Alliance of Specialty Medicine

Sound Policy. Quality Care.

August 21, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

**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 [CMS-1844-P]**

Dear Administrator Oz:

The Alliance of Specialty Medicine (the "Alliance"), representing more than 100,000 specialty physicians from fifteen specialty and subspecialty societies, is deeply committed to improving access to specialty medical care by advancing sound health policy. On behalf of the undersigned members, we write to provide feedback on specific Medicare provider enrollment proposals included in the aforementioned proposed rule.

## Revocations and Denials of Enrollment

### *Modifications of Current Revocation Provisions*

CMS proposes several modifications to its existing revocation authorities to provide greater flexibility in addressing provider enrollment issues, and with the goal of strengthening program integrity and better addressing fraudulent, abusive, and non-compliant providers. Specifically, CMS proposes to remove the existing factors used to determine whether a provider has engaged in a pattern or practice of submitting claims that fail to meet Medicare requirements; expand revocation authority based on false or misleading information submitted on or associated with any CMS or Medicare enrollment-related form; extend revocation authority across a provider's other Medicare enrollments when one enrollment is denied; and significantly expand the circumstances under which revocations may be applied retroactively.

While the Alliance strongly supports efforts to protect the Medicare program from fraud, waste, and abuse, we are concerned that several of these proposals would substantially expand CMS' discretionary authority and create uncertainty regarding the circumstances that may result in revocation. We are particularly concerned with the proposed expansion of retroactive revocation authority, which could result in recoupment of Medicare payments for medically necessary services furnished while a physician reasonably believed he or she remained properly enrolled. ***We urge CMS to avoid using subjective standards governing revocation decisions and reserve retroactive revocation for cases involving fraud, intentional misrepresentation, or similarly egregious conduct rather than administrative or technical noncompliance.***

The Alliance is also concerned that the proposed expansion of revocation authorities could expose physician practices to substantial retrospective financial liability for administrative enrollment violations that do not involve fraud or intentional misconduct. For example, if CMS later determines that a provider failed to satisfy revised enrollment, affiliation disclosure, ownership reporting, or shared-space requirements, physicians could face retroactive revocation of billing privileges and recoupment of Medicare payments for services furnished in good faith while they reasonably believed they remained compliant. ***Given that several proposals in this rule would expand existing definitions and introduce new reporting obligations, the Alliance urges CMS to refrain from imposing retrospective revocation penalties based on newly expanded interpretations of relationships, affiliations, ownership structures, or enrollment requirements. At a minimum, CMS should provide clear definitions, objective standards, adequate provider education, and a reasonable implementation period before imposing enforcement actions tied to these new requirements.***

Further, CMS proposes a new revocation authority that would allow the agency to revoke a provider's or supplier's enrollment if it determines the enrollment presents a high risk of fraud, waste, or abuse due to the provider's or supplier's location within a limited geographic area that has an excessive number of providers and suppliers. CMS states that the terms "limited geographic area" and "excessive number" would have their ordinary, plain-language meaning and that an actual finding of fraud, waste, or abuse would not be required before revocation. Although CMS explains that the proposal is not intended to revoke good-faith providers and would only be exercised when the circumstances and risk truly justify it, the agency proposes broad discretion in making that determination. While we appreciate efforts to address organized fraud schemes, we are concerned that the proposed revocation authority relies on subjective standards that provide little assurance for legitimate providers. Many specialty physicians intentionally locate near hospitals, ambulatory surgery centers (ASCs), and other medical facilities to improve patient access and care coordination. Similarly, physicians often lease space in medical office buildings with numerous unrelated practices. Providers have no ability to control who occupies neighboring office space or whether CMS may later determine that a particular area contains an excessive number of providers. These common practice arrangements should not, by themselves, create program integrity concerns. ***We urge CMS to establish objective criteria, to include defining "limited geographic area" and "excessive number," and require evidence of a meaningful program integrity risk before exercising this authority.***

Finally, CMS proposes to establish a new revocation authority if a provider or supplier, or any owner, managing employee or organization, officer, or director, was convicted within the previous 10 years of a Federal or State misdemeanor related to sexual assault or financial misconduct that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries. CMS states that "financial misconduct" would be interpreted according to its plain meaning and emphasizes that not every such misdemeanor conviction would result in revocation. CMS proposes that the effective date of the revocation would be the date of the conviction. We support CMS' efforts to protect the Medicare program and its beneficiaries from individuals whose conduct demonstrates a genuine program integrity concern, but ***request additional guidance regarding how it will determine whether a misdemeanor constitutes "financial misconduct," including when such a conviction will be considered detrimental to the best interests of the Medicare program.***

### *Revised and New Denial Reasons*

CMS proposes several revisions to its existing denial authorities. Specifically, CMS would expand the existing denial authorities related to Medicare debt, payment suspensions, and program terminations or suspensions to include managing employees, managing organizations, and/or individuals and entities with business or financial relationships with the provider; expand the existing denial authority for false or misleading information to encompass information submitted on or associated with any CMS or Medicare enrollment-related form, rather than only the enrollment application; establish new denial authorities related to certain misdemeanor convictions involving sexual assault or financial misconduct and providers sharing the same suite

or office as another provider whose Medicare enrollment has been denied or revoked; and establish a new denial authority where a prospective provider or supplier attempts to enroll under another party's identity.

We are deeply concerned that these proposals would substantially expand the circumstances under which a physician's Medicare enrollment may be denied, including based on the actions of third parties and circumstances beyond the physician's reasonable knowledge or control. Physician practices routinely contract with numerous other entities to support their clinical operations (e.g., laboratories, diagnostic testing facilities, and other health care providers and suppliers). While providers exercise appropriate oversight over these relationships, they generally do not have visibility into whether these entities have outstanding Medicare debt, are subject to a Medicare or Medicaid payment suspension, or have experienced other adverse actions that could affect the physician's own enrollment. Given these concerns, ***CMS should not finalize policies that apply to these relationships.***

The Alliance also supports CMS' efforts to ensure the accuracy of Medicare enrollment information but is concerned that expanding the false or misleading information authority to encompass any CMS or Medicare enrollment-related form could result in denials based on inadvertent administrative errors rather than intentional misrepresentations. ***CMS should clearly distinguish between intentional fraud and technical or clerical errors that are promptly corrected.***

Finally, the Alliance is concerned with the proposal to deny enrollment based on a provider sharing the same suite or office as another provider whose Medicare enrollment has been denied or revoked. Physicians have no ability to control the enrollment status of unrelated providers sharing the same office or suite, and these common leasing arrangements should not, by themselves, create a basis for denying Medicare enrollment. ***We urge CMS to establish objective standards and require evidence of a meaningful program integrity concern before exercising this authority.***

### *Reapplication Bar*

CMS proposes to revise the reapplication bar provisions to allow CMS to impose a reapplication bar of up to ten years based on any denial reason under § 424.530(a), rather than limiting the authority to denials involving false or misleading information. CMS also proposes to remove the regulatory factors it currently considers in determining whether to impose a reapplication bar and its duration, while retaining the discretionary nature of the authority.

We are concerned that expanding the reapplication bar to apply to every denial authority could result in disproportionately severe consequences for providers whose enrollment applications are denied for administrative or technical reasons, rather than conduct demonstrating actual fraud or abuse. Although CMS notes that the authority remains discretionary, eliminating the existing regulatory factors reduces transparency regarding when a reapplication bar will be imposed and how its duration will be determined.

Given the significant impact a reapplication bar can have on physician participation in Medicare and beneficiary access to specialty care, ***the Alliance urges CMS to retain objective factors to guide its exercise of discretion and reserve lengthy reapplication bars for providers that present a demonstrable risk to the Medicare program or its beneficiaries.***

## Preclusion List

CMS proposes to expand the circumstances under which an individual may be placed on the Medicare Preclusion List. Specifically, CMS proposes to expand the existing category for felony convictions that CMS deems detrimental to the best interests of the Medicare program to include felony convictions of the

provider's or prescriber's owner, managing employee, managing organization, corporate director, or corporate officer.

We are concerned that this proposal would impose significant administrative burden on physician practices by effectively requiring them to investigate the legal histories of owners, officers, directors, managing employees, and other individuals whose conduct could affect the practice's participation in Medicare. While physician practices should conduct reasonable due diligence, there are limits to what providers can know and verify. Information regarding prior convictions or other legal matters may not be readily available, may be concealed, or may otherwise not be discoverable through ordinary business diligence. Yet physician practices could face significant consequences despite acting in good faith and having no knowledge of the underlying conduct.

***We urge CMS to clearly define the due diligence expected of providers and ensure that physician practices are not held responsible for information they could not reasonably have known or verified. We also urge CMS to provide providers with notice and an opportunity to address these issues before preclusion is imposed.***

## Temporary Moratoria

CMS proposes several revisions to its temporary moratoria regulations. Among other changes, CMS proposes to clarify that the effective date of a temporary moratorium is the date the moratorium notice is filed for public inspection at the Office of the Federal Register; specify that certain changes in ownership requiring an initial enrollment are not exempt from a temporary moratorium; and clarify the types of enrollment applications that are considered "new" for purposes of a moratorium, including reactivation applications, enrollment applications submitted by previously revoked or voluntarily terminated providers seeking to reenroll, and certain ownership changes requiring an initial enrollment.

Recognizing that temporary enrollment moratoria can be an important tool for addressing fraud, waste, and abuse in geographic areas or provider types that present heightened program integrity concerns, ***we encourage CMS to ensure that these authorities remain appropriately targeted and do not unintentionally delay or impede enrollment for legitimate physician practices undergoing routine business changes***.

## Private Equity Companies (PECs) and Real Estate Investment Trusts (REITs)

CMS announces its intent to revise the Medicare enrollment applications for clinics, group practices, certain other suppliers, DMEPOS suppliers, and Medicare Diabetes Prevention Program suppliers to require applicants to identify whether any organizations disclosed on the enrollment application are PECs or REITs. CMS explains that, given concerns regarding PE investment in health care, it seeks to better understand the prevalence of PEC and REIT involvement with Medicare Part B suppliers and collect information regarding ownership structures.

The Alliance understands CMS' interest in collecting information regarding Medicare provider ownership structures and appreciates that this plan is intended to improve the agency's understanding of the prevalence of PECs and REITs within the Medicare program. In fact, this is an area in which the Alliance has consistently expressed concern in the context of Medicare physician payment reform, as several of our organizations have shared their members' firsthand experiences with the challenges that can accompany certain PE investment models. For example, while PE investment may improve administrative efficiency, some models prioritize short-term financial returns over the long-term viability of physician practices, resulting in business decisions that undermine physician autonomy, shift resources away from services that may be less profitable but medically necessary, and contribute to physician turnover and burnout. In some cases, once a practice is no longer viewed as meeting financial expectations, it may be sold, consolidated, or closed, ultimately reducing patients' access to specialty physicians and care.

For these reasons, ***the Alliance supports CMS' efforts to better understand the prevalence of PE ownership within the Medicare program***. To promote accurate and consistent reporting, ***we encourage CMS to provide clear definitions and reporting instructions so providers understand which entities must be disclosed and how these reporting requirements should be applied across provider types.***

## Managing Employees

CMS proposes to expand the definition of "managing employee" by expressly including medical directors, clinical directors, departmental heads, supervising physicians, nursing directors, alternate administrators, and all other clinical personnel who meet the managing employee definition. CMS states that these categories would apply across all provider and supplier types, further noting that it believes individuals in these positions already qualify as managing employees and should have always been reported.

The Alliance respectfully disagrees with CMS' assertion that these individuals "*should have always been reported*" as managing employees. The current regulation defines a managing employee in functional terms and expressly identifies only hospice and skilled nursing facility administrators and medical directors. It does not expressly identify medical directors, clinical directors, departmental heads, supervising physicians, nursing directors, or alternate administrators for other provider types. Moreover, this proposal appears to capture individuals who, despite their title, may have limited or no meaningful managerial authority over the provider or supplier. Expanding the definition in this manner would create significant uncertainty and administrative burden, particularly for larger organizations with complex management structures.

For these reasons, ***the Alliance opposes this proposal***. However, if CMS finalizes this proposal, it should – at a minimum – provide clear illustrative examples of individuals who would and would not qualify as managing employees, establish an appropriate implementation period before initiating enforcement actions, and hold providers and suppliers harmless for failing to report individuals who, under CMS' revised interpretation, would now be considered managing employees but were not previously understood to fall within the regulatory definition***.***

## Affiliations

CMS proposes several revisions to the Medicare affiliation disclosure requirements. Specifically, CMS proposes to eliminate the existing five-year lookback period for reporting affiliations, requiring providers to disclose affiliations regardless of when they occurred or ended; expand the definition of "affiliation" to include any marketing, business, fulfillment, financial, managerial, or beneficiary relationship; and clarify that affiliations include interests in which owning or managing employees or organizations exercise operational control. CMS states these changes are intended to address concerns regarding the limitations of the current affiliation requirements and strengthen CMS' ability to identify affiliations that may pose an undue risk of fraud, waste, or abuse.

First, we are concerned that the proposed revisions to the affiliation disclosure requirements would substantially increase administrative burden for physician practices while creating significant uncertainty regarding the scope of reportable relationships. Eliminating the existing five-year reporting limitation and expanding the definition of "affiliation" to encompass a broad range of marketing, business, fulfillment, financial, and managerial relationships could require physician practices to identify and monitor an expansive universe of current and historical relationships that often have little connection to Medicare program integrity.

Second, physician practices routinely maintain contractual relationships with a host of third party entities, including billing companies, information technology vendors, management companies, staffing firms, and numerous other entities to support their operations. Many of these relationships change over time through mergers, acquisitions, ownership changes, subcontracting arrangements, or other business transactions that may not be known to the physician practice. It is wholly unreasonable to expect physician practices to investigate and continually monitor every historical or ongoing affiliation involving every contractor,

consultant, vendor, or other business entity with which they interact. To that end, ***we urge CMS to retain a reasonable temporal limitation on affiliation reporting and more narrowly tailor the definition of affiliation to relationships that present a meaningful nexus to Medicare program integrity. At a minimum, CMS should clearly define the scope of reportable affiliations and establish reasonable due diligence expectations that reflect what providers can realistically know and verify through ordinary business practices.***

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We appreciate the opportunity to provide feedback on the aforementioned provider enrollment provisions in the aforementioned proposed rule. Should you have any questions or would like to meet with the Alliance to discuss these recommendations further, please contact us at info@specialtydocs.org.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Otolaryngology–Head and Neck Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society
Society of Interventional Radiology