The Hospital + Healthsystem Association of Pennsylvania

August 31, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1844-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Calendar Year 2027 Home Health Prospective Payment System Rate Update; Requirements; Medicare Provider Enrollment, Durable Medical Equipment and DME, Prosthetics, Orthotics, and Supplies Policies; 91 Fed. Reg. 41,216 (July 6, 2026).

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 235 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2027 home health (HH) prospective payment system (PPS) proposed rule.

HAP has two significant concerns. First, CMS' proposed payment update of 2.4 percent is inadequate. The agency's market basket estimate continues to be too low and its proposed productivity cut too high. Moreover, CMS would make a 3.0 percent temporary reduction that it states is necessary to achieve budget neutrality under the revised HH payment system implemented in 2020. As explained further below, HH agencies play an essential role in the continuum of care, helping Medicare beneficiaries safely transition from the hospital to home, reducing avoidable readmissions and mortality, lowering downstream costs, and supporting hospital capacity. **HAP urges CMS to take steps to ensure that Medicare payments to HH agencies are adequate, thus protecting beneficiary access to timely post-acute care and avoiding further strain on hospitals and the broader care continuum.**

Second, the proposed rule includes substantial changes to Medicare provider enrollment authorities that would apply not only to HH agencies but also to all providers and suppliers enrolled in Medicare. HAP supports CMS' goal of ensuring that provider enrollment rules protect beneficiaries, safeguard the Medicare Trust Fund and hold bad actors accountable. We are concerned, however, that many of the proposed changes would impose significant reporting burdens and place the Medicare enrollment status of compliant providers at risk. **To ensure all affected stakeholders are aware of these proposals and have an opportunity to provide informed input, we strongly urge CMS to issue these Medicare enrollment changes through standalone rulemaking. Issuing a separate proposed rule, rather than incorporating program-wide enrollment changes into a home health payment regulation, would be more consistent with CMS' longstanding commitment to transparency, and would provide all affected stakeholders a meaningful opportunity to comment.**

Provider Enrollment Provisions

The rule includes proposals that would substantially change Medicare provider enrollment authorities not only for HH agencies, but also for hospitals, health systems, and other Medicare providers and suppliers. HAP is concerned that CMS included these proposals in an unrelated HH payment rule. **Indeed, placing these far-reaching provider enrollment proposals in this HH proposed rule raises potential Administrative Procedures Act notice-and-comment concerns.** See MCI Telecommunications Corp. v. FCC, 57 F.3d 1136, 1141–42 (D.C. Cir. 1995) ("Through its placement of the announcement concerning feature groups, the Commission has practiced just the sort of obscuration that the APA abjures."); see also National Electrical Manufacturers Ass'n v. EPA, 99 F.3d 1170, 1174 n.3 (D.C. Cir. 1996) ("In MCI Telecommunications, the only warning given to long distance carriers of a proposed rule with far-reaching implications for their operations was contained in a single footnote to the background section of a notice directed to a different type of regulated entity, enhanced services providers. The court held that 'an agency may not turn the provision of notice into a bureaucratic game of hide and seek' and that the buried notice in question represented 'just the sort of obscuration that the APA abjures.'" 57 F.3d at 1142." (emphasis added)). Hospitals and health systems, as well as other types of providers, generally focus their regulatory review on rules directly affecting them. **Because only a subset of providers offer HH services, this proposed rule likely has not received adequate review from the full range of affected regulated entities. CMS should use standalone rulemaking when proposing enrollment reforms of this broad scope.** Standalone rulemaking would help ensure that the impacted providers are aware of the proposals and that the public comments are more representative of the views of the impacted providers.

Further, several of CMS' proposals fail to directly target actual fraud risk and could result in significant enrollment consequences for non-fraudulent providers acting in good faith based only on technical errors, inadvertent mistakes, distant affiliations, or conduct outside their control. Enrollment denials and revocations can have serious consequences, such as interference with patient access, operational disruptions, and heavy liabilities.

Moreover, HAP is concerned that the proposals to change and expand the definitions of "affiliation" and "managing employee" would impose significantly greater and overly broad reporting burdens on providers. For instance, the proposed definition of "managing employee," which would be required for enrollment, disclosure of affiliations, and reporting, includes an excessively broad list of positions. In hospitals and health systems, it would be unworkable to list every proposed managing employee for the hospital or service line, particularly because clinical leaders across departments and service lines experience frequent turnover, so each change would require another filing.

For these reasons and as detailed further below, HAP urges CMS to finalize only those enrollment policies that are narrowly tailored, supported by objective standards, and accompanied by procedural safeguards that protect good faith providers and preserve beneficiary access to care.

Revocations and Denials of Enrollment

HAP understands and appreciates CMS' interest in strengthening payment safeguards. However, several proposed revisions to the revocation and denial regulations lack the objective criteria and proportionality necessary for fair application. As discussed below, CMS should retain meaningful guardrails, distinguish technical noncompliance from fraud or intentional misconduct, and ensure that providers have clear standards and a meaningful opportunity to respond before severe enrollment consequences are imposed.

Modifications to Existing Revocation Provisions

Abuse of Billing Privileges

CMS proposes to eliminate the four factors it must currently consider before revoking a provider's enrollment for a "pattern or practice" of submitting noncompliant Medicare claims. These factors include (1) the provider's adverse action history, (2) the share of noncompliant claims, (3) the reasons for noncompliance, and (4) any history of noncompliance. CMS says these factors have limited its ability to use this authority and are burdensome to apply. The proposal would only retain the standard of "pattern or practice" without further boundaries or specifics.

HAP opposes eliminating this framework. The four factors that CMS proposes to eliminate provide important guardrails and require the agency to consider the totality of circumstances before taking the weighty step of sanctioning a provider. Retaining these guardrails is critical for hospitals and health systems, which submit large volumes of Medicare claims and may experience unintentional isolated errors or technical denials. Without defined factors, CMS could revoke enrollment based on an insignificant number of inadvertent, immaterial, or corrected claims, while leaving providers with little basis to understand or challenge the determination.

HAP recommends that CMS either retain the existing four-factor framework or replace it with clear, objective criteria that require CMS to:

- **Evaluate alleged noncompliance in relation to the provider's total Medicare claims volume.**
- **Distinguish isolated technical or billing errors from evidence of fraud, abuse, or intentional misconduct.**
- **Consider the provider's compliance history and good-faith corrective actions before revocation.**

Moreover, we encourage CMS to define the circumstances that constitute a revocable "pattern or practice" so providers understand the standard and can meaningfully respond before enrollment is revoked.

False or Misleading Information

CMS proposes to allow revocation when a provider submits false or misleading information on any CMS or Medicare enrollment-related form, not just the provider enrollment application. It states that the provider's intent in submitting the information is irrelevant; only the accuracy of the information matters.

HAP supports accurate and truthful reporting. However, this proposal is too broad. Hospitals and health systems routinely submit numerous enrollment-related materials, including change-of-information filings, electronic funds transfer forms, revalidations, and related documents. Under the proposal, even an inadvertent or corrected error could support revocation, regardless of intent, pattern, materiality or harm to beneficiaries or the Medicare program. This also gives the agency excessive discretion to decide which providers it will revoke since many are likely to submit unintentional mistakes.

Therefore, HAP urges CMS to limit revocation under this provision to cases involving a demonstrable intent to mislead or a pattern of significant inaccuracies. Isolated errors that are inadvertent, insignificant, or quickly corrected should not jeopardize a legitimate provider's Medicare enrollment.

Extension of Revocation

CMS proposes that if any enrollment application submitted by a particular provider is denied, it could use this as the basis to revoke all other Medicare enrollments held by the same provider. CMS justifies this by stating that some denials involve behaviors so serious as to support revocation beyond a single enrollment.

HAP urges CMS not to finalize this proposal. Hospitals and health systems often have multiple Medicare enrollments across various provider types, locations and service lines. A denial involving one new site or enrollment application—such as for missing paperwork, timing or operational readiness issues—should not put long-standing, compliant enrollments at risk elsewhere in the organization. What's more, if a particular enrollee's behavior was so serious as to warrant broader revocation, it is likely that CMS already has the available tools to address such serious behavior. **As such, we recommend that CMS specifically apply any cross-enrollment revocation authority to cases involving fraud, significant misrepresentation, or conduct that directly threatens beneficiary safety or Medicare program integrity. Further, before revoking other enrollments, CMS also should give the provider notice and a meaningful chance to respond.**

Expansion and Reorganization of Retroactive Revocation Grounds

CMS proposes to make all Medicare enrollment revocations retroactive to the date the provider's noncompliance started, rather than applying prospective effective dates as is currently permitted for certain revocations—typically 30 days after CMS or its contractor mails the notice to the provider.

HAP opposes this retroactive revocation proposal. Retroactive revocation may be appropriate for fraud, intentional misconduct, or direct threats to patient safety or program integrity. However, it should not apply to technical or administrative mistakes, such as a missed reporting deadline, when there is no deliberate misconduct, beneficiary harm, or risk to Medicare funds. **Therefore, HAP urges CMS to retain prospective effective dates for technical or administrative noncompliance and use retroactivity for serious misconduct or clear patient-safety risks. At minimum, CMS should create a safe harbor for providers that promptly correct noncompliance after it is discovered**.

Claim Submissions After Revocation

CMS proposes to shorten the time period for which revoked providers may continue to submit Medicare claims from 60 days to 15 days. We are concerned that a 15-day window is too short for providers to identify and submit legitimate claims for services furnished to Medicare beneficiaries before the revocation date, particularly given intricate revenue processes, heavy administrative caseloads, and external financial intermediaries. **As such, HAP urges CMS to maintain the current 60-day claims submission period. If CMS shortens the period, we ask that it allow no fewer than 30 days.**

Additions of New Revocation Provisions

High-Risk Enrollments

CMS proposes a new revocation authority that would permit the agency to revoke a provider's enrollment if CMS determines that the provider is located in a "limited geographic area" with an "excessive number of providers and suppliers," creating an alleged high risk of fraud, waste, or abuse. **HAP is concerned that this proposal is vague, overly broad, and insufficiently tied to provider-specific conduct and threats because it uses provider density alone as evidence of fraud.** For example, the proposal does not define "limited geographic area" or "excessive number," leaving CMS with broad discretion to characterize ordinary provider concentration as suspect.

In addition, we have serious concerns that geographic location alone is not a sufficiently clear indicator of wrongdoing to justify revocation. It is commonplace for hospitals, health systems, and other providers to locate in metropolitan and high-demand areas because that is where patients need care. Nevertheless, the proposal correctly notes that, if finalized, this proposal would permit revocation based on "not whether the provider or nearby providers have actually engaged in fraudulent conduct." Put another way, providers who are entirely innocent but happen to locate near others would be subject to serious penalty. That is antithetical to basic principles of fairness.

HAP, in accord with the American Hospital Association, also has serious concerns about the legal basis for this proposal. While the agency argues that this proposal "is akin to section 1866(j)(5) of the Act (codified in § 424.519)," those provisions actually weaken the agency's case.

Under those provisions, the affected provider at least has an affiliation with an entity that had previously been suspended or excluded. Here, revocation is permitted absent either affiliation or a prior adverse finding. Likewise, as the agency recognizes, § 424.519 is grounded in a specific statute giving broad authority based on affiliation alone. Here, Congress has not enacted any such statute that would allow revocation based solely on location. CMS is instead relying on its general legal authorities for this significant expansion of power. We do not believe existing law provides it with such authority. **We therefore urge the agency to withdraw it.**

If CMS does finalize this provision, HAP urges it to define the terms "limited geographic area" and "excessive number" using objective, quantifiable criteria rooted in analysis of claims data. It should also require provider-specific evidence that the enrollment itself presents a high risk of fraud, waste, or abuse.

Modifications to Existing Denial Reasons

Medicare Debt, Payment Suspension, and Other Program Terminations/Suspensions

CMS proposes to greatly expand when it may deny a provider's Medicare enrollment. Under current rules, CMS may deny enrollment based on issues tied to the provider itself, such as the provider's own Medicare debt, payment suspensions from other programs involving the provider or its owners or managing employees, or terminations or suspensions from other programs involving the provider. However, CMS proposes to extend these denial rules to include not only owners and managing employees, but also any person or entity that has "any form of business or financial relationship" with the provider. **HAP is concerned that this proposed expansion is too broad and could extend to unreasonable circumstances.**

Specifically, the proposal could cover many ordinary business relationships that have nothing to do with whether a provider should be allowed to participate in Medicare. For example, hospitals, health systems, and other providers work with hundreds, and sometimes thousands, of vendors, contractors, consultants, staffing agencies, and other organizations. Under the proposed language, a Medicare debt or payment suspension involving any one of these parties could be used to deny the provider's Medicare enrollment application, or change-of-information submission or revalidation. HAP understands CMS' concern that some outside parties can have significant influence over a provider. However, the phrase "any form of business or financial relationship" is so broad that it could include entities with little or no meaningful connection to the provider's Medicare operations.

The proposal also would be difficult, if not impossible, for providers to administer. Providers may not always be aware of older Medicare debts or payment issues connected to a business partner, especially if the issue arose before an acquisition or from a relationship several steps removed from the provider. Yet, under the proposal, that information could still be used to deny enrollment. HAP agrees that providers should conduct reasonable due diligence, particularly when financial debt is involved. But any such obligation should be based on a good-

faith, reasonable standard rather than an expectation that providers can uncover every issue connected to every business relationship.

As such, HAP urges CMS not to finalize this provision as proposed. However, if CMS nonetheless proceeds, we ask the agency to:

- **Adopt a reasonable, good-faith standard to allow providers to conduct due diligence without being held accountable for disclosures that were not discovered despite their efforts to perform due diligence.**
- **Establish a standard that omits negligible or minor relationships or connections.**
- **Limit qualifying relationships to individuals or organizations with significant influence over the provider's operations, management, or Medicare billing.**
- **Prior to denial, give affected providers the ability to show that the relationship does not impact Medicare program integrity.**

Additions of New Denial Reasons

Revocation or Denial in Same Suite

CMS proposes a new denial basis that would allow it to deny a provider's enrollment if its practice location is in the same suite or office as another provider whose Medicare enrollment has been revoked or denied. HAP opposes this proposal, which is overly broad. Hospitals and health systems routinely accommodate multiple provider types in the same facility, such as physician practices, outpatient clinics, ambulatory surgery centers, and laboratory services, each of which may have separate Medicare enrollments from the hospital. While these providers usually have operational relationships with the hospital, such as through credentialing, privileging, or contractual arrangements, simply sharing space does not suggest common ownership, control, or risk of fraud. As such, it should not be the basis for denying enrollment. CMS' assurance that it will use its discretion in applying this authority is not adequate.

Therefore, HAP recommends that CMS:

- **Require that a material linkage is involved, such as common ownership, management or operational control, rather than merely physical proximity.**
- **Include a presumption that denial should not apply if the enrolling provider has no ownership, management, financial, or operational relationship with the revoked or denied provider.**

Managing Employees

CMS proposes to expand the definition of "managing employee" to include medical directors, clinical directors, department heads, supervising physicians, nursing directors, alternate administrators, and other clinical personnel who exercise operational or managerial control over

a provider's day-to-day operations. It describes the change as a clarification. It is not. Instead, this proposal would significantly expand the individuals that hospitals, health systems, and other providers would be required to report on Medicare enrollment applications. Indeed, we are concerned that the revised definition would sweep in broad categories of clinical and operational leaders without clear thresholds for authority, responsibility, or influence over Medicare program integrity. Many of these roles are substantially different from owners or senior executives who have overall control of the hospital or health system. Without objective criteria, providers will struggle to determine which individuals may trigger enrollment consequences such as denial, revocation, or affiliation disclosures. Moreover, this proposal would substantially increase the operational burden on hospitals. A single hospital may have many medical directors, nursing directors, department leaders, supervising physicians, and clinical leaders, while a health system may have hundreds across campuses and service lines. Because these roles change frequently, the proposal could require never-ending enrollment updates and inappropriately increase the risk of unintended omissions and related enrollment consequences. **As such, we urge CMS not to finalize this proposal.**

If CMS nevertheless intends to advance this policy, HAP requests that it:

- **Narrow the definition of "managing employees" for the purposes of enrollment-related consequences proposed in this rule (such as revocation, denial, and affiliation disclosures) to include only individuals who have direct supervisory control over Medicare operations or program integrity.**
- **Provide a reasonable transition period and issue sub-regulatory guidance for applying the revised definition across organizations with complex structures.**
- **Clarify whether and how providers would be required to address retroactive reporting for individuals who would be newly covered by the revised definition of "managing employee."**

Affiliations

CMS' current rules require that providers must disclose certain affiliations on the Medicare enrollment applications. Specifically, such reporting is required when the provider, an owner or managing employee has or had, within the previous five years, an affiliation with a current or former Medicare, Medicaid, or Children's Health Insurance Program provider that experienced a disclosable event. The current CMS definition for "affiliation" includes any of the following relationships:

- A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization
- A general or limited partnership interest, regardless of the percentage, that an individual or entity has in another organization
- An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including sole proprietorships)

- An interest in which an individual is acting as an officer or director of a corporation
- Any reassignment relationship permitted under current regulations

As we have previously noted in comments to CMS, even this existing framework is overly broad and burdensome compared to any program integrity benefits that have arisen out of it. Yet, in this rule, the agency proposes to expand this framework even more by:

- Removing the five-year lookback period on disclosures of affiliations and expanding the definition to encompass any point in the provider's enrollment, which would require an affiliation to be reported regardless of how long ago such an affiliation occurred or ended.
- Broadening the definition of affiliation to include owning an entity or managing employees or organizations of an entity that exercises operational or managerial control over another organization.
- Expanding the definition of affiliation to add a new category that would result in the inclusion of any marketing, business, fulfillment, financial, managerial, or beneficiary relationships

HAP has concerns with CMS' proposed affiliation disclosure framework. Specifically, it would create broad, unclear, and potentially unworkable disclosure obligations for hospitals and health systems by:

- Eliminating any time limit on affiliation disclosures, which would create an open-ended compliance burden. Hospitals and health systems often have long operating histories and complex, multi-tiered ownership and management structures. Over decades, thousands of individuals may have served in roles that could qualify as "managing employees" under CMS' proposed expanded definition. Tracking and disclosing each person's affiliations indefinitely would be extremely difficult, if not impossible, for many providers. Indeed, it is an infeasible and excessive burden to ask an organization for details reaching back to multiple decades of affiliation.
- Including an overly broad range of affiliations. For example, CMS' proposal raises questions about whether every clinician who provides care to hospital patients could be viewed as having a "beneficiary relationship." Without clearer guidance on which roles are covered, providers would face ongoing uncertainty about when disclosure obligations apply and whose information must be reported.
- Raising significant practical concerns about data availability. Large providers, particularly hospitals and health systems, may have no feasible way to identify affiliations involving former managing employees from many years ago, particularly when those individuals have long since left the organization. Requiring providers to disclose information they cannot reasonably know or obtain would create compliance risk without a corresponding Medicare program integrity benefit.

Therefore, HAP urges CMS not to finalize its proposed changes to the affiliation framework. However, if it moves forward, we recommend that it:

- **Limit the lookback period to only apply to the main provider and its current owners and managing employees, rather than extending it to all former managing employees and their historical affiliations.**
- **Adopt a "reasonableness standard" though rulemaking or sub-regulatory guidance that will consider providers' good faith efforts to identify and disclose relevant information while at the same time acknowledging that there will be limitations to what a provider knows.**
- **Provide a safe harbor for good faith compliance, recognizing that providers cannot reasonably be expected to have complete records of all historical affiliations of all individuals who ever qualified as managing employees.**

In addition, we incorporate additional comments provided in the American Hospital Association's response to the proposed rule by reference.

We appreciate your consideration of these issues. If you have any questions, contact **me**, or **Brooke Bowers**, HAP's director, financial reimbursement and analysis.

Sincerely,

Jolene H. Calla, Esq.
Vice President, Finance & Legal Affairs