August 31, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Subject: CMS-1844-P — Medicare Provider Enrollment Provisions of the Calendar Year 2027 Home Health Prospective Payment System Proposed Rule

Submitted electronically via www.regulations.gov

Dear Administrator Oz:

The 19 undersigned organizations represent providers and suppliers from across the Medicare continuum — including hospitals, physician and clinician practices, post-acute and long-term care providers, home health and hospice agencies, suppliers, and the beneficiaries we serve. Although the provider enrollment provisions of the CY 2027 HH PPS Proposed Rule appear within a home health payment rule, they would apply to every provider and supplier enrolled in the Medicare program. We write jointly to urge CMS to reconsider them.

We fundamentally support CMS's efforts to protect the Medicare Trust Funds and Medicare beneficiaries from fraud, waste, and abuse. Enrollment policy is a critical tool for keeping unqualified and fraudulent actors out of the program. As proposed, however, these provisions substantially expand CMS's denial, revocation, reporting, and related enforcement authorities while removing or failing to establish objective standards and procedural safeguards. The foreseeable result is severe enrollment consequences for legitimate providers based on technical errors, conduct outside their control, or broadly defined third-party associations rather than intentional or egregious misconduct — and when a legitimate provider is removed from Medicare, it is beneficiaries who lose access to care. The proposals also would subject providers to substantial new burdens, not accounted for in the regulatory impact analysis, without cause. We offer the following recommendations to ensure CMS can pursue bad actors without penalizing legitimate providers.

Issue Provider Enrollment Changes Through Standalone Rulemaking

Placing program-wide enrollment changes inside a home health payment rule departs from more than two decades of CMS practice[1] and leaves many affected providers — who have no connection to home health and no reason to track that rule — unaware that their Medicare participation is at stake.

[1] Since 2003, CMS has established and revised the standards governing Medicare provider enrollment through standalone rulemaking. See Medicare Program; Requirements for Establishing and Maintaining Medicare Billing Privileges, 68 FR 22064 (Apr. 25, 2003); Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process, 84 FR 47794 (Sept. 10, 2019).

CMS should bifurcate the existing rulemaking and address the Medicare enrollment proposals in a new notice of proposed rulemaking after CMS has had an opportunity to engage with providers. Not only will CMS have a better understanding of the operational realities of the proposals under consideration, but all stakeholders would be made aware of the proposals through a separate rule.

Distinguish Intentional Misconduct from Good-Faith Error

Enrollment revocation is an extraordinarily consequential remedy. Providers should not face essentially the same sanction for a clerical mistake, a documentation deficiency, or conflicting CMS/MAC guidance as actors engaged in deliberate fraud.

CMS should adopt materiality and, where appropriate, knowledge or intent standards, including requiring a showing of intent to mislead or a pattern of inaccurate submissions before denial or revocation based on false or misleading information, and should reserve denial and revocation for significant program-integrity risks rather than routine compliance errors.

Establish Reasonable Due-Diligence Protections for Third-Party Relationships

The Proposed Rule would sweep a far broader universe of third parties — particularly newly defined managing employees and affiliates — into the basis for denying or revoking a provider's enrollment. There must be a meaningful nexus between the third party's conduct and the enrolled provider including whether the provider knew or reasonably could have known of the conduct and whether it presents a current, material risk attributable to the provider.

CMS should adopt reasonable due-diligence standards and a good-faith safe harbor rather than strict organizational liability; retain the existing five-year lookback period for affiliation disclosures; apply a materiality threshold to the expanded denial provisions concerning Medicare debt, payment suspensions, and program terminations; and significantly narrow the proposed "managing employee" definition to individuals exercising direct supervisory control.

Preserve Meaningful Due Process and an Opportunity to Cure

Many of the proposals expand the circumstances in which CMS may deny, revoke, retroactively revoke, preclude, or bar reapplication without giving the provider any opportunity to correct the underlying problem.

Providers should be able to correct inaccurate information, cure technical deficiencies, disassociate from a problematic individual or entity, and rebut CMS's alleged connection between the conduct and the provider before losing enrollment. Where CMS proposes to extend a problem involving one enrollment to a provider's other enrollments — or to other federal health care programs — it should be required to make a separate, individualized finding of material program-integrity risk, with notice and an opportunity to respond.

Conclusion

We wish to be abundantly clear: our organizations do not oppose stronger fraud enforcement, and we support targeted use of the substantial authorities CMS already holds to remove individuals and entities that engage in fraudulent or abusive conduct. But CMS can target bad actors without creating an enrollment regime in which broad discretion, undefined standards, third-party conduct, or technical

compliance failures produce disproportionate consequences for legitimate providers. These are consequences that unnecessarily risk driving these providers out of Medicare and narrowing beneficiary access to care. We appreciate the opportunity to comment on the Proposed Rule.

Sincerely,

LeadingAge
ADVION
Aging Life Care Association
Alliance for Aging Research
American Health Care Association
American Hospital Association
American Medical Rehabilitation Providers Association
American Postal Workers Union, Retirees Department
Catholic Health Association of the United States
Federation of American Hospitals
Lutheran Services in America
Medical Group Management Association
National Alliance for Care at Home
National Association of Pediatric Nurse Practitioners
National Center for Assisted Living
National Council for Mental Wellbeing
National Partnership for Healthcare and Hospice Innovation
National Rural Health Association
Post-Acute and Long-Term Care Medical Association

cc: Kimberly Brandt, Deputy Administrator & Chief Operating Officer
Jeneen Iwugo, Acting Director, Center for Program Integrity