" screening category that are subject to fingerprinting must use the CMS-designated fingerprinting contractor to ensure consistency.

Position
AAHomecare supports this proposal.

H. Enrollment Notification, Rebuttals, and Appeals

Proposal
CMS is proposing to allow e-mail to be an acceptable form of notice for initial enrollment determinations by CMS and the MACs.

Position
AAHomecare generally supports electronic communications, including email notifications for initial enrollment determinations. Due to potential spam issues, however, we support additional paper communication via certified mail (which requires a signature), not only regular mail service.

Proposal
CMS is proposing that for providers/suppliers that do not agree with their reactivation effective date, they may rebut their assigned reactivation effective date via the general deactivation rebuttal procedures in § 424.546.

Position
AAHomecare supports this proposal, but the effective date should be the date of submission, not the date the Medicare contractor received the supplier's reactivation submission.

I. Accreditation Organization Issues - Proposed Changes to 42 C.F.R. §424.58

Proposal
CMS is proposing that accrediting organizations must agree to notify CMS of suspected fraud, waste, or abuse by a DMEPOS supplier within 3 calendar days.

Position
AAHomecare generally supports this initiative, particularly if CMS ensures an effective communication mechanism between the AOs and CMS.

J. Expansion of DMEPOS to Include External Infusion Pumps and Drugs – Proposed Changes to 42 C.F.R. §414.202

Proposal
Effective April 1, 2027, the definition of DME will expand to include certain external infusion pumps and associated home infusion drugs. To qualify, the drug must require administration or supervision by a health care professional (such as a physician or registered nurse) who is physically on-site at home during the infusion. Additionally, the drug must be infused at least 12 times per year (at least once a month).

Position
AAHomecare generally supports CMS's implementation of the expanded DME benefit for infusion pumps and drugs under Section 6222(a) of the Consolidated Appropriations Act (CAA) and agrees with most of the definitions and criteria CMS has proposed. We support the comments of the National Home Infusion Association (NHIA), which express concern that the Proposed Rule does not specify how the need for an infusion pump is determined for drugs that qualify using the new criteria and is silent on how drugs added to the DME benefit will be assigned to categories under the Part B home infusion therapy services benefit. Without that link, patients cannot receive the professional services the statute requires for these drugs to be furnished safely in the home.

K. Competitive Bidding – Country of Origin Disclosure

Proposal
CMS is proposing that, under the Medicare DMEPOS competitive bidding program, contract suppliers be required to report on the country of origin for lead items on Form C (the Semi-Annual Report), and that this information would be displayed in the Medicare Supplier Directory for beneficiaries.

Position
AAHomecare opposes this proposal. Further, we question whether beneficiaries actually are interested in the country-of-origin information. More importantly, particularly for the current product categories, beneficiaries want to know which contract suppliers carry their manufacturer and model

which are already required. We do not believe there is any additional value in warranting the increased documentation burden for contract suppliers and therefore oppose this proposal.

We are concerned that the competitive bidding program, as currently structured, will create opportunities for unvetted or bad actor foreign entities to enter the Medicare market with substandard or non-compliant products. With the primary focus on cost reduction, there is a real risk that suppliers may seek the lowest-cost options from manufacturers that have not demonstrated long-term reliability in the Medicare population. The result could be an influx of supplies and devices that lack proper quality controls, cybersecurity protections, or interoperability standards, putting vulnerable Medicare beneficiaries at risk.

As a result, instead of simply requiring suppliers to report "Country of Origin" information on Form C, AAHomecare urges CMS to implement strong supplier vetting criteria, manufacturer quality standards, and supply/device approval safeguards to ensure that all products made available under this program meet the highest standards of safety, efficacy, and patient support.

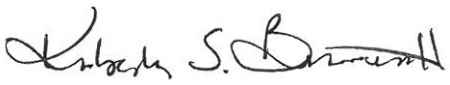
5. Conclusion

AAHomecare remains a devoted partner in the shared mission to protect the integrity of Medicare and its trust fund dollars, while ensuring that its recipients maintain access to essential equipment and related services. We support a comprehensive but targeted strategy that includes strengthening provider enrollment and leveraging technology to identify and prevent fraudulent entities from entering the Medicare market.

By working together, we can make strides in ensuring bad actors do not take advantage of Medicare while supporting the many legitimate suppliers who are committed to supporting patients in their homes.

We appreciate the opportunity to provide these comments. Please contact me at kimb@aahomecare.org for further information.

Sincerely,



Kim Brummett
Sr. VP, Regulatory Affairs