JOINT COMMENTS OF ARIZONA HEALTH CARE ORGANIZATIONS

CMS-1844-P | Medicare Provider Enrollment Provisions

August 28, 2026

The Honorable Mehmet Oz, M.D.
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: CMS-1844-P, Medicare Provider Enrollment Provisions of the CY 2027 Home Health Prospective Payment System Proposed Rule

Dear Administrator Oz:

The undersigned members of the Arizonans for Better Healthcare Coalition represent hospitals and health systems, physician organizations and medical groups, Community Health Centers, behavioral health and addiction treatment providers, health plans, and post-acute and aging services providers across Arizona. We write jointly because the provider enrollment provisions in this proposed rule apply to every Medicare-enrolled provider and supplier type, and the operational, clinical, and network consequences our members anticipate are shared across the full continuum of care.

We support CMS's commitment to safeguarding Medicare program integrity and preventing bad actors from exploiting federal healthcare programs. However, several proposed provisions extend far beyond high-risk fraudulent behavior. Instead, they establish overly broad reporting and liability standards that capture good-faith providers, penalize standard healthcare delivery models, and impose severe enrollment consequences on individuals and relationships with no demonstrated link to fraud. We urge CMS to refine and narrow these proposals prior to finalization.

A Workable Regulatory Standard for General Provider Enrollment

CMS has previously acknowledged that administrative reporting standards must reflect the practical realities of complex healthcare operations. When reporting expansive operational and affiliation data, providers should be held to a **reasonable due diligence standard**—making good-faith, maximum feasible efforts to collect required information, documenting those efforts, and notifying Medicare Administrative Contractors (MACs) when historical or third-party information cannot be obtained.

Furthermore, CMS should establish a mandatory notice and opportunity-to-correct period before initiating adverse actions such as enrollment denial, revocation, or reapplication bars. CMS should reserve the most severe remedies strictly for intentional, material, or fraudulent noncompliance.

1. The Expanded "Managing Employee" Definition Disrupts Routine Clinical Leadership Structures

Under 42 CFR § 424.502, CMS proposes to expand the definition of "managing employee" to explicitly include departmental chairs, clinical and medical directors, nursing leaders, supervising physicians, and alternate administrators, regardless of whether they are directly employed or independent contractors.

This expansion creates severe compliance and operational hurdles across provider types:

- **Hospitals and Health Systems:** Large hospital systems rely on dozens of clinical department heads (e.g., chiefs of cardiology, surgery, radiology, or emergency medicine), service-line leaders, and contracted specialty group leads. Attaching the personal regulatory histories of every clinical lead to the institutional enrollment of a major medical center is unworkable and misconstrues clinical oversight as general corporate governance.

- **Physician Practices & Medical Groups:** In multi-specialty practices, supervising physicians and medical directors are practicing clinicians whose primary role is direct patient care, not executive financial or administrative control.
- **Behavioral Health & Substance Use Providers:** Behavioral health organizations and Community Mental Health Centers (CMHCs) rely extensively on contracted psychiatric directors, registered and certified Psychiatric-Mental Health Nurse Practitioners (NPs), licensed Psychiatrists and Psychologists, clinical supervisors, and licensed clinical staff such as social workers (LCSWs), Professional Counselors (LPCs), and Marriage and Family Therapists (LMFTs), who oversee distributed outpatient programs, crisis response units, and residential sites. Attaching personal historical reporting requirements to non-executive clinical supervisory staff exacerbates existing behavioral health workforce shortages and misapplies corporate governance rules to routine clinical supervision.
- **Community Health Centers (CHCs) & FQHCs:** Distributed clinical leadership across multi-site community centers would face duplicative, overlapping reporting burdens layered on top of existing federal grant reporting requirements.
- **Post-Acute and Long-Term Care:** Medical directors are frequently contracted part-time practitioners who serve multiple community facilities, limiting the ability of any single facility to verify personal administrative histories.

> **Recommendation:** CMS should adopt a single, functional test tied directly to operational and executive management authority over the billing entity, rather than clinical titles. CMS should explicitly clarify that providers are not liable for non-disclosed background information of independent contractors that could not reasonably have been discovered through standard due diligence.

2. Eliminating the Affiliation Look-Back Period Penalizes Long-Standing Healthcare Institutions

Under 42 CFR § 424.519, CMS proposes to eliminate the 5-year look-back on reportable affiliations and to expand the definition to reach any past marketing, business, fulfillment, financial, managerial, or beneficiary relationship.

Many of our member organizations, including health systems, community hospitals, integrated behavioral health networks, and established medical groups, have participated in Medicare for decades. Reconstructing every qualifying relationship across that period, including relationships with entities that no longer exist and whose records our members never held, is not a compliance obligation they can satisfy.

The proposal also discourages exactly the kind of integration across hospitals, behavioral health clinics, community health centers, physician practices, and post-acute providers (such as Accountable Care Organizations and Clinically Integrated Networks) that improves care coordination for patients moving between those settings.

> **Recommendation:** CMS should maintain a defined, reasonable look-back period (such as 5 years) and establish clear, objective materiality thresholds for what constitutes a reportable affiliation.

3. Revocation, Denial, and Bar Provisions Must Require a Finding of Provider Misconduct

The proposals in this section share a structure. Each authorizes CMS to deny, revoke, or bar a provider based on something other than that provider's own noncompliance — the density of its neighborhood, the outcome of a different application, an unpaid debt belonging to someone it does business with, a conviction in the personal history of a volunteer board member. Together they would move Medicare enrollment away from a determination about a provider's conduct and toward a determination about its associations.

Section 1866(b)(2) of the Social Security Act (42 U.S.C. 1395cc(b)(2)) conditions the Secretary's authority to refuse or terminate a provider agreement on reasonable notice to the provider and the public and on a determination that the provider has failed to comply substantially with the agreement, the statute, or the regulations. For institutional providers signing this letter, that condition is not satisfied by a finding about geography, an affiliate, or an application filed for a different location. Separately, across all provider types, CMS proposes deleting enumerated evaluation factors in several places without proposing anything in their place. Removing the criteria that make an agency determination reviewable, and offering no replacement, is difficult to reconcile with reasoned decision-making.

3A. Grounds requiring no misconduct finding

- **High-risk enrollment location, 42 CFR 424.535(a)(24), and shared suite or office, 42 CFR 424.530(a)(19).** CMS proposes to treat provider concentration in a limited geographic area as a basis for revocation, and co-location with a denied or revoked provider as a basis for denial, without numerical thresholds, geographic limits, or mandatory evaluation factors. Hospital campuses are concentrations of Medicare-enrolled entities by design and, for provider-based departments, by regulatory requirement. A single medical office building on an Arizona hospital campus may house provider-based departments, employed and independent physician practices, imaging, infusion, and a DMEPOS supplier. We ask CMS to exclude fixed-site institutional providers, provider-based departments, and on-campus locations from both grounds, and to exclude co-location arrangements that predate the other provider's adverse action.
- **Extension of revocation, 42 CFR 424.535(i).** CMS proposes allowing a denied enrollment application to support revocation of the provider's other, unrelated enrollments. A health system holds many enrollments — the hospital itself, provider-based departments, hospital-based home health and hospice, distinct-part units, rural health clinics, employed physician groups, DMEPOS. Denials for nonoperational status frequently originate in contractor or site-visit error and are reversed on appeal, but the proposal would allow action against unrelated enrollments before that appeal concludes. We ask CMS to confine this authority to revocations. If CMS extends it to denials, we ask that it require a documented nexus between the denied application and each enrollment proposed for revocation, and that it take no action until the denial is final after appeal.
- **Debt and payment suspension, 42 CFR 424.530(a)(6) and (a)(7).** CMS proposes to extend these denial grounds beyond owners to managing employees, managing organizations, and any individual or entity with a business or financial relationship with the provider. A hospital's business and financial relationships number in the thousands — group practices, staffing firms, equipment vendors, joint ventures, landlords, laboratories. CMS does not define "business or financial relationship," and no hospital can monitor the Medicare debt status of every party in that universe. We ask CMS to define the term, limit it to relationships involving operational or financial control, and confirm that a provider is not liable for information it did not know and could not reasonably have discovered.
- **Misdemeanor convictions, proposed 42 CFR 424.530(a)(16) and 424.535(a)(16).** This ground reaches convictions of the provider's officers and directors. Arizona's community, district, and tribally affiliated hospitals are governed by volunteer boards drawn from the towns they serve, and those boards are already difficult to fill. Attaching a hospital's enrollment to the ten-year personal misdemeanor history of an unpaid board member, on a standard defined only as conduct CMS deems detrimental to the Medicare program, creates a screening obligation with no stated threshold and a real disincentive to community board service. We ask CMS to define the standard, require a nexus between the offense and health care operations or program funds, and exclude uncompensated members of a governing body who exercise no operational control.

3B. Consequences that attach without an independent finding

- **Retroactive revocation, 42 CFR 424.535(g).** CMS proposes extending retroactive effective dates to nearly every revocation ground, including failures to timely report enrollment changes—retroactive to the day after the reporting due date—and violations of provider-specific conditions or standards of participation. Two consequences follow for hospitals. First, combined with the expanded managing employee definition and the ninety-day reporting window at 42 CFR 424.516(e)(2), an unreported change in clinical leadership becomes a revocation effective months before anyone identified the omission, with every claim paid in the interval reclassified as an overpayment. Second, applying retroactive dates to condition-of-participation findings converts the survey and plan-of-correction process into retroactive payment denial. Hospitals identify and remediate deficiencies continuously; that is what the survey system is designed to produce. We ask CMS not to apply retroactive effective dates to reporting-only deficiencies absent intentional concealment, and not to apply them to condition- or standard-level findings that the provider corrects through an accepted plan of correction.
- **Reapplication bar, 42 CFR 424.530(f).** CMS proposes to extend the bar from denials involving false information to any denial, for up to ten years, while removing the factors that currently guide whether a bar applies and for how long. A ten-year exclusion imposed without stated criteria is a sanction, not a screening decision. We ask

CMS to retain guiding factors, tie the duration of any bar to the seriousness of the underlying denial, and confirm that CMS will not issue a bar for a denial that is reversed on appeal.

- **Abuse of billing privileges, 42 CFR 424.535(a)(8)(ii).** CMS proposes removing the four factors it currently weighs before finding a revocable pattern or practice, including the percentage of claims denied, and declines to set any minimum number or percentage of noncompliant claims. Removing the percentage factor removes the denominator. Hospitals are the highest-volume billers in Medicare, and a system submitting millions of claims a year at a 0.1 percent error rate produces thousands of noncompliant claims in absolute terms while performing better than nearly anyone. CMS states that a pattern or practice could rest on a finding that several claims failed to meet requirements. Against a high-volume institutional biller, that is not a standard. We ask CMS to retain a proportionality factor, or to state expressly that absolute claim counts alone cannot establish a pattern for high-volume providers.
- **Change in majority ownership non-compliance.** A new denial and revocation ground for home health agencies, hospices, and DMEPOS suppliers. We ask CMS to confirm that transactions in which a hospital or health system acquires a home health agency or hospice from a distressed or closing operator, and which are disclosed to the Medicare Administrative Contractor in advance, will not trigger this ground.

3C. Procedural safeguards CMS should preserve or extend

- **Post-revocation claims, 42 CFR 424.535(h).** CMS proposes shortening the claims submission window from sixty days to fifteen calendar days running from the date of the notice letter, and separately proposes permitting notice by email. Hospital inpatient claims cannot be submitted until discharge, coding, and DRG assignment are complete; a patient admitted before the effective date may still be hospitalized when a fifteen-day window closes; late charges post after the initial bill. We ask CMS to retain the sixty-day window, run it from receipt rather than from the date of a letter, and expressly provide for claims covering stays in progress on the effective date.
- **Corrective action plans, 42 CFR 405.809.** CMS proposes to codify the availability of corrective action plans, but only for actions taken under 42 CFR 424.530(a)(1) and 424.535(a)(1). Most of what this rule adds is curable: an unreported managing employee, a missing sign, an incomplete document, an undisclosed affiliation. We ask CMS to extend corrective action plan availability to the reporting, documentation, operational, signage, and affiliation grounds. Doing so would give effect throughout this rule to the reasonable due diligence standard CMS has already articulated in its February 2026 SNF guidance.
- **Reversal of revocation.** We also ask CMS to expand the existing pathway allowing a provider to undo a revocation by proving it terminated its relationship with an implicated individual or entity. That mechanism resolves the underlying program integrity concern directly, and faster than an appeal. It should be available across more of the grounds in this rule, particularly those resting on the conduct of a third party.

These grounds carry a network effect worth CMS's attention. A revocation that follows from fraud or from a quality failure is foreseeable to the plans and health systems that contract with that provider. A revocation that follows from geography, from a denial at a different location, or from an affiliate's unpaid debt is not. Provider networks are built on the assumption that participation is predictable, and network adequacy obligations run to the members those networks serve. In Arizona, where a single hospital is often the only one in its county, an unforeseeable revocation is not a contracting problem. It is an access event. We ask CMS to weigh that consequence when finalizing any ground that does not require a finding of misconduct. We further ask that, before revoking an institutional provider on any ground that does not require a finding of fraud, quality failure, or intentional misconduct, CMS document its consideration of beneficiary access in the affected service area.

The access concern is particularly acute for behavioral health. MedPAC's 2025 survey found that 29 percent of Medicare beneficiaries who tried to obtain a new mental health professional reported that finding one was a "big problem." CMS has also spent recent years expanding the Medicare behavioral health workforce, including allowing marriage and family therapists and mental health counselors to enroll and bill Medicare independently beginning January 1, 2024. Broad administrative revocation rules should not work at cross-purposes with that access policy. Before revoking an inpatient psychiatric facility, behavioral health organization, or behavioral health clinician on grounds that do not require fraud, quality failure, or intentional misconduct, CMS should consider whether equivalent behavioral health capacity is actually available in the affected service area.

> **Recommendation:** CMS should withdraw or narrow these provisions, restore objective evaluation factors for billing abuse and reapplication bars, maintain the 60-day post-revocation claims window, and expand the "reversal of revocation" pathway when a provider promptly dissociates from an implicated individual or entity.

4. Operational, Signage, and Documentation Rules Duplicate Oversight and Clash with Specialized Delivery Models

CMS proposes new criteria for determining whether a provider is operational under 42 CFR § 424.502, a visible business signage requirement under 42 CFR § 424.510(f), and a clarification under 42 CFR § 424.516 that required documentation must be accurate, complete, and compliant rather than simply retained and produced on request.

General providers, hospital departments, outpatient clinics, and behavioral health facilities are already subject to extensive federal and state oversight, including:

- Medicare Conditions of Participation (CoPs) and Conditions for Coverage.
- Arizona Department of Health Services (ADHS) facility licensure and regular state surveys.
- Rigorous national accreditation standards (e.g., The Joint Commission, DNV, CARF, AAAHC).
- Life Safety Code inspections.

Furthermore, rigid physical operational and exterior signage requirements fail to account for modern healthcare delivery models—including mobile crisis teams, field-based behavioral health services, intensive telehealth platforms, and specialized residential addiction treatment facilities that intentionally maintain discreet signage to protect patient privacy, maintain HIPAA confidentiality, and minimize community stigma.

> **Recommendation:** CMS should deem providers accredited or surveyed by state health agencies and recognized accrediting bodies as meeting operational criteria, exempt field-based and privacy-sensitive behavioral health sites from rigid exterior signage mandates, and establish a materiality standard so minor signage or formatting errors do not trigger enrollment denial or revocation.

5. Public Moratoria Notice Requirements

The proposal would start a temporary moratorium on the Federal Register public inspection filing date rather than the publication date, which shortens the notice providers actually receive, and would apply moratoria to reactivations and re-enrollments following a voluntary, good-faith termination.

> **Recommendation:** CMS should maintain the official publication date as the effective moratoria trigger and explicitly exempt good-faith reactivations, service line expansions, and routine re-enrollments.

6. Unintended Downstream Medicaid (AHCCCS) Disruptions

Under 42 CFR § 455.416, a Medicare revocation for cause that becomes final after appeal obligates AHCCCS to terminate that provider from Arizona's Medicaid program as well. CMS guidance limits that obligation to revocations grounded in fraud, program integrity, or quality of care. Several of the grounds proposed here, including the high-risk location ground, the extension of revocation from a denied enrollment, and the broadened debt and payment suspension grounds, do not require CMS to find that any of those three occurred.

If an acute care hospital, trauma center, community behavioral health clinic, substance use treatment provider, safety-net clinic, or specialty practice loses Medicare enrollment due to a broadened administrative ground, an automatic AHCCCS termination would immediately destabilize Arizona's Medicaid safety net and disrupt patient access to care.

> **Recommendation:** CMS must clarify in the final rule that mandatory state Medicaid termination under 42 CFR § 455.416 applies strictly to revocations based on direct findings of fraud, gross clinical misconduct, or severe program abuse—not technical, geographic, or affiliate-based administrative revocations.

7. Realistic Alignment of Regulatory Burden Estimates

CMS projects roughly $82 million in annual Medicare savings, driven largely by expanded retroactive revocation, and anticipates no meaningful new information collection burden. That estimate assumes providers already perform this work. Expanding the categories of reportable individuals and relationships expands the work even where the underlying compliance function exists.

Health systems, behavioral health centers, and physician networks will be required to divert substantial compliance, legal, and credentialing resources to track non-executive clinicians, reconstruct limitless historical affiliations, obtain disclosures from uncooperative third parties, and submit frequent Form CMS-855 updates.

> **Recommendation:** CMS should conduct a comprehensive Regulatory Impact Analysis (RIA) that realistically accounts for the cumulative administrative and financial burden imposed across all provider sectors.

Conclusion

Our coalition members stand united in supporting effective measures against healthcare fraud. However, enrollment rules must remain precise, balanced, and targeted at bad actors rather than creating administrative traps for compliant healthcare delivery systems. We welcome the opportunity to discuss these comments with CMS leadership and staff prior to issuing the final rule.

Respectfully submitted,

Arizona's Healthcare Associations