



November 13, 2025

The Honorable Mehmet Oz, M.D.
Administrator
The Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Juliet Hodgkins
Acting Inspector General
Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Re: Request for Immediate Guidance on Rebilling of Repriced Part B Claims Submitted on or after October 1, 2025

Dear Administrator Oz and Acting Inspector General Hodgkins:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) thanks you for your longstanding leadership in supporting medical groups' ability to offer high-quality care. With Congress passing legislation to extend the expiration date of 1.0 work Geographic Practice Cost Indices (GPCI) floor to Medicare claims paid from October 1, 2025, to January 30, 2026, MGMA members are in a position of considerable uncertainty, facing potential billing disruptions and compliance risk. Similar uncertainties face their Medicare patients if services already billed are later repriced pursuant to congressional action, affecting the application of Part B deductibles and co-payments.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following recommendations.

Following the expiration of 1.0 work GPCI floor on September 30, 2025, the Centers for Medicare & Medicaid Services (CMS) has been paying Medicare claims in locations subject to the GPCI floor at rates below the floor. Medicare contractors have been processing these claims, paying practices, and calculating patient deductible and copay responsibilities, all at the reduced level. The Continuing Appropriations Act, 2026, extends the 1.0 work GPCI floor until January 30, 2026; this extension appears to retroactively apply the floor to claims with dates of service on or after October 1, 2025. We ask that CMS issue guidance that states the extension applies retroactively and provides clarity on how the agency will reprocess claims.

While this legislation is necessary to remedy the unwarranted cut to reimbursement that medical groups in localities affected by the floor have faced, these claims will be repriced, payments adjusted, and allowable

copays increased. In that scenario, physician practices will be faced with rebilling patients an additional increment which could in some cases be less than \$1.00 and in many, if not most, cases will be small amounts that are less than the administrative cost of rebilling. Such rebilling will leave patients confused, and providers will be blamed even though rebilling is necessary through no fault of their own. Alternatively, providers might choose to forego the incremental copay, but in that event, may risk civil money penalties and even program exclusion under Medicare's beneficiary inducements statute and regulations (the "Beneficiary Inducements CMP"). Social Security Act 1128A (a)(5) and 42 CFR 1003.1000.

MGMA respectfully requests that in these strictly limited circumstances, assuming they arise, CMS and OIG should immediately advise the physician community that failure to bill and collect *de minimis* (e.g. up to \$15 per claim) incremental copays from patients arising from retroactive congressional action will not be considered remuneration, as defined in 42 CFR 1003.101, for purposes of the Beneficiary Inducements CMP. In the alternative, OIG could promulgate a time-limited waiver of the statute applicable to these incremental copays or announce that it would use its discretion not to pursue enforcement action in these circumstances. Any of these three alternatives would be amply justified in the current circumstances for several reasons.

First, any incremental co-pay waived would be attributable to services already rendered to existing patients and would not be advertised or promoted in an attempt to recruit new Medicare patients or provide new services. The motivation for waiving the co-pay would be to reduce patient confusion and save the practice from duplicate billing expenses, not the steering of patients. Thus, the inducement element of the statute would not be implicated.

Second, if the regulatory relief were provided uniformly to all providers, there should be no significant effect on competition, again suggesting that the inducement element is lacking.

Third, the relief would be applicable only to a very narrow slice of billings, specifically those claims submitted in localities below the 1.0 work GPCI floor on or after October 1, 2025, and processed by Medicare's contractors before Congress reinstated the floor.

Fourth, the relief would be narrowly targeted on incremental copay increases of a *de minimis* nature. MGMA suggest \$15 as the appropriate cap per claim so as to be consistent with OIG's existing cap on one-time non-cash gifts to beneficiaries.

Fifth, the relief would have no impact on the ultimate cost-sharing obligations of most beneficiaries since many would have no claims during the limited relief window.

MGMA appreciates your consideration of this request and looks forward to your response at your earliest convenience. We would be pleased to discuss this with you at any time. If you have any questions, please reach out to me at agilberg@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders M. Gilberg
Senior Vice President, Government Affairs