August 31, 2026

SUBMITTED ELECTRONICALLY

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Coalition to Preserve Rehabilitation's Comments in Response to the 2027 Proposals Impacting Medicare Billing Privileges (CMS-1844-P)

Dear Administrator Oz:

On behalf of the undersigned members of the Coalition to Preserve Rehabilitation ("CPR"), we appreciate the opportunity to submit these comments to the Centers for Medicare and Medicaid Services ("CMS") in response to the 2027 Home Health Prospective Payment System proposed rule (CMS-1844-P). Our comments are focused primarily on the proposals impacting enrollment of all providers and suppliers under the Medicare program.

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain the maximum level of health and independent function. CPR is comprised of organizations that represent patients—as well as the providers who serve them—who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

CPR strongly supports CMS's efforts to protect the integrity of the Medicare program. Fraud, waste, and abuse have no place in Medicare, and CMS should have appropriate tools to identify fraudulent actors and prevent improper payments. At the same time, program integrity policies must distinguish between deliberate misconduct and technical, inadvertent, or disputed compliance issues. They must also recognize that the consequences of erroneous enrollment action extend beyond the provider or supplier involved. When a legitimate rehabilitation provider or supplier loses Medicare participation, beneficiaries may lose access to the specialized services, established clinical relationships, and medically necessary equipment and technologies they need to improve or maintain function and live healthy lives.

I. Lack of Demonstrated Need for Such Broad Expansion of Enrollment Authority

CMS describes the proposed enrollment changes as necessary to "keep unqualified providers and suppliers out of the Medicare program" and prevent improper payments. The goal is unquestionably important; however, the proposed rule does not establish that the broad new authorities CMS seeks are appropriate to achieve that goal.

The Medicare program already includes extensive safeguards designed to prevent, identify, and address fraud, waste and abuse. These include enrollment requirements, screening, certification and/or licensure requirements, claims reviews, and overpayment authorities. CMS already may deny or revoke enrollment for a wide range of serious misconduct, including false or misleading information, certain criminal convictions, failure to comply with enrollment requirements, and patterns of improper billing, among other reasons. This proposed rule does not adequately identify the specific deficiencies in these existing authorities that prevent CMS from addressing fraudulent providers and suppliers.

Against this backdrop, CMS should identify the specific gaps in its existing authorities that justify the proposed expansion. This analysis is critical to prevent overly broad authorities that may impose substantial consequences on compliant providers and suppliers without producing commensurate benefits for the Medicare program. The impact is not only felt by providers and suppliers, but also Medicare beneficiaries. Patients needing rehabilitative care often depend on timely access to a qualified practitioner. If otherwise compliant rehabilitation providers and suppliers are improperly excluded from Medicare, Medicare beneficiaries may face disruptions in care, longer wait times, and fewer treatment options. ***Accordingly, CMS should carefully consider whether the following proposals could inadvertently reduce access to medically necessary rehabilitation services.***

II. CMS Should Not Remove Factors Informing Abuse of Billing Privileges

CPR is particularly concerned with CMS's proposal to eliminate the four factors currently identified in 42 C.F.R. § 424.535(a)(8) for determining whether a provider or supplier has engaged in a pattern or practice of submitting claims that do not meet Medicare requirements. CMS acknowledges that it is proposing to remove these factors because they constrain the agency's ability to address the range of factual circumstances it encounters and because CMS believes it needs "maximum flexibility" to address those circumstances. The agency further indicates that a "pattern or practice" could potentially be established by several claims that do not meet Medicare requirements, while expressly declining to establish any minimum threshold for revocation.

CPR strongly disagrees with this approach. The existing factors do not constitute arbitrary restrictions on CMS. Instead, they provide predictable and objective standards that help ensure the agency's consistent application of revocation. These standards are particularly helpful when the provider or supplier at issue furnishes care subject to complex coverage, coding, and reimbursement requirements. Accordingly, CPR wishes to impress on CMS that a pattern of claim denials should not be transformed into a basis for revocation without careful consideration of why the claims were denied, whether the provider/supplier acted in good faith, whether the

underlying services were actually furnished, and whether the provider/supplier has demonstrated a broader pattern of abusive conduct. ***CPR strongly urges CMS to retain the objective factors governing 'abuse of billing privileges' determinations.***

III. CMS Should Not Make Virtually All Revocations Retroactive

CPR vehemently opposes CMS's proposal to expand retroactive revocation to virtually all Medicare enrollment revocation grounds.

Under the current framework, enrollment revocation generally becomes effective prospectively, although CMS has authority to make revocation retroactive in specifically defined circumstances. CMS is proposing to allow retroactive revocation based on additional grounds, with the effective date potentially reaching back to the date CMS determines that the provider or supplier first became noncompliant. This proposal would encompass grounds involving enrollment noncompliance, misuse of a billing number, application fee requirements, document retention and access, reserve operating funds, abusive prescribing, False Claims Act judgments, prior revocations, abusive ordering or certification, patient harm, and condition or standard violations. ***If finalized as written, this proposal would have enormous financial consequences.***

If CMS revokes enrollment retroactively, payments made during that intervening period between noncompliance and notice of noncompliance could become subject to recoupment. CPR believes this approach is fundamentally unfair when applied to technical or inadvertent deficiencies. There is a profound difference between a provider or supplier that intentionally defrauds the Medicare program and a provider or supplier that, for example, fails to satisfy an enrollment documentation requirement on the date CMS later determines was required. Yet, the proposed retroactive framework could subject both providers/suppliers to extraordinarily consequential financial remedies.

The problem is particularly acute for rehabilitation providers and suppliers because rehabilitation episodes often extend over substantial periods of time. Practitioners may furnish repeated therapy services, complex interdisciplinary care, or customized equipment and related services based upon their good-faith understanding that they are enrolled and authorized to participate in Medicare. Retroactive revocation could result in substantial liabilities for services that were medically necessary and appropriate and provided in good faith.

For these reasons, CPR strongly encourages CMS to retain prospective revocation as the general rule.

IV. Proposed Reduction to the Claims Submission Period from 60 Days to 15 Days

CMS also proposes to reduce the period during which a revoked provider/supplier may submit claims for items and services furnished before the effective date of revocation from 60 calendar days to 15 days. We are concerned that this proposal would be insufficient for providers and suppliers to identify and submit all outstanding claims. This would be a substantial administrative burden at precisely the time the organization is likely to be responding to the underlying enrollment action and pursuing its appeal rights. The burden could be particularly

significant for rehabilitation providers and suppliers whose claims may involve multiple services, practitioners, locations, and medical records. ***Given the substantial operational burden, we urge the agency to retain the existing 60-day claim submission period.***

V. Geographic Concentration Should Not Be Used As a Basis for Revocation

CPR strongly opposes the proposed new authority to revoke Medicare enrollment based upon CMS's determination that a provider or supplier presents a high risk of fraud, waste, or abuse because it is located in a geographic area containing an excessive number of providers or suppliers. Under the proposed rule, a 'high-risk' finding would not necessarily be based upon the conduct of the individual provider or supplier. CMS could consider broader market conditions, including the concentration of providers/suppliers in common buildings and complexes, and the provider or supplier in question would not necessarily need to furnish the same type of services as the others in the area. This proposal abandons the basic principle of due process.

Geographic concentration does not establish fraud. In many communities, provider concentration reflects legitimate market forces, population density, proximity to hospitals, specialty care, or beneficiary demand. From the medical rehabilitation perspective, geographic concentration may reflect the need for specialized services or the presence of major rehabilitation hospitals and medical centers, and a provider/supplier should not lose its Medicare enrollment because others happen to operate nearby. Nor should a legitimate provider/supplier bear the consequences or alleged misconduct by unrelated entities simply because they share a geographic market or building.

The proposal is also particularly problematic because CMS has not established an objective definition of an "excessive" number of providers or suppliers. Without a clear threshold and a demonstrated causal relationship between geographic concentration and fraud, this proposal would give CMS extraordinary discretion without an adequate factual foundation. ***CPR urges CMS to withdraw this proposal.***

VI. Enrollment Denials Based Merely on Sharing a Suite or Office

Similarly, CMS is proposing to deny enrollment to a provider or supplier whose practice location is in the same suite or office as another provider or supplier whose Medicare enrollment has been denied or revoked. CMS states that it would not invoke the provision in every instance and would use it when deemed appropriate. CPR strongly objects to this approach.

The mere fact that two providers or suppliers occupy the same suite does not establish common ownership, common control, fraud, or any other misconduct. Health care providers routinely share office space, administrative resources, reception areas, equipment, or other facilities for legitimate business reasons. A provider or supplier should not have its Medicare enrollment denied because of another provider or supplier's actions unless CMS can establish a direct and meaningful connection between the two entities and demonstrate that the applicant itself presents a program integrity risk. CMS's statement that the provision would only be invoked "when it

deems proper" does not solve the problem. ***For these reasons, CPR encourages CMS to withdraw this proposal.***

VII. Proposed Expansion of False and Misleading Information Authorities

CMS proposes to expand the existing denial and revocation provisions concerning false or misleading information to encompass information submitted on any CMS or Medicare enrollment-related form, including documents submitted to CMS contractors. This proposal would reach documents associated with enrollment, revalidation, reactivation, voluntary termination, and changes to electronic funds transfer information, among other matters. CMS also proposes that the provisions would not depend on whether the provider technically certified the information as "true."

CMS must distinguish intentional falsification from inadvertent errors, misunderstandings, typographical mistakes, incomplete responses, or reasonable disagreements concerning information requested by CMS or its contractors. The broader the universe of documents covered by this provision, the greater the risk that an immaterial, inadvertent error could become the basis for an enrollment sanction. The consequences are especially serious because CMS is simultaneously proposing retroactive revocation and broader reapplication bars. ***CPR encourages CMS to limit this authority to materially false or misleading information that is knowingly or intentionally submitted and that is relevant to Medicare enrollment or program integrity.***

VIII. Extension of Enrollment Consequences Across Separate Enrollments

CMS proposes to expand its authority to revoke a provider's/supplier's other Medicare enrollments following an enrollment denial, rather than limiting such action to circumstances in which another enrollment has been revoked. Although CMS characterizes this authority as discretionary and emphasizes that a denial would not automatically trigger revocation of other enrollments, CPR remains concerned that this proposal nevertheless raises significant concerns about the potential breadth and consequences of this authority.

Providers and suppliers may maintain multiple Medicare enrollments because they operate in different locations, furnish different categories of services, or participate through distinct organizational structures. A denial involving one enrollment should not automatically place every other Medicare enrollment at risk absent a specific finding that the underlying conduct is relevant to those other enrollments. ***CPR believes that CMS should be required to establish a clear nexus between the basis for one enrollment action and the other enrollment or enrollments before imposing additional sanctions.***

IX. Proposed Extension of Debt and Payment-Suspension Denial Authorities

CMS proposes to expand existing denial authorities involving Medicare debt and payment suspensions to encompass managing employees, managing organizations, and individuals and entities with other forms of business or financial relationships with the provider or supplier.

CMS explains that it intends to prevent entities from modifying their ownership or organizational structure to avoid the existing rules.

CPR understands the concern about individuals attempting to evade Medicare enforcement through nominal changes in corporate structure. However, expanding these provisions to any business or financial relationship is far too broad.

Modern health care organizations have extensive contractual relationships. Rehabilitation providers may contract with management companies, physician groups, hospitals, technology vendors, billing companies, therapists, manufacturers, suppliers, and other entities. A commercial relationship does not establish control, culpability, or responsibility for another entity's Medicare debt or payment suspension. For these reasons, CPR encourages CMS to focus on ownership, control, and demonstrable responsibility rather than broad categories or business relationships.

X. Proposed Expansion of the Reapplication Bar

CPR strongly opposes CMS's proposal to authorize a reapplication bar of up to ten years for any basis for enrollment denial under 42 C.F.R. § 424.530(a). Currently, CMS may impose a reapplication bar of up to ten years when an enrollment application is denied because the provider submitted false or misleading information or omitted information to obtain Medicare enrollment. CMS is proposing to extend this authority to every denial ground. ***CPR believes this to be an extraordinary expansion of enforcement authority.*** A ten-year bar should be reserved only for submitting false or misleading information.

From CPR's perspective, this proposal is even more concerning when considered together with CMS's other proposed changes. If CMS expands the grounds for denial while simultaneously expanding the reapplication bar to every denial, the agency effectively creates a pathway by which an increasingly broad range of conduct can result in years-long exclusion. ***Accordingly, CPR strongly urges CMS to retain the current limitation of the reapplication bar to the most serious enrollment misconduct.***

XI. Conclusion

CPR strongly supports CMS's efforts to combat fraud, waste, and abuse. However, the Medicare enrollment proposals contained in this proposed rule go substantially beyond targeted program integrity measures. The potential consequences of these proposals will extend far beyond providers and suppliers. They threaten the availability and continuity of rehabilitation services for Medicare beneficiaries who depend upon specialized providers and suppliers for their health, function, independence, and quality of life.

For these reasons, CPR respectfully but strongly urges CMS to withdraw the proposed provider enrollment provisions from the final rule.

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We appreciate your consideration of these comments and look forward to continuing to work with CMS to protect the integrity of the Medicare program while ensuring the beneficiaries with disabilities and complex rehabilitation needs have reliable access to the care they need. Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
ADVION
ALS Association
American Academy of Physical Medicine & Rehabilitation (AAPM&R)
American Association of People with Disabilities
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Rehabilitation Nurses
Brain Injury Association of America*
Child Neurology Foundation
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation of America
Falling Forward Foundation*
Lakeshore Foundation
Muscular Dystrophy Association
National Association of Rehabilitation Providers and Agencies
National Clinician Task Force
National Disability Rights Network (NDRN)
RESNA
Spina Bifida Association

**** CPR Steering Committee Member***