August 31, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

Dear Administrator Oz:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the Calendar Year (CY) 2027 Home Health Prospective Payment System Rate Update proposed rule, that includes numerous proposals to change Medicare enrollment, revalidation, and revocation policies that will affect all provider and supplier types, including physicians, medical groups and other physician organizations. With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties.

MGMA supports sensible measures to protect Medicare beneficiaries from fraud, waste, and abuse. While commonsense program integrity measures are prudent to safeguard the Medicare Trust Fund, we caution the Centers for Medicare & Medicaid Services (CMS) that the wide-ranging proposed Medicare enrollment changes would undermine physician practice operations and add undue compliance burden to already stretched thin physician practices dealing with declining Medicare reimbursement among numerous other financial and staffing concerns. These proposals may lead to unintended consequences such as medical groups operating in good faith who have not committed any fraud suffering enrollment consequences due to factors outside of their control, administrative or technical errors, or affiliations from years ago.

We urge CMS to withdraw these sweeping Medicare enrollment proposals as their cumulative effect would be significant and detrimental to medical group operations. These complex and extensive changes would introduce significant uncertainty and apprehension for physician practices treating Medicare beneficiaries, as many of these proposals are overly ambiguous and would not allow adequate due process. Further complicating these proposals is the potential for a swift turnaround on implementing these changes and their impact on an enrollment process that is laborious and cumbersome. The Provider Enrollment, Chain and Ownership System (PECOS) already needs to be streamlined and improved to reduce

administrative hurdles that MGMA members have highlighted for years. These proposals unnecessarily compound current issues.

We call on the agency to work with stakeholders on a targeted approach to balance program integrity concerns with legal and compliance costs. We believe a tailored approach would better assist CMS with weeding out bad actors while avoiding negative consequences for physician practices operating in good faith who are focused on providing high-quality care to their communities.

Expansion and Reorganization of Retroactive Revocation Grounds

CMS proposes to make all revocations retroactive effective as of the date of the triggering event. This proposal includes plans to restructure current prospective revocations and realign existing retroactive grounds so that all revocations are retroactive to the date of the non-compliance event. This expansion includes retroactive revocation for general non-compliance, licensure, and provider agreements; exclusions/debarments, felony convictions, false information, and non-operational status; failure to satisfy enrollment requirements; misuse of billing number; abuse of billing privileges; reporting enrollment data changes; and more.

Retrospective revocations have historically been used for more serious violations, e.g. exclusion of a provider or supplier from participation in Medicare or Medicaid, state medical licensure disciplinary actions and felony convictions. This significant expansion of retroactive revocations to not just serious violations but potentially far smaller administrative or data entry errors would be a draconian measure. Retroactive revocations should be reserved for significant violations given the severity of the consequences. We urge CMS to not move forward with this broad expansion.

Modification to Existing Revocation Provisions

Abuse of Billing Privileges

CMS proposes to remove the four factors the agency previously used to determine if revocation of enrollment was warranted for the submission of a pattern or practice of non-compliant claims. The agency states that they need maximum flexibility to address all possible scenarios without the rigid constraints of the four factors currently in regulation. From the provider's perspective, "maximum flexibility" could well lead to arbitrary action, resulting in the loss of billing privileges instead of resolution of billing and coding disputes through established channels.

MGMA urges CMS not to remove the abuse of billing privileges factors to maintain clarity, so all providers understand the factors used to determine revocation. Removing these longstanding guardrails, while at the same time granting CMS broad discretion, increases confusion for Medicare-enrolled providers and diverges from established precedent. This leaves open the possibility of isolated billing issues leading to revocation. Stability is critical – these proposals introduce the possibility of unintentional errors triggering a total loss of billing privileges. Patients will suffer when they immediately lose access to long-time trusted providers.

False or Misleading Information

CMS proposes to expand revocation for the submission of false or misleading information on any CMS or Medicare enrollment-related form, including enrollment-related forms created by

and/or submitted to CMS contractors. The submission of false or misleading information need not be intended to gain or maintain Medicare enrollment.

This expansion opens the door for revocations based on inadvertent administrative errors on a myriad of different enrollment forms that are not intentional deceptions. The term "misleading" is not a defined term in the Medicare statute or regulations and potentially could be invoked to apply to innocent mistakes in the expanded list of forms which had no material bearing on the provider's qualifications to serve Medicare patients. MGMA urges CMS not to finalize this proposal and to focus on intentionally false or misleading statements to avoid penalizing practices operating in good faith.

High-Risk Enrollments

CMS proposes adding a new reason for revocation where the agency may revoke a provider's enrollment if it deems the enrollment as presenting a high risk of fraud, waste, or abuse due to the provider's location within a limited geographic area that has an excessive number of providers and suppliers. This is in response to recent examples of fraud related to hospice providers, home health agencies, and other providers being congregated in a small geographic region.

This change has the potential to capture compliant providers who have not committed any wrongdoing in highly dense urban areas. There are numerous examples of multiple providers in close proximity due to purely geographic or other legitimate reasons; opening these providers up to revocation based solely on their location circumvents basic principles of due process. Physician practices that have not engaged in misconduct should not have their Medicare billing privileges revoked simply for being in operation. As noted below, this proposed change is equally problematic when applied to denial of enrollment for a new provider or a new location for an existing provider. MGMA urges CMS to withdraw this proposal.

Extension of Revocations

CMS proposes to expand its ability to revoke all Medicare enrollments held by a provider following the denial of any new enrollment application by the provider or its affiliate. CMS emphasizes that this would be a discretionary authority and offers examples of fraudulent behavior as justification for this policy.

CMS already possesses the tools to address conduct that would warrant a revocation related to fraud or other serious conduct. Revoking all Medicare enrollments for the denial of a single enrollment potentially based on an administrative or other inadvertent error, and without the ability to respond, would be unwarranted and an overly punitive measure. MGMA urges CMS not to move forward with this proposal.

Expanded and New Denial Grounds

Medicare Debt

Current regulations allow CMS to deny enrollment if the enrolling provider or owner has an existing Medicare debt; or was previously the owner of a provider that had a Medicare debt when the latter provider's enrollment was voluntarily terminated, involuntarily terminated, or revoked. CMS is proposing to expand this provision to apply to managing employees, managing

organizations, and individuals and entities with any other form of business or financial relationship with the provider.

This expansion encompasses many potential business relationships such as vendors and contractors that may have a debt and yet have a minor relationship with the practice. While we support reasonable due diligence, this provision would be difficult for medical groups to comply with as "any form of business or financial relationship" is overly broad and could capture a wide range of relationships that do not materially impact medical group operations or expose the Medicare program to abuse by the provider. Medical groups working in good faith and reasonably attempting to comply may not be able to ascertain every issue under this proposal as written. MGMA urges CMS not to finalize this proposal.

Same Suite/Office

CMS is introducing a new denial ground 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. The proposed rule discusses situations CMS has seen where providers in the same suite engage in fraud schemes as a reason for this change. The agency emphasizes that sharing an office or suite would not, by itself, automatically result in a denial.

This proposal would give CMS great discretion to deny Medicare enrollment for a provider based on location and without any reason other than the proximity to another provider who has had their enrollment denied or revoked. While the agency states it would only invoke this provision when proper, simply sharing an office or suite should not be the sole reason from a denial. There should be objective criteria and a material link to the revoked or denied provider. The potential for arbitrary denials is simply too great. MGMA urges CMS not to finalize this proposal.

Managing Employees

Currently, CMS defines a "managing employee" as, in part, a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider. The agency is proposing to expand the definition of "managing employee" to include medical directors, clinical directors, departmental heads, supervising physicians, nursing directors, alternate administrators, and all other clinical personal that meet the managing employee definition.

This broad definitional expansion would introduce substantial Medicare enrollment reporting complications. In addition to the sheer increase in reporting volume, medical groups will have to make difficult decisions to determine the scope of employees to report given the open-ended language in the proposal and lack of objective criteria to determine who should be reported. Given frequent employee turnover at many practices, this proposed change compounds administrative burden due to frequent reporting updates. Larger medical groups may have myriad department leaders and other employees that would fall under this new definition while not providing oversight of the organization like a senior executive. MGMA urges CMS to withdraw this proposal.

Affiliations

Upon CMS request, an initially enrolling or revalidating provider 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 remove the 5-year period, and all affiliations would have to be reported regardless of how long ago it occurred or ended. The agency also proposes to add new paragraph to the "affiliation" definition, that would include any marketing, business, fulfillment, financial, managerial, or beneficiary relationship.

This significant expansion of affiliate reporting would add substantial compliance costs to medical groups and in many ways would be fundamentally unworkable in practice. Removing the 5-year lookback period would require physician practices, who often have long operating histories and complex ownership structures, to track numerous former employees and business relationships for affiliation disclosures from many years ago. Practices attempting to comply in good faith may not be able to capture the full extent of affiliations due to data availably issues, yet there is no safe harbor or reasonableness standard to ensure that they won't be penalized. CMS should not finalize this proposal.

Conclusion

While MGMA supports reasonable Medicare enrollment requirements and fraud prevention measures, we call on CMS to withdraw its extensive proposed changes to avoid introducing untenable administrative burdens on medical groups focused on providing the highest level of care possible to Medicare beneficiaries. These provisions are ambiguous, penalize groups for activity outside of their control, threaten denial or revocation for technical errors, and would inundate practices with unworkable reporting requirements. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders M. Gilberg
Senior Vice President, Government Affairs