American Society of Echocardiography

August 24, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1844-P

Re: CMS-1844-P, 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 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Policies, 91 Fed. Reg. 41216 (July 6, 2026)

Dear Administrator Oz:

On behalf of the American Society of Echocardiography (ASE), the Society for Cardiovascular Ultrasound Professionals, we appreciate the opportunity to comment on the Medicare provider-enrollment provisions in the proposed Home Health Prospective Payment System rule. ASE is the largest global organization for cardiovascular ultrasound imaging serving more than 20,000 physicians, sonographers, nurses, veterinarians, and scientists and as such is the leader and advocate, setting practice standards and guidelines for the field. Since 1975, the Society has been committed to advancing cardiovascular ultrasound to improve lives.

ASE supports CMS's commitment to safeguarding the Medicare program and protecting beneficiaries from fraud, waste, and abuse. Effective program-integrity policy should identify and address bad actors while preserving fair process, minimizing avoidable administrative burden on compliant clinicians and practices, and preventing unnecessary disruptions in beneficiaries' access to care. These considerations are especially important when an enrollment action may affect the ability of a practice or facility to furnish or bill for essential diagnostic services.

Retroactive Revocations

CMS proposes to revise 42 CFR § 424.535(g) so that revocations would generally take effect retroactively, rather than retaining the current prospective effective date for certain grounds. The proposal would make a revocation based on general noncompliance effective on the date CMS or its contractor determines the noncompliance began, among many other retroactive effective dates.

ASE agrees that retroactive revocation may be appropriate in limited, high-risk circumstances in which the facts establish that a provider or supplier was not eligible to participate in Medicare or engaged in conduct that presents a clear threat to program integrity. However, ASE is concerned that applying retroactive revocation to every revocation ground, including technical or administrative noncompliance, could impose disproportionate financial consequences on otherwise legitimate providers and suppliers. A retroactive effective date can expose a practice to recoupment for services that were medically necessary, actually furnished, and billed in good faith before the provider had

notice of the alleged deficiency. It can also interrupt access to diagnostic and specialty care for beneficiaries if the affected organization must curtail services while attempting to resolve an enrollment matter.

ASE therefore recommends that CMS:

- **Retain a prospective effective date for low-risk and curable noncompliance**: CMS should preserve the existing prospective approach for technical, inadvertent, or readily correctable enrollment deficiencies that do not involve fraud, patient harm, deliberate misrepresentation, loss of eligibility, or a demonstrated threat to the Medicare program.
- **Apply retroactivity only after an individualized program-integrity determination**: Before assigning a retroactive date, CMS should document the factual basis for concluding that the provider was noncompliant as of that date and explain why retroactivity, rather than prospective revocation or a corrective action, is warranted.
- **Define the beginning date of noncompliance with objective standards**: The final policy should specify the evidence CMS will use to establish that date and should not rely on inference alone where records reasonably support a different conclusion.
- **Provide meaningful notice and opportunity to respond before recoupment**: Revocation notices should identify the applicable authority, evidence, alleged date noncompliance began, proposed recovery period, and available rebuttal, corrective-action, and appeal options. CMS should consider delaying recoupment attributable solely to the retroactive effective date until the provider has received a meaningful opportunity for administrative review.
- **Protect beneficiaries and medically necessary care**: CMS should implement operational safeguards to avoid abrupt loss of access when a provider's enrollment status is challenged, particularly in rural, underserved, or otherwise capacity-constrained communities.

These safeguards would not weaken CMS's enforcement authority. They would help distinguish intentional or harmful conduct from isolated administrative errors and support an enforcement framework that is transparent, predictable, and proportionate.

Change in Majority Ownership

CMS proposes new denial and revocation authorities for a hospice, home health agency (HHA), or DMEPOS supplier that fails to comply with applicable change-in-majority-ownership requirements. Under proposed 42 CFR §§ 424.530(a)(22) and 424.535(a)(25), CMS could deny or revoke an enrollment for noncompliance with the requirements in §§ 424.550(b) or 424.551. The proposal is intended to address efforts to avoid the applicable 36-month rule and the associated new-enrollment, survey, or accreditation requirements.

ASE supports CMS's objective of ensuring that ownership changes do not become a mechanism to circumvent Medicare enrollment, survey, accreditation, or other program-integrity requirements. CMS should be able to take action when an entity intentionally conceals a qualifying transaction or structures an arrangement to evade requirements that would apply to a new owner.

At the same time, CMS should implement the policy with clear, prospective instructions and safeguards for legitimate transactions. The proposed authorities may have substantial consequences for entities, their clinicians, and the Medicare beneficiaries receiving care from them. Confusion about whether a transaction constitutes a change in majority ownership should not result in revocation where the entity acted in good faith and promptly corrects a reporting or procedural deficiency.

Suspensions, Terminations, and Other Actions Involving Owners or Managing Employees

CMS proposes to revise 42 CFR § 424.530(a)(14) to allow denial when a provider or supplier, or an owner, managing employee, or managing organization, is currently terminated, suspended, or otherwise barred from participation in a State Medicaid program or another Federal health care program. CMS also proposes to revise the definition of "managing employee" in 42 CFR § 424.502 to identify examples of personnel who may meet the definition when they exercise operational or managerial control, including certain medical directors, clinical directors, departmental heads, supervising physicians, and nursing directors.

ASE supports CMS's ability to examine program-integrity actions involving individuals and entities that actually own, control, or direct a provider or supplier. An enrollment denial may be appropriate when the relevant person has a meaningful connection to the conduct at issue and the circumstances demonstrate a present risk to Medicare or beneficiaries.

ASE is concerned, however, that these provisions could be interpreted too broadly if they are applied based on a clinical title or tangential relationship rather than the person's actual authority and connection to the conduct. Physicians and other clinicians frequently serve as medical directors, clinical leaders, department chairs, or supervising professionals without exercising ownership, financial control, or responsibility for enrollment and billing operations. Treating such roles as a per se basis for disclosure, scrutiny, or adverse action could discourage clinicians from accepting legitimate leadership positions and create avoidable administrative burden without advancing program integrity.

ASE recommends that CMS:

- **Require a clear nexus to the provider or supplier and the underlying conduct**: Before denying enrollment based on an associated party's history, CMS should determine that the person exercised meaningful ownership, operational, financial, compliance, or managerial control relevant to the conduct giving rise to the adverse action.
- **Apply a functional, not title-based, managing-employee standard**: The final rule and accompanying guidance should expressly state that a medical director, clinical director, department head, supervising physician, or nursing director is not a managing employee solely by virtue of title. Disclosure and adverse-action analysis should depend on the individual's actual functions and authority.
- **Limit the relevance of unrelated or remote actions**: CMS should consider the nature, severity, recency, and finality of an underlying program or licensure action; whether it remains in effect; the individual's role in that action; remedial measures; and the relationship of the conduct to the new provider or supplier.
- **Provide detailed notice and a meaningful rebuttal opportunity**: Notices should identify the associated person, the specific prior action, the evidence showing the person's relevant authority or relationship, and the factors supporting CMS's risk determination. Providers should be able to submit evidence that the person lacks relevant control or that the cited action is unrelated to the current enrollment.
- **Ensure consistency and transparency:** CMS should publish interpretive guidance and monitor contractor decisions to ensure that similarly situated providers, suppliers, and clinicians receive consistent treatment.

Other Associated-Party Relationships

The proposed rule would also expand the payment-suspension denial provision to include an individual or entity with "any other form of business or financial relationship" with the provider or

supplier. ASE urges CMS not to finalize this phrase without a clear limiting principle. Health care organizations often have ordinary contractual relationships with clinicians, hospitals, vendors, laboratories, technology companies, management-service organizations, and other entities that neither own nor control the provider.

CMS should limit any such authority to relationships involving a substantial ownership interest, actual control over billing or enrollment operations, or the ability to influence the conduct that presents the program-integrity concern. At a minimum, CMS should define the phrase through regulation or detailed public guidance and require a demonstrable nexus between the relationship and the risk identified by CMS.

Implementation and Due-Process Safeguards

Because enrollment actions can have significant effects on practice operations and patient access, ASE urges CMS to implement the provider-enrollment policies through a balanced framework that is both effective and administrable. In addition to the recommendations above, CMS should:

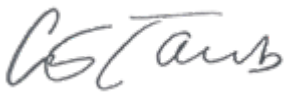
- Issue comprehensive, plain-language guidance and training for providers, suppliers, and Medicare Administrative Contractors before the effective date.
- Use standardized notices that clearly state the facts, regulatory basis, effective date, scope of any payment consequences, and available administrative remedies.
- Establish consistent standards for corrective action, rebuttals, and appeals, including expedited review when beneficiary access is at risk.
- Collect and publish de-identified, aggregate data on the use of new enrollment authorities, including the number of actions, cited grounds, reversal rates, and any identified access concerns.

Conclusion

ASE appreciates CMS's efforts to strengthen Medicare program integrity. The Society supports targeted action against fraud, abuse, and intentional noncompliance, but urges CMS to finalize these provisions with clear standards, an individualized risk assessment, meaningful due process, and safeguards against unnecessary disruption of medically necessary care. Such an approach will better protect Medicare beneficiaries and taxpayer resources while allowing compliant clinicians and practices to continue delivering high-quality cardiovascular diagnostic services.

Thank you for considering these comments. ASE welcomes the opportunity to provide additional information or to work with CMS on implementation guidance. If you have any questions, please contact Katherine Stark, ASE Director of Advocacy at kstark@asecho.org.

Sincerely,



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