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Contents

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OPPS Rule Proposes Targeted Reviews of PBDs, New Attestation, More EMTALA Oversight

CMS will perform risk-based reviews of compliance with provider-based requirements, taking some of the heat off hospitals, according to the proposed 2027 outpatient prospective payment system (OPPS) regulation.[1] Whether off-campus provider-based departments (PBDs) are plucked for a "targeted" review will depend partly on how their compliance attestations square with other information CMS has about them.

The regulation, which was published in the July 7 *Federal Register*, also puts meat on the bones of the new attestation requirement for all hospitals with off-campus PBDs. CMS would replace Medicare administrative contractor (MAC)-specific attestations with its own electronic version and hospitals would be spared from producing mounds of documentation at the same time as the attestation (see box, pages 5-6).[2]

"It means hospitals will be speeding down the highway and recognize that 95% of the time you're not going to be a target," said attorney Andrew Ruskin, with K&L Gates. CMS doesn't have the resources to do anything exhaustive.

"The important takeaway for hospitals" is that CMS isn't making the requirements less burdensome, said attorney Emily Cook, with McDermott, Will & Schulte. "They're proposing to make the submission process less burdensome." But CMS won't let PBDs slide. "They made it very clear they're going to be checking people's work," she said.

Rule Would Take a Toll on 340B Drugs

A streamlined attestation may be the only break hospitals get in the proposed OPPS rule. Otherwise, they will take some hits. For one thing, there's a massive payment cut to 340B drugs from average sales price (ASP) plus 6% to ASP minus 33.4%. Although CMS didn't reduce payments for non-340B drugs, they may be next, because CMS has the statutory authority to do it, Cook said.

The proposed 340B payment rate leaves nothing for overhead and related costs, Cook noted. CMS said add-on payments are probably unnecessary because of its "prudent approach to estimating" average acquisition costs and because hospitals will negotiate additional discounts.

Site Neutral Isn't Budget Neutral

The blow is softened by the fact that most of the 340B cuts are budget neutral, which means the money comes back to hospitals for nondrug goods and services. To that effect, CMS would increase their conversion factor by 8.44%.

But hospitals don't get so lucky with budget neutrality in another proposal. CMS plans to expand the site-neutral payment policy to imaging without contrast, which means Medicare pays PBDs the same (lower) amount for services as it pays freestanding physician practices. The lost dollars in this case aren't offset. (Rural sole community hospitals are exempt.)

The site-neutral proposal applies to "excepted" PBDs, which are the PBDs that set up shop before Nov. 2, 2015, and are otherwise entitled to full OPPS payments. For imaging ambulatory payment classifications without contrast, excepted PBDs will face the same Physician Fee Schedule Relativity Adjuster as non-excepted PBDs, which opened their doors after Nov. 2, 2015. The relativity adjuster, which lowers the payment to 40% of the OPPS amount, also applies to drug

administration in another site-neutral policy that took effect in January.

"We're in for a season of cuts," said Valerie Rinkle, president of Valorize Consulting. But she's relieved CMS didn't take site neutrality further.

"The ironic thing is policymakers who are all for site neutrality are assuming the payment rate on the physician fee schedule is legit," Rinkle said. That's not necessarily the case. A big reason physicians sell their practices to hospitals "is they can't make money on the physician fee schedule," she noted. The idea hospitals buy them to rake in the dough "is just one perspective of the argument."

'Hospitals Will Have a Bit of a Reckoning'

Between the OPPS proposed rule and the One Big Beautiful Bill Act, which sharply cut Medicaid and Affordable Care Act marketplace subsidies, Ruskin sees an existential threat to certain hospitals. "If you're a safety-net hospital, this administration wants you to close," he said. "Teaching hospitals in large cities are being hit 10 ways to Sunday."

CMS is expected to keep chipping away at services where hospitals are paid more than physician practices. In CMS's eyes, "there's no reason for excepted outpatient locations to bill significantly more for simple noncontrast imaging," said attorney Sandra DiVarco, with McDermott, Will & Schulte. "It's difficult because there's push and pull with some of what we see in the press about hospitals building Taj Mahal-like hospitals and contrasting it with their saying, 'We have no money because you keep taking it away.' Hospitals will have a bit of a reckoning."

PBDs Attest by 2028 and Five Years Later

To get back to PBDs, the proposed rule spells out two provisions from the 2026 Consolidated Appropriations Act (CAA): hospitals are required to submit attestations that their off-campus PBDs comply with Medicare requirements and get a National Provider Identifier (NPI) for every one of them.

If hospitals don't submit an attestation by Jan. 1, 2028, Medicare will stop paying for services provided at their off-campus PBDs. Congress left the details to CMS, which has come up with a multistep process.

For starters, hospitals would complete CMS's new attestation (when it's finalized) and submit it electronically. They won't have to produce supporting documentation upfront, which CMS said reduces the administrative burden on hospitals and promotes "a more efficient review process for MACs and CMS."

Instead of reviewing every item on the attestation, CMS will start with the big picture, comparing it to information it already has about the PBD, and make an initial determination about the PBD's compliance.

Then CMS will dive deeper with risk-based assessments, which may include site visits, remote audits, investigations or requests for additional documentation.

MACs and possibly program integrity contractors "would employ standardized review, validation, and risk-based screening processes to assess attestations for completeness, consistency with the provider's enrollment records, and compliance with the applicable requirements of § 413.65" (the provider-based regulation).

Although it otherwise doesn't elaborate on the risk-based approach, "CMS has a lot of data mining capabilities they could put into play here," DiVarco noted. For example, CMS could check on the PBD's NPI history and whether it satisfies licensure requirements.

Cook is worried hospitals will think they're off the documentation hook, but that's not the case. Many PBD compliance requirements aren't "intuitive based on a general understanding of the operations of a particular location," she noted. It isn't too soon to evaluate your compliance and get documentation ducks in a row, DiVarco added. Hospitals that already have this work under way are finding not everything is up to code.

After the initial attestation, PBDs would be required to submit a follow-up five years later.

The attorneys recommend hospitals comment on the proposed rule, such as 340B payment cuts, even if the American Hospital Association speaks up. "At the

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end of the day, if CMS is hearing from multiple providers, that may help shift some of CMS's perceptions on these things," DiVarco said.

What Exactly Is the Definition of a PBD?

Hospitals also should ask CMS for clarity on the definition of an off-campus PBD, Ruskin said. He appreciates that CMS streamlined the PBD attestation and will do targeted reviews, "but it's still necessary for them to answer the metaphysical question of what's a department," Ruskin said.

For example, if a provider-based location has 20 different service lines, should the hospital report their addresses separately on the Provider Enrollment, Chain, and Ownership System (PECOS) or just the main PBD location? Should all the service lines have separate NPIs and attestations?

CMS doesn't assert that only an address matters for compliance purposes, but it does say that PECOS matters, "and that's about listing the address," Ruskin said. "CMS accepts the different ways people do it," but with renewed focus on PBDs, hospitals should seek clarification.

Another question is whether hospitals are required to change an off-campus PBD's NPI when its services change. If so, the PBD could lose its excepted status and full OPPS payments, he noted.

End of IPO List Gets Closer

CMS also continued with its three-year phase-out of the inpatient-only (IPO) list. It plans to kick an additional 638 services off the IPO list, leaving them to the jurisdiction of the Two-Midnight Rule. The services are auditory, digestive, endocrine, female genital, hemic and lymphatic systems, integumentary, male genital, maternity care and delivery, mediastinum and diaphragm, respiratory and urinary services.

The demise of the IPO list will be hard on hospitals that don't have a good process for checking whether an outpatient surgery satisfies Medicare requirements in local coverage determinations (LCDs) and national coverage determinations (NCDs), Rinkle said. When inpatient procedures aren't automatically covered, more of them will face scrutiny under LCDs and NCDs, she noted.

And MACs have more visibility into outpatient procedures because they're reported with CPT codes on outpatient claims, Rinkle said. In contrast, inpatient procedures are reported with ICD procedure codes on inpatient claims. "It's easier to see discrete surgeries on an outpatient claim," she said. If the patient hasn't had six months of conservative therapy before the procedure, for example, as required in certain LCDs, the MACs "will take all the money away. It's already happening" with hip and knee replacements.

Surveyors Would Look More Closely at EMTALA

The proposed rule also increases the odds that a hospital will be cited by surveyors for Emergency Medical Treatment and Labor Act (EMTALA) noncompliance. The way it is now, CMS surveyors mostly review a hospital's EMTALA compliance in response to a complaint, DiVarco said. Now CMS wants accreditation organizations with deeming authority, such as the Joint Commission, to assess hospital compliance with EMTALA administrative requirements during accreditation and reaccreditation surveys.

The idea is to use compliance requirements driven more by paperwork, such as whether the hospital maintains a list of on-call physicians and logs all people who present to the emergency room, because it could uncover the type of patient harm EMTALA was designed to prevent. "Hopefully, it will motivate hospitals to pay more attention to some of the paperwork pieces because they're often cited as part of EMTALA findings," DiVarco noted.

Survey May Lead to Challenges of 340B Cut

The sharp reduction in payments for 340B drugs may ring a bell because the first Trump administration did the same thing, with a new reimbursement rate of ASP minus 22.5%. Ultimately, the U.S. Supreme Court rebuffed it because CMS hadn't conducted a hospital outpatient drug acquisition cost survey first, and ASP plus 6% was reinstated.

But CMS learned its lesson because earlier this year it surveyed hospitals on the costs of every separately payable drug under the OPPS. That survey paved the way for the steeper 340B payment cuts that materialized in the 2027 proposed rule.

Another court battle may be looming, attorneys say. The fact the survey was "faulty" is one of the grounds for potentially challenging the proposed payment cut, Ruskin said. Only 23.1% of 340B hospitals responded to the survey, which he said isn't a representative sample of hospitals, as required by law.

Hospitals still have a hangover from the reversal of earlier 340B payment cuts. After they were voided by the high court, CMS repaid 340B hospitals the delta between ASP plus 6% and ASP minus 22.5%, but set in motion the recoupment of the $7.8 billion extra it gave hospitals for nondrug goods and services, as required by budget neutrality.

On Jan. 1, 2026, CMS started applying a 0.5% reduction in the conversion factor annually to nondrug items and services, with plans to continue it until all the money is recovered from hospitals. Now, CMS is proposing to accelerate the repayment by increasing it to 3%.

Will Hospitals Morph into ICUs?

With the convergence of payment cuts and the end of the IPO list, Rinkle is starting to envision a future where hospitals are mostly intensive care units (ICUs) supported by hospital care at home or transition to outpatient care. "You reserve provider based for high-intensity, high-acuity services."

Meanwhile, hospitals may want to transition some off-campus PBDs to freestanding clinics, depending on the service line, although they would have to be owned by the corporate parent, not a specific hospital, Rinkle said. "They would minimize the administrative overhead and costs because they don't have to meet hospital regulatory requirements."

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Endnotes

1 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots, 91 Fed. Reg. 41,734 (July 7, 2026), https://bit.ly/4paStPb.

2 Nina Youngstrom, "CMS's Proposed Attestation for Provider-Based Departments," *Report on Medicare Compliance* 35, no. 25 (July 13, 2026).

OIG Rebuffs Online Referral Service; 'We're Not Going Back to 1995'

It seems like the HHS Office of Inspector General (OIG) jumped into the wayback machine for an unfavorable advisory opinion about online home health referral management software, according to an attorney. The opinion (26-15) is consistent with one from 15 years ago, but times have changed, and the new one doesn't seem to account for that, the attorney said.[1]

According to the opinion, posted June 30, the requestor, which operates home health agencies (HHAs), asked OIG whether paying a subscription fee for a vendor's online referral management software would run afoul of the Anti-Kickback Statute (AKS). OIG said yes, if there's an intent to induce referrals. OIG had the same response to subscription-based referral software for post-acute providers in a 2011 advisory opinion.[2]

The advisory opinion is unenlightening partly because OIG "largely mimicked" what it said in the 2011 opinion "without any thought as to changes of facts, changes of law or current practice in the country," said attorney Jeffrey Fitzgerald, with Polsinelli. Technology for referral and other services has been normalized, he said. "We're not going back to 1995 where it's all faxes and phone calls. It's 2026. If you don't use this software, you're using some other software."

Also, he thinks a safe harbor revised in 2020 probably would immunize this arrangement from the AKS.

Referrals: First Come, First Served

According to the advisory opinion, hospitals refer many of the requestor's home health patients for post-discharge care. Medicare requires hospitals to give patients who are discharged home but referred for home health services a list of HHAs that are available, participate in Medicare and serve the patient's geographic area.

The requester explained that hospital referrals to HHAs often are determined on a first-come, first-served basis. As a result, the faster an HHA responds to a hospital's request for home health care, the better its odds of getting the referral.

The vendor's software connects hospitals with HHAs. Because the requestor pays the vendor a subscription fee, the requestor gets electronic referrals from the hospitals hunting for a home-health slot.

The vendor gives participating hospitals a list of all HHAs in the region, whether or not they subscribe to the software. But only HHAs that pay for the software receive electronic communications from the hospitals. Prices for the subscription vary based on, among other things, the location of the HHA or the number of jointly owned HHAs that buy the software.

When a hospital subscribes but an HHA doesn't, the hospital sends a referral by fax, email, phone or hand delivery. If the HHA wants the referral, it must phone the hospital. If they both subscribe to the software, HHAs can accept requests electronically.

"Requestor certified that, based on its experience, these alternative methods of receiving and responding to requests for availability from hospitals create delays that, in practice, effectively exclude HHAs that do not subscribe to the Software," the opinion explains.

OIG: There's a Risk of Unfair Competition

OIG concluded that the arrangement implicates the AKS because the requestor is paying remuneration to the vendor in return for its software arranging home health services when federal healthcare programs may pick up the tab.

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Excerpt of CMS's Proposed Attestation for Provider-Based Departments

CMS posted a draft of its new electronic attestation for off-campus provider-based departments (PBDs) in the proposed 2027 outpatient prospective payment system regulation (see story, p. 1).[1] All hospitals are now required to attest to their off-campus PBD's compliance with provider-based regulations by Jan. 1, 2028.[2] Below is an excerpt.

For Comment Only
Off-Campus Provider-Based Status Attestation

Main Provider Information

Field	Value
Main Provider Name	
Address Line 1	
Address Line 2	
City	
State	
Zip Code	
Main Provider CCN	
Main Provider NPI	
Servicing MAC	

Main Provider Information

Field	Value
Off-Campus Provider-Based Department Name	
Address Line 1	
Address Line 2	
City	
State	
Zip Code	
Facility NPI	
Type (Clinic, RHC, Remote Location)	
Contact Name	
Contact Email	
Date Became Provider-Based	

Certification Statement

I certify that I have carefully read the attached sections of the Federal provider-based regulations, before signing this attestation, and that the facility/organization complies with the following requirements to be provider-based to the main provider.

I attest that the facility/organization complies with the following requirements to be provider-based to the main provider (please indicate Yes or No for each requirement):

Requirement 1 — Licensure

The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license.

☐ Yes ☐ No ☐ N/A

If the provider and facility/organization are located in a state having a health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers, the commission or agency has not found that the facility/organization is not part of the provider.

☐ Yes ☐ No ☐ N/A

Requirement 2 — Clinical Integration

The clinical services of the facility or organization seeking provider-based status and the main provider are integrated.

2a. Professional staff of the facility or organization have clinical privileges at the main provider.

☐ Yes ☐ No ☐ N/A

2b. The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

☐ Yes ☐ No ☐ N/A

2c. The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

☐ Yes ☐ No ☐ N/A

2d. Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

☐ Yes ☐ No ☐ N/A

2e. Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

☐ Yes ☐ No ☐ N/A

2f. Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

☐ Yes ☐ No ☐ N/A

Requirement 3 — Financial Integration

The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared

income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.

☐ Yes ☐ No ☐ N/A

Requirement 4 — Public Representation

The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

☐ Yes ☐ No ☐ N/A

Endnotes

1 Nina Youngstrom, "OPPS Rule Proposes Targeted Reviews of PBDs, New Attestation, More EMTALA Oversight," *Report on Medicare Compliance* 35, no. 25 (July 13, 2026).

2 Centers for Medicare & Medicaid Services, "Off-Campus Provider-Based Status Attestation," proposal for comment, July 2, 2026, https://bit.ly/4eT5YiT.

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Although there's a safe harbor for referral services, OIG said the arrangement doesn't fit squarely into it. The safe harbor protects payments between a referral service and a participant from the definition of remuneration if certain conditions are satisfied. For example, all participants must pay the same referral fee.

The arrangement also presents a risk of inappropriate steering and unfair competition, OIG said. Because hospitals frequently discharge patients to HHAs on a first-come, first-served basis, HHAs that electronically receive and respond to referral requests through the software "would have a significant competitive advantage over non-paying HHAs," OIG said. The delays caused by fax and phone may keep patient referrals away from HHAs that don't subscribe.

"Consequently, it appears that HHAs paying the Vendor's fees would get patients because they paid for the opportunity rather than on the basis of the quality of care they offer," OIG said.

The arrangement also raises the specter of overutilization. The subscription costs create an incentive for HHAs to bill for services that aren't medically necessary.

Earlier Opinion Said the Same Thing

A 2011 advisory opinion saw a similar arrangement the same way. The requester in that case was a company that provides an online referral service giving hospitals access to a national listing of licensed post-acute care (PAC) providers, including skilled nursing facilities, HHAs and assisted living facilities. PAC providers would pay a fee to electronically receive, and respond to, hospital requests for referrals.

OIG again noted the arrangement doesn't qualify for safe harbor protection and concluded it posed more than a minimal risk under the AKS for several reasons. For example, because hospitals often discharge patients to PAC providers on a first-come, first-served basis, PAC providers with the capacity to get referrals and respond to them electronically "would have a significant competitive advantage over non-paying Providers." It also may create an incentive for overbilling if providers sign up for the referral service even though they can't afford to.

Lawyer: Changes Should Have Factored In

Even though the regulatory and technology landscape has changed since the 2011 opinion, it's almost copy-pasted into the new opinion, Fitzgerald said. He cites three changes that aren't factored into the new version:

- CMS updated its discharge planning rules in 2019 and 2025. "Those changes made the process more intentional, patient-centered and data-driven, and less the purported first come, first served," he said.
- OIG revised the personal services safe harbor in 2020, and it seems like the arrangement would qualify for it, Fitzgerald said. For example, the updated safe harbor doesn't require aggregate compensation to be set in advance. "But there's no discussion of the personal services safe harbor at all," he said.
- Digital tools for communication "are much more an everyday thing than they were 15 years ago," Fitzgerald said. "The idea that software is used to transmit information from a hospital to an HHA is part of the world we live in now."

Also, in recent years, OIG has sent different signals in two favorable advisory opinions (19-04[3] and 23-05[4]) about online provider directories that are somewhat related to subscription-based referral services.

"We should be using digital tools to connect the hospital electronic medical records to home health medical records, but OIG provides no guidance as to how it can be done in a compliant way."

Contact Fitzgerald at jfitzgerald@polsinelli.com. ✧

Endnotes

1 U.S. Department of Health and Human Services, Office of Inspector General, "OIG Advisory Opinion No. 26-15 (Unfavorable)," advisory opinion, June 25, 2026, https://bit.ly/4y7SZlb.

2 U.S. Department of Health and Human Services, Office of Inspector General, "OIG Advisory Opinion No. 11-06," advisory opinion, May 13, 2011, https://bit.ly/4pct6wo.

3 U.S. Department of Health and Human Services, Office of Inspector General, "OIG Advisory Opinion No. 19-04," advisory opinion, September 5, 2019, https://bit.ly/4pbtV8s.

4 U.S. Department of Health and Human Services, Office of Inspector General, "OIG Advisory Opinion No. 23-04 (Favorable)," advisory opinion, July 6, 2023, https://bit.ly/4faupr6.

OIG Strips NYS MFCU of Funding; State Is Known as 'the Leader in Compliance'

Calling the New York state Medicaid Fraud Control Unit (MFCU) "the poorest performing" of MFCUs its size, the HHS Office of Inspector General (OIG) has yanked its funding, according to a June 30 letter from HHS Inspector General Thomas March Bell to the state.[1]

The "decertification" comes three weeks after OIG did the same thing to the Hawaii MFCU for allegedly falling asleep at the wheel. More decertifications may be coming, and several state MFCUs, such as Colorado's, have been recertified with conditions.[2]

CMS Transmittals and *Federal Register* Regulations, June 26-July 9, 2026

Transmittals

Pub. 100-04, Medicare Claims Processing

- Implementation CR - Send Transplant Program Hospital Type and the New Organ Types to the Fiscal Intermediary Shared System (FISS) on Provider Enrollment Chain & Ownership System (PECOS) Extract Files and for FISS to Process so PECOS is the System of Record for the Transplant Program Hospital Type and for the Organs Type Transplanted at the Hospital, Trans. 13,863 (July 9, 2026)
- Quarterly Update to Home Health (HH) Grouper, Trans. 13,793 (July 8, 2026)
- Quarterly Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement, Trans. 13,794 (July 8, 2026)
- Fiscal Year (FY) 2027 Annual Update to the Medicare Code Editor (MCE) and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and Procedure Coding System (ICD-10-PCS), Trans. 13,813 (July 8, 2026)
- July 2026 Quarterly Update to the Clinical Laboratory Fee Schedule (CLFS) and Clinical Laboratory Improvement Amendments (CLIA): Healthcare Common Procedure Coding System (HCPCS) Codes, Waived Tests, and Reasonable Charge Payments, Trans. 13,855 (July 2, 2026)
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2026, Trans. 13,849 (July 2, 2026)
- July Quarterly Update for 2026 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule, Trans. 13,846 (July 1, 2026)
- July 2026 Integrated Outpatient Code Editor (I/OCE) Specifications Version 27.2, Trans. 13,844 (July 1, 2026)
- File Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions, Trans. 13,830 (June 30, 2026)
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2026 Update, Trans. 13,845 (June 30, 2026)
- October 2026 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files, Trans. 13,831 (June 30, 2026)
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 32.3, Effective October 1, 2026, Trans. 13,829 (June 30, 2026)

Pub. 100-08, Medicare Program Integrity

- Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08 - Calendar Year (CY) 2026 Home Health Prospective Payment System (HH PPS) Final Rule, Trans. 13,717 (July 8, 2026)

Pub. 100-20, One-Time Notification

- Implementation of Editing for Programs of All-Inclusive Care for the Elderly (PACE) Inpatient Claims Submitted for Indirect Medical Education (IME) Payment, Trans. 13,854 (July 2, 2026)

Pub. 100-07, State Operations Provider Certification

- Revisions to State Operations Manual (SOM), Chapter 7, Trans. 244 (June 26, 2026)

Federal Register

Proposed Rule

- Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; and Quality Reporting Programs; Including the Hospital Outpatient Quality Reporting Program and Ambulatory Surgical Center Quality Program; Request for Information on Strengthening the Standardization and Comparability of Hospital Price Transparency (HPT) Data; Prior Authorization; Accrediting Organization (AO) Deeming for Emergency Medical Treatment and Labor Act (EMTALA); and Notices of Closure of Teaching Hospitals and Opportunities To Apply for Available Slots, 91 Fed. Reg. 41,734 (July 7, 2026)
- Medicare Program; CY 2027 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Acute Kidney Injury Dialysis (AKI) Payment, and ESRD Quality Incentive Program, 91 Fed. Reg 38,784 (June 26, 2026)
- 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, 91 Fed. Reg. 41,216 (July 6, 2026)

Request for Information

- Request for Information (RFI): Pharmacy Benefit Manager Compensation and Data Collection, 91 Fed. Reg. 39,028 (June 29, 2026)

Correction

- Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 39,028 (June 29, 2026)

Notice of Meeting

- Medicare Program; Announcement of the Advisory Panel on Hospital Outpatient Payment Meeting—August 24, 2026, 91 Fed. Reg. 42,196 (July 8, 2026)

It's a sign of the times, as the Trump administration ramps up its crackdown on Medicare and Medicaid fraud. The crackdown includes a review of the effectiveness of all MFCUs, Bell explained in a May 13 letter to state attorneys general and MFCUs. OIG's findings so far are listed state by state on its website.[3]

"In an ideal world, this accountability would be a priority, but it hasn't been and now it's going to be," said attorney Judy Waltz, with Foley & Lardner LLP.

But Waltz was mystified by the decertification of the New York MFCU because the state's fraud-fighting prowess is well known. Among other things, the state requires healthcare organizations that participate in Medicaid to have compliance programs, which are monitored by the New York Office of Medicaid Inspector General (OMIG).

"New York State is considered the leader in compliance," Waltz said. "It doesn't make any sense that its MFCU has been identified as underperforming. I'm thinking it's maybe because their OMIG was so good they didn't have as much fraud to catch." Maybe if fraud prevention statistics were included with fraud recoveries, OIG wouldn't have alleged the MFCU is underperforming.

'Unit Only Secured Eight or Nine Convictions'

In the May 13 letter, Bell warned states they may face consequences if their MFCU doesn't "effectively fulfill its statutory functions and responsibilities." Consequences include a corrective action plan; loss of MFCU funding from the federal government; or "denial of recertification, which could lead to the loss of all Federal grant funds" to Medicaid in that state.

In New York's case, Bell said its MFCU wasn't living up to fraud-fighting expectations or satisfying grant requirements.

"OIG has determined that a major factor of the New York MFCU's performance was a deliberate leadership choice that led the Unit to focus on 'high-impact, complex fraud cases.' This decision has shifted focus from criminal fraud and patient abuse and neglect to civil fraud cases, even though the relevant statutes and regulations make clear that State MFCUs are expected also to prosecute criminal cases."

With federal funding gone for MCFUs in two states (so far), the states will have to pick up the slack, Waltz said. If they don't, "the state's Medicaid program expenditures are at risk."

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Endnotes

1 U.S. Department of Health and Human Services, Office of Inspector General, "Attorney General Letitia A. James; Director Amy Held," letter from T. March Bell to Letitia A. James and Amy Held, June 30, 2026, https://bit.ly/4gZyIlc.

2 U.S. Department of Health and Human Services, Office of Inspector General, "Attorney General Phil Weiser; Director Rebecca Weber," letter from T. March Bell to Phil Weiser and Rebecca Weber, July 1, 2026, https://bit.ly/3SONebS.

3 U.S. Department of Health and Human Services, Office of Inspector General, "MFCU Recertification Letters," accessed July 10, 2026, https://bit.ly/4vrx7P5.

NEWS BRIEFS

◆ **Memphis, Tennessee, gynecologist Sanjeev Kumar was sentenced to 20 years in prison in connection with his January conviction for adulteration of medical devices, the U.S. Attorney's Office for the Western District of Tennessee said July 8.**[1] When Kumar performed hysteroscopy with biopsy to diagnose endometrial cancer, he used hysteroscopes and graspers. The devices either were single use or could be disinfected for reprocessing. "Kumar routinely failed to subject the reusable devices to vital reprocessing steps between patient use thereby endangering patient safety," the U.S. attorney's office said. Even single-use devices weren't correctly labeled. "Thousands of women were subjected to hysteroscopies with biopsy using the dirty devices," the U.S. attorney's office said. "Kumar used adulterated medical devices in more than 15,000 hysteroscopy with biopsy procedures on Medicare and Medicaid patients between September of 2019 and April of 2024." Kumar bought fewer than 200 new hysteroscopes and three of the six single-use graspers of a certain kind that he bought in 2019 were still used in the office in April 2024, the U.S. attorney's office said.

◆ **The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is now available for long-term acute care hospitals, CMS in its July 9 MLN Connects.**[2] PEPPER is a free compliance monitoring tool.

Endnotes

1 U.S. Department of Justice, U.S. Attorney's Office for the Western District of Tennessee, "Memphis Gynecologist Sentenced to 20 Years in Prison for Adulterating Medical Devices and Health Care Fraud," news release, July 8, 2026, https://bit.ly/4peXOVH.

2 Centers for Medicare & Medicaid Services, "MLN Connects Newsletter for July 9, 2026," Medicare Learning Network, July 9, 2026, https://go.cms.gov/4vX9VsQ.