Law Offices of
Stephenson
Acquisto
& Colman

Disclaimer — Review of CMS Annual Rulemaking

The following summary and analysis of the Centers for Medicare & Medicaid Services (CMS) annual rulemaking is provided for general informational purposes only. It reflects our review of the rule as published as of the date of this communication and does not constitute legal, compliance, or regulatory advice.

Proposed rules are not final and are subject to change. Where this material addresses a proposed rule, the provisions discussed represent CMS's proposals only. A proposed rule does not constitute final agency action, carries no binding effect, and may be modified, withdrawn, or adopted in materially different form following the public comment period. Payment rates, thresholds, effective dates, program requirements, and other terms may change before a final rule is issued. Nothing in this material should be relied upon as a statement of the requirements that will ultimately take effect.

The rule is subject to individual review, interpretation, and implementation. Application of the rule depends on each organization's specific facts, operational structure, patient or beneficiary population, and existing compliance posture. This material does not account for those individual circumstances. Each reader and organization is responsible for its own independent review of the rule, for forming its own interpretation of how the rule applies, and for determining the appropriate manner and timing of implementation within its operations.

No legal advice; no attorney-client relationship. This material is not a definitive legal interpretation of any CMS rule and should not be construed as legal advice or as a substitute for review of the official rule text published in the Federal Register. Reading or relying on this material does not create an attorney-client relationship.

Consult qualified counsel. Given the complexity of CMS rulemaking and the potential for change, readers and organizations — including providers, payers, administrators, and other healthcare stakeholders — should consult qualified legal, compliance, or regulatory counsel for guidance tailored to their specific circumstances before taking or refraining from any action based on the rule.

LAW OFFICES OF STEPHENSON ACQUISTO & COLMAN

CY 2027 OPPS Proposed Rule — Detail on the Price Transparency RFI and the EMTALA Accreditation-Survey Proposal

Both items below remain provisional. The Price Transparency section is a Request for Information (RFI) only — it proposes no binding requirement and any change would come through future notice-and-comment rulemaking. The EMTALA item is an actual proposed regulatory amendment, subject to comment before finalization.

I. Request for Information on Standardization and Comparability of Hospital Price Transparency Data (§ XXIII)

Background and posture

Since January 1, 2021, every hospital operating in the United States must disclose pricing two ways: a comprehensive **machine-readable file (MRF)** and a **consumer-friendly display**. (Medicare OPPS and ASC Payment Systems Proposed Rule § B) The RFI is driven by **Executive Order 14221** ("Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information"), issued February 25, 2025. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

It builds on the CY 2026 OPPS/ASC final rule, which already tightened MRF requirements — hospitals must now encode dollar-based data (the median and 10th/90th percentile allowed amounts, plus claim counts) for charges based on a percentage or algorithm, attest that the MRF is true, accurate, and complete, name a senior official responsible for the encoding, and include a Type 2 National Provider Identifier. Those changes took effect January 1, 2026, with enforcement beginning April 1, 2026. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

This is a solicitation of comment, not a proposal. CMS states it anticipates issuing further guidance and proposing additional requirements through future rulemaking. (Medicare OPPS and ASC Payment Systems Proposed Rule § B) The RFI has two parts: an MRF component and a consumer-friendly display component.

A. Machine-readable file (MRF) questions

The central concern is standardization of **complex contracting terms** that currently sit in unstructured free-text fields and are not uniformly encoded across hospitals. CMS identifies four in particular:

- **Outlier provisions** — additional reimbursement for exceptionally high-cost cases;
- **Stop-loss clauses** — additional reimbursement once a patient's treatment costs exceed a pre-negotiated threshold;

- **Rate-tiering arrangements** — payers categorizing hospitals into tiers based on cost and quality; and
- **Carve-out provisions** — separating high-cost specialized services from standard bundled rates. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

CMS asks whether these should be treated as item- or service-level payer-specific negotiated charges (already required in the algorithm data element) or as broad general contract provisions, and what standardized format would best capture them. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

A second MRF theme is **payer/plan name standardization.** CMS notes it has seen the same payer rendered as "Blue Cross," "BlueCross," "BC," and "BCBS," which frustrates cross-hospital comparison, and it asks whether to require a standardized payer-name list or a unique payer/plan identifier (e.g., a TIN or EIN). (Medicare OPPS and ASC Payment Systems Proposed Rule § B) It also asks about parsing free-text fields, adding new structured data elements, and expanding the valid values for contract methodology beyond the current set (fee schedule, capitation, per diem, case rate, other). (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

B. Consumer-friendly display questions

Under the CY 2020 HPT final rule, hospitals must display **300 total items and services, 70 of them CMS-specified**, and may satisfy this either through a **shoppable services file** or a **price estimator tool**. (Medicare OPPS and ASC Payment Systems Proposed Rule § B) Following listening sessions in June and July 2025, CMS raises several possibilities for comment: (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

- **Eliminating the "deemed compliance" treatment for price estimator tools** (currently at 45 CFR 180.60(a)(2)). Because estimator tools vary widely, CMS suggests deeming them compliant may limit comparability, and asks what effect removing that deemed-compliance status would have. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)
- **Revisiting the list of 70 CMS-specified shoppable services** — whether to increase or decrease the number and which items to add, remove, or update; it cites CPT code 29826 (arthroscopic shoulder procedure add-on) as an example of a possibly outdated or non-shoppable entry, noting the list has not been updated since CY 2020. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)
- **Requiring a shoppable services file** and asking what mechanisms could make the underlying estimator-tool data available separately. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)
- **Clarifying ancillary and bundled services** — how to present ancillary items, implants, and bundled services so consumers understand total expected cost and can distinguish included from excluded services. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

- **Reconciling display vs. MRF discrepancies** — CMS reports that standard charges in a hospital's display do not always match its MRF, and that some hospitals show a discounted cash price in the estimator tool while attesting (by omission) in the MRF that none exists. It seeks explanations. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

II. Accrediting Organization (AO) Deeming Authority for EMTALA (§ XVIII)

What EMTALA requires and how it is structured

EMTALA (enacted 1986; section 1867 of the Act, 42 U.S.C. 1395dd) was designed to prevent "patient dumping." (Medicare OPPS and ASC Payment Systems Proposed Rule § B) CMS implements it through two distinct regulatory categories:

- **§ 489.20(l), (m), (q), and (r) — administrative requirements:** post EMTALA signage; maintain a central log of individuals presenting to the emergency department; retain transfer records for 5 years; and maintain an on-call physician list. These are documentary/procedural provider-agreement commitments. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)
- **§ 489.24 — substantive care protections:** the medical screening examination, stabilizing treatment, appropriate-transfer, and receiving-hospital obligations. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

Most hospitals participate in Medicare through accreditation by a CMS-approved **accrediting organization (AO)**, which "deems" them to meet Medicare requirements. More than 90% of Medicare-participating hospitals (excluding CAHs and REHs) and more than 40% of CAHs are AO-accredited; no rural emergency hospitals are currently deemed. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

The proposal

CMS proposes to **clarify § 488.5(a)** so that an AO with a CMS-approved hospital accreditation program **may assess compliance with the § 489.20 administrative EMTALA requirements as part of its initial accreditation and reaccreditation surveys.** The rule would formally require AOs to fold review of those specified obligations into the existing accreditation framework. (Medicare OPPS and ASC Payment Systems Proposed Rule § B) Mechanically, CMS would add a **new § 488.5(a)(21)**, requiring an AO's application to describe the policies and procedures it will use to assess § 489.20(l), (m), (q), and (r) compliance during surveys, and to cite and address deficiencies through its established procedures. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

Key limit: the proposal does **not** authorize AOs to assess or enforce the substantive § 489.24 protections. CMS and the OIG retain that authority. If an AO identifies a potential

§ 489.24 violation during a survey, it must refer the matter to CMS for further review and possible State Survey Agency (SA) investigation. (Medicare OPPS and ASC Payment Systems Proposed Rule § B) For § 489.20 deficiencies the AO identifies, the hospital would submit an acceptable Plan of Correction; if rejected, the AO must contact CMS. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

Existing enforcement tools are preserved: OIG civil monetary penalties and physician exclusion under section 1867(d), and CMS termination of the Medicare provider agreement under section 1866(b)(2) and § 489.53. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

CMS's rationale

CMS reports that in **CY 2025 it issued 1,071 EMTALA citations — 521 under § 489.20, 530 under § 489.24, and 20 under both** — and treats administrative compliance as a leading indicator of overall EMTALA program integrity. (Medicare OPPS and ASC Payment Systems Proposed Rule § B) It expects three benefits: minimizing operational disruption by handling administrative review within the accreditation survey rather than through separate investigations; improving consistency of compliance with the record-based requirements; and freeing State Survey Agencies to concentrate on complaint-based § 489.24 investigations that require case-specific clinical fact-finding. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)

CMS also notes the proposal does not change the confidentiality framework for accreditation survey findings under section 1865(b) of the Act; most AO survey reports remain outside the disclosure rules that apply to SA-conducted surveys, though findings referred to CMS as potential § 489.24 violations follow the existing SA-investigation disclosure procedures. (Medicare OPPS and ASC Payment Systems Proposed Rule § B)