American Society for
Gastrointestinal Endoscopy

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August 31, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20543

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 American Society for Gastrointestinal Endoscopy (ASGE) appreciates the opportunity to comment on the CY 2027 Home Health Prospective Payment System proposed rule, published in the *Federal Register* on July 6, 2026. Specifically, we offer comments on Centers for Medicare and Medicaid Service's (CMS') proposals related to provider enrollment.

ASGE is the global leader of advancement in the field of gastrointestinal (GI) endoscopy and upholds the highest standards for gastrointestinal endoscopic practice and fosters research to encourage continuous innovation. It empowers members with the latest information, state-of-the art education and unparalleled resources to advance professional and patient care goals. With more than 17,000 members worldwide, ASGE provides a diverse, inclusive and engaged community to foster sharing, learning, advocacy and growth in GI endoscopy.

We support CMS' ongoing efforts to combat fraud, waste, and abuse in the Medicare program. Protecting the integrity of Medicare is essential to ensuring that taxpayer dollars are used responsibly and that beneficiaries have continued access to high-quality care.

Effective fraud prevention and detection help safeguard Medicare resources, strengthen public confidence in the program, and ensure that funds are directed toward legitimate health care services and the beneficiaries who rely on them. We commend CMS for its continued work to identify improper activity and collaboration with health care providers to prevent and address fraud. However, these efforts must be balanced with appropriate protections for legitimate health care delivery activities and to ensure that policies do not inadvertently impose barriers to beneficiary access to care.

NEW REVOCATIONS REASONS

CMS proposes to expand its existing authority to revoke a provider's enrollment retroactively to the date on which the provider's noncompliance began by making all revocation reasons subject to retroactive application. Given the significant expansion of CMS' authority that this proposal entails, it is important that retroactive revocations be grounded in a clear and substantial basis of fraud, abuse, or other conduct warranting such action.

High-risk Based on Excess Providers in an Area – § 424.535(a)(24)

CMS proposes to newly add that it may revoke a provider's or supplier's enrollment if it deems the enrollment as presenting 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. We appreciate that CMS has clarified the proposal is not designed to revoke good-faith providers who otherwise present no apparent risks even though they might be in an area (e.g., same building, complex or other small area) with numerous other providers.

Despite CMS' assurance that the proposal is not intended to target good-faith providers simply because they are located in an area with a high concentration of providers or suppliers, there is concern that relying on geographic concentration as a basis for determining an individual provider or supplier presents a high risk of fraud, waste, or abuse could result in legitimate providers being subject to heightened scrutiny or adverse enrollment actions based on circumstances outside of their control. As such, we ask whether CMS has considered establishing other specific indicators of or the potential for fraud, waste, or abuse, alongside geographic concentration, when making a determination of assessed risk for purposes of enrollment revocation.

Certain Misdemeanor Convictions – § 424.535(a)(16)

As proposed, CMS would revoke enrollment if a provider or supplier—or any owner, managing employee or organization, officer, or director thereof—was convicted of a Federal or State misdemeanor related to sexual assault or financial misconduct within the past 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries.

We acknowledge that CMS states in the proposed rule that not every conviction would result in enrollment revocation. Nevertheless, we remain concerned the proposed authority could result in physicians, other health care professionals, and providers being subject to revocation of their Medicare enrollment based on a misdemeanor conviction of an individual working for or affiliated with the organization, even where the organization's professional leadership had no knowledge of, or involvement in, the underlying conduct.

This concern is particularly significant given the increasing consolidation of health care providers and the prevalence of large organizations with numerous locations and complex ownership structures, including private equity and corporate ownership. Holding an entire organization responsible for the isolated misconduct of an individual, particularly where the physician members of the organization had no knowledge of or role in that conduct, could produce disproportionate consequences for patients, providers, and the Medicare program.

Accordingly, we strongly recommend that CMS narrow this provision to apply only to individuals who have been convicted within the preceding 10 years of a misdemeanor specifically involving sexual assault or financial misconduct, and that CMS require a meaningful nexus between the individual's conduct and the organization's Medicare enrollment before revocation may be imposed.

NEW DENIAL REASONS

Misdemeanor Convictions – § 424.530(a)(16)

CMS proposes to duplicate proposed § 424.535(a)(16) as a new denial ground. We direct CMS to our comments above regarding § 424.535(a)(16).

Revocation or Denial in Same Suite – § 424.530(a)(19)

CMS proposes a new denial ground based on the provider having its practice location in the same suite or office as another provider whose Medicare enrollment has been revoked or denied.

While CMS states in the rule that it will only invoke § 424.530(a)(19) when proper, we have reservations about this proposed CMS expanded authority.

We are concerned that CMS' proposed denial authority based solely on a provider sharing a suite or office with another provider whose Medicare enrollment has been revoked or denied is overly broad and could result in adverse action against legitimate providers that have no connection to the underlying conduct.

Sharing a physical practice location does not, on its own, establish that providers share ownership, management, billing operations, employees, patients, or other business relationships, nor does it demonstrate that a provider presents a risk of fraud, waste, or abuse. This is

particularly concerning in medical office buildings, multispecialty practices, and other settings where unrelated providers may legitimately share space or operate under common leases or building arrangements. A provider may also have little or no ability to know that another provider occupying the same suite has been subject to an enrollment denial or revocation.

We appreciate CMS' efforts to identify potential indicators of program integrity risk. However, the proposed provision should be narrowly tailored so that a provider is not denied enrollment based solely on its physical proximity to another provider. At a minimum, CMS should require additional provider-specific evidence demonstrating a substantive relationship with the excluded or revoked provider or other indicators of fraud, waste, or abuse before imposing a denial. Physical co-location should be treated, at most, as a factor warranting further inquiry—not as an independent basis for denying a legitimate provider's Medicare enrollment.

PRIVATE EQUITY COMPANIES (PECS) AND REAL ESTATE INVESTMENT TRUSTS (REITS)

CMS is proposing to require clinics and group practices, among other providers and suppliers, to report on Medicare enrollment applications (Form CMS-855B) whether any party listed on the application is a PEC or a REIT. Such that this provision is included among proposals to prevent unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare, we are deeply concerned disclosure of ownership information will be used as a proxy for suspicion of wrong-doing or program-integrity risk.

We support appropriate transparency regarding the ownership and management of Medicare providers and suppliers. However, we are concerned that requiring disclosure of private equity involvement could have consequences beyond providing CMS with information necessary to administer the Medicare program. In particular, CMS should ensure the identification of a private equity investment or other financial interest is not treated, either explicitly or implicitly, as evidence that a provider or supplier presents a heightened risk of fraud, waste, abuse, or inappropriate care.

Private equity ownership or investment is a financial structure, not an indication of misconduct. The fact an organization has private equity backing does not establish that it engages in improper billing, compromises clinical decision-making, provides lower-quality care, or otherwise poses a risk to the Medicare program. Nor should differences in profitability between private equity-backed and non-private-equity-backed organizations be viewed as evidence of improper conduct.

We are particularly concerned that disclosure requirements could, over time, facilitate regulatory or political scrutiny directed at private equity-backed organizations based on their ownership structure rather than on objective evidence of program-integrity concerns. Should CMS finalize this proposal, safeguards must be in place to ensure legitimate differences in ownership or financing models do not become a basis for discriminatory treatment, heightened scrutiny, or

adverse enrollment actions absent provider-specific evidence of fraud, waste, abuse, or other violations of Medicare requirements.

If CMS determines that ownership information is necessary to better understand the Medicare provider landscape, that information should be used in a neutral and evidence-based manner. CMS should expressly affirm that private equity ownership or the profitability of an organization will not, by itself, constitute a basis for heightened risk designation, denial or revocation of Medicare enrollment, increased auditing, or other adverse action. Any such action should instead be based on objective, provider-specific evidence demonstrating an actual risk to Medicare program integrity.

CONCLUSION

ASGE supports CMS' efforts to strengthen Medicare program integrity and combat fraud, waste, and abuse. However, these efforts should be carefully tailored to address demonstrated risks rather than rely on broad assumptions based on ownership structure, geographic location, shared practice space, or isolated conduct by individuals. CMS should ensure that expanded enrollment authorities are applied objectively, and with appropriate due process, while protecting legitimate providers and suppliers from adverse action based on circumstances that do not demonstrate an actual program-integrity risk. Transparency can strengthen Medicare oversight, but it should not become a proxy for heightened scrutiny or discriminatory treatment of particular ownership or business models. We encourage CMS to refine these proposals accordingly and focus its enforcement authorities on evidence of actual fraud, abuse, or other conduct that threatens the integrity of the Medicare program.

Should you have questions or require additional information, please contact Lakitia Mayo, ASGE Chief Policy and Member Engagement Officer, at (630) 570-5641 or lmayo@asge.org.

Sincerely,

Jonathan Cohen, MD, MASGE
ASGE President Elect