Issue Brief

FEDERAL ISSUE BRIEF

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

August 4, 2026

CMS Finalizes Fiscal Year IPPS 2027 Update

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) are issuing a final rule to update the Inpatient Prospective Inpatient Payment System (IPPS) and Long-Term Hospital Prospective Payment System (LTCH PPS) for FY 2027.

A copy of the 2,704-page display document is available at: https://public-inspection.federalregister.gov/2026-15833.pdf.

The rule is scheduled for publication in the August 4 ***Federal Register***.

CMS says the IPPS tables for this fiscal year (FY) 2027 rule are available on the CMS website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. This link is not correct.

For the 2027 material use: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2027-ipps-proposed-rule-home-page

Comment

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Comment

The above table of contents does not reflect subheads. For example, it does not include a line for the Summary of the Major Provisions identified below. If included, the table could be twice the size being presented.

Executive Summary (Page 4)

Summary of the Major Provisions (Page 11)

The following is a summary of the major provisions in this final rule. (Page 12)

> **a. Requirements to Prohibit Unlawful Discrimination by Graduate Medical Education Programs and Nursing and Allied Health Education Programs –** in addition to meeting other applicable requirements, an approved medical residency training program must not discriminate, or promote or encourage discrimination, on the basis of race, color, national origin, sex, age, disability, or religion, including the use of those characteristics or intentional proxies for those characteristics as a selection criterion for employment, program participation, resource allocation, or similar activities, opportunities, or benefits.

> **b. Modifications to the Criteria for New Residency Programs –** in addition to receiving initial accreditation by the appropriate accrediting body, for a residency program to be considered new, at least 90 percent of the individual residents must not have previous experience training in another program in the same specialty.

c. Hospital Readmissions Reduction Program (HRRP) – CMS is finalizing the adoption of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure with modifications beginning with 2 years of early look reports for the FY 2028 and FY 2029 program years, and use beginning with the FY 2030 program year.

d. Hospital Value-Based Purchasing (VBP) Program – CMS is finalizing modifications to five condition-specific and procedure-specific mortality measures beginning with the FY 2032 program year:

(1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Myocardial Infarction (AMI) Hospitalization measure;

(2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization measure;

(3) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure;

(4) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization measure; and

(5) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery measure.

e. Hospital Inpatient Quality Reporting Program – CMS is finalizing the adoption of three new measures:

(1) Excess Days in Acute Care After Hospitalization for Diabetes measure beginning with the FY 2029 payment determination;

(2) Advance Care Planning eCQM beginning with the FY 2030 payment determination; and

(3) Hospital Harm-Postoperative Venous Thromboembolism eCQM beginning with the FY 2030 payment determination.

CMS is also finalizing the adoption of five modified mortality measures in the Hospital Inpatient Quality Reporting Program beginning with the FY 2028 payment determination before subsequently modifying them in the Hospital Value-Based Purchasing Program:

(1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization measure;

(2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization measure;

(3) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure;

(4) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following COPD Hospitalization measure; and

(5) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following CABG Surgery measure.

CMS is finalizing modifications to three claims-based measures beginning with the FY 2028 payment determination:

(1) Excess Days in Acute Care after Hospitalization for AMI;

(2) Excess Days in Acute Care after Hospitalization for Heart Failure; and

(3) Excess Days in Acute Care after Hospitalization for Pneumonia.

CMS is finalizing the removal of three measures beginning with the FY 2030 payment determination:

(1) Venous Thromboembolism Prophylaxis (VTE-1) eCQM; (

(2) Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM; and

(3) Discharged on Antithrombotic Therapy (STK-02) eCQM.

CMS is finalizing changes to data reporting and submission requirements for eCQMs and structural measures:

(1) mandatory reporting for the Malnutrition Care Score eCQM beginning with the FY 2030 payment determination;

(2) mandatory reporting for the Hospital Harm eCQMs after 2 years of self-selected reporting beginning with the FY 2030 payment determination with modifications; and (3) an update to the reporting of the Maternal Morbidity Structural measure beginning with the FY 2028 payment determination.

f. PPS-Exempt Cancer Hospital (PCH) Quality Reporting Program – CMS is finalizing the adoption of two new measures with modifications: (1) Advance Care Planning eCQM beginning with the FY 2030 program year; and (2) Malnutrition Care Score eCQM beginning with the FY 2030 program year. CMS is finalizing the removal of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP COVID–19 Vaccination) measure beginning with the FY 2028 program year.

g. Long-Term Care Hospital Quality Reporting Program (LTCH QRP) – CMS will remove two measures, beginning with the FY 2028 LTCH QRP.

h. Medicare Promoting Interoperability Program – CMS is finalizing:

(1) revisions to the definition of certified EHR technology (CEHRT) for the Medicare Promoting Interoperability Program based on Office of the National Coordinator for Health Information Technology (ONC) proposals to update the ONC Health IT Certification Program;

(2) removal of attestations related to ONC Direct Review and ONC Authorized Certification Body (ONC-ACB) Surveillance;

(3) removal of the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure;

(4) modification of the Electronic Prior Authorization measure;

(5) adoption of the Unique Device Identifiers (UDIs) for Implantable Medical Devices measure within the Public Health and Clinical Data Exchange objective; (

6) adoption of two new eCQMs in alignment with the Hospital Inpatient Quality Reporting Program; and

(7) removal of three eCQMs in alignment with the Hospital Inpatient Quality Reporting Program.

i. Transforming Episode Accountability Model (TEAM) – CMS is finalizing changes to a few areas of the model, including:

(1) adding 3 Medicare Severity Diagnosis Related Groups (MS-DRGs) that would initiate a spinal fusion anchor hospitalization;

(2) clarifying quality measure performance periods for certain quality measures;

(3) using a rolling concurrent Composite Quality Score (CQS) baseline period for certain quality measures;

(4) adding an Ambulatory Payment Classification (APC) and MS-DRG update factor to target prices; and

(5) using the full baseline period to construct the prospective normalization factor.

j. Comprehensive Care for Joint Replacement Expanded (CJR-X) Model – CMS is finalizing expansion of the CJR Model. The CJR-X Model will be a mandatory model that will be tested under the authority of section 1115A of the Act, beginning on January 1, 2028 for acute care hospitals paid under the IPPS and OPPS with limited exclusions. Participating hospitals will be accountable for the cost and quality of care for lower extremity joint replacement (LEJR) episodes from the hospital inpatient or hospital outpatient admission through 90 days after the beneficiary is discharged from the hospital or hospital outpatient procedure.

CMS is finalizing multiple policies for CJR-X, including:

(1) a January 1, 2028 start date;

(2) acute care hospitals as the participant and accountable entity;

(3) LEJR as the episode of care;

(4) five quality measures and a composite quality score (CQS) to assess quality performance; (5) regional risk-adjusted target prices that include capped normalization and trend factors; (6) pricing-specific policies for certain hospitals, such as low volume hospitals and safety net hospitals;

(7) provider and beneficiary overlap permitted with most models;

(8) allowing participant hospitals to have financial arrangements;

(9) waiving certain Medicare Program requirements;

(10) permitting beneficiary-identifiable and regional aggregated data sharing; and

(11) options for Alternative Payment Model (APM) participation.

Summary of Costs and Benefits (Page 16)

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Update to the IPPS Payment Rates and Other Payment Policies	As discussed in Appendix A of this final rule, acute care hospitals are estimated to experience a $2.9 billion increase in payments in FY 2027, primarily driven by the changes in FY 2027 operating payments, including outlier payments, uncompensated care payments, capital payments, new technology add-on payments, and the expiration of the temporary changes in the low-volume hospital program and the expiration of the MDH program on January 1, 2027.
Update to the LTCH PPS Payment Rates and Other Payment Policies	As discussed in Appendix A, based on the best available data for the 319 LTCHs in CMS' analysis, CMS estimates that the changes to the payment rates and factors that CMS presents in the preamble of and Addendum, which reflect the update to the LTCH PPS standard Federal payment rate for FY 2027, will result in an estimated increase in payments in FY 2027 of approximately $54 million.
Requirements to Prohibit Unlawful Discrimination by Graduate Medical Education Programs and Nursing and Allied Health Education Programs	As discussed in Appendix A, regarding CMS' policies concerning unlawful discrimination by approved programs and accrediting bodies, as of October 1, 2026, CMS does not expect that approved programs or accrediting bodies will continue to or newly engage in unlawful discrimination on the basis of race or other protected characteristics.
Changes to the Hospital Readmissions Reduction Program	CMS estimated that its changes for the Hospital Readmissions Reduction Program will result in no financial impact for the FY 2027 payment determination.
Changes to the Value-based Incentive Payments under the Hospital Value-Based Purchasing Program	CMS estimates that there will be no net financial impact to the Hospital Value-Based Purchasing Program for the FY 2027 program year in the aggregate because, by law, the amount available for value-based incentive payments under the program in a given year must be equal to the total amount of base operating MS-DRG payment amount reductions for that year, as estimated by the Secretary. The estimated amount of base operating MS-DRG payment

Provision Description	Description of Costs, Transfers, Savings, and Benefits
	amount reductions for the FY 2027 program year and, therefore, the estimated amount available for value-based incentive payments for FY 2027 discharges is approximately $1.9 billion.
Changes to the Hospital IQR Program	Across 3,050 IPPS hospitals, CMS estimates that its changes for the Hospital Inpatient Quality Reporting Program will result in an increase of 8,133 hours and $447,803 to the information collection burden for the FY 2030 payment determination and subsequent years.
Changes to the PCH Quality Reporting Program	Across 11 PCHs, CMS estimated that its changes for the PCH Quality Reporting Program will result in a decrease of 84 hours and $4,975 to the information collection burden for the FY 2028 program year and subsequent years.
Changes to the LTCH QRP	Across 318 LTCHs, CMS estimated that its changes for the LTCH QRP will result in a total information collection burden decrease of 4,473 hours associated with its policies and updated burden estimates and a total cost decrease of approximately $203,056.74 for the FY 2028 LTCH QRP.
Changes to the Medicare Promoting Interoperability Program	Across 4,550 eligible hospitals and CAHs, CMS estimated that its changes for the Medicare Promoting Interoperability Program will result in a total information collection burden increase of 3,886 hours and $213,962 for the EHR reporting period in CY 2026 and subsequent years.
Transforming Episode Accountability Model (TEAM)	CMS estimates for the TEAM policies that there will be no significant change from the savings estimate in the FY 2026 IPPS/LTCH PPS final rule.
CJR-X	CMS estimates that the CJR-X model will result in saving the Medicare program $725 million across 5 performance years. CMS notes these estimates represent only a portion of the potential savings CJR-X may generate, as the model does not have a specified end date.

CHANGES TO THE PROSPECTIVE PAYMENT RATES

Changes in the Inpatient Hospital Update for FY 2027 (§ 412.64(d)) (Pages 723, 2,696)

FY 2027 Inpatient Hospital Update

Based on more recent data available for this FY 2027 IPPS/LTCH PPS rule (that is, IGI's second quarter 2026 forecast of the 2023-based IPPS market basket rate-of-increase with historical data through the

first quarter of 2026), CMS estimates that the FY 2027 market basket increase used to determine the applicable percentage increase for the IPPS is 3.2 percent.

IGI's second quarter 2026 forecast of the productivity adjustment estimate of the productivity adjustment for FY 2026 is 0.9 percentage point.

Therefore, the applicable percentage increase applied to the standardized amount for hospitals that are considered to be a meaningful EHR user under section 1886(b)(3)(B)(ix) of the Act and submit quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act is **2.3 percent**. (Page 731)

The applicable percentage increase under the IPPS for FY 2027 is equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to all of the following:

- **A reduction of one-quarter** of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) for hospitals that fail to submit quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act.
- **A reduction of three-quarters** of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) for hospitals not considered to be meaningful EHR users in accordance with section 1886(b)(3)(B)(ix) of the Act.
- An adjustment based on changes in economy-wide multifactor productivity (the productivity adjustment) in accordance with section 1886(b)(3)(B)(xi)(II) of the Act. Section 1886(b)(3)(B)(xi) of the Act, as added by section 3401(a) of the ***Affordable Care Act***, states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

CMS has determined four applicable percentage increases to the standardized amount for FY 2027, as specified in the following table: (Page 738)

FY 2027 APPLICABLE PERCENTAGE INCREASES FOR THE IPPS

FY 2027	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	3.2	3.2	3.2	3.2
Adjustment for Failure to Submit Quality Data under Section 1886(b)(3)(B)(viii) of the Act	0.0	0.0	-0.8	-0.8
Proposed Adjustment for Failure to be a Meaningful EHR User under Section 1886(b)(3)(B)(ix) of the Act	0.0	-2.4	0.0	-2.4
Proposed Productivity Adjustment under Section 1886(b)(3)(B)(xi) of the Act	-0.9	-0.9	-0.9	-0.9
Proposed Applicable Percentage Increase Applied to Standardized Amount	**2.3**	**-0.1**	**1.5**	**-0.9**

The current (FY 2026) large urban labor rate is $4,456.72 and the non-labor rate is $2,295.89 for a total of $6,752.61. The other area labor rate is $4,186.62 and the non-labor component is $2,565.89 also for a total of $6,752.61. The $6,752.61 amount is adjusted by dividing the outlier, geographic and the rural demonstration reclassification factors, etc. as shown in the table below resulting in a gross payment rate of $7,444.36 for FY 2026. This amount is then further adjusted by multiplying by the FY 2027 adjustments.

The following table (Page 2,449) illustrates the changes from the current FY 2026 national standardized amounts to the Final FY 2027 national standardized amounts.

Changes from FY 2026 Standardized Amounts to the Final

FY 2027 Standardized Amounts

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2026 Base Rate after removing: 1. FY 2026 Geographic Reclassification Budget Neutrality (0.956835) . FY 2026 Operating Outlier Offset (0.949) 3. FY 2026 Cap Policy Wage Index Budget Neutrality Factor (0.999397) 4. Transition for the Discontinuation of the Low Wage Index Hospital Policy Budget Neutrality Factor (0.999726) 5. FY 2026 Rural Demonstration Budget Neutrality Factor (0.999552)	If Wage Index is Greater Than 1.0000: Labor (66.0%): $4,914.60 *(Combined labor and nonlabor = $7,446.36)* Nonlabor (34.0%): $2,531.76 *(Combined labor and nonlabor = $7,446.36)*	If Wage Index is Greater Than 1.0000: Labor (66.0%): $4,914.60 *(Combined labor and nonlabor = $7,446.36)* Nonlabor (34.0%): $2,531.76 *(Combined labor and nonlabor = $7,446.36)*	If Wage Index is Greater Than 1.0000: Labor (66.0%): $4,914.60 *(Combined labor and nonlabor = $7,446.36)* Nonlabor (34.0%): $2,531.76 *(Combined labor and nonlabor = $7,446.36)*	If Wage Index is Greater Than 1.0000: Labor (66.0%): $4,914.60 *(Combined labor and nonlabor = $7,446.36)* Nonlabor (34.0%): $2,531.76 *(Combined labor and nonlabor = $7,446.36)*
FY 2027 Update Factor	1.023	0.999	1.015	0.991
FY 2027 MS-DRG Reclassification and Recalibration Budget Neutrality Factor Before Cap	0.998748	0.998748	0.998748	0.998748
FY 2027 Cap Policy MS-DRG Weight Budget Neutrality Factor	0.999730	0.999730	0.999730	0.999730
FY 2027 Wage Index Budget Neutrality Factor	1.000312	1.000312	1.000312	1.000312
FY 2027 Reclassification Budget Neutrality Factor	0.949363	0.949363	0.949363	0.949363
FY 2027 Cap Policy Wage Index Budget Neutrality Factor	0.999379	0.999379	0.999379	0.999379

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2027 Transition for the Discontinuation of the Low Wage Index Hospital Policy Budget Neutrality Factor	0.999777	0.999777	0.999777	0.999777
FY 2027 Operating Outlier Factor	0.949	0.949	0.949	0.949
Total Labor and Non-Labor	$6,848.98	$6,688.30	$6,795.42	$6,634.74
National Standardized Amount for FY 2027 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (66.0/34.0)	**Labor: $4,520.33 Nonlabor: $2,328.65**	**Labor: $4,414.28 Nonlabor: $2,274.02**	**Labor: $4,484.98 Nonlabor: $2,310.44**	**Labor: $4,378.93 Nonlabor: $2,255.81**
National Standardized Amount for FY 2027 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $4,246.37 Nonlabor: $2,602.61**	**Labor: $4,146.75 Nonlabor: $2,541.55**	**Labor: $4,213.16 Nonlabor: $2,582.26**	**Labor: $4,113.54 Nonlabor: $2,521.20**

Changes to the IPPS for Capital-Related Costs (Pages 953 and 2,466)

The FY 2027 capital rate is **$545.22**

Comparison of Factors and Adjustments: FY 2026 Capital Federal Rate and FY 2027 Capital Federal Rate

	FY 2026	FY 2027	Change	Percent Change
Update Factor[1]	1.0280	1.0310	1.0310	3.10
GAF/DRG Adjustment Factor[1]	0.9918	1.0139	1.0139	1.39
GAF Cap/Transition Adjustment Factor[2]	0.9989	0.9913	0.9923	-0.77
Outlier Adjustment Factor[3]	0.9616	0.9642	1.0027	0.27
Capital Federal Rate	$524.15	**545.22**	1.0402	4.02[4]

1 The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rate. Thus, for example, the incremental change from FY 2026 to FY 2027 resulting from the application of the proposed 1.0139 GAF/DRG budget neutrality adjustment factor for FY 2027 is a net change of 1.0139 (or 1.39 percent).

2 The GAF Cap/Transition budget neutrality adjustment factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the proposed FY 2027 GAF Cap/Transition budget neutrality adjustment factor is 0.9913/0.9989 or 0.9923 (or -0.77 percent).

3 The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the proposed FY 2027 outlier adjustment factor is 0.9642/0.9616 or 1.0027 (or 0.27 percent).

4 Percent change may not sum due to rounding.

Labor-Related Share for the FY 2027 Wage Index (Page 2,384)

CMS is finalizing to use a labor-related share of 66.0 percent for the national standardized amounts for all IPPS hospitals (including hospitals in Puerto Rico) that have a wage index value that is greater than 1.0000. Consistent with section 1886(d)(3)(E) of the Act, CMS is applying the wage index to a labor-related share of 62 percent of the national standardized amount for all IPPS hospitals (including hospitals in Puerto Rico) whose wage index values are less than or equal to 1.0000.

Outlier Payments (Page 2,444)

CMS is finalizing an outlier fixed-loss cost threshold for FY 2027 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, estimated supplemental payment for eligible IHS/Tribal hospitals and Puerto Rico hospitals, and any add on payments for new technology, **plus $49,346.**

Comments

Once again, CMS has underpaid hospitals for outlier payments.

CMS' current estimate, using available FY 2025 claims data, is that actual outlier payments for FY 2025 were approximately 4.90 percent of actual total MS-DRG payments. "Therefore, the data indicate that, for FY 2025, the percentage of actual outlier payments relative to actual total payments is lower than we projected for FY 2025."

"Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2025 are equal to 5.1 percent of total MS-DRG payments. A retroactive change to the fixed-loss outlier threshold would affect all hospitals subject to the IPPS, thereby undercutting the predictability of the system as a whole."

Changes for Hospitals Excluded from the IPPS (Page 956)

Certain hospitals excluded from a prospective payment system, including children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (that is, hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) receive payment for inpatient hospital services they furnish on the basis of reasonable costs, subject to a rate-of-increase ceiling.

CHANGES TO THE HOSPITAL WAGE INDEX FOR ACUTE CARE HOSPITALS (Page 578)

The FY 2027 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2023 (cost reports with a begin date on or after October 1, 2022 and before October 1, 2023).

CMS calculated the FY 2027 wage index using the Worksheet S–3, Parts II and III wage data of 3,006 hospitals.

The FY 2027 wage index data available as of January 30, 2026 are at:

https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wageindex-files/fy-2027-wage-index-home-page.

Occupational Mix Adjustment to the FY 2027 Wage Index (Page 605)

The FY 2027 Occupational Mix Adjusted National Average Hourly Wage is $58.83.

The FY 2027 national average hourly wages for each occupational mix nursing subcategory mix are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$60.42
National LPN and Surgical Technician	$35.01
National Nurse Aide, Orderly, and Attendant	$23.54
National Medical Assistant	$23.13
National Nurse Category	$50.06

Hospital Redesignations and Reclassifications (Page 611)

Hospitals may have their geographic area changed for wage index payment by applying for urban to rural reclassification under section 1886(d)(8)(E) of the Act (implemented at § 412.103), reclassification by the Medicare Geographic Classification Review Board (MGCRB) under section 1886(d)(10) of the Act, Lugar status redesignations under section 1886(d)(8)(B) of the Act, or a combination of the foregoing.

MGCRB Reclassification Issues for FY 2027 (Page 616)

There were 284 hospitals approved for wage index reclassifications in FY 2025 that will continue for

FY 2027, and 333 hospitals approved for wage index reclassifications in FY 2026 that will continue for FY 2027. Of all the hospitals approved for reclassification for FY 2025, FY 2026, and FY 2027, 1,118 hospitals (approximately 35 percent of IPPS hospitals) are in a MGCRB reclassification status for FY 2027 (with 302 of these hospitals reclassified back to their urban geographic location).

Applications for FY 2028 reclassifications are due to the MGCRB by September 1, 2026.

Applications and other information about MGCRB reclassifications may be obtained beginning in mid-July 2026 on the CMS website at:

https://www.cms.gov/medicare/regulations-guidance/geographic-classification-review-board.

CMS is adopting its proposal to revise the regulations at § 412.230(c)(1) to state: "To demonstrate proximity to the area, the hospital must submit evidence from a nationally recognized electronic mapping service of the shortest route from the front entrance of the hospital over improved roads or waterways traveled by ferry boats to the county line of the requested area and the distance of that route."

Wage Index Adjustments: Rural Floor, Imputed Floor, State Frontier Floor, Out-Migration Adjustment, Cap on Wage Index Decrease Policies, and Continuation of Transition for the Discontinuation of the Low Wage Index Hospital Policy. (Page 626)

Rural Floor (Page 626)

Section 4410(a) of the ***Balanced Budget Act*** of 1997 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State.

CMS estimates that 991 hospitals will receive the rural floor in FY 2027.

Imputed Floor (Page 629)

Section 1886(d)(3)(E)(iv)(I) and (II) of the Act provides that for discharges occurring on or after October 1, 2021, the area wage index applicable to any hospital in an all-urban State may not be less than the minimum area wage index for the fiscal year for hospitals in that State established using the methodology described in § 412.64(h)(4)(vi) as in effect for FY 2018.

States that would be all-urban States as defined in section 1886(d)(3)(E)(iv)(IV) of the Act, and thus hospitals in such States that would be eligible to receive an increase in their wage index due to application of the imputed floor for FY 2027. These hospitals are identified in Table 3 (which is available on the CMS website).

State Frontier Floor for FY 2027 (Page 631)

CMS says 31 hospitals will receive the frontier floor value of 1.00 for their FY 2027 wage index. These hospitals are located in Montana, North Dakota, South Dakota, and Wyoming. CMS notes that while Nevada meets the criteria of a frontier State, all hospitals within the State currently receive a wage index value greater than 1.00.

Out-Migration Adjustment Based on Commuting Patterns of Hospital Employees (Page 632)

CMS is finalizing, as proposed, that the FY 2027 out-migration adjustments continue to be based on the same policies, procedures, and computation that were used for the FY 2012 out-migration adjustment.

Cap on Wage Index Decreases and Budget Neutrality Adjustment (Page 636)

CMS will continue to apply a 5-percent cap on any decrease to a hospital's wage index from its wage index in the prior FY, regardless of the circumstances causing the decline

Continued Transition for the Discontinuation of the Low Wage Index Hospital Policy

(Page 638)

In the FY 2020 IPPS/LTCH PPS final rule, CMS finalized a temporary budget-neutral policy to address wage index disparities affecting **low-wage index hospitals**.

On July 23, 2024, the Court of Appeals for the D.C. Circuit held that the Secretary lacked authority under section 1886(d)(3)(E) or 1886(d)(5)(I)(ii) of the Act to adopt the low wage index hospital policy for FY 2020 and that the policy and related budget neutrality adjustment must be vacated. (Bridgeport Hosp. v. Becerra, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024).

After considering the appellate court's decision, CMS is discontinuing the low wage index hospital policy for FY 2026 and subsequent years.

CMS adopted a narrow budget-neutral transitional exception to the calculation of FY 2026 IPPS payments for low-wage index hospitals significantly impacted by the discontinuation of the low-wage index hospital policy.

CMS is extending the transitional exception to the calculation payments for FY 2027 for these hospitals in the same manner as it did for the FY 2026 wage index.

If the hospital is significantly impacted by the discontinuation of the low wage index hospital policy, meaning the hospital's FY 2027 wage index is decreasing by more than 14.2625 percent from the hospital's FY 2024 wage index, then the transitional payment exception for FY 2027 for that hospital will be equal to the additional FY 2027 amount the hospital would be paid under the IPPS if its FY 2027 wage index were equal to 85.7375 percent of its FY 2024 wage index. (Page 639)

FY 2027 Wage Index Tables (Page 643)

CMS has included the following wage index tables: Table 2 titled "Case-Mix Index and Wage Index Table by CCN"; Table 3 titled "Wage Index Table by CBSA"; Table 4A titled ''List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act''; and Table 4B titled ''Counties redesignated under section 1886(d)(8)(B) of the Act (Lugar Counties).''

PAYMENT ADJUSTMENT FOR MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSHS) FOR FY 2027 (§ 412.106) (Page 648)

Section 1886(d)(5)(F) of the Act provides for additional Medicare payments to subsection (d) hospitals that serve a significantly disproportionate number of low-income patients. The Act specifies two methods by which a hospital may qualify for the Medicare disproportionate share hospital (DSH) adjustment.

Under the first method, hospitals that are located in an urban area and have 100 or more beds may receive a Medicare DSH payment adjustment if the hospital can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to patients with low incomes. This method is commonly referred to as the "Pickle method."

The second method for qualifying for the DSH payment adjustment, the more commonly used method, is based on the hospital's disproportionate patient percentage (DPP), under which the DSH payment adjustment is based on a complex statutory formula that includes the hospital's geographic designation, the number of beds in the hospital, and the level of the hospital's DPP.

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

Section 1886(r)(2) of the Act provides that, for each eligible hospital in FY 2014 and subsequent years, the remaining estimate of 75 percent of uncompensated care payment is the product of three factors.

Factor (1) 75 percent of the total amount of DSH payments that would otherwise be made under section 1886(d)(5)(F) of the Act. (Page 647)

The June 2026 Office of the Actuary (OACT) estimate for Medicare DSH payments for FY 2027, without regard to application of section 1886(r)(1) of the Act, is approximately $15.767 billion. (Page 670)

Therefore, based on this June 2026 estimate, the estimate of empirically justified Medicare DSH payments for FY 2027, with application of section 1886(r)(1) of the Act, is approximately $3.94 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2027).

CMS states that the final Factor 1 for FY 2027 is **$11,825,250,000**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2027 ($15,767,000,000 minus $3,941,750,000).

Comment

There may be a math error in CMS' calculations above. CMS says total estimated FY 2027 DSH payments will total $15.767 billion. Twenty five percent of the total is $3.94 billion. [$15.767 - $3.94 = $11.827 billion. I agree so far. However, CMS then states "the final Factor 1 for FY 2027 is $11,825,250,000, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2027 ($15,767,000,000 minus $3,941,750,000)."

How does CMS state the 25 percent amount is rounded to $3.94 billion for the purposes of the empirical payments and increased to $3.941 for the purposes of the 75 percent uncompensated care payment? CMS should be consistent about rounding.

Factor (2) = 1 minus the percent change in the percent of individuals who are uninsured.

CMS is continuing to use the methodology that was used in fiscal years (FYs) 2018 through 2026 to determine Factor 2 for FY 2027 – to use the National Health Expenditure Accounts (NHEA) data to determine the percentage point change in the percent of individuals who are uninsured.

OACT has estimated that the uninsured rate for the historical baseline year of 2013 was 14.0 percent, and that the uninsured rates for CYs 2026 and 2027 are projected to be 9.2 and 9.5percent, respectively.

The calculation of the final Factor 2 for FY 2027 is as follows:

- Percent of individuals without insurance for CY 2013: 14.0 percent.
- Percent of individuals without insurance for CY 2026: 9.2 percent.
- Percent of individuals without insurance for CY 2027: 9.5 percent.
- Percent of individuals without insurance for FY 2027: (0.25 times 0.092) + (0.75 times 0.095) = 9.4 percent.
- Factor 2 is calculated as 1 minus the percent change in the percent of individuals without insurance between CY 2013 and FY 2027.
- Factor 2 is as follows: 1 – |((0.14 – 0.094)/0.14)| = 1 – 0.3286 = 0.6714

CMS says Factor 2 for FY 2027 would be **67.14 percent**.

The final FY 2027 uncompensated care amount is equivalent to Factor 1 multiplied by Factor 2, which is **$7,939,472,850**.

The following shows the 75 percent yearly amounts for DSH payments.

- The FY 2014 "pool" was $9.033 billion
- The FY 2015 "pool" was $7.648 billion
- The FY 2016 "pool" was $6.406 billion
- The FY 2017 "pool" was $6.054 billion
- The FY 2018 "pool" was $6.767 billion
- The FY 2019 "pool" was $8.273 billion
- The FY 2020 "pool" was $8.351 billion
- The FY 2021 "pool" was $8.290 billion
- The FY 2022 "pool" was $7.192 billion
- The FY 2023 "pool" was $6.874 billion
- The FY 2024 "pool" was $5.938 billion
- The FY 2025 "pool" was $5.706 billion
- The FY 2026 "pool" was $7.713 billion

The pool amount for FY 2027 will be $7.939, which is $226 million more than the current FY 2026 amount.

Calculation of Factor 3 for FY 2027 (Page 682)

Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and each subsection (d) Puerto Rico hospital with the potential to receive Medicare DSH payments relative to the estimated uncompensated care amount for all

hospitals estimated to receive Medicare DSH payments in the fiscal year for which the uncompensated care payment is to be made.

OTHER DECISIONS AND CHANGES TO THE IPPS FOR OPERATING COSTS (Page 709)

Changes to MS–DRGs Subject to Post-acute Care Transfer Policy and MS–DRG Special Payments Policies (§ 412.4)

CMS' policy set forth in § 412.4(f) provides that when a patient is transferred and his or her length of stay is less than the geometric mean length of stay for the MS–DRG to which the case is assigned, the transferring hospital is generally paid based on a graduated per diem rate for each day of stay, not to exceed the full MS–DRG payment that would have been made if the patient had been discharged without being transferred.

For MS-DRGs subject to the post-acute care policy that exhibit exceptionally higher shares of costs very early in the hospital stay, § 412.4(f) includes a special payment methodology that adjusts the per diem payment. For these MS-DRGs, hospitals receive 50 percent of the full MS-DRG payment, plus the single per diem payment, for the first day of the stay, as well as a per diem payment for subsequent days (up to the full MS–DRG payment (§ 412.4(f)(6))).

CMS proposed and has finalized changes to a number of MS-DRGs, effective for FY 2027. The rule contains a series of tables beginning on page 716 that Lists New or Revised MS-DRGs Subject to Review of Post-acute Care Transfer Policy Status for FY 2027.

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (§ 412.96) (Page 744)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and

- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

Case-mix (Page 457)

If rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2027, they must have a CMI value for FY 2025 that is

- **1.778** (national--all urban); or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table:

Region	Case-Mix Index Values
1. New England (CT, ME, MA, NH, RI, VT)	1.4865
2. Middle Atlantic (PA, NJ, NY)	1.5595
3. East North Central (IL, IN, MI, OH, WI)	1.6506
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.6851
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.6298
6. East South Central (AL, KY, MS, TN)	1.5649
7. West South Central (AR, LA, OK, TX)	1.7720
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.7903
9. Pacific (AK, CA, HI, OR, WA)	1.7284

A hospital must also have the number of discharges for its cost reporting period that began during FY 2024 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or

- If less, the median number of discharges for urban hospitals in the census region in which the hospital is located.

CMS says that because the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges, 5,000 discharges is the minimum criterion for all hospitals, except for osteopathic hospitals for which the minimum criterion is 3,000 discharges.

Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Page 750)

The ***Consolidated Appropriations Act***, 2026, provided an extension of the temporary changes to the qualifying criteria and payment adjustment methodology for certain low-volume hospitals through FY 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026.

CMS is adopting its proposal to make conforming changes to paragraphs (b)(2)(iii) and (c)(3) introductory text of § 412.101 to reflect that the low-volume hospital payment adjustment policy in effect through FY 2026 and the portion of fiscal year 2027 beginning on October 1, 2026, and ending on December 31, 2026 is the same low-volume hospital payment adjustment policy in effect for FYs 2019. (Page 754)

Payment Adjustment for the Portion of FY 2027 Beginning on January 1, 2027 and Subsequent Fiscal Years (Page 754)

Absent further Congressional action, effective for the portion of FY 2027 beginning on January 1, 2027, and ending on September 30, 2027, and for FY 2028 and subsequent fiscal years, under current policy at § 412.101(b), to qualify as a low-volume hospital, a subsection (d) hospital must be more than 25 road miles from another subsection (d) hospital and have less than 200 discharges (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges) during the fiscal year.

Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (Page 766)

CMS is making conforming changes to the regulations governing the MDH program at § 412.108(a)(1) and (c)(2)(iii) and the general payment rules at § 412.90(j) to reflect the extension of the MDH program through December 31, 2026.

Absent Congressional action, beginning January 1, 2027, all hospitals that previously qualified for MDH status under section 1886(d)(5)(G) of the Act will no longer have MDH status and will be paid based on the Federal rate.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83) (Page 772)

CMS is requiring that, in addition to meeting other applicable requirements, an approved medical residency training program must not discriminate, or promote or encourage discrimination, on the basis of race, color, national origin, sex, age, disability, or religion, including the use of those characteristics or intentional proxies for those characteristics as a selection criterion for employment, program participation, resource allocation, or similar activities, opportunities, or benefits.

Effective for programs started on or after October 1, 2026, in order for a residency program to be considered new, in addition to receiving initial accreditation from the appropriate accrediting body, at least 90 percent of the individual resident trainees (not FTEs) must not have previous training in the same specialty as the new program. (Page 488)

Comment

Calculating both GME and IME has always been a difficult task. There are many issues at hand, and as evidenced by length of this section of the rule which extends nearly 70 pages. Those involved in this subject provision need to read all of the material being presented.

Reasonable Cost Payment for Nursing and Allied Health Education Programs (§413.85 and §413.87) (Page 841)

Under section 1861(v) of the Act, Medicare has historically paid providers for Medicare's share of the costs that providers incur in connection with approved educational activities. The costs of these activities are excluded from the definition of "inpatient hospital operating costs" and are not included in the calculation of payment rates for hospitals or hospital units paid under the IPPS, IRF PPS, or IPF PPS, and are excluded from the rate-of-increase ceiling for certain facilities not paid on a PPS. These costs are separately identified and "passed through" (that is, paid separately on a reasonable cost basis).

In the CY 2026 OPPS/ASC final rule for purposes of Medicare GME payment, CMS finalized changes to the definition of "approved medical residency program" and equivalent terms, to state that accrediting organizations may not use accreditation criteria that promote or encourage discrimination on the basis of race, color, national origin, sex, age, disability, or religion, including the use of those characteristics or intentional proxies for those characteristics as a selection criterion for employment, program participation, resource allocation, or similar activities, opportunities, or benefits.

CMS is finalizing, without modification, its proposal to codify the anti-discrimination requirements under new 42 CFR 413.84 and to cross reference that section as necessary in the regulations at § 413.85. CMS is also finalizing, without modification, its proposal to amend § 413.85(e) to remove the language specifying individual accrediting organizations of nursing and allied health education programs. These changes will be effective October 1, 2026. (Page 851)

Changes to the Regulations for Determining the Net Cost of Nursing and Allied Health Education Programs and Clarifications Regarding the Correct Allocation of Overhead Costs

CMS is finalizing, with modification, its proposed amendments to the regulations at 42 CFR 413.85(d)(2)(i) and (ii) to codify the requirement that tuition and other revenue must be subtracted from the direct costs of approved educational activities prior to the allocation of indirect costs, as determined under the Medicare cost-finding principles in § 413.24.

The effective date of this change would be cost reporting periods beginning on or after October 1, 2026. (Page 863)

CMS is finalizing, with modification, its proposal to define allowable indirect costs at § 413.85(d)(2)(i)(C) as limited to those costs that the provider itself incurs and that are directly attributable to the approved educational activities. (Page 873)

Payment Adjustment for Certain Immunotherapy Cases (§§ 412.85 and 412.312) (Page 881)

For FY 2027, CMS proposed to continue to apply an adjustment to the payment amount for expanded access use of immunotherapy and applicable clinical trial cases, and other cases where the immunotherapy product is not purchased in the usual manner, such as obtained at no cost, that group

to MS-DRG 018, calculated using the same methodology, as modified in the FY 2024 IPPS/LTCH PPS final rule.

Using March 2026 update of the FY 2025 MedPAR data, CMS is finalizing an adjustor of 0.16 for FY 2027, which will be multiplied by the final FY 2027 relative weight for MS–DRG 018 as part of the calculation of the payment for claims determined to be applicable clinical trial cases, expanded use access immunotherapy claims, and other cases where the immunotherapy product is not purchased in the usual manner, such as obtained at no cost, that group to MS-DRG 018.

CMS is finalizing proposal without modification. (Page 885)

Hospital Readmissions Reduction Program (Page 886)

The table below shows the Hospital Readmissions Reduction Program measure set for the FY 2027 program year and subsequent years, that is, the "applicable conditions" used to calculate excess readmission ratios.

Summary of Previously Finalized and Proposed Hospital 30-Day, All-Cause, Risk-Standardized Unplanned Readmission Measures in the Hospital Readmissions Reduction Program

Applicable Condition or Procedure	FY 2027	FY 2028	FY 2029
Acute Myocardial Infarction	X	X	X
Chronic Obstructive Pulmonary Disease	X	X	X
Heart Failure	X	X	X
Pneumonia	X	X	X
Coronary Artery Bypass Graft Surgery	X	X	X
Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty	X	X	X
Sepsis			X*

CMS will adopt the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure as part of the Hospital Readmissions Reduction Program measure set beginning with an early look for the FY 2028 (applicable period of July 1, 2024 to June 30, 2026) and FY 2029 (applicable period of July 1, 2025 to June 30, 2027) program years. The measure will then be used in the Hospital Readmissions Reduction Program for payment adjustment beginning with the FY 2030 program year (applicable period of July 1, 2026 to June 30, 2028) and subsequent years.

(Page 933)

CMS says that for FY 2027, 2,358 hospital are subject to being penalized, and with the Sepsis measure the total would be 2,450. (Page 904)

Hospital Value-Based Purchasing Program (Page 934)

CMS estimates the available pool of funds for value-based incentive payments in the FY 2027 program year, which, in accordance with section 1886(o)(7)(C)(v) of the Act, will be 2.00 percent of base operating DRG payments, or a total of approximately $1.9 billion.

CMS proposed to adopt substantive measure updates to five condition-specific and procedure-specific mortality measures, in the Clinical Outcome domain, beginning with the July 1, 2028 through June 30, 2030 performance period for the FY 2032 program year.

The following table identifies these measures.

MORT-30-AMI**	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization	0230
MORT-30-HF**	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization	0229
MORT-30-PN**	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization	0468
MORT-30-COPD**	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893
MORT-30-CABG**	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery	2558
COMP-HIP-KNEE***	Hospital Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	1550

** In this proposed rule, CMS proposes modifications to the MORT–30–AMI, MORT–30–HF, MORT–30–PN, MORT–30–COPD, MORT–30–CABG measures beginning with the FY 2032 program year.

*** In the FY 2026 IPPS/LTCH PPS final rule, CMS finalized modifications to the COMP-HIP-KNEE measure in the Hospital Value-Based Purchasing Program beginning with the FY 2033 program year (90 FR 36943 through 36948). The updated COMPHIP-KNEE measure will include Medicare Advantage beneficiaries in the measure cohort and a reduced reporting period from 3 to 2 years beginning with the FY 2033 program year.

CMS says these updates are contingent on the adoption of the same modified mortality measures in the Hospital Inpatient Quality Reporting Program beginning with the FY 2028 payment determination.

CMS notes that it "adopted certain measures for the Clinical Outcomes domain (MORT–30–AMI, MORT–30–HF, MORT–30–PN, MORT–30–COPD, MORT–30– CABG, and COMP–HIP–KNEE) and the Efficiency and Cost Reduction domain (MSPB Hospital) for future program years to ensure that we can adopt baseline and performance periods of sufficient length for performance scoring purposes."

(Page 944)

Hospital-Acquired Condition (HAC) Reduction Program (Page 946)

CMS is not making any updates for the HAC Reduction Program. CMS says 721 hospital fall in the worst 25 percent level. (Page 2,601)

CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Page 33)

Changes to Specific MS-DRG Classifications

Comment

This is a relatively long section spanning in excess of 200 pages.

Short-term External Heart Assist Systems (Page 48)

CMS received a request to reassign cases reporting procedure codes describing the insertion of a short-term external heart assist device from MDC 04 MS-DRGs 163, 164, and 165 (Major Chest Procedures with MCC, with CC, and without CC/MCC, respectively) to MDC 05 (Diseases and Disorders of the Circulatory System) MS-DRG 215 (Other Heart Assist System Implant).

CMS did not propose and is not reassigning cases reporting procedure codes describing the insertion of a short-term external heart assist device from MDC 04 MS-DRGs 163, 164, and 165 (Major Chest Procedures with MCC, with CC, and without CC/MCC, respectively) to MDC 05 MS-DRG 215 (Other Heart Assist System Implant) for FY 2027. (Page 59)

Fluorescence Guided Procedures of the Trunk Region using Pafolacianine (Page 60)

CYTALUX® (pafolacianine) is a folate receptor–targeted fluorescent optical imaging agent used as an adjunct for the identification of malignant and non-malignant pulmonary lesions in adult patients with known or suspected lung cancer. CYTALUX® binds to the folate receptors on these cancer cells and is endocytosed into folate receptor positive cancer cells.

CMS is finalizing its proposal to maintain the current structure of MS-DRGs 163, 164, and 165.

WiSE® CRT System (Page 66)

The WiSE® CRT System is an implantable cardiac pacing system that delivers left ventricular endocardial pacing (LVEP) specifically for cardiac resynchronization therapy (CRT) without the use of wires or leads going into the heart.

CMS is finalizing its proposal to reassign procedure code X2HN37B (Insertion of endocardiac pacing electrode into left ventricle, percutaneous approach, new technology group 11) from MS-DRG 264 to MS-DRGs 228 and 229, without modification, effective October 1, 2026, for FY 2027.

CMS is also finalizing its proposal to delete the procedure code combination of X2HN37B and XHH80HB from the GROUPER logic of MS-DRGs 242, 243, and 244, without modification, for FY 2027. Under this finalization, procedure code X2HN37B will not need to be reported as part of a procedure code combination or procedure code "cluster" to satisfy the logic for assignment to MS-DRGs 228 and 229.

When reported as a standalone procedure, ICD-10-PCS code XHH80HB (Insertion of ultrasound transmitter and battery for endocardiac pacing electrode into chest subcutaneous tissue and fascia, open approach, new technology group 11) will be assigned to new MDC 05 MS-DRG 210 (Cardiac Pacemaker Revision or Device Replacement with MCC) and new MS-DRG 211 (Cardiac Pacemaker

Revision or Device Replacement without MCC).

CMS is finalizing its proposal to delete MS-DRGs 258, 259, 260, 261, and 262, effective October 1, 2026, without modification. CMS is also finalizing its proposal to create new MS-DRG 210 (Cardiac Pacemaker Revision or Device Replacement with MCC) and new MS-DRG 211 (Cardiac Pacemaker Revision or Device Replacement without MCC) for cases reporting procedure codes describing cardiac pacemaker revision or device replacement effective October 1, 2026, without modification.

Spinal Fusion and Pelvic Fixation Procedures (Page 88)

CMS is finalizing its proposal, without modification, to create new MS-DRGs 523, 524, and 525. CMS is also finalizing its proposal to reassign cases reporting an extensive spinal fusion procedure from MS-DRGs 426, 427, 428, 456, 457 and 458 and to reassign cases reporting a spinal fusion procedure with use of the aprevo® device or the iFuse Bedrock™ Granite Implant System from MS-DRGs 402, 426, 427, 428, 447, 448, 450, 451, 456, 457 and 458 to new MS-DRGs 523, 524, and 525. Lastly, CMS is finalizing its proposal to revise the titles for MS-DRGs 426, 447, and 450 to remove the reference to "Custom-made Anatomically Designed Interbody Fusion Device" and to revise the titles for MS-DRGs 456, 457, and 458 to remove the reference to "Extensive Fusions".

Hip or Knee Procedures with Periprosthetic Joint Infection (Page 114)

CMS received a request to reassign cases reporting a hip or knee procedure with a principal diagnosis of periprosthetic joint infection (PJI).

CMS is finalizing its proposals to

> (1) remove the restriction logic for MS-DRGs 466, 467, and 468 and MS-DRGs 485, 486, and 487,
>
> (2) remove ICD-10-CM diagnosis codes T84.53XA and T84.54XA from the logic for case assignment to MS-DRGs 485, 486, and 487,
>
> (3) delete MS-DRGs 466, 467, and 468 and MS-DRGs 485, 486, and 487, 4) create new base MS-DRG 449, with modification of the MS-DRG title to reflect "Revision of Hip or Knee Prosthesis" and new base MS-DRG 400,
>
> (5) redesignate procedure code XW0V0P7 from non-O.R. to non-O.R. affecting specified MS-DRGs,
>
> (6) create new MS-DRG 403 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC or Insertion of Antibiotic-eluting Bone Void Filler) to reflect cases reporting a hip or knee procedure with a principal diagnosis of PJI and the reassignment of cases reporting ICD-10-PCS code XW0V0P7 from the lower severity level to the higher (with MCC) severity level and create new MS-DRG 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection without MCC), and
>
> (7) reassign cases reporting ICD-10-PCS code XW0V0P7 from the lower severity level (without CC/MCC or with CC) to the higher (with MCC) severity level and revise the titles to the previously listed MS-DRGs 463, 474, 477, 480, and 492 to reflect the reassignment

CMS is also finalizing its proposal to remove the 20 procedure codes previously listed to appropriately reflect the logic list for new base MS-DRG 449 and to ensure cases group correctly. Lastly, CMS is finalizing its proposal to revise the term "and" to "or" for the titles for MS-DRGs 463, 464, and 465.

These finalized changes, including the finalized logic lists for case assignment, are also reflected in the ICD-10 MS-DRG GROUPER Software, Version 44, and the ICD-10 MS-DRG Definitions Manual, Version 44, (available on the CMS website at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software. (Page 137)

CERAMENT® G Antibiotic-eluting Bone Void Filler (Page 139)

CMS finalizing its proposal to reassign cases reporting procedure code XW0V0P7 from the lower severity level MS-DRGs 617 and 618 to the higher severity (MCC) level MS-DRG 616 and from the lower severity level MS-DRGs 629 and 630 to the higher (MCC) level MS-DRG 628. CMS is also finalizing its proposal to revise the titles of MS-DRG 616 and MS-DRG 628 to reflect the reassignment of cases reporting procedure code XW0V0P7 by adding the phrase "Insertion of Antibiotic-eluting

Bone Void Filler" as also reflected in the ICD-10 MS-DRG Definitions Manual Version 44.

Prostatectomy (Page 145)

CMS is finalizing its proposal to remove the eight ICD-10-PCS procedure code combinations listed previously from the GROUPER logic of MDC 11 MS-DRGs 665, 666, and 667 (Prostatectomy with MCC, with CC, and without CC/MCC, respectively), without modification, effective October 1, 2026.

Islet Cell Transplantation (Page 147)

CMS is finalizing its proposal to add the 11 ICD-10-PCS procedure codes that describe the introduction of pancreatic islet cells to a new "Islet Cell Transplant Procedures" logic list in MS-DRGs 008, 010, and 019, effective October 1, 2026, without modification. Additionally, CMS is also finalizing its proposal to delete the sixth logic list entitled "or Principal Diagnosis" that is defined by ICD-10-CM diagnosis codes E10.21 (Type 1 diabetes mellitus with diabetic nephropathy), E10.22 (Type 1 diabetes mellitus with diabetic chronic kidney disease) and E10.29 (Type 1 diabetes mellitus with other diabetic kidney complication) and the seventh logic list entitled "and Non-Operating Room Procedures" from MS-DRGs 673, 674, and 675. Lastly, for consistency, CMS is finalizing its proposals to change the title of MS-DRG 008 from "Simultaneous Pancreas and Kidney Transplant" to "Simultaneous Pancreas, Islet Cell and Kidney Transplant," to change the title of MS-DRG 010 from "Pancreas Transplant" to "Pancreas or Islet Cell Transplant" and to change the title of MS-DRG 019 from "Simultaneous Pancreas and Kidney Transplant with Hemodialysis" to "Simultaneous Pancreas, Islet Cell and Kidney Transplant with Hemodialysis" to better reflect the assigned procedures, effective October 1, 2026.

CMS is finalizing its proposal to delete the eight ICD-10-PCS procedure code combinations listed previously from the GROUPER logic of MDC 12 MS-DRGs 707 and 708 (Major Male Pelvic Procedures with CC/MCC and without CC/MCC, respectively), without modification, effective October 1, 2026.

Comment

This is an extremely long section – more than 230-pages. There are more MS-DRG items including operating vs non-operating room procedures, Non-O.R. Procedures to O.R. Procedures, Proposed Changes to the MS-DRG Diagnosis Codes for FY 2027, and Proposed Changes to Severity Levels. These items begin on page 165. The items include;

- Fluorescence Guided Procedures of Female Reproductive System using Pafolacianine (Page 165)
- Significant HIV Related Conditions (Page 180)
- Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989 (Page 182)
- Operating Room (O.R.) and Non-O.R. Procedures (Page 184)
- Changes to the MS-DRG Diagnosis Codes for FY 2027 (Page 202)
- Changes to the ICD-10-CM and ICD-10-PCS Coding Systems (Page 234)
- Changes to the Surgical Hierarchies (Page 239)
- Maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems (Page 247)
- Replaced Devices Offered without Cost or with a Credit (Page 262)

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES FOR FY 2027 (Page 284)

FY 2027 Status of Technologies Receiving New Technology Add-On Payments for FY 2026

In this section of the final rule, CMS discusses the FY 2027 status of the 54 new technology add-on payments approved for FY 2026, as set forth in the table that follows. Note of the 54 payments approved for FY 2026, only 41 will continue in FY 2027.

CONTINUATION OF TECHNOLOGIES APPROVED FOR FY 2026 NEW TECHNOLOGY ADD-ON PAYMENTS STILL CONSIDERED NEW FOR FY 2027 BECAUSE THE 3-YEAR ANNIVERSARY DATE WILL OCCUR ON OR AFTER OCTOBER 1, 2026 (Page 325)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
1	*Annalise Enterprise CTB Triage—OH*	*10/10/2023*	*10/01/2024*	*10/10/2026*	$241.39	XXE0X1A
2	*ASTar® System*	*04/26/2024*	*10/01/2024*	*04/26/2027*	$97.50	XXE5X2A
3	*Edwards EVOQUE™ Tricuspid Valve Replacement System ("EVOQUE™ System")*	*02/01/2024*	*10/01/2024*	*02/01/2027*	$31,850.00	X2RJ3RA
4	*GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device)*	*01/12/2024*	*10/01/2024*	*01/12/2027*	$47,238.75	X2VE3SA
5	*LimFlow™ System*	*11/01/2023*	*10/01/2024*	*11/01/2026*	$16,250.00	041M3JS, 041N3JS, 041P3JS, 041Q3JS, 041R3JS, 041S3JS, 041T3JS, or 041U3JS
6	*Paradise™ Ultrasound Renal Denervation System*	*11/7/2023*	*10/01/2024*	*11/07/2026*	$14,950.00	X051329
7	*PulseSelect™ Pulsed Field Ablation (PFA) Loop Catheter*	*12/13/2023*	*10/01/2024*	*12/13/2026*	$6,337.50	02583ZF
8	*Symplicity Spyral™ Multi-Electrode Renal Denervation Catheter*	*11/17/2023*	*10/01/2024*	*11/17/2026*	$10,400.00	X05133A
9	*TriClip™ G4*	*04/01/2024*	*10/01/2024*	*04/01/2027*	$26,000.00	02UJ3JZ
10	*VADER® Pedicle System*	*02/26/2024*	*10/01/2024*	*02/26/2027*	$28,242.50	XRH60FA, XRH63FA, XRH64FA, XRH70FA, XRH73FA, XRH74FA, XRH80FA, XRH83FA, XRH84FA, XRHA0FA, XRHA3FA, XRHA4FA,

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
						XRHB0FA, XRHB3FA, XRHB4FA, XRHC0FA, XRHC3FA, XRHC4FA, XRHD0FA, XRHD3FA, or XRHD4FA in combination with one of the following: M46.20, M46.22, M46.23, M46.24, M46.25, M46.26, M46.27, M46.30, M46.32, M46.33, M46.34, M46.35, M46.36, M46.37, M46.39, M46.40, M46.42, M46.43, M46.44, M46.45, M46.46, M46.47, M46.49, M46.50, M46.51, M46.52, M46.53, M46.54, M46.55, M46.56, M46.57, M46.59, M46.80, M46.82, M46.83, M46.84, M46.85, M46.86, M46.87, M46.89, M46.90, M46.92, M46.93, M46.94, M46.95, M46.96, M46.97, or M46.99
11	*ZEVTERA™ (ceftobiprole medocaril); ABSSSI and CABP indications*	*09/30/2024*	*10/01/2024*	*09/30/2027*	$5,287.50	XW0335A or XW0435A
12	*ZEVTERA™ (ceftobiprole medocaril); SAB indication*	*09/30/2024*	*10/01/2024*	*09/30/2027*	$16,215.00	XW0335A or XW0435A **in combination with** R78.81 (**in combination with** B95.61 or B95.62)
13	*CASGEVY™ (exagamglogene autotemcel); Sickle Cell Disease*	*12/08/2023*	*10/01/2024*	*12/08/2026*	$1,650,000.00	XW133J8 or XW143J8 **in combination with** one of the following: D57.1, D57.20, D57.40, D57.42, D57.44, or D57.80

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
	indication					
14	*HEPZATO™ KIT (melphalan for injection/hepatic delivery system)*	*01/08/2024*	*10/01/2024*	*01/08/2027*	$118,625.00	XW053T9 **in combination with** 5A1C00Z
15	*LYFGENIA™ (lovotibeglogene autotemcel)*	*12/08/2023*	*10/01/2024*	*12/08/2026*	$2,325,000.00	XW133H9 or XW143H9
16	*4WEB Medical Ankle Truss System*	*01/31/2025*	*10/01/2025*	*01/31/2028*	$15,275.00	XRGJ0B9, XRGK0B9, XRGL0B9, or XRGM0B9
17	*AeroPace® System*	*12/04/2024*	*10/01/2025*	*12/04/2027*	$23,650.90	X2H13XB
18	*AGENT™ Paclitaxel-Coated Balloon Catheter*	*02/29/2024*	*10/01/2025*	*02/29/2027*	$4,013.75	XW0J3HA, XW0J3JA, XW0J3KA, XW0J3LA, XW0K3HA, XW0K3JA, XW0K3KA, XW0K3LA, XW0L3HA, XW0L3JA, XW0L3KA, XW0L3LA, XW0M3HA, XW0M3JA, XW0M3KA, or XW0M3LA
19	*alfapump® system*	*12/20/2024*	*10/01/2025*	*12/20/2027*	$21,450.00	0W1G3J6 **in combination with** 0JH80YZ
20	*aprevo®-C cervical interbody fusion device*	*11/15/2024*	*10/01/2025*	*11/15/2027*	$21,125.00	XRG10RB, XRG13RB, XRG14RB, XRG20RB, XRG23RB, XRG24RB, XRG40RB, XRG43RB, or XRG44RB
21	*CERAMENT® G (open fracture indication)*	*03/13/2024*	*10/01/2025*	*03/13/2027*	$5,687.50	XW0V0P7 **without** any of the ICD-10-CM diagnosis codes in category M86
22	*Emily's Care Nourish Test System (Model 1)*	*05/03/2024*	*10/01/2025*	*05/03/2027*	$3,347.50	XXEZXAB **in combination with** one of the following: P05.01, P05.02, P05.03, P05.04, P05.05, P05.11, P05.12, P05.13, P05.14, P05.15, P07.00, P07.01, P07.02, P07.03, P07.14, or P07.15
23	*Esprit™ BTK Everolimus Eluting Resorbable Scaffold System*	*04/26/2024*	*10/01/2025*	*04/26/2027*	$6,922.50	X27P3TA, X27Q3TA, X27R3TA, X27S3TA, X27T3TA, or X27U3TA

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
24	*EUROPA™ Posterior Cervical Fusion System*	*11/19/2024*	*10/01/2025*	*11/19/2027*	$80,548.00	XRH10GB, XRH13GB, XRH14GB, XRH20GB, XRH23GB, XRH24GB, XRH40GB, XRH43GB, XRH44GB, XRH60GB, XRH63GB, or XRH64GB
25	*iFuse TORQ TNT™ Implant System*	*08/19/2024*	*10/01/2025*	*08/19/2027*	$4,135.95	XRGE0HB, XRGE3HB, XRGF0HB, XRGF3HB, XNSN0HB, XNSN3HB, XNSP0HB, XNSP3HB, XNH60HB, XNH63HB, XNH70HB, or XNH73HB
26	*Merit Wrapsody® Cell Impermeable Endoprosthesis (CIE)*	*01/02/2025*	*10/01/2025*	*01/02/2028*	$3,770.00	X27535B, X27635B, X27735B, X27835B, X27935B, X27A35B, X27B35B, X27C35B, X27D35B, or X27E35B
27	*Minima Stent System*	*08/28/2024*	*10/01/2025*	*08/28/2027*	$22,685.00	X27339B, X27439B, X27W39B, or X27X39B
28	*MY01 Continuous Compartmental Pressure Monitor*	*04/29/2025*	*10/01/2025*	*04/29/2028*	$2,112.50	XX2F3W9
29	*PBC Separator with Selux AST System*	*02/15/2024*	*10/01/2025*	*02/15/2027*	$87.78	XXE5XY9
30	*restor3d TIDAL™ Fusion Cage*	*03/24/2025*	*10/01/2025*	*03/24/2028*	$18,196.75	XRGK0CA, XRGM0CA, XRGJ0CA, or XRGL0CA
31	*ShortCut™*	*09/27/2024*	*10/01/2025*	*09/27/2027*	$9,750.00	X28F3VA
32	*The WiSE CRT System*	*04/11/2025*	*10/01/2025*	*04/11/2028*	$41,145.00	X2HN37B **in combination with** XHH80HB
33	*TriVerity Test*	*01/10/2025*	*10/01/2025*	*01/10/2028*	$243.75	XXE5XBB
34	*VITEK® REVEAL™ AST System*	*10/21/2024*	*10/01/2025*	*10/21/2027*	$81.25	XXE5X4A
35	*EMBLAVEO™ (aztreonam-avibactam)*	*02/07/2025*	*10/01/2025*	*02/07/2028*	$9,000.68	XW033PB or XW043PB
36	*CONTEPO™ (fosfomycin)*	*10/22/2025*	*01/01/2026*	*10/22/2028*	$8,775.00	XW033WB or XW043WB
37	*AURLUMYN™ (iloprost injection)*	*11/01/2024*	*10/01/2025*	*11/01/2027*	$28,600.00	XW033QB or XW043QB

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
38	*BREYANZI® (lisocabtagene maraleucel)*	*03/14/2024*	*10/01/2025*	*03/14/2027*	$316,860.05	XW033N7 or XW043N7 **in combination with** one of the following: C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C91.10, or C91.12
39	*GRAFAPEX™ (treosulfan)*	*01/21/2025*	*10/01/2025*	*01/21/2028*	$21,411.00	XW03388 or XW04388
40	*IMDELLTRA® (tarlatamab-dlle)*	*05/16/2024*	*10/01/2025*	*05/16/2027*	$7,117.50	XW033NA or XW043NA
41	*TECELRA® (afamitresgene autoleucel)*	*08/01/2024*	*10/01/2025*	*08/01/2027*	$472,550.00	XW03368 or XW04368

Since only 41 of the FY 2026 new technology add-on payments will continue to receive the status in FY 2027, it means that 13 FY 2026 approved technologies will lose the status for FY 2027. They are listed in the table below.

Technology		Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market
1	*CYTALUX® (pafolacianine) (lung indication)*	*06/05/2023*	*10/01/2023*	*06/05/2026*
2	*EPKINLY™ (epcoritamab-bysp) and COLUMVI™ (glofitamab-gxbm)*	*05/19/2023*	*10/01/2023*	*05/19/2026*
3	*Aveir™ AR Leadless Pacemaker*	*06/29/2023*	*10/01/2023*	*06/29/2026*
4	*Aveir™ Dual-Chamber Leadless Pacemaker*	*06/29/2023*	*10/01/2023*	*06/29/2026*
5	*Ceribell Status Epilepticus Monitor*	*05/23/2023*	*10/01/2023*	*05/23/2026*
6	*DETOUR System*	*06/07/2023*	*10/01/2023*	*06/07/2026*
7	*DefenCath® (taurolidine/heparin)*	*11/15/2023*	*01/01/2024*	*11/15/2026*
8	*Phagenyx® System*	*04/12/2023*	*10/01/2023*	*04/12/2026*

Technology		Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market
9	*REZZAYO™ (rezafungin for injection)*	*07/19/2023*	*10/01/2023*	*07/19/2026*
10	*SAINT Neuromodulation System*	*09/30/2023*	*10/01/2023*	*09/30/2026*
11	*TOPS™ System*	*06/15/2023*	*10/01/2023*	*06/15/2026*
12	*XACDURO®* *(sulbactam/durlobactam)*	*05/23/2023*	*10/01/2023*	*05/23/2026*
13	*RECELL® Autologous Cell Harvesting Device*	*06/07/2023*	*10/01/2025*	*06/07/2026*

FY 2027 Applications for New Technology Add-On Payments (Traditional Pathway)

(Page 336)

CMS received 15 applications for new technology add-on payments for FY 2027 under the new technology add-on payment traditional pathway.

Of the 15 applications received, 3 applicants were not eligible for consideration for new technology add-on payment because they did not meet requirements, and 4 applicants withdrew their applications prior to the issuance of the proposed rule. In addition, prior to the issuance of this final rule, one additional application for Orca-T was withdrawn. [15-3-4-1=7] CMS is not approving 4 of the 7.

As a result, CMS is approving FY 2027 new technology add-on payments for three technologies.

1. GAMIFANT® (emapalumab-lzsg) (Page 380)
2. YARTEMLEA® (narsoplimab-wuug) (Page 415)
3. ZEVASKYN™ (prademagene zamikeracel) (Page 420)

FY 2027 Applications for New Technology Add-On Payments (Alternative Pathways)

(Page 434)

CMS received 32 applications for new technology add-on payments for FY 2027 under the new technology add-on payment alternative pathway. Of the 32 applications received, 7 applications were not eligible for consideration because they did not meet requirements; and 3 applicants withdrew their applications prior to the issuance of the proposed rule.

Prior to the issuance of this final rule, 5 additional applicants (for CERAMENT® V, MediBeacon® Transdermal GFR Measurement System [TGFR], Micro Medical Solutions MicroStent and the MicroStent XL Peripheral Vascular Stent System, PMCardio® STEMI AI ECG Model, and VUNO Med-DeepCARS®) withdrew their applications or did not meet the May 1 deadline for FDA approval or clearance of the technology, and therefore are not eligible for consideration for new technology add-on payments for FY 2027.

CMS is providing an overview of the new technology add-on payment application and CMS's preliminary assessment for each alternative pathway application, and propose whether or not each technology would be eligible for the new technology add-on payment for FY 2027.

1. Bayesian Health Sepsis Flagging Device (Page 442)
   Approved, finalizing that the maximum new technology add-on payment for a case involving the use of the Bayesian Health Sepsis Flagging Device at $61.84 for FY 2027.
2. BriefCase-Triage: CARE (Clinical AI Reasoning Engine) Multi-Triage CT Body-Triage: (Page 446)

   Approved, the maximum new technology add-on payment for a case involving the use of BriefCase-Triage is $137.53 for FY 2027.

3. CARA System (Page 449)

   Because the CARA System has not received FDA marketing authorization as a Breakthrough Device, it *does not qualify* for new technology add-on payments for FY 2027.

4. Ceribell Delirium Monitor System (Page 457)
   Approved, finalizing that the maximum new technology add-on payment for a case involving the use of the Ceribell Delirium Monitor System is $2,171 for FY 2027.
5. CMORE® CT System (posterior cervico-thoracic system) (Page 463)

   Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the CMORE® CT System is $60,905 for FY 2027.

6. GORE® VIABAHN® FORTEGRA Venous Stent (Page 467)

   Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the GORE® VIABAHN® FORTEGRA Venous Stent is $7,186.40 for FY 2027.

7. Infuse™ Bone Graft (Page 470)

   Approved - finalizing that the maximum new technology add-on payment for a case involving the use of Infuse™ Bone Graft is $4,396.60 for FY 2027.

8. InVision Precision Cardiac Amyloid (Page 474)

   Approved – finalizing that the maximum new technology add-on payment for a case involving the use of PCA is $2,275.00 for FY 2027.

9. Nelli™ Seizure Monitoring System (Page 477)

   Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the Nelli™ Seizure Monitoring System is $975 for FY 2027

10. NEXUS® Aortic Arch Stent Graft System (Page 480)

    Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the NEXUS® Aortic Arch Stent Graft System is $35,880 for FY 2027.

11. OmniaSecure™ MRI SureScan™ Lead Model 3930M (Page 485)

    Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the OmniaSecure™ defibrillation lead is $7,796.75 for FY 2027.

12. PearlMatrix™ P-15 Peptide Enhanced Bone Graft (Page 488)

    Approved - finalizing that the maximum new technology add-on payment for a case involving the use of PearlMatrix™ P-15 Peptide Enhanced Bone Graft is $3,380 for FY 2027.

13. SAPIEN M3 Transcatheter Mitral Valve Replacement System (Page 493)

    Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the SAPIEN M3 TMVR System is $35,100 for FY 2027.

14. SetPoint System® (Page 495)

    Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the SetPoint System® is $38,675 for FY 2027.

15. Spur® Peripheral Retrievable Stent System (Page 498)

    Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the Spur® Peripheral Retrievable Stent System is $2,596.75 for FY 2027.

16. Trilogy™ Transcatheter Aortic Valve Regurgitation System (Page 498)

    Approved - finalizing that the maximum new technology add-on payment for a case involving the use of the Trilogy™ Transcatheter Aortic Valve Regurgitation System is $25,675 for FY 2027.

17. ViaOne™ Epicardial Access System (Page 504)

    Approved - finalizing that the maximum new technology add-on payment for a case involving the use of ViaOne™ is $1,300 for FY 2027

Alternative Pathway Repeal for New Technology Add-on Payment and Outpatient Prospective Payment System (OPPS) Device Pass-through (Page 509)

CMS is finalizing a policy that for all applications received for new technology add-on payments for FY 2028 and subsequent fiscal years, including applications for FDA-designated Breakthrough Devices and

QIDPs, or drugs approved under FDA's LPAD pathway, CMS will evaluate whether the technology is new and not substantially similar to an existing technology, and the technology must demonstrate that it meets the requirements under § 412.87(b) that it represent an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

That is, beginning with applications received for new technology add-on payments for FY 2028 and subsequent fiscal years, all applicants will need to demonstrate that the technology meets all three of the criteria as specified at § 412.87(b) in order to receive the additional payment: (1) the medical

service or technology must be new; (2) the medical service or technology must be costly such

that the DRG rate otherwise applicable to discharges involving the medical service or technology

is determined to be inadequate; and (3) the service or technology must demonstrate a substantial

clinical improvement over existing services or technologies.

In addition, CMS is finalizing a limited exception such that the following technologies will remain eligible to apply for new technology add-on payment under the alternative pathway through FY 2029: (1) a new medical device that is part of FDA's Breakthrough Devices Program and has received Breakthrough Device designation as of September 30, 2026, and has received marketing authorization as a Breakthrough Device for the indication covered by the Breakthrough Device designation by May 1, 2028; (2) new medical product that is designated by FDA as a Qualified Infectious Disease Product (QIDP) as

of September 30, 2026, and has received marketing authorization for the indication covered by the QIDP designation by May 1, 2028; and (3) a new medical product that is approved under FDA's Antibacterial and Antifungal Drugs (LPAD) pathway and used for the indication approved under the LPAD pathway by May 1, 2028.

Technologies that have previously been approved for new technology add-on payments under the alternative pathway, as well as technologies that have been approved for FY 2027 new technology add-on payments under the alternative pathway, will remain eligible for add-on payment under the alternative pathway. (Page 575)

QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS (Page 1,024)

Comments

As usual, the material regarding quality is long – more than 400 pages.

The following material is from CMS' fact sheet accompanying the rule.

Requirements and Changes

Hospitals that do not submit quality data or do not meet all Hospital Inpatient Quality Reporting Program requirements are subject to a one-fourth reduction in their Annual Payment Update under the IPPS.

CMS is finalizing the adoption of three new measures:

- Excess Days in Acute Care After Hospitalization for Diabetes measure beginning with the FY 2029 payment determination. (Page 1,119)
- Hospital Harm-Postoperative Venous Thromboembolism electronic clinical quality measure (eCQM) beginning with the FY 2030 payment determination. (Page 1,148)

- Advance Care Planning eCQM beginning with the FY 2030 payment determination. (Page 1,025)

CMS is finalizing the removal of three measures beginning with the FY 2030 payment determination:

- Venous Thromboembolism Prophylaxis eCQM. (Page 1,172)
- Intensive Care Unit Venous Thromboembolism Prophylaxis eCQM. (Page 1,172)
- Discharged on Antithrombotic Therapy eCQM. (1,177)

CMS is finalizing modifications to three measures beginning with the FY 2028 payment determination. Modifications include adding Medicare Advantage patients and shortening the performance period from 3 years to 2 years: (Page 1,182)

- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction.
- Excess Days in Acute Care after Hospitalization for Heart Failure.
- Excess Days in Acute Care after Hospitalization for Pneumonia.

CMS is finalizing the adoption of five modified mortality measures, beginning with the FY 2028 payment determination, before moving the modified versions to the Hospital Value-Based Purchasing Program. Modifications include adding Medicare Advantage patients and shortening the performance period from 3 years to 2 years: (Page 1,056)

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization measure.
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization measure.
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization measure.
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease Hospitalization measure.
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft Surgery measure.

CMS is also finalizing changes to the data reporting and submission requirements for some eCQMs and structural measures, specifically:

- Mandatory reporting for the Malnutrition Care Score eCQM beginning with the FY 2030 payment determination. (Page 1,225)
- Establishing a mandatory reporting policy to make hospital harm eCQMs mandatory after 2 years of reporting beginning with the FY 2030 payment determination. CMS notes that the proposed policy has been modified such that the data will be publicly reported on the Provider Data Catalog for the first year of mandatory reporting before publicly reporting on the Care Compare tool at Medicare.gov, including Hospital Star Ratings, beginning with the second year of mandatory reporting. (Page 1,226)
- An update to the reporting of the Maternal Morbidity Structural measure beginning with the FY 2028 payment determination to identify which perinatal quality collaborative the hospital participates in. (Page 1,240)

The following table summarizes the previously finalized and newly finalized Hospital Inpatient Quality Reporting Program measures for the FY 2028 to FY 2031 payment determinations. (Page 1,204)

Hospital Inpatient Quality Reporting Program Measure Set By Data Collection Method and Payment Determination (PD)

Measure Name	CBE Number	FY 2028 PD	FY 2029 PD	FY 2030 PD	FY 2031 PD
Patient Experience of Care Survey Measures					
Hospital Consumer Assessment of Healthcare Providers and Systems Survey (including Care Transition Measure)	0166 (0228)	✓	✓	✓	✓
Chart-Abstracted Clinical Process of Care Measures					
Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500	✓	✓	✓	✓
Structural Measures					
Maternal Morbidity Structural Measure	N/A	✓	✓	✓	✓
Patient Safety Structural Measure	N/A	✓	✓	✓	✓
Age Friendly Hospital Measure	N/A	✓	✓	✓	✓
Claims-Based Patient Safety Measures					
Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (Inpatient Surgical	4125	✓	✓	✓	✓

Measure Name	CBE Number	FY 2028 PD	FY 2029 PD	FY 2030 PD	FY 2031 PD
Complications Rate)					
Claims-Based Mortality/Complications Measures					
Hospital 30-Day, All-Cause, Risk Standardized Mortality- Rate Following Acute Ischemic Stroke	N/A	✓	✓	✓	✓
Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA and/or TKA	1550	✓	✓		
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization (MORT–30–AMI)**	0230	Adopted	✓	✓	✓
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (MORT–30–HF)**	0229	Adopted	✓	✓	✓
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia	0468	Adopted	✓	✓	✓
Hospitalization (MORT–30–PN)**					
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT–30–COPD)**	1893	Adopted	✓	✓	✓
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT–30–CABG) measures**	2558	Adopted	✓	✓	✓
Claims-Based Coordination of Care Measures					
Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction***	2881	✓	✓	✓	✓
Excess Days in Acute Care after Hospitalization for Heart Failure***	2880	✓	✓	✓	✓
Excess Days in Acute Care after Hospitalization for Pneumonia***	2882	✓	✓	✓	✓
Excess Days in Acute Care after Hospitalization for Diabetes****	N/A		Adopted	✓	✓
National Healthcare Safety Network Measures					

Measure Name	CBE Number	FY 2028 PD	FY 2029 PD	FY 2030 PD	FY 2031 PD
HCP Influenza Vaccination	0431	✓	✓	✓	✓
Catheter- Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations	0138	✓	✓	✓	✓
Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations	0139	✓	✓	✓	✓
Claims and Electronic Data Measures					
Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure (HWM)	3502e	✓	✓	✓	✓
Hybrid Hospital-Wide All-Cause Readmission Measure (HWR)	2879e	✓	✓	✓	✓
Patient-Reported Outcome Performance Measures					
Hospital-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (PRO-PM)	3559	✓	✓	✓	✓
Electronic Clinical Quality Measures					
Discharged on Antithrombotic Therapy*****	0435e	✓*	✓*	Removed	
Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436e	✓*	✓*	✓	✓
Antithrombotic Therapy by the End of Hospital Day Two	0438e	✓*	✓*	✓*	✓*
Venous Thromboembolism Prophylaxis*****	0371e	☐*	☐*	Removed	
Intensive Care Unit Venous Thromboembolism Prophylaxis*****	0372e	☐*	☐*	Removed	
Safe Use of Opioids—Concurrent Prescribing	3316e	✓	✓	✓	✓
Hospital Harm—Opioid-Related Adverse Events	3501e	✓*	✓	✓	✓
Hospital Harm—Severe Hypoglycemia	3503e	✓	✓	✓	✓
Hospital Harm—Severe Hyperglycemia	3533e	✓	✓	✓	✓

Measure Name	CBE Number	FY 2028 PD	FY 2029 PD	FY 2030 PD	FY 2031 PD
Hospital Harm—Pressure Injury	3498e	✓*	✓*	✓	✓
Hospital Harm—Acute Kidney Injury	3713e	✓*	✓*	✓	✓
Hospital Harm—Falls with Injury******	4120e	✓*	✓*	Mandatory	✓
Hospital Harm—Postoperative Respiratory Failure******	4130e	✓*	✓*	Mandatory	✓
Hospital Harm—Postoperative Venous Thromboembolism*******	5325e			Self-selected	✓*
Cesarean Birth	0471e	✓	✓	✓	✓
Severe Obstetric Complications	3687e	✓	✓	✓	✓
Malnutrition Care Score******	3592e	✓*	V*	Mandatory	✓
Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Hospital Level – Inpatient)	3663e	✓*	✓*	✓*	✓*

Measure is mandatory for the specified payment determination year.

* Measure is a self-selected eCQM for the specified payment determination year. Hospitals are required to self-select three eCQMs, in addition to all mandatory eCQMs, to submit for the specified payment determination year.

** In this final rule, CMS is finalizing adoption of the MORT-30-AMI, MORT-30-HF, MORT-30-PN, MORT-30-COPD, and MORT-30-CABG for the FY 2028 payment determination through the FY 2031 payment determination.

*** In this final rule, CMS is finalizing modifications to the AMI EDAC, HF EDAC, and PN EDAC measures beginning with the FY 2028 payment determination.

**** In this final rule, CMS is finalizing adoption beginning with FY 2029 payment determination.

***** In this final rule, CMS is finalizing removal beginning with the FY 2030 payment determination.

****** In this final rule, CMS is finalizing modification from self-selected to mandatory reporting beginning with the FY 2030 payment determination.

******* In this final rule, CMS is finalizing adoption beginning with the FY 2030 payment determination.

CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) for FY 2027 (Pages 971 & 2,485)

Changes to the LTCH PPS Payment Rates and Other Changes to the LTCH PPS for FY 2027

CMS is establishing an annual update to the LTCH PPS standard Federal payment rate of **2.3 percent** (that is, the most recent estimate of the 2022-based LTCH market basket increase of **3.2 percent** less a proposed productivity adjustment of -**0.9 percentage point**).

The area wage level adjustment budget neutrality factor of 1.002679.

CMS is establishing an LTCH PPS standard Federal payment rate of **$52,132.76** (calculated as the current rate of $50,824.51 x 1.023 x 1.002679) for FY 2027.

For LTCHs that fail to submit quality reporting data for FY 2027, in accordance with the requirements of the LTCH QRP under section 1866(m)(5) of the Act, CMS is establishing an LTCH PPS standard Federal payment rate of **$51,113.55** (calculated as $50,824.51 x 1.003 x 1.002679) for FY 2027. (Page 2,487)

Comment

CMS says it estimates an increase in LTCH payments of $54 million.

Adjustment for Area Wage Levels Under the LTCH PPS for FY 2027 (Page 2,487)

The FY 2027 LTCH PPS standard Federal payment rate wage index values that will be applicable for LTCH PPS standard Federal payment rate discharges occurring on or after October 1, 2026, through September 30, 2027, are presented in Table 12A (for urban areas) and Table 12B (for rural areas) and available on the CMS website.

Labor-Related Share for the LTCH PPS Standard Federal Payment Rate

(Page 2,492)

CMS is finalizing a total labor-related share for FY 2027 of 73.0 percent.

Cap on LTCH PPS Wage Index Decreases (Page 2,496)

An LTCH's wage index will not be less than 95 percent of its wage index for the prior fiscal year.

Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases (Page 2,505)

CMS is finalizing its proposal to maintain the FY 2027 LTCH PPS high-cost outlier fixed-loss amount at its FY 2026 level of $78,936. CMS says it continues to believe that maintaining the fixed-loss amount at its FY 2026 level of $78,936 is a reasonable estimate of a fixed-loss amount that will result in estimated LTCH PPS outlier payments being equal to 7.975 percent of total LTCH PPS payments for FY 2027.

High-Cost Outlier Payments for Site Neutral Payment Rate Cases (Page 2,525)

For FY 2027, CMS is setting the fixed-loss amount for site neutral payment rate cases equal to the FY 2027 IPPS fixed-loss amount of **$49,346.**

Changes to the Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

(Page 1,274)

CMS is;

- Removing two measures, specifically the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure and the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure, beginning with the FY 2028 LTCH QRP

CHANGES TO THE MEDICARE PROMOTING INTEROPERABILTY PROGRAM (Page 1,306)

The Medicare Promoting Interoperability Program encourages eligible hospitals and critical access hospitals to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology (CEHRT).

CMS is finalizing policies to:

- Remove and revise certification criteria required for the Medicare Promoting Interoperability Program in alignment with proposals made by the Office of the National Coordinator for Health IT (ONC) in the Health Data, Technology, and Interoperability: Assistant Secretary for Technology Policy (ASTP)/ONC Deregulatory Actions to Unleash Prosperity proposed rule (HTI-5 proposed rule).
- Remove ONC Direct Review and ONC-Authorized Certification Body (ONC-ACB) Surveillance attestations beginning with the EHR reporting period in CY 2026.
- Remove, with modification to delay removal an additional year, the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures beginning with the EHR reporting period in CY 2029.
- Modify the Electronic Prior Authorization measure as an optional bonus measure for the EHR reporting period in CY 2027 and mandatory beginning with the EHR reporting period in CY 2028.
- Add the Unique Device Identifiers for Implantable Medical Devices measure to the Public Health and Clinical Data Exchange objective beginning with the EHR reporting period in CY 2027.
- Adopt two new eCQMs beginning with the FY 2030 payment determination in alignment with the Hospital Inpatient Quality Reporting Program (the Hospital Harm-Postoperative Venous Thromboembolism and the Advance Care Planning eCQMs).
- Remove three eCQMs beginning with the FY 2030 payment determination in alignment with the Hospital Inpatient Quality Reporting Program (Venous Thromboembolism Prophylaxis, Intensive Care Unit Venous Thromboembolism Prophylaxis, and Discharged on Antithrombotic Therapy eCQMs).

OTHER PROVISIONS INCLUDED IN THIS RULE

CHANGES TO THE TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM) (Page 1,436)

TEAM is a 5-year mandatory alternative payment model tested by the CMS Innovation Center that began on January 1, 2026, and will end on December 31, 2030. TEAM tests whether an episode-based pricing methodology linked with quality measure performance for select acute care hospitals reduces Medicare program expenditures while preserving or improving the quality of care for Medicare beneficiaries who initiate certain episode categories. Specifically, TEAM tests five surgical episode categories: Coronary Artery Bypass Graft Surgery (CABG), Lower Extremity Joint Replacement (LEJR), Major Bowel Procedure, Surgical Hip/Femur Fracture Treatment (SHFFT), and Spinal Fusion.

Episodes (spinal fusion MS-DRG additions & CJR-X attribution) (Page 1,446)

- CMS finalizes, without modification, adding three new MS-DRGs (523, 524, 525) to the spinal fusion episode category effective October 1, 2026, to align with new IPPS spinal fusion classifications.
- CMS finalizes an attribution rule (new §512.537(b)(4)) so that if a beneficiary in a Comprehensive Care for Joint Replacement Expanded (CJR-X) episode has a TEAM-triggering procedure at a TEAM hospital during CJR-X's 90-day post-discharge window, that episode is *not* attributed to the TEAM hospital (though the spending still feeds into TEAM's target-price benchmarking).

Quality Measures (Page 1,449)

- Confirms the finalized 7-measure set (Hybrid HWR, PSI-90, THA/TKA PRO-PM, two Hospital Harm measures, ISCMR, Information Transfer PRO-PM) drawn from existing CMS reporting programs — no separate TEAM reporting required.
- Finalizes, without modification, specific measurement performance periods for the Hospital Harm measures and ISCMR (Table X.A.-02), rejecting requests to delay because the measures don't affect scoring until PY2 and hospitals already had lead time under other IQR reporting.

CQS Baseline Methodology — a notable reversal (Page 1,454)

- CMS had proposed a *sliding historical* CQS baseline (rolling historical window) plus shifting several measures from calendar-year to July–June baseline periods.
- After comments, CMS is finalizing **with modification**: the adoption of a **concurrent CQS baseline** methodology (baseline = the same period as the performance year itself), reasoning this better rewards continuous quality improvement against current care standards rather than static historical benchmarks. The calendar-year → July–June alignment for Hybrid HWR, PSI-90, THA/TKA PRO-PM, and ISCMR is finalized as proposed (Table X.A.-03 gives the full finalized schedule through PY5).

Pricing Methodology (Page 1,472)

- **APC Update Factor** (finalized without modification): a new multiplier applied to the prospective trend factor to reconcile calendar-year OPPS/ASC weight changes into target prices, calculated after each year's OPPS/ASC final rule is published.
- **MS-DRG Update Factor** (finalized without modification): analogous mechanism for fiscal-year MS-DRG weight/definition changes affecting Q4 episodes of a performance year, including a mapping/scenario framework (Table X.A.-06) for handling MS-DRGs that shift between TEAM-eligible and non-eligible status across fiscal years.
- **Normalization factor construction** (finalized without modification): starting PY2, the risk-adjustment multiplier and normalization factor will be calculated using *all* baseline-period episodes (not just the most recent baseline year), improving predictive accuracy per CMS's internal analysis.

Two Requests for Information

- **ASC Episodes RFI**: CMS explicitly declines to respond comment-by-comment given the breadth and diversity of input, but says it will use the feedback to inform potential future rulemaking on incorporating ASC episodes into TEAM.
- **Physician-Owned Hospitals (POH) RFI**: Comments ran heavily supportive of a voluntary POH opt-in (framed around specialty expertise, competition, and access), against a smaller but pointed set of objections (cherry-picking, patient steering, program-integrity risk, potential harm to full-service/rural hospitals, concerns about interaction with CJR-X). CMS states it intends to propose (in future rulemaking, not this rule) a policy allowing POHs outside mandatory TEAM CBSAs to opt in, with monitoring and beneficiary-protection safeguards to be worked out later. No fraud-and-abuse waivers are being issued in this final rule.

EXPANSION THE COMPREHENSIVE JOINT REPLACEMENT (CJR) MODEL (Page 1515)

CJR was a Phase I mandatory alternative payment model tested by the Center for Medicare and Medicaid Innovation (Innovation Center) between April 1, 2016, and December 31, 2024, in all eligible acute care hospitals within selected Metropolitan Statistical Areas (MSAs). Based on evaluation results indicating the model successfully reduced spending without reducing quality of care and the Secretary determining that the model has met the requirements for expansion.

CJR Model history:

A Phase I mandatory bundled-payment model (Apr. 2016–Dec. 2024) for lower extremity joint replacement (LEJR/hip-knee) episodes, tested in select MSAs (67 initially, later 34 mandatory). Target prices were set per MS-DRG/episode type, compared retrospectively to actual spending, with reconciliation payments/repayments.

Removal of TKA/THA from the Inpatient-Only list, and COVID-era payment waivers, distorted early results — PY5 showed a $95.4M statistically significant loss, but PYs 6–7 (the "CJR Extension," with a revised methodology) **produced $112.7 million in net savings** while maintaining quality (7th Annual Evaluation Report).

CMS is finalizing expansion of CJR into "CJR-X," a mandatory nationwide Phase II model for all eligible acute care hospitals, codified at 42 CFR §§ 512.600–512.695.

Start date: proposed Oct. 1, 2027; finalized as January 1, 2028, with performance years aligned to the calendar year (rather than fiscal year) — chiefly to smooth the transition of TEAM participants into CJR-X once TEAM ends (allowing entry on Jan. 1, 2031 rather than after a 9-month gap).

Statutory Requirements for Expansion (Page 1523)

CMS makes the three findings required under §1115A(c) of the Act to expand a tested model nationally:

Expansion is expected to reduce spending without reducing quality (supported by **the $112.7M savings finding**). The CMS Chief Actuary certified expansion would reduce or not increase net program spending. Expansion would not deny/limit coverage of benefits.

CMS designates CJR-X as a Phase II model (not a new Phase I test). It rejects commenter arguments that expansion exceeds Innovation Center authority or that CJR-X (with modifications) requires separate Phase I testing, and declines to test CJR-X only regionally, citing the CJR Model's decade of regional testing as sufficient foundation for national rollout.

Provisions of the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model

(Page 1,566)

Participants: Hospitals (as defined under §1886(d)(1)(B)) are the CJR-X participants — mandatory nationwide for all acute care hospitals paid under both IPPS and OPPS that initiate LEJR episodes.

IHS/Tribal hospitals, Critical Access Hospitals, Rural Emergency Hospitals, and Rural Community Hospital Demonstration participants **are excluded** (not paid under both IPPS/OPPS). ASCs were considered but **not included**.

CMS declined to create additional exceptions for rural, low-volume, or resource-constrained hospitals (rejecting calls for opt-in participation, volume-based exemptions, or hardship processes), instead relying on payment-methodology protections.

Beneficiary Population (Page 1593)

Included beneficiaries must, at the time of the anchor procedure/hospitalization: be enrolled in Medicare Part A & B; have Medicare as primary payer; not be ESRD-eligible; not be enrolled in any managed care plan (MA, HCPP, cost-based HMO); and not be covered under a UMWA health plan.

Episode Definition (Page 1604)

Episodes are triggered by MS-DRGs 469, 470, 521, 522 (inpatient) or HCPCS 27130 (THA)/27447 (TKA) on outpatient claims — finalized without modification. Ninety (90)-day post-discharge period (continuing the CJR/CJR Extension approach; contrasts with TEAM's 30-day window).

"Anchor hospitalization" and "anchor procedure" definitions finalized with modification for technical clarity; rules address same-day/near-day conversions between outpatient procedures and inpatient admissions, and inter-hospital transfers.

Ankle replacements and outpatient TAA (HCPCS 27702, tested in TEAM) are excluded from CJR-X. Exclusion lists (of hospitals/beneficiaries) will be posted, per finalized policy.

Scope of Episode (Page 1,609)

CMS is finalizing without modification the proposed MS-DRG and HCPCS codes at § 512.625(a) to trigger CJR-X episodes.

In summary, CMS proposed that the following circumstances would cancel an episode:

- The beneficiary no longer meets the criteria for inclusion.
- The beneficiary dies during the episode.
- The CJR-X participant is subject to the EUC policy.

- The beneficiary is in a TEAM episode and has a LEJR procedure at a CJR-X participant during the 30-day post-discharge period after a TEAM anchor hospitalization or anchor procedure.

Quality Measures & Composite Quality Score (Page 1639)

Measures

(a) Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CMIT ID #350) (Page 1,653)

(b) Hospital Visits within 7 days of Hospital Outpatient Department (HOPD) Surgery (CMIT ID #344, OP-36) (Page 1,658)

(c) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (CMIT ID #338) (Page 1,651)

(d) Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS) (CMIT ID #162) (Page 1,666)

(e) Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618) (Page 1,673)

Pricing & Payment Methodology (Pages 1,722)

Preliminary Target Price = Benchmark Price × Prospective Trend Factor × Prospective Normalization Factor × Risk Adjustment Multipliers × Discount Factor.

Uses a 3-year rolling regional baseline (MS-DRG/HCPCS, region-level), similar to TEAM's approach, rather than hospital-specific pricing — intended to reduce the "ratchet effect" concern raised by

commenters (target prices declining over time as savings are absorbed into future baselines). CMS acknowledged this concern but retained the rolling 3-year regional baseline as the right balance of accuracy vs. predictability. (Page 1,725)

Discount factor: finalized at a maximum of 2.0 percent (down from the 3.0 percent used in the original CJR/BPCI Advanced), and it is quality-adjusted: hospitals with excellent CQS performance get 0.0 percent, good performance 1.0 percent, and standard performance the full 2.0 percent discount — narrowing the effective savings the hospital must achieve to break even. (Page 1,760)

High-cost outlier cap: episode spending capped at the 99th percentile by MS-DRG/HCPCS/region/baseline year, both for benchmark construction and for reconciliation-year spending; CMS declined to lower the threshold or add hospital-specific outlier caps.

Retrospective Market Trend Factor adjustment capped at ±3 percent of the prospective trend.

(Page 1,760)

Low-volume exclusion from reconciliation: hospitals with fewer than 31 episodes in the baseline period are excluded from upside/downside risk (finalized as proposed, rejecting calls to raise this threshold). (Page 1,768)

Risk adjustment: includes a hospital-level safety-net risk adjuster for hospitals serving a higher proportion of dual-eligible beneficiaries (evaluation found dual-eligible mix, not volume alone, correlated with poor performance). (Page 1,774)

Stop-loss/stop-gain: 20 percent symmetric limit for most participants; a lower 5 percent stop-loss for rural hospitals, Medicare-dependent/small rural hospitals (MDH), sole community hospitals (SCH), and safety-net hospitals (a new protection not present in the original CJR Model, added because safety-net hospitals evaluated as disproportionately likely to owe repayments). (Page 1,812)

Reconciliation payments/repayments are one-time lump-sum transactions.(Page 1,828)

Appeals Process (Page 1,829)

CJR-X participants may file a notice of calculation error within 30 calendar days of a reconciliation report, subject to the same review limitations as other Innovation Center models §512.170/§512.660.

Concurrent Participation with Other Models (Page 1,830)

CJR-X permits concurrent participation with total-cost-of-care models (ACO REACH, MSSP, LEAD, etc.) — consistent with the original CJR Model's approach — because CMS believes population-based and episode-based models can operate complementarily.

CJR-X does not allow overlap with TEAM: if an LEJR episode occurs at a TEAM-participant hospital, it is attributed to TEAM, not CJR-X, to avoid duplicative accountability.

Financial Arrangements (Page 1849)

Establishes a "CJR-X collaborator" framework and gainsharing provisions similar to the original CJR Model/TEAM: sharing arrangements (gainsharing/alignment payments), distribution arrangements, and downstream distribution arrangements, subject to fraud-and-abuse waivers/safe harbors.

ACOs may serve as CJR-X collaborators but not simultaneously as the CJR-X participant.

No cap is reinstated on gainsharing payments (consistent with the CJR Extension's PY6–8 elimination of the 50 percent gainsharing cap).

Program Rule Waivers (Page 1914)

SNF 3-Day Rule: waived for CJR-X beneficiaries admitted to a qualifying SNF, including for hospitals/CAHs with swing-bed agreements — finalized largely as proposed.

Post-discharge home visits: up to 9 visits per 90-day episode may be billed/paid via an "incident to" waiver (fewer than the CJR Extension's 13-visit allowance), furnished by clinical staff to beneficiaries not otherwise qualifying for home health.

Telehealth: waives certain originating-site/geographic restrictions to allow telehealth in the beneficiary's home.

CMS declined broader waivers of the homebound requirement for home health, home health initiation-of-care timing, and the multiple-procedure payment reduction.

Data Sharing (Page 1,951)

CJR-X participants (under a data sharing agreement) may request summary or raw beneficiary-identifiable claims data for the 3-year baseline period and monthly during the performance year, to support monitoring, care redesign, and episode management — modeled closely on the original CJR data-sharing framework.

Advanced APM / QP Options (Page 1,983)

CJR-X is designated an Advanced APM, offering both an Advanced APM (AAPM) track (requiring CEHRT attestation, enabling clinicians to be assessed for Qualifying APM Participant/QP status) and a non-AAPM track. QP/Partial QP thresholds follow standard QPP rules (≥75 percent/50 percent Part B payments or ≥50 percent/35percent patient counts through an Advanced APM Entity during the Jan. 1–Aug. 31 performance period).

Standard Provisions & Termination (Page 1,992)

Standard Innovation Center provisions apply (cooperation with evaluation, audits/record retention, monitoring/compliance, remedial actions). CJR-X termination follows the general §512.165 process; termination decisions are not subject to administrative or judicial review under §1115A(d)(2) of the Act. CMS received no comments on termination and finalized it as proposed.

Comment

The above section is nearly 500 pages. The material presented above in no way provides the information contained in the rulemaking. There is much redundancy and presentations of proposed and final outcomes. This is item is extremely complex and confusing.

Organ Acquisition and Reasonable Cost Payment Policies, and Reimbursement Appeals for Independent Organ Procurement Organizations and Histocompatibility Laboratories

(Page 1,997)

As part of broader efforts to strengthen Medicare cost reimbursement and appeals policies to ensure payment accuracy and reduce inappropriate spending, this rule finalizes the proposal that Medicare reconcile organ acquisition costs for non-renal organs for Independent Organ Procurement Organizations (IOPOs) and Histocompatibility Laboratories (HCLs) with a modification for a 2-year delayed implementation date for cost reporting periods beginning on or after October 1, 2028. This rule also finalizes the proposal to clarify and codify certain longstanding policies on allowable costs under Medicare's reasonable cost principles for all provider types, including public education for Organ Procurement Organizations. This rule also finalizes the proposal to clarify and codify Medicare's longstanding policies for allocating overhead costs across all provider types. Additionally, this final rule codifies the Administrator's discretionary review of reimbursement appeals for IOPOs and HCLs.

Tables Referenced in this Rule are Generally Available on the CMS Website. (Page 2,534)

https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps

CMS has provided the following;

Table 1A-1E (ZIP): This excel spreadsheet contains the FY 2027 Operating and Capital National Standardized Amounts.

FY 2027 Rule Tables 2, 3 and 4A and 4B (Wage Index Tables) (ZIP):

Table 2- Case-Mix Index and Wage Index Table by CMS Certification Number (CCN)

Table 3- Wage Index Table by CBSA;

Table 4A -List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act

Table 4B - Counties Redesignated under Section 1886(d)(8)(B) of the Act (LUGAR COUNTIES)

Table 5 (ZIP): MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay

Tables 6A-6J.2 and Tables 6P.1a-6P.5b (ZIP):

Table 6A-New Diagnosis Codes;

Table 6B-New Procedure Codes;

Table 6C-Invalid Diagnosis Codes;

Table 6D-Invalid Procedure Codes;

Table 6E-Revised Diagnosis Code Titles;

Table 6F-RevisedProcedure Codes

Table 6G.1- Secondary Diagnosis Order Additions to the CC Exclusions List;

Table 6G.2- Principal Diagnosis Order Additions to the CC Exclusions List;

Table 6H.1- Secondary Diagnosis Order Deletions to the CC Exclusions List;

Table 6H.2- Principal Diagnosis Order Deletions to the CC Exclusions List;

Table 6I. – Complete MCC List

Table 6I.1- Additions to the MCC List;

Table 6J.- Complete CC List;

Table 6J.1 - Additions to the CC List

Table 6J.2 - Deletions to the CC List.

Table 6K- Complete CC Exclusion List

Tables 8A, 8B, and 8C (ZIP):

Tables 8A and 8B contain the FY 2027 IPPS operating and capital statewide average cost-to-charge-ratios.

Table 8C contains the FY 2027 LTCH statewide average cost-to-charge-ratios.

Table 10 (ZIP): Relevant ICD-10 Codes for Certain FY 2027 New Technology Add-On Payment Applications

Table 16A (ZIP): Proxy Hospital Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2027.

Table 18 (ZIP): FY 2027 Medicare DSH Uncompensated Care Payment Factor 3.

Final Comments and Thoughts

To say the least once again, CMS PPS rules are out of control. This IPPS rule at 2,704 pages is absolutely absurd. The Medicare Act signed by President Johnson was 138 pages. The first IPPS final

rule (January 3, 1984 was 106 pages (as listed in the ***Federal Register***). There is simply too much unneeded history in these rules.

The update factor—market basket at 3.2 percent seems rather low. CMS avoids the issue of not addressing actual rates of increases over the years. Rather, it continues illogical and irrational statements avoiding what it calls retroactive adjustments. Correcting prior estimates do not have to be made retroactively. Increases or decreases can be made to future year adjustments. CMS does such for the Skilled Nursing Facility PPS.

The rule does not provide clear "Final Decision" paragraphs. Rather, the reader must wade through much to find CMS' final actions.

CMS has repeated a significant amount from its proposed version. Much is now simply past history and truly unneeded. To include such confuses the reader.

For the most part, the provided web links do not work. Many links take you to FY 2026 information, proposed FY 2027 material, or to error pages. We agree that links are valuable in understanding issues, but link errors year after year are simply inexcusable.

There is a current theme is this rulemaking. CMS' intent to change anything appears to have one priority. Does the change reduce Medicare spending?