August 31, 2026

Mehmet Oz, M.D., Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1844-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1844-P; Calendar Year 2027 Home Health Prospective Payment System Rate Update; Requirements for the Home Health Quality Reporting Program; Home Health and the Expanded Home Health Value-Based Purchasing Model; and Other Provisions (91 FR 41216, July 6, 2026) (the "Proposed Rule") – Provider Enrollment Provisions Concerning Private Equity Companies and Real Estate Investment Trusts

Dear Administrator Oz:

The American Investment Council ("AIC") appreciates the opportunity to submit these comments to the Centers for Medicare & Medicaid Services ("CMS") in response to the above-captioned Proposed Rule, and specifically the provider enrollment discussion of Private Equity Companies ("PECs") and Real Estate Investment Trusts ("REITs"), in which CMS announces its intention to revise Forms CMS-855B, CMS-855S, and CMS-20134 to require all suppliers completing those forms to identify whether any organization disclosed thereon is a PEC or a REIT.

AIC is an advocacy, communications, and research organization established to advance access to capital, job creation, retirement security, innovation, and economic growth by promoting responsible long-term investment. AIC's members are the world's leading private equity and private credit firms, united by their commitment to growing and strengthening the businesses in which they invest. AIC members are long-term investors in American businesses across virtually every sector and state in the economy. [1]

Private equity has a long history of health care investing in the United States, playing a critical role in supporting access to quality, affordable health care, particularly by supplying capital for technology, equipment, and expanded service lines that smaller providers could not otherwise finance. The Medicare Payment Advisory Commission ("MedPAC") itself has recognized that

[1] For further information about AIC and its members, please visit our website at www.investmentcouncil.org.

private equity investments provide a broad range of provider entities with capital and expertise to navigate an increasingly complex health care landscape.[2]

AIC has historically served as a constructive partner in CMS's efforts to enhance the transparency of provider and supplier ownership, and it submitted detailed comments on the proposed rule that preceded the November 17, 2023 final rule on skilled nursing facility ("SNF") ownership disclosure.[3] AIC's support for appropriately designed transparency has not changed. AIC is deeply concerned, however, by the preamble's characterization of private equity investment as a threat to Medicare beneficiaries program-wide, culminating in the assertion that "[t]his is a Medicare-wide issue"[4], because that characterization is unsupported by the sources the preamble cites and is contradicted by the two most authoritative, independent government reviews of the question: MedPAC's June 2021 report to the Congress on private equity and Medicare, and the U.S. Government Accountability Office's ("GAO's") September 2025 report on physician consolidation.[5]

Accordingly, and as explained in greater detail below, AIC encourages CMS to review the basis of authority of the Proposed Rule as AIC is concerned it exceeds Congressional intent. Should CMS proceed, AIC encourages CMS to: (i) withdraw or substantially revise the preamble's "Medicare-wide" characterization in any final rule, and ground any findings concerning private equity in the complete record, including the GAO and MedPAC reports the preamble does not address; (ii) before revising any enrollment form, adopt precise and accurate definitions of "PEC" and "REIT" that are limited to entities holding a controlling interest in a supplier, consistent with AIC's 2023 comments; and (iii) address the announced form revisions through the Paperwork Reduction Act ("PRA") process with a full burden analysis, published definitions and instructions, and a demonstration that the resulting data will actually serve CMS's stated research objectives.

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[2] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, ch. 3, "Congressional Request: Private Equity and Medicare" (June 2021) ("MedPAC Report"), available at https://www.medpac.gov.

[3] Comment Letter of the American Investment Council, Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities (File No. CMS-6084-P) (Apr. 14, 2023) ("AIC 2023 Comments").

[4] 91 Fed. Reg. at 41,298.

[5] U.S. Government Accountability Office, *Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation*, GAO-25-107450 (Sept. 2025) ("GAO Report"), available at https://www.gao.gov/products/gao-25-107450.

I. The Proposed Expansion of PEC/REIT Disclosure to All Providers and Suppliers Is Unwarranted and Exceeds Congressional Intent

CMS proposes to require all suppliers completing Forms CMS-855B, CMS-855S, and CMS-20134 to identify whether any disclosed entity is a PEC or a REIT. Significantly, CMS acknowledges that it is *not* relying on section 1124(c) of the Social Security Act as authority for this expansion. Instead, CMS invokes its general rulemaking authority under sections 1102, 1866(j), and 1871 of the Act.

This reliance on general authority to accomplish what Congress specifically declined to require is troubling. When Congress enacted section 1124(c) of the Social Security Act, the purpose was to increase the ownership, governance, and management disclosure requirements for SNFs and non-skilled nursing facilities, which in turn captured types of complex ownership and management arrangements that are commonly used by PECs and REITs. Congress was aware of PE investment across the healthcare sector and made a conscious decision to target only SNFs for these heightened disclosure obligations. CMS's proposal to expand these requirements to all Medicare suppliers through general rulemaking authority effectively overrides Congress's deliberate choice to limit the scope of section 1124(c).

If Congress had intended PEC and REIT disclosure to apply Medicare-wide, it could have enacted such a requirement. It did not. CMS should not use its general rulemaking authority to achieve an outcome that Congress specifically chose not to mandate. The agency's assertion that "[t]his is a Medicare-wide issue" does not substitute for Congressional authorization to impose Medicare-wide requirements.

Moreover, the underlying definitions of "private equity company" and "real estate investment trust" that CMS proposes to carry forward into these expanded forms remain the same definitions that AIC criticized in its April 2023 comments on the November 2023 final rule. AIC's concerns about the overbreadth and inaccuracy of these definitions, which we reiterate in Sections III and IV below remain entirely unaddressed. Expanding a flawed definitional framework to additional categories of providers only compounds the existing problems.

II. The Preamble's Characterization of Private Equity as a "Medicare-wide" Problem is Unsupported by the Sources CMS Cites and Contradicted by the Government's Own Expert Research

The preamble rests its characterization on two sources: a quotation from a single study of nursing homes, reproduced secondhand from the preamble to the 2023 SNF ownership final rule,[6] and a series of quotations from the May 2025 edition of the American Medical Association's Journal of Ethics.[7] Neither source can bear the weight the preamble places on it. More importantly, when the federal government's own experts examined precisely this question, through MedPAC in response to a request from the House Committee on Ways and Means concerning private equity and Medicare, and GAO in response to a congressional directive to examine health care consolidation, including the involvement of private equity, across Medicare and Medicaid, both reached conclusions materially at odds with the preamble's narrative.

A. A single nursing home study should not support a program-wide finding, and MedPAC, which reviewed the same study, concluded that the nursing home literature is "mixed"

The only empirical claim of beneficiary harm in the preamble is the quotation, carried forward from the 2023 SNF rulemaking, of a single working paper estimating mortality effects of private equity ownership of nursing homes.[8] Whatever the merits of that study's estimates within its own sector, it examined one provider type, and it is one study within a substantial literature. MedPAC reviewed that very study alongside the balance of the nursing home literature in its June 2021

[6] 91 Fed. Reg. at 41,297–98 (quoting 88 Fed. Reg. 80,141, 80,144 (Nov. 17, 2023)). The quoted study is Atul Gupta, Sabrina T. Howell, Constantine Yannelis & Abhinav Gupta, *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes* (Nat'l Bureau of Econ. Research, Working Paper No. 28474, Feb. 2021). The study's findings should be viewed in light of limitations in its sample and control group. Of the facilities represented in the study's ten largest transactions, nearly 85% were managed by non-mainstream private equity firms, nearly two-thirds were managed by just two firms, and several of the firms accounting for the greatest number of transactions are now defunct. Many of the firms examined were generally smaller firms or did not employ traditional buyout strategies. The study also included nonprofit nursing facilities in its control group, despite material differences between nonprofit and for-profit facilities in patient selection and payer mix, including the proportion of Medicaid patients served. Comparing private-equity-owned facilities with nonprofit facilities may therefore materially affect the study's empirical conclusions; a comparison with other for-profit facilities would better account for those differences.

[7] 91 Fed. Reg. at 41,298 (quoting the May 2025 edition of the American Medical Association's Journal of Ethics and the associated website).

[8] *See supra* note 7.

report and reached a conclusion the preamble nowhere acknowledges: "the findings in the literature on the average effects of PE ownership on nursing home quality and costs are mixed."[9]

The literature MedPAC surveyed illustrates this very point. Its analysis linking facility data to detailed resident-level records found that private equity ownership does not lead to lower quality across 17 resident-level quality measures in the years following acquisition.[10] Another study found heterogeneous effects, with private equity owners increasing staffing in competitive markets and shifting staffing toward registered nurses in response to quality-rating incentives.[11] And the pandemic-era evidence, the most demanding real-world test of nursing home ownership and resident safety, found no statistically significant differences between private equity-owned facilities and other facilities in staffing levels, COVID-19 cases or deaths, or deaths from any cause,[12] with a separate analysis finding that private equity ownership was associated with a decreased probability of confirmed resident and staff cases and with greater availability of personal protective equipment.[13] MedPAC further cautioned that this entire body of research is complicated by data limitations as there is no single data source identifying private equity ownership, studies vary in their methods and definitions, and researchers likely undercount PE-owned providers.[14]

In short, the expert commission that Congress established to advise it on Medicare examined the same evidence the preamble quotes, in response to a congressional request specifically about private equity and Medicare and did not conclude that private equity ownership harms beneficiaries even within the nursing home sector, much less across the Medicare program.

B. The Journal of Ethics quotations are commentary, not evidence

The preamble's remaining citations consist of quotations from essays in an issue of a medical ethics journal and from the journal's website. These are characterizing statements, concerning

[9] MedPAC Report, ch. 3 (summarizing the nursing home literature and concluding that "the findings in the literature on the average effects of PE ownership on nursing home quality and costs are mixed").

[10] Sean Shenghsiu Huang & John R. Bowblis, *Private equity ownership and nursing home quality: an instrumental variables approach*, 19 Int'l J. Health Econ. & Mgmt. 273 (2019) (summarized in MedPAC Report, ch. 3).

[11] Ashvin Gandhi, YoungJun Song & Prabhava Upadrashta, *Private Equity, Consumers, and Competition: Evidence from the Nursing Home Industry* (2020) (summarized in MedPAC Report, ch. 3).

[12] Robert Tyler Braun et al., *Comparative Performance of Private Equity–Owned US Nursing Homes During the COVID-19 Pandemic*, 3 JAMA Network Open e2026702 (Oct. 28, 2020) (summarized in MedPAC Report, ch. 3).

[13] Ashvin Gandhi, YoungJun Song & Prabhava Upadrashta, *Have Private Equity Owned Nursing Homes Fared Worse Under COVID-19?* (Oct. 2020) (summarized in MedPAC Report, ch. 3).

[14] MedPAC Report, ch. 3 (noting, among other limitations, that no single data source identifies PE ownership of health care providers, that studies vary in their methods, time periods, and definitions of private equity, and that researchers likely undercount PE-owned providers).

physicians' fiduciary duties, the ethics of practice sales, and residency programs and not empirical research on Medicare outcomes. The justification within the quoted material, a 2023 systematic review said to associate private equity ownership with increased costs, is an aggregation of associational studies spanning all payers and care settings; as discussed below, studies of that design are precisely what GAO excluded from its contemporaneous review because they "could not support causal inferences."[15]

The preamble's quoted characterization of private equity ownership as existing to "reduce staff, sell assets, and refinance debt" likewise is in conflict with MedPAC's detailed study of private equity business models, which found that the profit-seeking strategies attributed to private equity are commonly used by other for-profit providers and "are not unique to PE-backed providers," and that sale-leaseback transactions are common across the industry and not limited to PE-owned facilities.[16] MedPAC also documented benefits the preamble omits entirely, including economies of scale in administrative functions, access to capital at lower cost than is available to small providers, and investment in electronic health records and clinical equipment.[17]

C. GAO's September 2025 Review: The most recent government examination of the question found no evidence that private equity investment in physician practices harms Medicare

In September 2025, less than a year before the Proposed Rule published, GAO issued its report on physician consolidation, prepared in response to a congressional directive to examine the extent of health care consolidation across Medicare and Medicaid markets and how the involvement of private equity could be contributing.[18] GAO reviewed approximately 100 studies published from January 2021 through July 2025, applying explicit methodological standards and excluding studies whose designs could not support causal inference.[19] Its findings bear directly on the Medicare supplier that would complete Form CMS-855B, the physician group practice, and they run contrary to the preamble's narrative in every relevant dimension:

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[15] GAO Report (describing the methodology for the literature review, which encompassed approximately 100 studies published from January 2021 through July 2025 and excluded studies "that used methods that could not support causal inferences, such as correlations and surveys").

[16] MedPAC Report, ch. 3 (observing that the profit-seeking strategies attributed to PE firms are also used by for-profit providers that are not PE owned and are not unique to PE-backed providers, and that sale-leaseback transactions are common across the industry and not limited to PE-owned facilities).

[17] MedPAC Report, ch. 3.

[18] GAO Report (describing the congressional mandate to which the report responds).

[19] Id.

First, the footprint is small: GAO reported that approximately 6.5 percent of physicians nationally worked in practices owned by private equity firms in 2024, a "small but growing share."[20]

Second, and most significantly, the only two studies GAO identified that rigorously examined the effect of private equity acquisition of physician specialty practices on spending in traditional Medicare, covering urology and ophthalmology, found that traditional Medicare spending did not change.[21]

Third, GAO did not identify any studies that sufficiently examined the causal effects of private equity investment on quality of care, and none that established causal effects on access; GAO expressly identified private equity's effects on quality and access as areas lacking rigorous study.[22] The preamble asserts "diminished quality of care"; while the government's own audit agency, applying recognized evidentiary standards to the identical question months before this rule was published, found no rigorous study supporting that claim.

Fourth, where GAO did find price and spending effects associated with private equity, they were confined to commercial insurance, varied by specialty, and were modest in magnitude.[23] Commercial-market pricing dynamics are thus not a Medicare problem and cannot support a "Medicare-wide" finding in a Medicare enrollment rulemaking.

Fifth, the one site-of-service finding in GAO's report supports private equity affiliation: Medicare patients whose physicians were affiliated with private equity-backed management services organizations were the most likely to receive selected services in lower-cost settings, with the probability that a colonoscopy with biopsy was performed in a physician office or ambulatory surgical center standing at 69 percent for such physicians. Specifically, when site-of-service economics directly drive traditional Medicare spending, private equity affiliation was associated with the cost-saving pattern.

D. MedPAC found minimal evidence of private equity effects in the physician sector and explained why traditional Medicare is structurally insulated from the pricing dynamics the preamble invokes

MedPAC's June 2021 report reached the same conclusion four years earlier: "[f]or physician practices, there is minimal peer-reviewed, empirical evidence of the impact of PE ownership on

[20] GAO Report (reporting American Medical Association survey data).

[21] GAO Report (summarizing the two studies of private equity acquisitions of urology and ophthalmology practices, respectively).

[22] GAO Report.

[23] GAO Report ("Highlights" and accompanying findings).

Medicare spending, quality of care, and patients' experience."[24] MedPAC also explained the structural reason the commercial-market literature does not translate to Medicare: the market-power strategies attributed to consolidating owners have "little immediate, direct impact on Medicare beneficiaries or spending because Medicare's prices are set administratively rather than negotiated."[25] And MedPAC's prevalence and outcomes findings across other sectors are equally difficult to square with a program-wide harm narrative: private equity firms own approximately 4 percent of hospitals and 11 percent of nursing homes and approximately 2 percent of Medicare Advantage organizations, accounting for less than 2 percent of MA enrollment; and PE-owned hospitals' cost and patient-experience differences relative to other hospitals were small, exhibited substantial overlap, may not be caused by PE ownership, and were accompanied by no statistically significant differences in mortality.[26]

Finally, MedPAC observed that it knew of no evidence indicating whether practices acquired by private equity behave differently from practices acquired by health systems or health plans[27], and GAO, four years later, identified no such comparative evidence either. For all of these reasons, AIC respectfully requests that, in any final rule, CMS withdraw or substantially revise the statement that private equity involvement is "a Medicare-wide issue," rely on the GAO and MedPAC reports directly, and confine any findings concerning private equity to what the record evidence actually supports.

III. The Definition of "Private Equity Company" Remains Inaccurate and Should Be Modified Before Any Expansion

As AIC noted in its April 2023 comments, the definition of "private equity company" adopted by CMS in the November 2023 final rule is fundamentally flawed. CMS now proposes to apply this same problematic definition to all Medicare Part B suppliers without addressing any of AIC's prior concerns. The definition remains overbroad, inaccurate, and poorly tailored to its stated purpose.

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[24] MedPAC Report, ch. 3.

[25] MedPAC Report, ch. 3 ("This strategy has little immediate, direct impact on Medicare beneficiaries or spending because Medicare's prices are set administratively rather than negotiated.").

[26] MedPAC Report, ch. 3 (reporting that PE firms own approximately 4 percent of hospitals and 11 percent of nursing homes; that PE firms own approximately 2 percent of Medicare Advantage organizations, accounting for less than 2 percent of MA enrollment; and that PE-owned hospitals' cost and patient-satisfaction differences relative to other hospitals "are not large," exhibit "substantial overlap," and "may not be caused by PE ownership," with no statistically significant differences in mortality across ownership categories).

[27] MedPAC Report, ch. 3 ("We do not know of evidence that indicates whether practices acquired by PE behave differently from practices acquired by health systems or plans.").

The current definition is so broad that it encompasses publicly-traded investment companies, mutual funds, family offices, and other entities that are plainly not "private equity" in any commonly understood sense. As AIC explained in its 2023 comments, those definitions are inaccurate and overbroad: the "private equity company" definition captures publicly traded companies and any pooled investment vehicle regardless of control, sweeps in purely passive investors, and simultaneously excludes operating companies that own providers outright, producing a "hodgepodge" of disclosures that does not support CMS's research objectives. Those defects are compounded in the physician practice and DMEPOS context.

Notably, MedPAC's own report demonstrates why definitional precision is a precondition to useful data. MedPAC observed that "private equity" encompasses distinct investment strategies like buyouts, growth capital, and venture capital funds, with very different economics, and it confined its analysis to buyout funds for exactly that reason; it further cautioned that ownership-disclosure thresholds keyed to 5 percent interests would sweep in limited partners such as pension funds "even though they are typically passive investors."[28] A checkbox that conflates a controlling buyout sponsor with a passive pension fund, a growth-capital minority investor, and a venture fund will not tell CMS anything useful about who controls Medicare suppliers.

The physician sector adds a further complication in regard to the management services organization ("MSO") structure that the SNF context did not present. As GAO noted, available data often cannot differentiate between private equity acquisition of a physician practice and acquisition of an MSO with which a practice merely affiliates, and ownership shares are not always known.[29] In many states, corporate-practice-of-medicine doctrines mean the investment firm owns no interest in the professional entity at all. A yes/no identification requirement that does not distinguish ownership from contractual affiliation will generate disclosures that are inconsistent across suppliers and unusable for research.

The Investment Advisers Act of 1940, as amended by the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010, established the comprehensive federal regulatory framework governing private fund sponsors. Acting under that statutory authority, the Securities and Exchange Commission developed the Form PF reporting framework, which requires investment advisers to private funds to classify and report information about their fund activities. That

[28] MedPAC Report, ch. 3 (explaining that the term "private equity" encompasses distinct investment strategies—including buyout, growth capital, and venture capital funds—and confining the Commission's analysis to buyout funds; further noting that identifying all individuals with an ownership stake of at least 5 percent in a PE fund would sweep in limited partners, such as pension funds, "even though they are typically passive investors").

[29] GAO Report (noting that available transaction data often cannot differentiate between private equity acquisition of a physician practice and acquisition of a management services organization with which a practice affiliates, and that ownership shares are not always known).

framework reflects precise, well-understood definitions developed through notice-and-comment rulemaking and refined through more than a decade of regulatory application.

The Form PF Glossary of Terms defines and distinguishes among private equity funds, hedge funds, liquidity funds, real estate funds, securitized asset funds, and venture capital funds. Those definitions reflect the actual structure of the private investment industry and have been applied by thousands of fund sponsors in regulatory reporting. They represent the gold standard for identifying private equity funds because they were developed by the primary federal regulator of private fund sponsors with expertise in the structure and operation of these entities.

Accordingly, AIC reiterates its recommendation from its 2023 comments that any PEC identification requirement adopt the following definition:[30]

> *Private equity fund means, for purposes of this subpart only, any "private fund" that purchased [a majority ownership share of]/[a controlling interest in] a supplier and that is not a "hedge fund," "liquidity fund," "real estate fund," "securitized asset fund" or "venture capital fund" and does not provide investors with redemption rights in the ordinary course, as such terms are defined in the Glossary of Terms for Form PF as required by the Investment Advisers Act of 1940, as amended.*

This definition would ensure that CMS captures actual private equity fund ownership, entities structured and operated as buyout funds that acquire controlling interests in healthcare providers, while excluding venture capital, hedge funds, mutual funds, pension funds making passive allocations, and other categories of investors that do not exercise operational control over their investments. It would give CMS information that is both more accurate and more useful than a checkbox that conflates a controlling buyout sponsor with passive or minority investors.

IV. REITs Should Not Be Subject to Expanded Disclosure Requirements

AIC reiterates its position that REITs should not be subject to PEC/REIT disclosure requirements at all, and that expanding such requirements to additional provider and supplier categories only amplifies this concern.

REITs that own healthcare-related real estate are landlords. They own the physical property and lease it to operators under triple-net lease arrangements. REITs do not hire or fire clinical staff, do not make clinical decisions, do not manage patient care, and do not exercise day-to-day operational control over the healthcare services provided in their buildings. Requiring disclosure of REIT

[30] Investment Advisers Act of 1940 § 204(b), 15 U.S.C. § 80b-4(b), as added by section 404 of the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, and U.S. Securities and Exchange Commission, Form PF, Glossary of Terms.

ownership provides CMS with information about who owns the *building* and not who operates the *healthcare facility*.

The original concerns that motivated section 1124(c) related to the physical condition of SNF facilities and potential underinvestment in physical plant by PE and REIT owners. Whatever the merits of those concerns in the SNF context, they have no application to physician practices, DMEPOS suppliers, or MDPP suppliers. CMS cites no evidence that REIT ownership of property leased to physician groups or medical equipment suppliers has any impact on the quality of care or services provided.

As AIC noted in its prior comments, the REIT definition adopted by CMS is broader than necessary. If CMS nonetheless proceeds with REIT disclosure requirements, it should at minimum narrow the definition to capture only REITs that qualify under IRC Section 856(a) *and* that exert day-to-day operational control over the healthcare provider or supplier. A REIT that simply owns property and leases it to a provider at arm's length should not be subject to disclosure requirements designed to illuminate operational control of healthcare facilities.

> *REIT means, for purposes of this subpart only, a "real estate investment trust" as that term is defined in Section 856(a) of the Internal Revenue Code, that leases or subleases real property to a supplier in the ordinary course of its business and that has the power, through the lease agreement or otherwise, to exert day-to-day operational, financial or managerial control over the supplier or a part thereof.*

V. The Proposed Revocation and Denial Provisions Are Overbroad and Pose Unique Risks to Non-Related Parties

Section 424.535(a)(24) of the Proposed Rule is dangerously overbroad. CMS would authorize revocation where it deems that a provider or supplier 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 intentionally leaves "*limited geographic area*" and "*excessive number*" undefined, stating that those terms would carry their ordinary meanings. CMS further states that no actual finding of fraud, waste, or abuse is required and declines to identify specific factors it must consider before taking revocation action.

This combination of an undefined geographic standard, an undefined numerical standard, and an assessed-risk threshold gives CMS exceptionally broad discretion to treat ordinary provider concentration as a basis for revocation. Geographic clustering may reflect patient demand, shared infrastructure, or legitimate market efficiencies; it is not, without more, evidence of fraud, waste, or abuse. A revocation authority that can be exercised without an actual finding of misconduct and

without prescribed decision criteria risks arbitrary and inconsistent application. CMS should not infer fraud risk from the mere proximity of providers operating in the same market.

Section 424.535(i) poses even greater risks. CMS proposes to expand that provision so that if one enrollment is revoked or denied, CMS may revoke any and all of the provider's other Medicare enrollments, including enrollments under different names, numerical identifiers or business identities and under different provider types. When combined with CMS's broad affiliation framework under § 424.519, including the proposed expansion of the "affiliation" definition to additional business, financial, managerial, and other relationships, this creates a cascading risk for private equity portfolio companies. A private equity firm may own multiple healthcare providers, each of which is separately incorporated and independently operated, with its own management, clinical staff, billing systems, and compliance program.

This poses a large threat that CMS could treat the affiliation between one portfolio company and other portfolio companies of the same PEC, or even within different funds of the same firm, as a basis to extend revocation to these separately incorporated, unrelated businesses. CMS should not have the authority to deny or revoke enrollments across a PEC's entire range of portfolio companies because it denied one company's enrollment, merely due to an "up the chain" common ownership without the presence of factual evidence that the two separate entities share the same managerial or operational processes or personnel that caused the actual basis for denial/revocation in the first place. PECs typically utilize independent local teams for each separate portfolio company who are functional specialists within the range of services provided by the distinct portfolio company. That being said, it would be outlandish for CMS to assume that two separate and distinct companies, providing separate and distinct services, are guilty of the same perceived violation without further investigation or analysis into the claim. CMS should limit any extension of an adverse enrollment action to another portfolio company unless it can show that the other company participated in or was responsible for the conduct underlying the original action.

Section 424.530(a)(19) proposes "same suite" denial grounds and raises separate concerns for unrelated providers that share office space. CMS proposes to deny enrollment if a provider's practice location is "*in the same suite or office as another provider or supplier whose Medicare enrollment has been revoked or denied.*" It is common for completely unrelated healthcare providers to share administrative office space or locate in the same medical office building for reasons of convenience, cost efficiency, or proximity to hospitals and other facilities. These providers may have no ownership relationship, no shared management, and no clinical or billing integration whatsoever. A revocation or denial involving one tenant should not automatically jeopardize the enrollment of an entirely separate company that merely shares a building address or common areas while maintaining wholly independent operations, personnel, billing, and compliance functions.

Taken together, these provisions create a domino effect that is disproportionate to any legitimate program integrity concern. AIC urges CMS to clarify that: (a) geographic proximity among providers does not create an inference of fraud risk under § 424.535(a)(24) absent evidence of actual misconduct; (b) the extension of revocation under § 424.535(i) will not be applied to separately incorporated and independently operated portfolio companies based solely on common private equity ownership; and (c) sharing a building address or common administrative space does not constitute being "in the same suite or office" for purposes of § 424.530(a)(19) where the providers are unrelated and maintain separate operations.[31]

VI. The Proposed Revocation Procedures Are Unduly Punitive and Provide Inadequate Due Process

CMS proposes to make all revocation grounds retroactive. Under the proposal, every revocation under § 424.535(a) would have a retroactive effective date, generally reaching back to the date CMS determines that the provider's non-compliance began or to another specified date tied to the alleged violation. The provider could therefore be required to return Medicare payments received after that date, even where it furnished legitimate services to Medicare beneficiaries during the intervening period. For healthcare providers serving vulnerable populations, the resulting repayment exposure and disruption to cash flow could pose an existential financial threat.

CMS also proposes to reduce the post-revocation claims submission period from 60 days to 15 days. Under proposed § 424.535(h), a revoked provider would have only 15 calendar days from the date of the revocation letter to submit all claims for services furnished before the revocation effective date, rather than the current 60-day period. For large healthcare organizations with complex billing systems, 15 days is wholly insufficient to identify, compile, validate, and submit all outstanding claims, particularly where the revocation effective date may be months or years in the past because of the proposed retroactive rules.

The proposed expansion of the reapplication bar is equally disproportionate. Under proposed § 424.530(f), CMS could prohibit a provider from enrolling in Medicare for up to 10 years following a denial for any reason, rather than limiting the bar to denials based on false or misleading information. A provider denied for a technical deficiency, such as an inadequate application fee, could theoretically face a decade-long bar, even though the denial does not establish fraud, dishonesty, or a threat to beneficiaries.

[31] 91 Fed. Reg. 41,216 (July 6, 2026). The PEC and REIT discussion appears at 91 Fed. Reg. at 41,297–98; the proposed revocation and denial provisions discussed in Sections V and VI appear at 91 Fed. Reg. at 41,285–95, including proposed §§ 424.535(a)(24) and (i) and § 424.530(a)(19); see also id. at 41,302–03 (proposed affiliation provisions under §§ 424.502 and 424.519).

CMS also proposes to remove the specific factors it currently must consider when deciding whether to impose a reapplication bar and how long it should last. Eliminating those guardrails would leave providers without meaningful notice of the circumstances that could trigger a decade-long exclusion and would give CMS unfettered discretion to impose a sanction untethered to the seriousness of the underlying denial. The procedural protections are particularly inadequate where the triggering determination may rest on assessed risk rather than actual misconduct.

Applied to private equity-backed providers, these changes could effectively destroy viable healthcare businesses and disrupt patient care. The combination of retroactive revocations, cascading extensions to other enrollments, 15-day claims windows, and 10-year reapplication bars means that a single adverse CMS determination, potentially based on "assessed risk" rather than actual misconduct—, could eliminate an entire healthcare enterprise from Medicare, with no realistic prospect of re-entry. AIC urges CMS to maintain the existing 60-day claims submission period, limit retroactive effective dates to cases involving actual fraud, and retain the current limitation of reapplication bars to denials based on false or misleading information.

VII. CMS Should Conduct a Full Paperwork Reduction Act Process ("PRA")

CMS acknowledges that the announced revisions to Forms CMS-855B and CMS-855S will impose an information collection burden to be addressed in future submissions to the Office of Management and Budget.[32] AIC requests that CMS commit, in any final rule, to publishing the proposed form language, including the operative definitions of "PEC" and "REIT" and the accompanying instructions, for public comment through the PRA process before any revision takes effect, and to providing burden estimates that reflect the legal analysis suppliers must undertake to determine whether each disclosed organization satisfies whatever definitions CMS adopts. Form CMS-855B alone is completed by hundreds of thousands of clinics, group practices, and other Part B supplier organizations.

CMS should also explain how this new requirement will produce data of research quality. MedPAC's report documented at length the limitations of Medicare's existing enrollment-based ownership data (self-reported, unverified, and historically incomplete) and its transparency recommendations were directed at verified, structured ownership information, including improved parent-organization hierarchies and not at binary self-identification.[33] Layering an undefined label

[32] 91 Fed. Reg. at 41,298 (collection of information discussion); see also id. at 41,285–86 (retroactive revocation effective dates), 41,290 (the proposed § 424.535(h) claims submission period), and 41,295 (the proposed § 424.530(f) reapplication bar).

[33] MedPAC Report, Ch. 3 (describing the limitations of self-reported, unverified ownership information in Medicare enrollment data and recommending more complete ownership data and greater transparency of ownership, including improved parent-organization hierarchies).

onto a data system with documented accuracy problems is unlikely to close the evidence gaps that MedPAC and GAO identified, and it is those gaps, and not any demonstrated harm, that constitute the actual state of the record.

Finally, the preamble, the GAO Report, and the MedPAC Report do not contain evidence concerning private equity or REIT involvement with DMEPOS suppliers or Medicare Diabetes Prevention Program suppliers. Neither government review so much as examines those supplier categories. Extending the identification requirement to Forms CMS-855S and CMS-20134 therefore lacks any basis, and those forms should be omitted from the initiative absent a record justifying their inclusion. The proposed expansion of PEC/REIT disclosure requirements to all Medicare Part B suppliers will impose significant administrative burdens on healthcare providers without generating information that meaningfully advances CMS's oversight objectives.

VIII. Conclusion

AIC supports ownership transparency that is accurately defined, appropriately reflective of control, and capable of producing data that informs policy. The Proposed Rule's preamble, however, advances a program-wide characterization of private equity investment that the government's own expert reviews contradict. MedPAC found minimal empirical evidence of private equity effects on Medicare in the physician sector and GAO found no change in traditional Medicare spending from private equity practice acquisitions and no substantiated evidence on quality or access.

AIC respectfully requests that CMS revise the preamble's characterization accordingly; review the basis of authority of the Proposed Rule; adopt controlling-interest definitions of "private equity fund" and "REIT" drawn from established federal regulatory frameworks; conduct any form revisions through a complete PRA process with published definitions and burden estimates; and withdraw Forms CMS-855S and CMS-20134 from the initiative absent record evidence supporting their inclusion.

AIC appreciates the opportunity to comment on the Proposed Rule and would be pleased to answer any questions that you might have concerning our comments.

Respectfully submitted,

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