Fiscal Year 2027 Medicare Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System Final Rule
(CMS-1849-F and CMS-0062-F)

Summary

On July 31, 2026, the Centers for Medicare & Medicaid Services (CMS) released its final rule describing federal fiscal year (FY) 2027 policies and rates for Medicare's inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS). The final rule was published in the *Federal Register* on August 4, 2026.

The payment rates and policies described in the FY 2027 IPPS final rule affect Medicare's operating and capital payments for short-term acute care hospital inpatient services and services provided in LTCHs paid under their respective prospective payment systems. Unless otherwise specified, policies will be effective October 1, 2026.

Beginning October 1, 2027, CMS is expanding the Comprehensive Joint Replacement (CJR-X) nationwide. CJR-X would be required for most hospitals, making it the first mandatory application of an episode-based payment model. In addition, CMS is eliminating the alternative pathway for a technology to be approved for new technology add-on payment (NTAP) where the technology only demonstrates costliness. A special Food and Drug Administration (FDA) approval pathway previously served as a proxy that the technology met newness and substantial clinical improvement criteria. There is also a policy that to be an approved medical residency training program or approved nursing and allied health education program to receive funding from CMS, these programs may not discriminate based on race, color, national origin, sex, age, disability, or religion.

CMS makes many data files available to support analysis of the final rule. These data files are generally available at: FY 2027 IPPS Final Rule Home Page | CMS. Numbered tables included in the IPPS/LTCH rule are only available on the CMS website at the above hyperlink.

I. IPPS Rate Updates and Impact of the Rule; Outliers

CMS estimates that the final rule will increase FY 2027 combined operating and capital payments to approximately 3,005 acute care hospitals paid under the IPPS by an estimated $2.9 billion. This net impact is primarily driven by the changes in FY 2027 operating payments, including uncompensated care payments (UCP), FY 2027 capital payments, and the expiration of the temporary changes in the low-volume hospital (LVH) and the Medicare Dependent Hospital (MDH) program and new technology add-on payments. These changes are relative to payments made in FY 2026.

A. Inpatient Hospital Operating Update

The above are changes to aggregate IPPS payments not reflecting changes in hospital admissions or case mix. The estimated percentage increase in IPPS *payment per service* is estimated at 2.3 percent for hospitals that successfully report quality measures and are meaningful users of electronic health records (EHR). The 2.3 percent rate increase is the net result of a market basket update of 3.2 percent less 0.9 percentage points for productivity. The payment rate update factors are summarized in the table below.

Hospitals that fail to participate successfully in the Hospital Inpatient Quality Reporting (IQR) Program or are not meaningful users of EHR do not receive the full payment rate increase. The table below shows the update. The reduction is ¼ of the market basket for hospitals failing IQR, ¾ of the market basket for hospitals that are not meaningful users of EHR, and 100 percent of the market basket for hospitals failing both programs.

Updates for Hospitals Failing IQR and/or EHR

	Penalty	Market Basket (MB)	Market Basket Net of Productivity	Reduction (Percentage Points)	Update
No IQR	25% of the MB	3.2	2.3	-0.8	1.5
No EHR	75% of the MB	3.2	2.3	-2.4	-0.1
No IQR/EHR	100% of the MB	3.2	2.3	-3.2	-0.9

B. Payment Impacts

CMS' impact table for IPPS operating costs shows FY 2027 payments increasing 1.7 percent. Not all policy changes are reflected in this total. For example, the total does not include new technology add-on payments (NTAP). The factors that are included in this total are shown in the following table.

Contributing Factor	National Percentage Change
FY 2027 Payment Rate Increase	+2.2[1]
FY 2027 Change to Outlier Payments	-0.6[2]
Expiration of the MDH Program	-0.1[3]
FY 2027 Change to Uncompensated Care Payments	+0.2
Total	+1.7

[1] CMS indicates that this figure is 2.2 percent. The update for all hospitals other than those not compliant with the IQR and EHR programs is 2.3 percent. The impact of the reduced update for hospitals not compliant with the IQR and EHR programs accounts for the 0.1 percentage point reduction to 2.2 percent.
[2] CMS targets 5.1 percent of IPPS payments as outliers but estimates that it will pay 5.9 percent of IPPS payments as outliers in FY 2026 or 0.8 percentage points more than the target. As a result, CMS estimates total payments will decrease by 0.8 percentage points due to targeting 5.1 percent of total IPPS payments as outliers for FY 2027 and attributes the other +0.2 percentage points to the "interactive effects among various add-on factors."
[3] At this time, the MDH program is set to expire on December 31, 2026 or 3 months into FY 2027. MDH program is a temporary program that has been set to expire many times previously before being extended again by Congress—sometimes retroactively.

Table I Impact Analysis

Detailed impact estimates are displayed in Table I of the final rule (reproduced in the Appendix to this summary). The following table summarizes the impact by selected hospital categories.

Hospital Type	All Changes
All Hospitals	1.7%
Urban	1.8%
Rural	1.1%
Major Teaching	2.1%

To the extent the impact on a given hospital category deviates from the national average of 1.7 percent, it suggests that there is a factor resulting in more of an impact on that category of hospital compared with all other hospitals. The impact would be redistributive from a policy that is budget neutral. The lower impacts on rural hospitals appear to be driven by the expiration of the MDH program as well as the MS-DRG changes and recalibration of the relative weights. As noted above, the MDH program has expired many times previously but has been extended by Congress in legislation.

Other provisions having an impact include:

NTAP. NTAP payments are not subject to budget neutrality. CMS is continuing NTAP payments for 41 technologies that remain eligible for add-on payments in FY 2027 and estimates Medicare will pay $840.5 million in FY 2027. CMS approved 16 alternative pathway applications where the FDA approval process is considered a proxy for newness and substantial clinical improvement and estimates total expenditures of $417.7 million. CMS approved 16 traditional NTAP applications and estimates total expenditures of $$481.5 million. In total, CMS estimates $1.7 billion in total spending on NTAP in FY 2027.

Uncompensated Care. Medicare payments to be distributed for uncompensated care costs are estimated to increase by $226.3 million or 2.9 percent in FY 2027. Supplemental payments to Puerto Rico, Indian Health Service (IHS) and Tribal Hospitals are estimated to increase another $1.5 million in FY 2027. The supplemental payments to hospitals in Puerto Rico and for IHS and Tribal Hospitals are analogous to uncompensated care payments for other hospitals and account for unique issues with cost reporting that apply to these hospitals. More detail on these calculations is found in section IV.

Low Volume Hospitals (LVH). Section 1886(d)(12) of the Social Security Act (the Act) establishes the LVH program and provides authority to the Secretary to establish the payment adjustment for LVHs. Originally, only hospitals with fewer than 200 total discharges qualified for the LVH adjustment. However, Congress temporarily changed the criteria to allow more hospitals to qualify. The more permissive qualifying criteria will expire on December 31, 2026, absent additional congressional intervention. CMS estimates that the expiration of those changes to the qualifying criteria will result in 589 fewer hospitals receiving the low volume hospital payment adjustment, resulting in lower spending of $258 million.

Hospital Readmissions Reduction Program (HRRP). CMS is adding sepsis as an applicable condition beginning with the FY 2030 payment year, with "early look" reports for each of FYs 2028 and 2029. In FY 2026, CMS adopted a policy to include Medicare Advantage (MA) beneficiaries in the patient cohorts and modify the applicable performance period from a 3-year period to a 2-year period beginning with the FY 2027 program year. CMS estimates penalties associated with the sepsis readmission measure will result in reduced expenditures of between $0 and $170 million and uses a midpoint savings estimate of $85 million for analysis.

The HRRP program is estimated to reduce FY 2027 payments to an estimated 2,832 hospitals or 83.26 percent of all hospitals eligible to receive a readmissions penalty. The readmissions penalty is estimated to affect 0.48 percent of Medicare payments to the hospitals. The impact section of the rule includes table I.G.6.-01 that illustrates the average net percentage payment adjustment by category of hospital (e.g., Large Urban, Other Urban, Rural) in FY 2027.

Hospital Value-Based Purchasing (HVBP) Program. The HVBP program is budget neutral but will redistribute 2 percent of base operating MS-DRG payments based on hospitals' performance scores or approximately $1.9 billion among 2,448 hospitals. Table 1.G.8.-01 in the impact section illustrates the average net percentage payment adjustment by category of hospital in FY 2027.

Hospital Acquired Conditions (HAC) Reduction Program. The HAC reduction program reduces payment to 2,891 hospitals, which are among the lowest quartile for HACs. Table 1.G.8.-01 (apparently duplicating the identifier of the prior table) shows the number of hospitals in the program and the number of hospitals that are in the lowest performing quartile by hospital category.

Rural Community Hospital Demonstration Program. CMS is continuing with the general methodology used in previous years to apply a budget neutrality adjustment for this program if

the program costs more than it would have in the absence of the demonstration. CMS proposed to apply both the FY 2027 and FY 2028 estimated costs of the demonstration into the budget neutrality offset to national IPPS rates for FY 2028. Therefore, no budget neutrality adjustment is being applied to the FY 2027 standardized amounts for this demonstration project.

Transforming Episode Accountability Model (TEAM). TEAM tests whether financial accountability for coronary artery bypass graft, lower extremity joint replacement, major bowel procedures, surgical hip/femur fracture treatment, and spinal fusions reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. Payment approaches that hold providers accountable for episode cost and performance can potentially create incentives for the implementation and coordination of care redesign between participants and other providers and suppliers such as physicians and post-acute care providers. TEAM began on January 1, 2026, and will end on December 31, 2030.

CMS estimates that TEAM will save the Medicare program approximately $368 million over the 5 performance years (2026 through 2030). While CMS is finalizing several additional policies related to TEAM in this final rule, CMS does not expect it will have a material impact on the Medicare savings estimate.

Effects of the Comprehensive Care for Joint Replacement Expansion (CJR-X) Model. CMS is expanding the CJR Model nationwide. CJR-X holds its participants accountable for the cost and quality of care for Medicare beneficiaries during a lower extremity joint replacement episode. For the first performance year (January 1, 2028–December 31, 2028), CMS projects CJR-X will generate $129 million in Medicare savings. Estimated savings increase to $133 million in performance year 2 and $137 million in performance year 3. In performance years 4 and 5, projected savings rise to $166 million and $171 million, respectively.

Acquisition Costs, Reasonable Costs, and Other Cost -Related Policies. CMS estimates total cost savings from reconciling non-renal organ acquisition costs to the Medicare Trust Fund will be $110 million in FY 2029, $380 million over 5 years (FYs 2027 to 2031), and $1.16 billion over 10 years (FYs 2027 to 2036).

C. IPPS Standardized Amounts

The following four rate categories continue in FY 2027 (before adjustments):

	Update
Full Update	2.3%
No IQR	1.5%
No EHR	-0.1%
No EHR/IQR	-0.9%

The applicable percentage changes above are prior to budget neutrality factors applied to the standardized amount. The adjustments to the standardized amounts are as follows:

- MS-DRG recalibration, 0.998748 (a decrease of 0.13 percent).
- MS-DRG recalibration cap, 0.99973 (a decrease of 0.03 percent).
- Wage index, 1.000312 (an increase of 0.03 percent).
- Geographic reclassification, 0.949363 (a decrease of 5.06 percent).
- Transition for eliminating low-wage index policy 0.999777 or -0.02 percent.
- 5 percent cap on wage index reductions, 0.999379 or -0.06 percent.
- The outlier offset factor is 0.949 or -5.1 percent.

Of the adjustments above, MS-DRG recalibration and wage index are maintained on the standardized amount from year to year. The prior year adjustments for geographic reclassification, budget neutrality for the 5 percent on reductions to the wage indexes and the outlier adjustment are removed from the FY 2026 standardized amount before the FY 2027 adjustments are applied. The net increase in the standardized amount results as follows:

Factor	Net Change
Update	2.3%
DRG Recalibration	-0.13%
DRG Recalibration Cap	-0.03%
Wage Index	-0.03%
Geographic Reclassification	-0.78%
25th Percentile Transition Budget Neutrality	0.01%
5% Cap on Wage Index Reductions	0.00%
Rural Community Hospital Demo	0.04%
Outlier	0.00%
Net Change*	1.43%

*Net change is the product of the prior factors, not the addition. As there will be no Rural Community Hospital Demonstration adjustment for FY 2027, the +0.04 percent is from removing the FY 2026 adjustment.

The increase in the capital rate is 3.03 percent from $524.15 to $540.03. The combined increase in the operating standardized amount and the capital rate is 1.54 percent for FY 2027.

The standardized amounts do not include the 2 percent Medicare sequester reduction that began in 2013 and will continue until at least 2032 under current law. The sequester reduction is applied as the last step in determining the payment amount for submitted claims and does not affect the underlying methodology used to calculate MS-DRG weights or standardized amounts.

Standardized Amounts for FY 2027

	Full Update=2.4%	Reduced Update Failed IQR = 1.6%	Reduced Update Failed EHR =0.0%	Reduced Update Failed IQR and EHR = -0.8%
Wage Index >1.0				
Labor (66.0%)	$4,520.83	$4,484.98	$4,412.28	$4,378.93
Non-Labor (34.0%)	$2,328.65	$2,310.44	$2,274.02	$2,255.81
WI<=1.0				
Labor (62%)	$4,246.37	$4,213.16	$4,146.75	$4,113.54
Non-Labor (38%)	$2,602.61	$2,582.26	$2,541.55	$2,521.20
National Capital Rate (All Hospitals)	$540.03			

D. Outlier Payments and Threshold

To qualify for outlier payments for high-cost cases, a case must have costs greater than the sum of the prospective payment rate for the MS-DRG, plus IME, DSH, UCP and NTAP plus the "outlier threshold" or "fixed-loss" amount, which is $40,397 for FY 2026. The sum of these components is the outlier "fixed-loss cost threshold" applicable to a case. To determine whether the costs of a case exceed the fixed-loss threshold, a hospital's total covered charges billed for the case are converted to estimated costs using the hospital's cost-to-charge ratio (CCR). An outlier payment for an eligible case is then made based on a marginal cost factor, which is 80 percent of the estimated costs above the fixed-loss cost threshold (90 percent for patients in the burn DRGs).

FY 2027 outlier threshold. CMS proposed to adopt an outlier threshold for FY 2027 of $51,704, an increase of 28 percent and $11,307 from the FY 2026 amount, a significantly larger increase than has been typical than recent years. If CMS did not incorporate its proposed reconciliation policy into its calculation of the FY 2027 proposed rule outlier threshold, it would have been $52,096. For the final rule, CMS calculated an outlier threshold of $49,346 with outlier payments accounting for 5.14 percent of total IPPS payments inclusive of estimated outlier reconciliation payments. If CMS did not incorporate estimated reconciliation payments in its outlier model, the threshold would be $49,728.

CMS projects that the outlier threshold for FY 2027 will result in outlier payments equal to 5.1 percent of operating DRG payments and 3.23 percent of capital payments. Accordingly, CMS is applying adjustments of 0.949 to the operating standardized amounts and 0.967684 to the capital federal rate to fund operating and capital outlier payments respectively.

FY 2027 outlier threshold methodology. CMS is following past practice targeting total outlier payments at 5.10 percent of total operating DRG payments including the adjustment for outlier reconciliation explained below (including outlier, all wage adjustments and UCP but continuing to exclude adjustments for value-based purchasing and the readmissions reduction program).

CMS' historical practice has been to calculate the outlier threshold based on the latest claims and cost report data. For FY 2027, the latest year of claims data is the March 2026 update to the FY 2025 Medicare Provider Analysis and Review File (MedPAR). The latest cost report data is the March 2025 update of the Provider-Specific File (PSF).

Charge Inflation. CMS proposed to continue the same basic general methodology to inflate the charges that it has used historically (with exceptions for the 2020 through 2022 years of the COVID-19 pandemic when hospital charging practices were atypical). Under this methodology, CMS computes the 1-year average annual rate-of-change in charges per case between FY 2024 and FY 2025, which is then applied twice to inflate the charges on the MedPAR claims by 2 years since CMS typically uses claims data for the fiscal year that is 2 years prior to the upcoming fiscal year.

These data are shown in the table below.

	Charges	Cases	Average Charge Per Case
FY 2024	$628,141,824,405	6,908,109	$ 90,928.19
FY 2025	$681,287,940,919	6,984,955	$ 97,536.48
Annual Rate of Increase			1.07268
Squared for 2 Years of Inflation			1.15063

CCRs. As it has done in the past, CMS is adjusting the CCRs from the March 2026 update of the PSF by comparing the percentage change in the national average case weighted operating CCR and capital CCR from the March 2025 update of the PSF to the national average case weighted operating CCR and capital CCR from the March 2026 update of the PSF.

These data are shown in the table below.

	March 2025 PSF	March 2026 PSF	% Change	Factor
Operating	0.240425	0.233434	-2.91%	0.970922
Capital	0.016402	0.01528	-6.84%	0.931594

Commenters expressed concern about the proposed increase in the fixed loss threshold, noting that it will have nearly doubled since FY 2020 compared to only a 15 percent increase over the prior decade. These commenters suggested alternatives to CMS' methodology for determining the charge inflation factor, CCR adjustments and limiting the annual increase to the fixed loss threshold. CMS responded that the commenters did not provide evidence that these approaches would more accurately predict the outlier threshold and could increase the likelihood that estimated outlier payments would deviate from the 5.1 percent target, resulting in non-budget neutral outlier payments.

There were several comments that CMS has received in prior years such as capping increases to the threshold or maintaining the threshold from one year to the next as CMS has done under the

LTCH PPS. CMS referred readers to its responses to those comments in prior *Federal Register* notices. In summary, CMS responded that commenters suggestions to cap or maintain the threshold from one year to the next would be inconsistent with the statute as such a threshold would not result in a projection of outlier payments that are not less than 5 percent nor more than 6 percent of projected total payments for FY 2027. There are many factors that can drive the threshold to increase or decrease from one fiscal year to the next making it challenging to pinpoint which exact factor is causing the threshold to increase.

CMS is finalizing its methodology to calculate the outlier threshold without change.

Reconciliation. Over the course of the year, Medicare makes outlier payments based on hospital data from a prior year. Outlier reconciliation occurs when the hospital's actual CCR for the period changes from the CCR used to make outlier payments by more than 10 percentage points or the hospital receives more than $0.5 million in outlier payments. Continuing a practice begun in FY 2020, CMS reflects reconciliation in the determination of the FY 2027 outlier threshold.

For the FY 2027 outlier threshold, CMS will use the historical outlier reconciliation amounts from the FY 2021 cost reports (cost reports with a beginning date on or after October 1, 2020, and on or before September 30, 2021). CMS indicates these are the most recent and complete set of cost reports which are finalized and/or approved by the MAC. For the FY 2027 final rule, CMS is using the March 2026 extract of the Hospital Cost Report Information System (HCRIS) to determine the reconciliation amounts.

CMS determines reconciled outlier payments as a percentage of total outlier payments for the year under analysis (FY 2021 for FY 2027). It then subtracts that amount (expressed as percentage points) from the 5.1 percent of total operating IPPS payments that CMS is targeting as outlier payments for the payment year.

When determining reconciliation for FYs 2020 through 2025, reconciliation was always negative (hospitals were owed additional outlier funding) and the effect was a decrease to the outlier threshold. For FY 2026, CMS found that reconciliation was a positive value (hospitals owed additional outlier funding to Medicare). For FY 2027, CMS found that reconciliation would be a small negative value (inadvertently described by CMS as a positive value in the proposed rule) although either way the result would round to an adjustment of 0.00 percent for outlier reconciliation.

As it found for FY 2026 using FY 2020 cost reports, CMS believes using the FY 2021 cost report data for FY 2027 reconciliation produces an anomalous result. For this reason, CMS proposed to hold the data constant from the FY 2025 IPPS final rule to determine the FY 2027 outlier threshold and apply a reconciliation adjustment of -0.04 percent which will target a slightly higher percentage of total payment as outliers (5.10 percent minus negative 0.04 percent or 5.14 percent). Public commenters supported this proposal.

Upon evaluating this issue with more recent data for the FY 2027 final rule, CMS found that outlier reconciliation resulted in a small positive value—providers owed Medicare additional

outlier funding—but like in the proposed rule would round to 0.0 percent of total outlier payments. CMS believes this small positive value may be an anomaly and not an accurate predictor of outlier reconciliations for FY 2027. Therefore, CMS is finalizing its proposal and will continue to hold the outlier reconciliation amount constant and apply a negative adjustment of 0.04 percent which will target 5.14 percent of total payments as operating outlier payments.

There is not a separate capital outlier threshold. CMS establishes a single unified outlier threshold based on the operating outlier threshold. Accordingly, CMS adjusts the capital rate to reflect the percentage of total payments estimated to be paid as capital outliers. CMS found the same result for capital reconciliation as it did for operating reconciliation that it characterized as anomalous—the result was positive indicating that hospitals owed outlier payments to Medicare, and the effect would be to increase the outlier threshold. For this reason, CMS is also using the FY 2025 capital reconciliation amounts (-0.03 percent) for determining the FY 2027 final rule outlier threshold.

FY 2025 Outlier Payments. CMS' current estimate, using available FY 2025 claims data, is that outlier payments for FY 2025 were approximately 4.90 percent of total MS-DRG payments or 0.2 percentage points less than the target of 5.1 percent—the amount the standardized amount was reduced to fund outliers. Following long-standing policy, the agency will not make retroactive adjustments to ensure that total outlier payments for FY 2025 are equal to the projected 5.1 percent of total MS-DRG payments and the amount of the reduction in the standardized amounts.

FY 2026 Outlier Payments. CMS says that FY 2026 claims data are unavailable to estimate the percentage of total payments made as outliers in FY 2025. However, in the impact section of the final rule, CMS estimates that, using FY 2025 data, outlier payments will be 0.8 percentage points higher (5.9 percent) than the 5.1 percent targeted and removed from the standardized amounts to fund outlier payments.

II. Medicare Severity (MS) Diagnosis-Related Groups (DRGs)

A. Adoption of the MS-DRGs in FY 2008

Section 1886(d) of the Act specifies that the Secretary shall establish a classification system (referred to as diagnosis-related groups (DRGs)) for inpatient discharges and adjust payments under the IPPS based on appropriate weighting factors assigned to each DRG. Therefore, under the IPPS, Medicare pays for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that DRG, relative to the average resources used to treat cases in all DRGs.

Section 1886(d)(4)(C) of the Act requires that the Secretary adjust the DRG classifications and relative weights at least annually to reflect changes in treatment patterns, technology, and any

other factors that may change the relative use of hospital resources. In FY 2008, CMS established a new DRG system expanding the number of DRGs from 538 to 755 to better recognize severity of illness. The new DRG system is known as the Medicare Severity or MS-DRGs.

When CMS adopted the MS-DRGs, it also adopted a budget neutrality adjustment to offset increases in expenditures associated with improvements in documentation and coding that do not represent a change in patient severity of illness. Congress later enacted statutory provisions governing how these budget neutrality adjustments are to be made. These statutory changes required CMS to recoup spending attributable to documentation and coding that it did not fully recapture in the Medicare rates prior to FY 2013. CMS refers readers to the FY 2023 IPPS final rule (87 FR 48799 through 48800) for detailed information on these issues.

CMS accomplished the required recoupment through downward adjustments to the standardized amounts—initially estimated at 0.8 percent annually for four years or 3.2 percent in total. Once the recoupment was completed, CMS planned to increase rates in FY 2018 by 3.2 percent to fully restore any reduction to the rates made to recoup excess prior spending. However, before CMS could make this +3.2 percent adjustment to the rates, section 404 of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 set forth the levels of positive adjustments for FYs 2018 through 2023. CMS later estimated that the final year recoupment adjustment would need to be 1.5 percent rather than 0.8 percent or 0.7 percentage points higher than initially estimated. The 21st Century Cures Act later slightly reduced the FY 2018 adjustment specified by MACRA

The offset adjustment to recoup expenditures associated with documentation and coding totaled 3.9 percent. Consistent with the schedule for restoring the IPPS rates to their prior levels, CMS applied adjustments consistent with those specified by MACRA and the 21st Century Cures Act. In total, CMS returned 2.9588 percentage points of the cumulative 3.9 percent reduction to the IPPS standardized amounts for documentation and coding. CMS argues that the statute does not authorize reinstating the remaining 0.9412 percentage points to the standardized amounts and rejected public comments in prior rules suggesting otherwise. The issue is now the subject of litigation in Federal Court.

Multiple commenters again reiterated that the law requires CMS to increase the standardized amount by 0.9412 percentage points to avoid carrying over reductions for documentation and coding made for FY 2013 through FY 2017 into rates after FY 2023. These comments indicate that, while the law specified the precise adjustments to be made to IPPS rates for FY 2018 through FY 2023, it also indicated any reductions for documentation and coding should not be carried forward into FY 2024 and subsequent year rates. CMS responded as it has in the past arguing that the statute set forth the levels of positive adjustments for FYs 2018 through 2023 that it should make. The statute did not specify how rates beyond those years are determined.

B. Changes to Specific MS-DRG Classifications

1. Discussion of Changes to Coding System and Basis for FY 2027 MS-DRG Updates

In this section, CMS repeats information it provided in the proposed rule about the agency's processes and policies related to the International Classification of Diseases, 10th Revision (ICD-10) and its basis for establishing FY 2027 MS-DRG updates. CMS explains that MS-DRG change requests are accepted by CMS annually through the Medicare Application Request Information System™ (MEARIS) at MEARIS™ | Home.[1] CMS notes that some requests require extensive research, and the agency may not be able to fully consider all the requests it receives for the upcoming fiscal year. Beginning with FY 2027 rulemaking, CMS is no longer summarizing requests it is unable to consider for the upcoming FY. If CMS is unable to consider the request, CMS will inform the requestors via MEARIS™.

Selected Comment/Response: A technology association raised concerns related to the transparency of MEARIS™ requests, and in particular, those related to CMS' recently established policy to no longer summarize requests the agency is unable to consider. Additionally, the commenter pointed out that public comments addressing the adequacy of the MS-DRG payment in connection with the proposed discontinuation of a new technology add-on payment for a specific technology, with a proposed corresponding adjustment to payment, are within the scope of rulemaking and should be considered for action in the final rule. In response, CMS believes that the agency's processes provide sufficient transparency through the agency's annual notice and comment rulemaking process, and does not believe it would be appropriate to finalize MS-DRG classification changes in connection with the proposed discontinuation of a new technology add-on payment for a specific technology in the absence of providing CMS' standard data analysis and corresponding resources that are made publicly available under the agency's established rulemaking process. However, in response to the comment, following this FY 2027 rulemaking and beginning with the FY 2028 rulemaking cycle, CMS indicates its intent to increase notification to requestors whose MS-DRG classification change requests are under review or deferred.

CMS repeats additional detailed information it provided in the proposed rule related to the various aids CMS makes available so the public can better analyze and understand the impact of the agency's proposals. For example, the test version of the ICD-10 MS-DRG GROUPER Software, Version 44, the draft version of the ICD-10 MS-DRG Definitions Manual, Version 44, the draft version of the Definitions of MCE Manual, Version 44, and the supplemental mapping files in Tables 6P.1a and 6P.1b of the FY 2026 and FY 2027 ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes are available here: MS-DRG Classifications and Software | CMS.

Selected Comment/Response: Commenters expressed appreciation for these aids and made suggestions for improving them. CMS noted that the agency will take the suggestions into consideration.

[1] This information collection requirement is subject to the Paperwork Reduction Act (PRA) of 1995 and was approved under OMB control number 0938-1431 which has an expiration date of 01/31/2029.

CMS repeats information it provided in the proposed rule regarding its processes for making proposals related to changes to MS-DRG classifications. For the proposed rule, CMS' MS-DRG analysis was based on ICD-10 claims data from the September 2025 update of the FY 2025 MedPAR file, which contains hospital bills received from October 1, 2024 through September 30, 2025. CMS goes on to describe what factors the agency takes into consideration when deciding on modifications to the MS-DRGs for particular circumstances that are brought to the agency's attention. In general, CMS considers whether the resource consumption and clinical characteristics of the patients with a given set of conditions are significantly different than the remaining patients in the MS-DRG. CMS generally prefers not to create a new MS-DRG unless it would include a substantial number of cases.

Beginning in FY 2021, CMS created a new complication or comorbidity (CC) or major complication or comorbidity (MCC) with a base MS-DRG to include the NonCC subgroup for a three-way severity level split.[2] CMS believes that this better reflects resource stratification and promotes stability in the relative weights by avoiding low volume counts for the NonCC level MS-DRGs. Accordingly, in CMS' analysis of the MS-DRG classification requests for FY 2027, the agency applied criteria to create subgroups, as described in the following table (reproduced below from the preamble):

Criteria Number	**Three-Way Split** 123 (MCC vs CC vs NonCC)	**Two-Way Split** 1_23 MCC vs (CC+NonCC)	**Two-Way Split** 12_3 (MCC+CC) vs NonCC
1. At least 500 cases in the MCC/CC/NonCC group	500+ cases for MCC group; and 500+ cases for CC group; and 500+ cases for NonCC group	500+ cases for MCC group; and 500+ cases for (CC+NonCC) group	500+ cases for (MCC+CC) group; and 500+ cases for NonCC group
2. At least 5% of the patients are in the MCC/CC/NonCC group	5%+ cases for MCC group; and 5%+ cases for CC group; and 5%+ cases for NonCC group	5%+ cases for MCC group; and 5%+ cases for (CC+NonCC) group	5%+ cases for (MCC+CC) group; and 5%+ cases for NonCC group
3. There is at least a 20% difference in average cost between subgroups	20%+ difference in average cost between MCC group and CC group; and 20%+ difference in average cost between CC group and NonCC group	20%+ difference in average cost between MCC group and (CC+NonCC) group	20%+ difference in average cost between (MCC+ CC) group and NonCC group
4. There is at least a $2,000 difference in average cost between subgroups	$2,000+ difference in average cost between MCC group and CC group; and $2,000+ difference in average cost between CC group and NonCC group	$2,000+ difference in average cost between MCC group and (CC+ NonCC) group	$2,000+ difference in average cost between (MCC+ CC) group and NonCC group
5. The R2 of the split groups is greater than or equal to 3	R2 $\geq$ 3.0 for the three-way split within the base MS-DRG	R2 $\geq$ 3.0 for the two-way 1_23 split within the base MS-DRG	R2 $\geq$ 3.0 for the two-way 12_3 split within the base MS-DRG

CMS explains that, when analyzing requests to create a new MS-DRG, the agency typically evaluates the most recent year of MedPAR claims data available. However, when evaluating requests to split an existing base MS-DRG into severity levels, CMS typically analyzes the most recent two years of data. This allows CMS to compare across years in order to avoid making

[2] See the FY 2021 IPPS/LTCH PPS final rule (85 FR 58448)

determinations about whether additional severity levels are warranted based on an isolated year's data fluctuation and to validate that the established severity levels within a base MS-DRG are supported.[3] CMS applies a step-wise process for evaluating if the creation of a new CC subgroup within a base MS-DRG is warranted by applying the criteria shown in the table above. After determining that all criteria are satisfied for a three-way split, a base MS-DRG is initially subdivided into the three subgroups (MCC, CC, and NonCC). Each subgroup is then analyzed against the criteria in the table. If the criteria are met, a three-way split is generally warranted. However, if the criteria fail, CMS determines if criteria are satisfied for a two-way split by subdividing the base MS-DRG into two subgroups (1_23 or 12_3). Each of these subgroups is then analyzed against the criteria in the table. If all five criteria for both two-way splits are met, CMS applies the two-way split with the highest R2 value. If criteria for both of the two-way splits fail, then a split is generally not warranted for the base MS-DRG.

2. MDC 04 (Diseases and Disorders of the Respiratory System)

a. Short-Term External Heart Assist Systems

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 describes the requestor's rationale as it relates to cases reporting procedure codes describing the insertion of the Impella® Ventricular Support Systems. The requestor identified cases reporting procedure codes describing the insertion of a short-term external heart assist device as reporting ICD-10-PCS codes 02HA3RZ and 5A0221D.

CMS notes that because the assistance with an Impella® is always coded with ICD-10-PCS code 5A0221D, the agency did not include this code in its analysis as the presence of the code would be expected to be identified in all cases. CMS agreed with the requestor that procedure code 02HA3RZ describes the insertion of a short-term external heart assist device; however, the agency identified the five additional ICD-10-PCS procedure codes (02HA0RS, 02HA0RZ, 02HA3RS, 02HA3RZ, 02HA4RS) that also describe the insertion of a short-term external heart assist device. In the preamble, CMS provides details of the analyses it performed and, as requested, explored alternative options for reassignment.

Proposal: CMS did not propose 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 to MDC 05 MS-DRG 215 for FY 2027.

Selected Comment/Response: CMS states it appreciates that many commenters expressed support for CMS' proposal. In response to a request that CMS evaluate cases by taking into account patient discharge status in order to consider mortality-stratified cost analyses before concluding that cases are not sufficiently distinct to justify further MS-DRG refinement or other payment

[3] As noted in prior rulemaking (80 FR 49368)

adjustments, CMS reiterates its analytic process and the factors it took into consideration, including factors related to costs. CMS acknowledges a recommendation by another commenter that CMS move the assignment of the procedure codes describing the insertion of a short-term external heart assist device from MDC 04 to MDC 05 to reflect the severity of the patient's condition and the complexity of care provided as well as the incremental resources consumed. However, CMS continues to believe that it would not be appropriate to move the diagnoses associated with the procedure from MDC 04 to MDC 05 because doing so would inadvertently result in cases reporting pulmonary embolism with O.R. procedures being assigned to an unrelated MS-DRG. CMS states that the agency will continue to monitor the claims data to determine if refinements may be warranted in the future.

Final Action: CMS is finalizing its proposal without modification, for FY 2027.

b. Fluorescence Guided Procedures of the Trunk Region using Pafolacianine

CMS received a request from the manufacturer of CYTALUX® to modify the GROUPER logic of MS-DRGs 163, 164, and 165 (Major Chest Procedures with MCC, with CC, and without CC/MCC, respectively) by reassigning cases with an ICD-10-PCS code that describes fluorescence guided surgery using CYTALUX® (pafolacianine) for the lung indication that currently map to the lower severity level MS-DRG 165 (without CC/MCC) to the higher severity level MS-DRG 163 (with MCC) or MS-DRG 164 (with CC). CMS summarizes the analysis performed by the requestor.

CMS examined claims data from the September 2025 update of the FY 2025 MedPAR file for MS-DRGs 163, 164, and 165 to identify cases reporting one of the five procedure codes (8E0W0EN, 8E0W3EN, 8E0W4EN, 8E0W7EN and 8E0W8EN) that describe fluorescence guided surgery using CYTALUX® (pafolacianine). Although the data analysis shows that cases in question demonstrate slightly higher average costs compared to all the cases in MS-DRG 165, CMS believes these cases are more suitably grouped to MS-DRG 165, where they are currently assigned, based on the closer similarities in resource utilization compared to all the cases in their respective MS-DRG. CMS explains that the MS-DRG system is a system of averages and it is expected that within the diagnostic related groups, some cases may demonstrate higher than average costs, while other cases may demonstrate lower than average costs. Moreover, the data do not indicate cases reporting the relevant procedure codes (without a secondary diagnosis code designated as a CC or MCC) utilize similar resources when compared to the cases assigned to MS-DRGs 163 and 164.

Proposal: CMS proposed to maintain the current structure of MS-DRGs 163, 164, and 165.

Selected Comment/Response: Several commenters agreed with the proposal. The manufacturer disagreed and urged CMS to reassign CYTALUX® lung surgery cases from MS-DRG 165 to the higher-paying MS-DRG 164 for FY 2027, arguing that these complex procedures incur costs far beyond current standard payments. Based on its own analysis, the commenter believes that existing Medicare claims understate true costs due to hospital billing confusion regarding discarded products and that maintaining the current classification after add-on payments expire

will create financial disincentives that limit patient access. In response, CMS maintains that CYTALUX® lung surgery cases without complications belong in MS-DRG 165, because their shorter hospital stays and lower average costs make them a better match for that group's resource utilization than MS-DRGs 163 and 164. CMS rejects the argument that its decision creates a financial disincentive, stating that hospitals are expected to provide the most appropriate treatment regardless of cost and that it is inappropriate to alter MS-DRG assignments solely to incentivize the use of a specific technology. CMS will continue to examine the claims data related to these cases to determine if refinements may be warranted in the future.

Final Action: CMS is finalizing its proposal without modification.

3. MDC 05 (Diseases and Disorders of the Circulatory System): WiSE® CRT System

In support of an FY 2026 new technology add-on payment application, CMS received a request to create new ICD-10-PCS codes to differentiate cardiac procedures involving the WiSE® CRT System. Effective October 1, 2025 (FY 2026), CMS implemented two ICD-10-PCS procedure codes (X2HN37B in combination with XHH80HB) and assigned the procedure code combination to MS-DRGs 242, 243, and 244. When reported as standalone procedures, the individual codes are assigned to either MDC 05 MS-DRG 264 or to MDC 05 MS-DRGs 258 and 259.

For FY 2027, CMS received a request to reassign the WiSE® CRT System procedure code X2HN37B from MS-DRGs 242, 243, and 244 to MS-DRGs 228 and 229 to better group it with other leadless pacemaker cases. CMS summarizes the analysis it performed and notes that the agency agreed with the requestor that the WiSE® CRT System is more closely aligned with the leadless pacemakers assigned to MS-DRGs 228 and 229 as compared to the insertion of conventional pacemakers assigned to MS-DRGs 242, 243, and 244.

Proposal: For FY 2027, CMS proposed to:

- Reassign procedure code X2HN37B from MS-DRG 264 to MS-DRGs 228 and 229.
- Delete the procedure code combination of X2HN37B and XHH80HB from the GROUPER logic of MS-DRGs 242, 243, and 244. (Procedure code X2HN37B would no longer require a companion code to be assigned to MS-DRGs 228 and 229, while standalone code XHH80HB would be assigned to proposed new MDC 05 MS-DRGs 210 and 211.)
- Delete MS-DRGs 258, 259, 260, 261, and 262 and create new MS-DRGs 210 and 211.[4]
- Delete base MS-DRG 264 and create two new MS-DRGs with a two-way severity level split for cases reporting other circulatory system Operating Room (O.R.) Procedures in MDC 05, specifically, MS-DRGs 361 and 362. Under this proposal, 1,447 procedure codes would be reassigned to the new MS-DRGs.

[4] Table 6P.2a associated with the FY 2027 IPPS/LTCH PPS proposed rule (which is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index) includes the list of procedure codes CMS proposed to define in the logic for proposed new MS-DRGs 210 and 211.

Selected Comment/Response: Commenters supported CMS' proposal to reassign procedure code X2HN37B and delete the procedure code combination logic. One commenter disagreed, expressing concerns regarding the lack of evidence to support CMS' proposed reassignment. This commenter suggested CMS defer the proposed reassignment. If the proposal is finalized, the commenter recommends that CMS specify that the assignment of code XHH80HB to new MS-DRGs 210 and 211 is a provisional. In response, CMS continues to believe that the agency's proposal is appropriate because procedure code X2HN37B is more closely aligned with the procedure codes that describe insertion of leadless pacemakers assigned to MS-DRGs 228 and 229.

Some commenters supported the proposal to delete MS-DRGs 258, 259, 260, 261, and 262 and to create two new MS-DRGs (MS-DRGs 210 and 211) with a two-way severity level split for cases reporting procedure codes describing cardiac pacemaker revision or device replacement in MDC 05 for FY 2027. Some commenters expressed concern that collapsing the cardiac pacemaker revision severity split from three levels to two would cause structural payment shortfalls for academic and safety-net hospitals that treat a higher volume of patients with complicating conditions, and requested that CMS commit to monitoring the claims data for new MS-DRGs 210 and 211. Other commenters raised concerns regarding inconsistencies and volume variances with CMS' proposals when grouping cases using the Version 44 test GROUPER. In response to these concerns, CMS falls back on its established methodology and maintains that the MS-DRG system is a system of averages, with outlier payments available to mitigate extreme financial losses for hospitals. As far as monitoring claims, CMS notes that the agency is statutorily mandated to adjust DRG classifications and relative weights at least annually. Regarding concerns related to use of the GROUPER, CMS provides details on the methodology it applied in the proposed rule and refers commenters to the ICD-10 MS-DRG Version 43.1 Definitions Manual for complete documentation of the GROUPER logic for MS-DRGs 258, 259, 260, 261 and 262.

Commenters supported CMS' proposal to delete base MS-DRG 264 and create two new MS-DRGs (MS-DRGs 361 and 362) with a two-way severity level split for cases reporting other circulatory system O.R. Procedures in MDC 05 for FY 2027.

Final Action: CMS is finalizing its proposals without modification.

4. MDC 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue)

a. Spinal Fusion and Pelvic Fixation Procedures

For FY 2027, CMS received a request from the manufacturer to reassign cases reporting the use of the iFuse Bedrock™ Granite Implant System (also referred to as tulip connector) in spinal fusion procedures that currently map to the lower severity level MS-DRG to the highest severity level (with MCC) MS-DRG for MS-DRGs 426, 427, and 428; MS-DRGs 447 and 448; MS-DRGs 456, 457, and 458. CMS also received a separate but related request from another manufacturer to reassign cases reporting the use of the aprevo® Intervertebral Body Fusion Device from MS-DRG 402 to MS-DRG 450—or alternatively, to reassign cases reporting the

use of aprevo® from MS-DRG 402 to MS-DRG 428, and separately, to reassign cases reporting the use of aprevo® from MS-DRG 428 to the higher severity level (with MCC) MS-DRG 426.

In response to these requests, CMS performed multiple analyses on the claims data from the September 2025 update of the FY 2025 MedPAR file. The analysis and CMS' findings are summarized in the preamble of the final rule.

Proposal: As a result of CMS' analysis, CMS disagreed with the requests and instead proposed to establish a new base MS-DRG with a 3-way split. Specifically, for FY 2027, CMS proposed to:

- Create new MS-DRGs 523, 524, and 525 (Extensive or Complex Spinal Fusion Procedures Except Cervical with MCC, with CC, and without CC/MCC, respectively).
- 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® custom-made anatomically designed interbody fusion device or the iFuse Bedrock™ Granite Implant System from MS-DRGs 402, 426, 427, 428, 447, 448, 450, 451, 456, 457 and 458 to proposed new MS-DRGs 523, 524, and 525.
- 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."

Selected Comment/Response: Commenters broadly expressed support for CMS' proposals. Some supporters raised questions or made recommendations that CMS addressed or will take into consideration.

Final Action: CMS is finalizing its proposals without modification.[5]

b. Hip or Knee Procedures with Periprosthetic Joint Infection

CMS describes separate requests the agency received in the FY 2026 rulemaking related to reassignment of cases (1) reporting a hip or knee procedure with a principal diagnosis of periprosthetic joint infection (PJI) and (2) reporting ICD-10-PCS code XW0V0P7 (Introduction of antibiotic-eluting bone void filler into bones, open approach, new technology group 7). For reasons described in the preamble, CMS declined to finalize changes in the FY 2026 final rule.

To address a renewed request to reassign cases with ICD-10-PCS code XW0V0P7 for FY 2027, CMS performed an analysis of cases reporting a hip or knee procedure with a principal diagnosis of PJI using the September 2025 update of the FY 2025 MEDPAR file for MS-DRGs 463, 464, 465, 466, 467, 468, 474, 475, 476, 477, 478, 479, 480, 481, 482, 485, 486, 487, 492, 493, and 494, with removal of the restriction logic.

Proposal: For FY 2027, CMS proposed to:

[5] The surgical hierarchy for the modification is discussed in section II.C.14 of the preamble of the final rule and this summary.

- Remove the restriction logic for MS-DRGs 466, 467, and 468 and MS-DRGs 485, 486, and 487.
- Remove ICD-10-CM diagnosis codes T84.53XA and T84.54XA from the logic for case assignment to MS-DRGs 485, 486, and 487.
- Delete MS-DRGs 466, 467, and 468 and MS-DRGs 485, 486, and 487.
- Create new base MS-DRG 449 and new base MS-DRG 400 with the logic lists as reflected in proposed rule Tables 6P.3c and 6P.3d, respectively.
- Redesignate procedure code XW0V0P7 from non-O.R. to non-O.R. affecting specified MS-DRGs.
- 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) with the logic lists as reflected in proposed rule Table 6P.3b.
- 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 of previously listed MS-DRGs.

Selected Comment/Response: Several commenters supported CMS' proposals. One commenter did not agree with the grouping methodology for MS-DRGs 463, 464, and 465 and requested further evaluation of the logic for them; however, CMS disagrees that there is a clinical coherence issue and declines the request. In response to some confusion expressed by commenters, CMS clarifies the intent of proposed new MS-DRG 449 by further revising the title.

Final Action: CMS is finalizing all its proposals as proposed with one modification. Specifically, CMS finalizes a modification to the title of new MS-DRG 449 (Revision of Hip or Knee Replacement) to reflect "Revision of Hip or Knee Prosthesis".

5. MDC 10 (Endocrine, Nutritional, and Metabolic Diseases and Disorders): CERAMENT G Antibiotic-eluting Bone Void Filler

As discussed in the preamble of section II.C.4 and this summary, CMS received a request to reassign cases reporting ICD-10-PCS code XW0V0P7 (Introduction of antibiotic-eluting bone void filler into bones, open approach, new technology group 7) from the lower severity level MS-DRG to the highest severity level (with MCC) MS-DRG within MDC 10 for MS-DRGs 616, 617, and 618 (Amputation of Lower Limb for Endocrine, Nutritional and Metabolic Disorders with MCC, with CC, without CC/MCC, respectively) and MS-DRGs 628, 629, and 630 (Other Endocrine, Nutritional and Metabolic O.R. Procedures with MCC, with CC, without CC/MCC, respectively). CMS summarizes the stated rationale for the requested change and the requestor's analysis of claims data. CMS then summarizes its own analysis and findings from claims data from the September 2025 update of the FY 2025 MedPAR file for MS-DRGs 616, 617, 618, 628, 629, and 630 and for cases reporting ICD-10-PCS code XW0V0P7 in which CMS observed that

the average costs of the cases reporting ICD-10-PCS code XW0V0P7 at the lower severity level are more aligned with the average costs of the cases at the higher MCC severity level.

Proposal: To better reflect the resource utilization and severity of illness of patients with diabetic osteomyelitis, for FY 2027, CMS proposed 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 severity (MCC) level MS-DRG 628. CMS also proposed to revise the title of MS-DRG 616 and 628 to reflect the reassignment of cases reporting procedure code XW0V0P7.

Selected Comment/Response: Commenters agreed with CMS' proposals.

Final Action: CMS is finalizing its proposals without modification.

6. MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract)

a. Prostatectomy

Consistent with CMS' annual review of the MS-DRGs, the agency identified that the current GROUPER logic for MDC 11 MS-DRGs 665, 666, and 667 (Prostatectomy with MCC, with CC, and without CC/MCC, respectively) contains a logic list referred to as "OPERATING ROOM PROCEDURES" that includes 14 ICD-10-PCS procedure codes describing the destruction, excision, and resection of the prostate and also includes eight ICD-10-PCS procedure code combinations or procedure code "clusters" that, when reported together, satisfy the logic for assignment to MS-DRGs 665, 666, and 667. For reasons described more fully in the preamble of the proposed rule, CMS determined that specific assignment of these procedure codes in procedure code combinations in MS-DRGs 665, 666, and 667 is not required.

Proposal: For FY 2027, CMS proposed to remove the eight ICD-10-PCS procedure code combinations from the GROUPER logic of MDC 11 MS-DRGs 665, 666, and 667 (Prostatectomy with MCC, with CC, and without CC/MCC, respectively).

Selected Comment/Response: Commenters supported CMS' proposal.

Final Action: CMS is finalizing its proposal without modification.

b. Islet Cell Transplantation

As discussed in section II.C.11.b.1, CMS received a request to change the designation of ICD-10-PCS code XW033DA (Introduction of donislecel-jujn allogeneic pancreatic islet cellular suspension into peripheral vein, percutaneous approach, new technology group 10) from a non-O.R. procedure to an O.R. procedure. In its review of this request, CMS noted that in the ICD-10 MS-DRGs Definitions Manual Version 43.1, procedure code XW033DA was designated as a non-O.R. procedure affecting assignment to MS-DRGs 673, 674, and 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC, and without CC/MCC, respectively).

Additionally, CMS noted that 11 ICD-10-PCS procedure codes describing the introduction of pancreatic islet cells are all designated as non-O.R. procedures affecting assignment to MS-DRGs 673, 674, and 675. These procedure codes describing islet cell transplantation were added to the GROUPER logic of DRG 315 (Other Kidney and Urinary Tract O.R. Procedures), the predecessor DRG of MS-DRGs 673, 674, and 675, to recognize the resource utilization associated with islet cell transplantation. CMS has previously acknowledged that islet cell transplants do not involve either the kidney or the urinary tract directly. It is only because the technical aspects of islet transplants are of a surgical nature that CMS modified surgical DRG 315 to reflect the transfusion of islet cells.

In the proposed rule, CMS expressed a belief that for clinical coherence, given the similarity in clinical indication, the cases reporting procedure codes that describe the introduction of pancreatic islet cells should be grouped with the subset of cases that report pancreas transplant procedures. Based on a data simulation using the September 2025 MedPAR file, CMS concluded that reassigning these 11 procedure codes to Pre-MDC MS-DRGs 008, 010, and 019 creates more clinically coherent categories and better reflects hospital resource use.

Proposal: For FY 2027, CMS proposed 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. CMS also proposed to delete the sixth logic list entitled "or Principal Diagnosis" that is defined by ICD-10-CM diagnosis codes E10.21, E10.22 and E10.29 and the seventh logic list entitled "and Non-Operating Room Procedures" from MS-DRGs 673, 674, and 675. Lastly, for consistency, CMS proposed to change the title of MS-DRG 008, 010, and 019 to better reflect the assigned procedures. CMS noted that the current "principal or secondary diagnosis" logic in MS-DRGs 008, 010, and 019 would be maintained. Additionally, to maintain stability, CMS proposed to add logic to MS-DRG 010 to exclude cases also reporting kidney transplant procedures to ensure cases will continue to group to MS-DRGs 008 and 019.

Selected Comment/Response: Commenters expressed support for CMS' proposals. One commenter stated a belief that assigning the 11 procedures codes into MS-DRG 010 (Pancreas Transplant) is structurally unsuitable and recommended that CMS create a new, dedicated Pre-MDC MS-DRG specifically for "Allogeneic Islet Cellular Therapies". Another commenter suggested that MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-Cell and Other Immunotherapies) would be a more appropriate assignment for ICD 10-PCS code XW033DA. Several commenters urged CMS to individually evaluate future islet cell therapies, noting that upcoming stem cell-derived technologies use lab-grown cells and differ significantly in manufacturing, resources, and clinical outcomes from traditional and more recent allogeneic islet cell therapies. In response, CMS notes that the agency is carefully considering the feedback previously received about ways CMS can continue to appropriately reflect resource utilization associated with cell and gene therapies while maintaining clinical coherence and stability in the relative weights under the IPPS MS-DRGs.

Final Action: CMS finalizes its proposals without modification.

7. MDC 12 (Diseases and Disorders of the Male Reproductive System)

Consistent with CMS' annual review of the MS-DRGs, CMS identified that the current GROUPER logic for MDC 12 MS-DRGs 707 and 708 (Major Male Pelvic Procedures with MCC and without CC/MCC, respectively) contains a logic list referred to as "OPERATING ROOM PROCEDURES" that includes 51 procedure codes describing various male pelvic procedures, including procedure codes describing the destruction or resection of the prostate, and also includes eight procedure code combinations or procedure code "clusters" that, when reported together, satisfy the logic for assignment to MS-DRGs 707 and 708. The code combinations are represented by two procedure codes and include one code for the resection of the prostate with one code for the resection of bilateral seminal vesicles. CMS analyzed the GROUPER logic and claims data from the September 2025 update of the September 2025 MedPAR file for all cases in MS-DRGs 707 and 708 and compared the results to cases reporting procedure codes describing transurethral prostatectomy and resection of bilateral seminal vesicles in these MS-DRGs.

Proposal: For FY 2027, CMS proposed to delete eight ICD-10-PCS procedure code combinations from the GROUPER logic of MDC 12 MS-DRGs 707 and 708 (Major Male Pelvic Procedures with CC/MCC and without CC/MCC, respectively). Under this proposal, cases reporting procedure codes 0VT00ZZ and 0VT04ZZ (Resection of prostate, open or percutaneous endoscopic approach, respectively) would group to MS-DRGs 707 and 708, even when a procedure code describing the resection of the bilateral seminal vesicles is not also reported. Additionally, under this proposal, cases reporting procedure codes 0VT07ZZ or 0VT08ZZ (Resection of prostate, via natural or artificial opening +/- endoscopic, respectively) would group to MS-DRGs 713 and 714 (Transurethral Prostatectomy with CC/MCC and without CC/MCC, respectively), even when a procedure code describing the resection of the bilateral seminal vesicles is not also reported. CMS also proposed to change the titles of MS-DRGs 715 and 716 and MS-DRGs 717 and 718.

Selected Comment/Response: Commenters supported CMS' proposed deletion of the eight procedure code combinations from MDC 12 MS-DRGs 707 and 708 and CMS' proposed title changes.

Final Action: CMS is finalizing its proposals without modification.

8. MDC 13 (Diseases and Disorders of the Female Reproductive System): Fluorescence Guided Procedures of the Female Reproductive System using Pafolacianine

CMS received a request from the manufacturer of CYTALUX® to modify the GROUPER logic of MS-DRGs 736, 737, and 738 (Uterine and Adnexa Procedures for Ovarian or Adnexal Malignancy with MCC, with CC, and without CC/MCC, respectively) by reassigning cases with an ICD-10-PCS code that describes fluorescence guided procedures of the female reproductive system using CYTALUX® (pafolacianine) to the higher severity level MS-DRG 736 (with MCC) or MS-DRG 737 (with CC). CMS provides background for CYTALUX® (pafolacianine), which is a folate receptor-targeted fluorescent optical imaging agent used as an

adjunct for intraoperative identification of ovarian cancer, and the requestor's rationale for the request. Following a review (described in the preamble of the final rule), CMS declined to propose the requested reassignment, because the agency believed it would be premature to do so for FY 2027 given its observed wide variance in average costs and small number of cases across the MS-DRGs.

However, during CMS' review, the agency noticed that in cases reporting uterine and adnexa procedures in MS-DRGs 736, 737, 738, 739, 740, and 741, the average costs and length of stay are generally similar without regard to the presence of diagnosis codes describing "ovarian or adnexal" malignancies or "non-ovarian or non-adnexal" malignancies. As a result, CMS believes that it may no longer be necessary to subdivide these MS-DRGs based on the diagnosis codes reported.

Proposal: CMS proposed the deletion of MS-DRGs 736, 737, 738, 739, 740, and 741, and the creation of new MS-DRGs 731 (Uterine and Adnexa Procedures for Malignancy with MCC), MS-DRG 732 (Uterine and Adnexa Procedures for Malignancy with CC), and MS-DRG 733 (Uterine and Adnexa Procedures for Malignancy without CC/MCC). CMS proposed to include the current list of 689 ICD-10-PCS procedure codes in the logic for MS-DRGs 736, 737, 738, 739, 740, and 741 for case assignment of uterine and adnexa procedures for the proposed new MS-DRGs.

Selected Comment/Response: Commenters supported CMS' proposals. One commenter sought clarification on how CMS would address concomitant procedures in the proposed new MS-DRGs. In response, CMS notes the availability of a test version of the ICD-10 MS-DRG GROUPER Software, Version 44. CMS states that when multiple surgical uterine and adnexa procedures are performed—each one of which, occurring by itself, could result in assignment of the case to a different MS-DRG within the MDC to which the principal diagnosis is assigned—application of the surgical hierarchy ensures that cases involving multiple surgical procedures are assigned to the MS-DRG associated with the most resource-intensive surgical class, as discussed in section II.C.14.

Final Action: CMS is finalizing its proposal without modification.

9. <u>MDC 25 (Human Immunodeficiency Virus Infections): Significant HIV Related Conditions</u>

The logic for case assignment under MDC 25 (Human Immunodeficiency Virus Infections) is comprised of ICD-10-CM diagnosis code B20 (Human immunodeficiency virus [HIV] disease) when reported as a principal diagnosis or when reported as a secondary diagnosis with a principal diagnosis of a significant HIV related condition. The logic for case assignment specifically to MS-DRGs 974, 975, and 976 (HIV with Major Related Condition with MCC, with CC, without CC/MCC, respectively) under MDC 25 is comprised of ICD-10-CM diagnosis code B20 when reported as a principal or secondary diagnosis with a principal or secondary diagnosis of a major related condition (as displayed in the ICD-10 MS-DRG Definitions Manual, Version 43.1).

In reviewing the listed diagnoses that fall under the MDC 25, CMS identified a number that overlap with the listed diagnoses in the logic list for case assignment to MS-DRGs 974, 975, and 976, as well as a subset of diagnoses that do not appear to describe a significant HIV related condition.

Proposal: For FY 2027, CMS proposed to remove the term "SIGNIFICANT" under the header for MDC 25 and revise it to reflect, "AND PRINCIPAL DIAGNOSIS OF HIV RELATED CONDITION". CMS broadcasted its intent to perform additional review and analysis of the diagnoses listed in the logic for case assignment to MDC 25 as well as the logic for case assignment to MS-DRGs 974, 975, and 976.

Selected Comment/Response: Commenters supported CMS' proposal.

Final Action: CMS is finalizing its proposal without modification.

10. Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989

CMS annually conducts a review of procedures producing assignment to MS-DRGs 981 through 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) or MS-DRGs 987 through 989 (Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) on the basis of volume, by procedure, to see if it would be appropriate to move cases reporting these procedure codes out of these MS-DRGs into one of the surgical MS-DRGs for the MDC into which the principal diagnosis falls. CMS also reviews the list of ICD-10-PCS procedure codes that, when in combination with their principal diagnosis code, result in assignment to MS-DRGs 981 through 983, or 987 through 989, to ascertain whether any of those procedure codes should be reassigned from one of those two groups of MS-DRGs to the other group of MS-DRGs based on average costs and the length of stay.

Based on the results of CMS' review of the claims data from the September 2025 update of the FY 2025 MedPAR file of cases found to group to MS-DRGs 981 through 983 and MS-DRGs 987 through 989, the agency did not identify any cases for reassignment. Additionally, CMS did not receive any requests suggesting reassignment.

Proposal: For FY 2027, CMS did not propose to move any cases reporting procedure codes from MS-DRGs 981 through 983 to MS-DRGs 987 through 989 or vice versa

Selected Comment/Response: Commenters expressed their support for CMS' proposal.

Final Action: CMS is finalizing its proposal without modification.

11. Operating Room (O.R.) and Non-O.R. Procedures

a. Background

Under the IPPS MS-DRGs (and former CMS MS-DRGs), CMS has a list of procedure codes that are considered operating room (O.R.) procedures. Currently, each ICD-10-PCS procedure code has designations that determine whether and in what way the presence of that procedure on a claim impacts the MS-DRG assignment. First, each procedure code is either designated as an O.R. or non-O.R. procedure for purposes of MS-DRG assignment. Second, each O.R. procedure is classified as either extensive or non-extensive. Third, each non-O.R. procedure is classified as either affecting or not affecting the MS-DRG assignment (with those that affect MS-DRG assignment referred to as "non-O.R. affecting the MS-DRG"). For new procedure codes that have been finalized through the ICD-10 Coordination and Maintenance Committee meeting process and are proposed to be classified as O.R. procedures or non-O.R. procedures affecting the MS-DRG, CMS recommends the MS-DRG assignment, makes them public in association with the proposed rule, and subjects them to public comment. CMS notes these proposed assignments are generally based on the assignment of predecessor codes or the assignment of similar codes.

For FY 2027, CMS received requests (discussed in the following sections) regarding changing the designation of specific ICD-10-PCS procedure codes from non-O.R. to O.R. procedures, which are discussed in this section of preamble, along with any proposals CMS is making based on its internal review and analysis. For each procedure, CMS considers:

- Whether the procedure would typically require the resources of an operating room;
- Whether it is an extensive or a non-extensive procedure; and
- To which MS-DRGs the procedure should be assigned.

CMS notes that, by default, any cases with a principal diagnosis associated with a particular MS-DRG would be grouped to that MS-DRG. Therefore, CMS only discusses MS-DRGs that require explicitly adding the relevant procedure codes to the GROUPER logic in order for those procedure codes to affect the MS-DRG assignment as intended. For procedures that would not typically require the resources of an operating room, CMS determines if the procedure should affect the MS-DRG assignment. In cases where CMS proposes to change the designation of procedure codes from non-O.R. procedures to O.R. procedures, it also proposes one or more MS-DRGs with which these procedures are clinically aligned and to which the procedure code would be assigned.

In addition, cases that contain O.R. procedures will map to MS-DRGs 981 through 983 or MS-DRGs 987 through 989 when they do not contain a principal diagnosis that corresponds to one of the MDCs to which that procedure is assigned. These procedures need not be assigned to MS-DRGs 981 through 989 in order for this to occur. Therefore, CMS does not specifically address this aspect when considering requests or making proposals.

Since the FY 2018 IPPS final rule, CMS has discussed its plans to conduct a multi-year comprehensive, systematic review of the O.R. and non-O.R. ICD-10-PCS procedure codes. However, CMS continues to believe additional time is necessary as the agency develops its process and methodology.

Selected Comment/Response: Many commenters generally expressed support for CMS' development of its process and methodology for conducting its systematic review of the O.R. and non-O.R. ICD-10-PCS procedure codes and requested that CMS work with clinicians and provide the public with opportunity to comment prior to adoption of changes to MS-DRG structures or procedure code designations. Others noted that CMS has expressed this intent for several years and indicated that the delay prolongs uncertainty for providers whose services may be affected by outdated procedure code designations. In response, CMS states that the agency will use the rulemaking process to provide opportunity for engagement and comment. In addition, CMS outlines the steps the agency has taken and continues to take in this multi-year process.

b. Non-O.R. Procedures to O.R. Procedures

(1) Introduction of Allogeneic Pancreatic Islet Cellular Suspension

For FY 2027, CMS received a request to change the designation of ICD-10-PCS code XW033DA (Introduction of donislecel-jujn allogeneic pancreatic islet cellular suspension into peripheral vein, percutaneous approach, new technology group 10) from a non-O.R. procedure to an O.R. procedure. In the ICD-10 MS-DRGs Definitions Manual Version 43.1, procedure code XW033DA is currently designated as a non-O.R. procedure affecting assignment to MS-DRGs 673, 674, and 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC, and without CC/MCC, respectively). CMS summarizes the requestor's rationale and assertion that code XW033DA should be assigned to Pre-MDC MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-Cell and Other Immunotherapies) because donislecel-jujn (Lantidra™) is similar to other CAR-T technologies that map to DRG 018 as a cellular product; regarding procedure complexity, it is high cost and indicated for a rare patient population.

CMS analyzed claims data from the September 2025 update of the FY 2025 MedPAR file for MS-DRGs 673, 674, and 675 for cases reporting procedure code XW033DA but did not find any cases. CMS noted that these procedures do not typically require the resources of an operating room and are not surgical in nature. As such, CMS disagreed with designating procedure code XW033DA, which describes the intravenous portal vein administration of donislecel-jujn, as an O.R. procedure.

Proposal: CMS proposed to maintain the current designation of procedure code XW033DA as "non-O.R. affecting the MS-DRG" for FY 2027.

Selected Comment/Response: Commenters supported CMS' proposal. Several commenters urged CMS to develop and publish, through notice-and-comment rulemaking, prospective criteria for assignment to MS-DRG 018 as the cell and gene therapy product landscape continues

to expand. In response, CMS notes that the agency is in the process of carefully considering the feedback it has previously received about ways in which CMS can continue to appropriately reflect resource utilization associated with cell and gene therapies while maintaining clinical coherence and stability in the relative weights under the IPPS MS-DRGs. CMS states it will take commenter feedback into consideration in future policy development.

Final Action: CMS is finalizing its proposal without modification.

(2) Percutaneous Introduction of AGN1 Bone Void Filler into Bones

CMS received a request to recognize ICD-10-PCS procedure code XW0V3WA (Introduction of AGN1 bone void filler into bones, percutaneous approach, new technology group 10) as an O.R. procedure for purposes of MS-DRG assignment. CMS summarizes the requestor's rationale for the request which is based on the Local Osteo-Enhancement Procedure (LOEP) (an investigational surgical procedure) and the anticipated FDA approval of the AGN1 LOEP Kit in late 2027. According to the requestor, there may be situations where the procedure could be performed as a standalone procedure. CMS notes that when the introduction of AGN1 bone void filler is reported with a procedure code that describes a surgical procedure, the ICD-10-PCS code describing the surgical procedure will determine the surgical MS-DRG assignment based on the principal diagnosis reported.

After its review and analysis of claims data from the September 2025 update of the FY 2025 MedPAR file to determine the MS-DRGs reporting procedure code XW0V3WA, CMS stated its belief that it would be premature to consider the request, given the limited number of cases across the MS-DRGs.

Proposal: Based on its analysis and review, CMS proposed to maintain the designation of procedure code XW0V3WA as non-O.R. for FY 2027.

Selected Comment/Response: Most commenters supported CMS' proposal. The requestor reiterated their position and request and raised concerns regarding potential inaccurate reporting of the investigational LOEP. In response, CMS reiterated its position and review of findings and indicates that more time is needed to allow for further analysis of the claims data to determine to what extent the percutaneous introduction of AGN1 bone void filler into bones has an effect on the hospital resources used by a patient in an inpatient admission.

Final Action: CMS is finalizing its proposal without modification.

12. Changes to the MS-DRG Diagnosis Codes for FY 2027

a. Background of the CC List and CC Exclusions List

Under the IPPS MS-DRG classification system, CMS has developed a standard list of diagnoses that are considered CCs. In the FY 2008 IPPS final rule,[6] CMS evaluated each diagnosis code to determine its impact on resource use and to determine the most appropriate CC subclassification (NonCC, CC, or MCC) assignment.

b. Overview of Comprehensive CC/MCC Analysis

The FY 2008 IPPS final rule describes CMS' process for establishing three different levels of CC severity into which CMS subdivides the diagnosis codes. The categorization of diagnoses as MCC, a CC, or a non-CC was accomplished using an iterative approach in which each diagnosis was evaluated to determine the extent to which its presence as a secondary diagnosis resulted in increased hospital resource use. More recently, as a result of the transition to ICD-10-CM, CMS conducted a comprehensive analysis once again and proposed changes to the severity level designations for 1,492 ICD-10-CM diagnosis codes.[7] As a result of careful consideration of public comments received, however, CMS postponed adoption of the proposed comprehensive changes in the severity level designations to allow further opportunity to provide additional information to the public on the methodology utilized and clinical rationale for its proposals.[8] CMS summarizes the interval steps it has taken since then, including:

- Finalizing a new Medicare Code Editor (MCE) code edit for "unspecified" codes, effective with discharges on and after April 1, 2022;[9]
- Finalizing an increase in the severity levels for diagnosis codes related to homelessness;[10] and
- The finalization of nine guiding principles it believes are meaningful indicators of expected resource use by secondary diagnosis.[11]

CMS plans to continue a comprehensive CC/MCC analysis using a combination of the prior mathematical analysis of claims data in combination with the guiding principles.

CMS notes that for FY 2025,[12] based on its analysis of the impact on resource use for the ICD-10-CM diagnosis codes that describe inadequate housing and housing instability and after consideration of public comments, CMS finalized changes to the severity levels for seven diagnosis codes. For FY 2027, CMS is finalizing changes to the severity level designation for the

[6] 72 FR 47152 through 47171
[7] FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19235 through 19246) for a detailed discussion and proposals.
[8] FY 2020 IPPS/LTCH PPS final rule (84 FR 42150 through 42152)
[9] FY 2022 IPPS/LTCH PPS final rule (86 FR 44940 through 44943)
[10] FY 2024 IPPS/LTCH PPS final rule (88 FR 58755 through 58759)
[11] FY 2025 IPPS/LTCH PPS final rule (89 FR 69076 through 69078)
[12] FY 2025 IPPS/LTCH PPS final rule (89 FR 69079 through 69084)

diagnosis codes that describe homelessness, inadequate housing and housing instability, as discussed below.

c. Changes to Severity Levels

(1) SDOH – Homelessness, Inadequate Housing, and Housing Instability

In prior rulemaking,[13] CMS finalized changes to the severity levels for diagnosis codes Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), and Z59.02 (Unsheltered homelessness) and for seven diagnosis codes that describe inadequate housing and housing instability from NonCC to CC.

In the proposed rule, as a continuation of CMS' examination of the SDOH Z codes, CMS reviewed the impact on resource use for the ICD-10-CM Z codes that describe homelessness, inadequate housing, and housing instability generated from an analysis of the September 2025 update of the FY 2025 MedPAR file claims file.[14] CMS summarized its findings and indicated its current belief that a change of designation from NonCC to CC should be based on the expected resource use associated with the treatment of an underlying medical condition or illness rather than social circumstances. Specifically, CMS believes that recognition of the contribution that patient social and economic circumstances add to the complexity of acute hospital care should be accomplished by separately coding those diagnoses that describe an acute exacerbation or deterioration of an underlying medical condition or illness, similar to the approach CMS undertook in categorizing chronic illness diagnoses as stated in the FY 2008 IPPS final rule.

Proposal: CMS proposed to change the severity level designation of diagnosis codes Z59.00 (Homelessness, unspecified), Z59.01 (Sheltered homelessness), Z59.02 (Unsheltered homelessness), Z59.10 (Inadequate housing, unspecified), Z59.11 (Inadequate housing environmental temperature), Z59.12 (Inadequate housing utilities), Z59.19 (Other inadequate housing), Z59.811 (Housing instability, housed, with risk of homelessness), Z59.812 (Housing instability, housed, homelessness in past 12 months) and Z59.819 (Housing instability, housed unspecified) from CC to NonCC for FY 2027.

Selected Comment/Response: Some commenters supported CMS' proposal and agreed that designating these codes as CCs is an imperfect proxy. Many others urged CMS to maintain the severity designation of these codes as CCs as critical to ensuring that hospital payment reflects the real world resource demands associated with caring for unhoused individuals and reflecting the realities faced by providers and community organizations serving some of the nation's most vulnerable populations. Other commenters recommended that CMS establish an alternative payment methodology before finalizing the proposal if CMS determines that the severity level designation is not the appropriate mechanism for recognizing social circumstances. In response,

[13] FY 2024 IPPS final rule (88 FR 58755 through 58759) and FY 2025 IPPS final rule (89 FR 69079 through 69084).

[14] Readers are referred to the FY 2008 IPPS final rule (72 FR 47159) for a complete discussion of CMS' historical approach to mathematically evaluating the extent to which the presence of an ICD-10-CM code as a secondary diagnosis results in increased hospital resource use.

CMS reiterates its rationale for the proposal, stating that recognition of the contribution that patient social and economic circumstances, such as homelessness, inadequate housing, and housing instability, add to the complexity of acute hospital care should be accomplished by coding medical diagnoses that describe an acute exacerbation or deterioration of an underlying medical condition or illness that is being treated in that inpatient admission.

Final Action: CMS is finalizing its proposal without modification.

(2) Newborn Affected by Malpresentation Before Labor

For FY 2027, CMS received a request to change the severity level designations of the ICD-10-CM diagnosis codes P01.7 (Newborn affected by malpresentation before labor) and P03.0 (Newborn affected by breech delivery and extraction) from NonCC to CC. The requestor did not provide additional rationale for this request. CMS evaluated the request by analyzing the claims data in the September 2025 update of the FY 2025 MedPAR file and found zero instances where diagnosis codes P01.7 or P03.0 were reported as secondary diagnoses.

Proposal: Based on the lack of claims data to evaluate to consider a severity level change, CMS proposed to maintain the severity level designation of codes P01.7 and P03.0 as NonCCs for FY 2027.

Selected Comment/Response: Some commenters supported the proposal while one disagreed, stating that malpresentation before labor requires elevated medical management and possible procedural interventions resulting in increased resources needed to manage this population. In response, CMS reiterates that the lack of claims data prevents CMS from considering a severity change. However, CMS also acknowledges that in the past, the agency has indicated it could make an exception for diagnoses related to newborns, maternity, and congenital anomalies.[15] As a result, CMS may consider reevaluating this issue in future rulemaking.

Final Action: CMS is finalizing its proposal without modification.

(3) Functional Quadriplegia

For FY 2027, CMS received a request to change the severity level designation of ICD-10-CM diagnosis code R53.2 (Functional quadriplegia) from MCC to NonCC. In the preamble, CMS summarizes the rationale provided by the requestor and the results of CMS' mathematical analysis of claims data for these codes in the September 2025 update of the FY 2025 MedPAR file. After considering the C1 and C2 values of ICD-10-CM diagnosis code R53.2, the lack of consistent claims data to support a severity level change, and consideration of the nine guiding principles, CMS believes R53.2 should remain designated as an MCC.

Proposal: CMS proposed to maintain the severity level designation of ICD-10-CM diagnosis code R53.2 as an MCC for FY 2027.

[15] FY 2008 IPPS final rule (72 FR 47158).

Selected Comment/Response: Commenters supported CMS' proposal.

Final Action: CMS finalizes its proposal without modification.

(4) Malnutrition

For FY 2027, CMS received a request to change the severity level designation of the following diagnosis codes from MCC to NonCC: E40 (Kwashiorkor), E41 (Nutritional marasmus), E42 (Marasmic kwashiorkor), E43 (Unspecified severe protein-calorie malnutrition). CMS summarizes the rationale provided by the requestor and the results of CMS' mathematical analysis of claims data for these codes in the September 2025 update of the FY 2025 MedPAR file. After considering the C1 and C2 values of ICD-10-CM diagnosis codes E40, E41, E42, and E43, the lack of consistent claims data to support a severity level change, and consideration of the nine guiding principles, CMS believes that these codes should remain designated as MCCs.

Proposal: CMS proposed to maintain the severity level designation of ICD-10-CM diagnosis codes E40, E41, E42, and E43 as MCCs for FY 2027.

Selected Comment/Response: Commenters supported CMS' proposal.

Final Action: CMS finalizes its proposal without modification.

(5) Prolonged First Stage (of Labor)

For FY 2027, CMS received a request to change the severity level designation of ICD-10-CM diagnosis code O63.0 (Prolonged first stage (of labor)) from NonCC to CC. CMS summarizes the requestor's rationale and analyses in support of the request. To evaluate this request, CMS analyzed the claims data in the September 2025 update of the FY 2025 MedPAR file and presents the agency's findings in the preamble. After considering the C1 and C2 values of ICD-10-CM diagnosis codes O63.0 and O63.9, the lack of sufficient claims data to support a severity level change, and consideration of the nine guiding principles, CMS believes diagnosis code O63.0 should remain designated as a NonCC and diagnosis code O63.9 should remain designated as a CC.

Proposal: CMS proposed to maintain the severity level designations of ICD-10-CM diagnosis codes O63.0 and O63.9 for FY 2027.

Selected Comment/Response: A commenter supported CMS' proposal. Others requested that CMS reconsider its proposal, stating that a prolonged first stage labor frequently necessitates heightened medical management and procedural intervention. Several commenters recommended that CMS evaluate all codes in the O63 category to determine whether the severity level should be changed. In response, CMS reiterates that the lack of claims data prevents CMS from considering a severity change. However CMS also acknowledges that in the past, the agency has indicated it could make an exception for diagnoses related to newborns, maternity,

and congenital anomalies.[16] As a result, CMS may consider reevaluating this issue in future rulemaking.

Final Action: CMS finalizes its proposal without modification.

d. Additions and Deletions to the Diagnosis Severity Levels for FY 2027

Proposal: For FY 2027, CMS proposed additions to the diagnosis code MCC severity levels list and additions and deletions to the diagnosis code CC severity levels list found in Tables 6I.1, and 6J.1&2 associated with the proposed rule. These tables were made available on the CMS website for review.

Selected Comment/Response: Commenters agreed with the proposed additions to the MCC and CC lists as shown in tables 6I.1 and 6J.1 associated with the proposed rule. Commenters also generally agreed with the proposed deletions to the CC list as shown in table 6J.2 associated with the proposed rule.

Final Action: CMS is finalizing the severity levels as reflected in the following tables that are associated with the final rule: Table 6I.- Complete MCC List-FY 2027; Table 6I.1 - Additions to the MCC List-FY 2027; Table 6J.- Complete CC List-FY 2027; Table 6J.1- Additions to the CC List-FY 2027; and Table 6J.2- Deletions to the CC List-FY 2027. The tables can be found on the CMS website at: FY 2027 IPPS Final Rule Home Page | CMS

e. CC Exclusions List for FY 2027

Through prior rulemaking, CMS created the CC Exclusions List to preclude coding of CCs for closely related conditions, to preclude duplicative or inconsistent coding from being treated as CCs, and to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair.[17] CMS also established excluded secondary diagnoses using the five following principles:

(1) Chronic and acute manifestations of the same condition should not be considered CCs for one another;
(2) Specific and nonspecific (NOS) diagnosis codes for the same condition should not be considered CCs for one another;
(3) Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another;
(4) Codes for the same condition in anatomically proximal sites should not be considered CCs for one another; and
(5) Closely related conditions should not be considered CCs for one another.

[16] FY 2008 IPPS final rule (72 FR 47158).
[17] 52 FR 33143

The ICD-10 MS-DRGs Version 43.1 CC Exclusion List is included as Appendix C in the ICD-10 MS-DRG Definitions Manual at MS-DRG Classifications and Software | CMS and includes three lists identified as Part 1, Part 2, and Part 3. Part 1 is the list of all diagnosis codes that are defined as a CC or MCC when reported as a secondary diagnosis. A link is provided to a collection of diagnosis codes, which when reported as the principal diagnosis would cause the CC or MCC diagnosis to be considered as a NonCC. Part 2 is the list of diagnosis codes designated as an MCC only for patients discharged alive; otherwise, they are assigned as a NonCC. Part 3 is the list of diagnosis codes that are designated as a CC or MCC and included in the definition of the logic for the listed MS-DRGs. When reported as a secondary diagnosis and grouped to one of the listed MS-DRGs, the diagnosis is excluded from acting as a CC/MCC for severity in DRG assignment (that is, suppression logic).

Proposal: CMS proposed changes to the ICD-10 MS-DRGs Version 44 CC Exclusion List based on the diagnosis code updates as discussed in section II.C.13 of the FY 2027 IPPS proposed rule. Tables 6G.1, 6G.2, 6H.1, and 6H.2 associated with the proposed rule showed the changes and are available for review on the CMS website.

Selected Comment/Response: CMS did not receive any comments opposing the proposed CC Exclusions List.

Final Action: CMS has developed the finalized CC Exclusions List as displayed in Table 6G.1.-Secondary Diagnosis Order Additions to the CC Exclusions List-FY 2027; Table 6G.2.-Principal Diagnosis Order Additions to the CC Exclusions List-FY 2027; Table 6H.1.-Secondary Diagnosis Order Deletions to the CC Exclusions List-FY 2027; Table 6H.2.-Principal Diagnosis Order Deletions to the CC Exclusions List-FY 2027; and Table 6K.-Complete List of CC Exclusions-FY 2027. These tables are available on the CMS website at: FY 2027 IPPS Final Rule Home Page | CMS and reflect the additions, deletions, and complete list of CC Exclusions under Version 44 of the ICD-10 MS-DRGs.

13. Changes to the ICD-10-CM and ICD-10-PCS Coding Systems

Proposal: CMS proposed the MDC and MS-DRG assignments for the new diagnosis codes and procedure codes as set forth in Table 6A.–New Diagnosis Codes and Table 6B.–New Procedure Codes. The proposed severity level designations for the new diagnosis codes were set forth in Table 6A and the proposed O.R. status for the new procedure codes were set forth in Table 6B. These tables were available for review on the CMS website associated with the proposed rule. CMS notes that because code titles are adopted as part of the ICD-10 Coordination and Maintenance Committee meeting process, they are not subject to comment in the proposed or final rules.

Selected Comment/Response: While commenters supported the proposed code assignments, a few urged CMS to reevaluate the future MS-DRG mapping for code X28M3DC (the SESAME procedure) which will become effective with discharges on and after October 1, 2026, for FY 2027. In response, CMS states its intent to monitor the reporting of this code, consistent with annual rulemaking, to determine the most appropriate MS-DRG assignment from both a clinical

coherence and resource utilization perspective. Another commenter urged CMS to use a distinct ICD-10-PCS qualifier for active mechanical clearance of chest tubes. In response, CMS encourages individuals with comments about MS-DRG classifications to submit these comments no later than October 20, 2026, via MEARIS™ at https://mearis.cms.gov/public/home, so that they can be considered for possible inclusion in the annual proposed rule.

Final Action: CMS is finalizing the MDC and MS-DRG assignments for the new diagnosis codes and procedure codes as set forth in 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, and Table 6F.–Revised Procedure Code Titles. These tables are available at FY 2027 IPPS Final Rule Home Page | CMS

14. Changes to the Surgical Hierarchies

The surgical hierarchy is an ordering of surgical classes from most resource-intensive to least resource-intensive. It ensures that cases involving multiple surgical procedures are assigned to the MS-DRG associated with the most resource-intensive surgical class. The methodology for determining the most resource-intensive surgical class involves weighting the average resources for each MS-DRG by frequency to determine the weighted average resources for each surgical class. CMS provides examples of instances when a surgical class with a lower average cost is ordered above a surgical class with a higher average cost, such as "other O.R. procedures" and when differences between the average costs for two surgical classes is very small.

For issues pertaining to the surgical hierarchy, as with other MS-DRG related requests, CMS encourages interested parties to submit comments via (MEARIS™) at MEARIS™ | Home by October 20, 2026.

Proposal: Based on the proposed changes for FY 2027, CMS proposed to revise the surgical hierarchy for the Pre-MDC, MDC 05, MDC 08, MDC 10, MDC 11, MDC 12, and MDC 13 as illustrated in a table displayed in the proposed rule (and reproduced in the preamble of the final rule). CMS noted that the proposed rankings would be subject to revision based on the finalized policies.

Comment/Response: While several commenters supported the proposed surgical hierarchy, one disagreed with the sequencing for certain MDC 10 MS-DRGs, arguing that a partial foot amputation is clinically more complex than a soft tissue excision and should not be sequenced lower when both procedures are performed together. In response, CMS maintains its proposed surgical hierarchy because its established methodology orders surgical classes based on total calculated weighted average resource costs rather than the clinical complexity of individual procedure codes.

Final Action: CMS is finalizing its proposals to modify the existing surgical hierarchy, effective with the ICD-10 MS-DRGs Version 44, without modification. The finalized changes are also reflected in Appendix D MS-DRG Surgical Hierarchy by MDC and MS-DRG of the ICD-10

MS-DRG Definitions Manual, Version 44 available on the CMS website at MS-DRG Classifications and Software | CMS.

15. Maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems

The ICD-10-CM Coordination and Maintenance Committee is responsible for approving coding changes and developing errata, addenda, and other modifications to the ICD-10-CM to reflect newly developed procedures and technologies and newly identified diseases. In this co-chaired committee, the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) has lead responsibility for the ICD-10-CM diagnosis codes while CMS has lead responsibility for the ICD-10-PCS procedure codes. The official list of ICD-10-CM and ICD-10-PCS codes can be found at ICD-10 | CMS.

CMS summarizes Committee activity and its timeline related to coding changes for implementation in FY 2027 and FY 2028 and provides links to recordings and materials for the Committee's recent meetings. The Committee encourages public participation. Questions and comments concerning the procedure codes should be submitted to CMS at: ICDProcedureCodeRequest@cms.hhs.gov. Questions and comments on coding issues involving diagnosis codes may be submitted to CDC/NCHS at: nchsicd10cm@cdc.gov.

Based on coding updates described in the final rule preamble, effective October 1, 2026, there are a total of 74,879 ICD-10-CM diagnosis codes and 79,256 ICD-10-PCS procedure codes for FY 2027 as shown in the following table reproduced from the final rule:

ICD-10-CM	**ICD-10-PCS**
FY 2026 ICD-10-CM 74,719 total codes	FY 2026 ICD-10-PCS 79,193 total codes
FY 2027 ICD-10-CM 190 additions	FY 2027 ICD-10-PCS 101 additions
FY 2027 ICD-10-CM 30 deletions	FY 2027 ICD-10-PCS 38 deletions
FY 2027 ICD-10-CM 74,879 total codes	**FY 2027 ICD-10-PCS 79,256 total codes**

16. Replaced Devices Offered without Cost or with a Credit

a. Background

In the FY 2008 and FY 2012 final rules,[18,19] CMS discussed Medicare payment for devices that are replaced without cost or where credit for a replaced device is furnished to the hospital. CMS specified that if a hospital received a credit for a recalled device equal to 50 percent or more of the cost of the replacement device, CMS would reduce a hospital's IPPS payment for those MS-DRGs.

[18] 72 FR 47246 through 47251
[19] 76 FR 51556 and 51557

b. Changes for FY 2027

Proposal: As discussed elsewhere in section II.C of the preamble, CMS proposed adding, deleting, and reassigning certain MS-DRGs under MDC 05 and MDC 08. CMS noted that several of the procedures assigned to those affected MS-DRGs were already on the list of MS-DRGs subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit. Therefore, CMS proposed that if the applicable proposed MS-DRG changes were to be finalized, the agency also would add proposed new MS-DRGs 210, 211 and 449 to the list of MS-DRGs subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit. CMS also proposed to continue to include the existing MS-DRGs currently subject to the policy.

Selected Comment/Response: CMS did not receive any comments in opposition of its proposals.

Final Action: Because CMS finalized its proposals related to new MS-DRGs 210, 211, and 449, CMS is finalizing its proposal related to the list of MS-DRGs subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit. Additionally, CMS is finalizing its proposal to continue to include the existing MS-DRGs currently subject to the policy.

C. Recalibration of the MS-DRG Relative Weights

The Secretary is required by statute to revise the MS-DRG groups and weights annually to reflect changes in technology, medical practice, and other factors. CMS uses the MedPAR file (fully coded diagnostic and procedure data for all Medicare inpatient hospital bills for discharges in a fiscal year) from the 2nd year preceding the ratesetting year (e.g., FY 2025 for FY 2027). It also uses Medicare cost report data from the 3rd year preceding the ratesetting year (e.g., FY 2024 for FY 2027).

In developing relative weights for FY 2027, CMS used:

FY 2025 MedPAR data: Bills received through March 31, 2026, from all hospitals subject to the IPPS and short-term, acute care hospitals in Maryland (which at that time were under a waiver from the IPPS). Medicare Advantage (MA) claims and claims from facilities currently classified as CAHs are excluded. CMS used data from approximately 6,961,093 Medicare discharges regrouped using the FY 2027 final rule MS-DRG classifications.

FY 2024 Medicare Cost Reports: Medicare cost report data files from HCRIS, principally for FY 2024 cost reporting periods, using the March 31, 2026 update of the FY 2024 HCRIS.

For FY 2027, CMS did not propose any changes to its methodology and calculated MS-DRG weights using national averages for the 19 CCRs. Accompanying the final rule, CMS posted the version of the HCRIS cost report data file it used to calculate the 19 CCRs for FY 2027, available at: FY 2027 IPPS Final Rule Home Page | CMS. (Select file #4 under FY 2027 Final Rule Data files, "FY 2027 Final Rule: HCRIS Data File (ZIP)".)

In cases where an MS-DRG with a higher severity level has a lower weight than its base or lower severity level MS-DRG (known as non-monotonicity), CMS will calculate a single weight for both MS-DRGs based on their combined cases. For FY 2027, this will occur for MS-DRG 217 and MS-DRG 218 (Cardiac Valve and Other Major Cardiothoracic Procedure with Cardiac Catheterization), MS-DRG 504 and MS-DRG 505 (Foot Procedures), and MS-DRG 582 and 584 (Mastectomy for Malignancy).

Commenters expressed concern that the current MS-DRG payment methodology systematically disadvantages rural hospitals relative to urban hospitals, as recalibrations reduce payments for the lower-acuity cases rural hospitals predominantly treat while denying them the benefits of rising relative weights for complex cases they rarely see. Commenters suggested CMS adopt a CMI-based payment adjustment modeled after the low wage index hospital policy finalized in the FY 2020 IPPS rule.[20] CMS responded that its recalibration methodology uses the best available data consistent with the statutory requirement to adjust the MS-DRG relative weights at least annually to account for changes in relative resource consumption while maintain budget neutrality. The final rule further indicates that the planned change to the relative weight methodology to incorporate market based rate will improve the accuracy of the resulting relative weights.

National Average CCRs. The FY 2027 final CCRs in comparison to the final FY 2026 CCRs are shown in the following table:

Group	Final FY 2026 CCR	Proposed FY 2027 CCR
Routine Days	0.394	0.375
Intensive Days	0.335	0.320
Drugs	0.177	0.178
Supplies & Equipment	0.297	0.293
Implantable Devices	0.255	0.246
Inhalation Therapy	0.148	0.140
Therapy Services	0.256	0.253
Anesthesia	0.071	0.071
Labor & Delivery	0.373	0.379
Operating Room	0.153	0.149
Cardiology	0.086	0.084
Cardiac Catheterization	0.098	0.094
Laboratory	0.098	0.093
Radiology	0.123	0.120
MRIs	0.065	0.063
CT Scans	0.032	0.032
Emergency Room	0.139	0.132
Blood and Blood Products	0.230	0.230
Other Services	0.327	0.319

[20] The low wage index policy to which these commenters refer was struck down by a Federal Court in 2024. See *Bridgeport Hosp. v. Becerra*, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024)

Relative Weight Calculation for CAR-T Cell Therapy (MS-DRG 018). Beginning with FY 2021, CMS adopted differential payment for clinical trial and expanded access use cases (also known as compassionate use) where the hospital does not incur the costs of the CAR-T product. For FY 2027, CMS is continuing its methodology for identifying clinical trial claims and expanded access use claims in MS-DRG 018 by excluding claims from the relative weight calculation with the presence of condition code "90" and claims that contain ICD-10-CM diagnosis code Z00.6 without payer-only code "ZC" or contain standardized drug charges below the median standardized drug charge of clinical trial cases in MS-DRG 018 ($25,323).

CMS estimates that the average costs of cases assigned to MS-DRG 018 that are identified as clinical trial cases ($64,963) were 16 percent of the average costs of the cases assigned to MS-DRG 018 that are identified as non-clinical trial cases ($410,125). Accordingly, CMS applied a payment adjustor of 0.16 to the applicable clinical trial and expanded access use immunotherapy cases when determining the payment amount for these cases. Additionally, CMS will use an adjusted case count for these cases in determining the calculation of the relative weights and for purposes of budget neutrality and outlier simulations.

Cap for Relative Weight Reductions. Beginning in FY 2023, CMS adopted a 10 percent cap on reductions to the relative weights in a single year that would be subject to budget neutrality. CMS is continuing this policy unchanged for FY 2027.

Other Issues. CMS is normalizing the relative weights by an adjustment factor of 1.945743 so that the average case weight after recalibration is equal to the average case weight before recalibration. The normalization adjustment is intended to ensure that recalibration by itself does not increase or decrease total payments under the IPPS.

For very low volume MS-DRGs (less than 10 cases, generally those for newborns but may include other types of cases), CMS maintains the prior year relative weight and adjusts it by the average change in the relative weight for all MS-DRGs. This policy will apply to 8 MS-DRGs (7 for newborns and 1 for Vaginal Delivery with Sterilization and/or D&C with MCC).

D. Add-On Payments for New Services and Technologies

1. Background

The statute[21] requires the Secretary to establish a mechanism for recognizing new medical services and technologies under the IPPS which will be considered "new" if it meets criteria established by the Secretary in rulemaking. Once it meets criteria, the new technology may be considered for an add-on payment if the DRG payment rate that would otherwise apply is inadequate.[22] The implementing regulations[23] specify three criteria for a new medical service or technology to receive add-on payments under the IPPS: (1) the medical service or technology must be new; (2) the medical service or technology must be costly such that the DRG rate

[21] Subparagraphs (K) and (L) of section 1886(d)(5) of the Social Security Act
[22] Section 1886(d)(5)(K)(vi) of the Act
[23] 42 CFR 412.87

otherwise applicable to discharges involving the medical service or technology is determined to be inadequate;[24] and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. In addition, certain transformative new devices, Qualified Infectious Disease Products (QIDPs), and drug approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD pathway) may qualify for a new technology add-on payment under an alternative pathway.[25]

a. New Technology Add-on Payment Criteria

Newness Criterion. CMS notes that a technology is no longer "new" after CMS has recalibrated the MS-DRGs based on available data to reflect the cost of the technology. Further, even if a technology receives a new FDA approval, it may not necessarily be considered "new" for purposes of new technology add-on payments if it is "substantially similar" to another technology that was approved by FDA and has been on the market for more than 2 or 3 years. CMS uses three criteria for evaluating whether a new technology is substantially similar to an existing technology, specifically, whether: (1) a product uses the same or a similar mechanism of action to achieve a therapeutic outcome; (2) a product is assigned to the same or a different MS-DRG; and (3) the new use of the technology involves the treatment of the same or similar type of disease and the same or similar patient population.

If a technology meets all three of the criteria, CMS considers it substantially similar to an existing technology and, for purposes of the new technology add-on payments, will not consider the medical service or technology "new".[26]

Cost Criterion. The statute requires CMS to assess the new technology for payment adequacy. CMS therefore evaluates whether the charges of the cases involving a new technology will exceed a threshold amount that is the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 75 percent of one standard deviation beyond the geometric mean standardized for all cases in the MS-DRG to which the new technology is assigned. If the new technology is assigned to several MS-DRGs, CMS uses the case-weighted average of all the relevant MS-DRGs. In the preamble, CMS summarizes its policies for determining the threshold values. The MS-DRG threshold amounts generally used in evaluating new technology add-on payment applications for FY 2027 are presented in a data file that is available, along with the other data files associated with the FY 2026 IPPS/LTCH PPS final rule on the CMS website.

[24] Section 1886(d)(5)(K)(i) of the Act requires the Secretary establish a mechanism to recognize the costs of new medical services and technologies under the payment system established for paying for the operating costs of inpatient hospital services. The system of payment for capital costs is established under section 1886(g) of the Act. CMS does not include capital costs in the add-on payments for a new medical service or technology and new technology add-on payments are not made for capitol-related costs (72 FR 47307 through 47308).
[25] 84 FR 42292 through 42297; regulations at §412.87(c) and (d), and 85 FR 58736.
[26] For detailed discussion of the criteria for substantial similarity, see FY 2006 IPPS final rule (70 FR 47351 through 47352) and the FY 2010 IPPS/LTCH PPS final rule (74 FR 43813 through 43814).

CMS notes that applicants should submit a significant sample of data to demonstrate that the new technology meets the high-cost threshold which will allow CMS to undertake an initial validation and analysis of the data.

Substantial Clinical Improvement Criterion. Under the third criterion, a new technology must represent an advance that substantially improves, relative to available technologies, the diagnosis or treatment of Medicare beneficiaries. CMS reiterates[27] that it does not rely upon FDA criteria in its evaluation of substantial clinical improvement, and this criterion does not depend on the standard of safety and effectiveness used by the FDA. Rather, the CMS standard relies on a demonstration of substantial clinical improvement in the Medicare population. The following aspects[28] are used by CMS in its evaluation of substantial clinical improvement:

- The totality of circumstances is considered when making a determination of substantial clinical improvement.
- A determination of substantial clinical improvement, which means: (i) the new service or technology offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments; (ii) the ability to diagnose a medical condition that is currently undetectable or diagnoses the condition earlier than allowed by currently available methods, with evidence that the detection or early detection affects the management of the patient; (iii) a significant improvement of clinical outcomes relative to services or technologies previously available;[29] or (iv) the totality of the circumstances otherwise demonstrates substantial clinical improvements, relative to available technologies, for the diagnosis or treatment of Medicare beneficiaries.
- Evidence from published or unpublished sources[30] from the US or elsewhere may be sufficient to establish an advance that substantially improves, relative to available technologies, the diagnosis or treatment of Medicare beneficiaries.
- The medical condition diagnosed or treated may have a low prevalence among Medicare beneficiaries.
- The new technology may represent an advance that substantially improves, relative to available options, the diagnosis or treatment of a subpopulation of patients with the medical condition.

[27] Initially discussed in the FY 2003 IPPS final rule (67 FR 50015).
[28] Established in the FY 2020 IPPS final rule and codified at §412.87(b)
[29] This significant improvement can be demonstrated by one or more of the following: a reduction in at least one clinically significant adverse event, including a reduction in mortality or a clinically significant complication; a decreased rate of at least one subsequent diagnostic or therapeutic intervention; a decreased number of future hospitalizations or physician visits; a more rapid beneficial resolution of the disease process treatment including, but not limited to, a reduced length of stay or recovery time; an improvement in one or more activities of daily living; an improved quality of life; or a demonstrated greater medication adherence or compliance.
[30] Sources may include: clinical trials, peer reviewed journal articles, study results, meta-analyses, consensus statements, white papers, patient surveys, case studies, reports, systematic literature reviews, letters from major healthcare associations, editorials and letters to the editor, and public comments. Other appropriate information sources may be considered.

b. Alternative Inpatient New Technology Add-on Payment Pathway

CMS has established alternative pathways through which some devices and drugs may apply and qualify for new technology add-on payments. The alternative pathways apply to medical devices that are part of the FDA's Breakthrough Devices Program, certain microbial products that are designated by the FDA as a Qualified Infectious Disease Product (QIDP), and drugs approved by FDA under the Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD). To receive approval for the new technology add-on payment under the alternative pathways, the technology must have the applicable FDA designation and meet all other eligibility requirements in the regulations in §412.87(c) and (d), as applicable. Of note, CMS is finalizing a repeal of these alternative pathways, unless specifically grandfathered under the alternative pathway eligibility criteria (as discussed in section II.E.7. of this summary).

Alternative Pathway for Certain Transformative New Devices. A medical device qualifies for this alternative pathway if the device is part of the FDA's Breakthrough Devices Program and has received marketing authorization for the indication covered by the Breakthrough Device designation. Such devices will be considered "new" by CMS until CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical technology. Devices in this alternative pathway must meet the cost criterion previously discussed and established by CMS for new technology applications; however, devices in this alternative pathway are not required to meet the previously discussed substantial clinical improvement criteria that otherwise would apply to new technology applications.[31]

Alternative Pathway for Certain Antimicrobial Products. A medical product may qualify for consideration under this alternative pathway if the product is designated by FDA as a QIDP and received FDA marketing authorization, or it is a drug approved under FDA's LPAD pathway and used for that approved indication. Such products will be considered "new" by CMS until CMS has recalibrated the DRGs, based on available data, to reflect the costs of an otherwise new medical technology. Products in this alternative pathway must meet the cost criterion previously discussed and established by CMS for new technology applications; however, products in this alternative pathway are not required to meet the previously discussed substantial clinical improvement criteria that otherwise would apply to new technology applications.[32]

c. Additional Payment for New Medical Service or Technology

The new medical service or technology add-on payment policy under the IPPS provides additional payments for cases with relatively high costs involving eligible new medical services or technologies, while preserving some of the incentives inherent under an average-based prospective payment system. The payment mechanism is based on the cost to hospitals for the new medical service or technology. CMS does not include or make capital-related costs in these payments. Payments are made if the costs of a discharge involving a new technology exceed the full DRG payment (including payments for IME and DSH but excluding outlier payments).

[31] The governing regulatory eligibility criteria for a medical device that has received a Breakthrough Device designation are at §412.87(c).
[32] The governing regulatory eligibility criteria for QDIPs and LPADs are at §412.87(d).

Unless the discharge qualifies for an outlier payment, the additional Medicare payment will be limited to the full MS-DRG payment plus 65 percent (or 75 percent for a QDIP or LPAD) of the estimated costs of the new technology or medical service. CMS notes that add-on payments for new medical services or technologies are not subject to budget neutrality.[33] Additionally, CMS finalizes payment amounts in each fiscal year final rule and does not make mid-year changes to those amounts. Updated cost information may be submitted and included in rulemaking to be considered for the following fiscal year.

For new technologies, other than a medical product designated as a QIDP or a product approved under FDA's LPAD, for discharges on or after October 1, 2019: Medicare's add-on payment is equal to the lesser of: (i) 65 percent of the costs of the new technology; or (ii) 65 percent of the difference between the standard DRG payment and the cost of the case.

For medical products designated as a QIDP, for discharges on or after October 1, 2019: Medicare's add-on payment is equal to the lesser of: (i) 75 percent of the costs of the new technology; or (ii) 75 percent of the difference between the standard DRG payment and the hospital's cost for the case.

For a medical product approved under FDA's LPAD pathway, for discharges on or after October 1, 2020: Medicare's add-on payment is equal to the lesser of: (i) 75 percent of the costs of the new medical service or technology; or (ii) 75 percent of the amount by which the costs of the case exceed the standard DRG payment.

For certain gene therapies approved for add-on payments that are indicated and used specifically for the treatment of sickle cell disease (SCD), for discharges on or after October 1, 2024: Medicare's add-on payment is equal to the lesser of: (i) 75 percent of the costs of the new medical service or technology; or (ii) 75 percent of the amount by which the costs of the case exceed the standard DRG payment. CMS notes these payment amounts only apply to Casgevy™ (exagamglogene autotemcel) and Lyfgenia™ (lovotibeglogene autotemcel) which were approved for new technology add-on payments in the FY 2025 IPPS final rule, when indicated and used specifically for the treatment of SCD.

d. Evaluation of Eligibility Criteria for New Services or Technology Applications

When evaluating a new services or technology application, CMS first determines whether the medical service or technology meets the newness criterion, and if so, CMS then makes a determination as to whether the technology meets the cost threshold and represents a substantial clinical improvement. Beginning with new technology add-on payment applications for FY 2025, for technologies that are not already FDA market authorized for the indication that is the subject of the new technology add-on payment application, applicants must have a complete and active FDA market authorization request and must provide CMS with documentation of FDA acceptance (for a 510k application or De Novo Classification request) or filing (for a PMA,

[33] Section 503(d)(2) of Pub. L. 108-173 provides there will be no reduction or adjustments in aggregate payments under the IPPS due to add-on payments for new technologies.

NDA, or BLA)[34] at the time of application submission. CMS considers the application to be complete when the full application has been submitted to FDA and FDA has provided documentation to the applicant indicating that FDA has determined that the application is sufficiently complete to allow for substantive review by FDA.

CMS notes that the FDA does not conduct a new filing review for NDA or BLA applications that were the subject of a Complete Response Letter (CRL) and were subsequently resubmitted to FDA. To address this situation, for applications submitted for FY 2027, CMS requires these new technology add-on payment applicants to provide CMS a copy of the resubmission acknowledgement letter from FDA that indicates that FDA considers the resubmission to be sufficient to restart the review clock and provides the new goal date for FDA review of the application. CMS states that if other situations arise that are not addressed in the preamble, or if the FDA changes its review processes, then applicants must provide CMS the most up-to-date documentation that indicates FDA has determined that the application is sufficiently complete to allow for substantive review by FDA.

Finally, CMS specifies that all applicants for a new technology add-on payment (except for an application that is submitted under the alternative pathway for certain antimicrobial products) must have FDA approval or clearance[35] by May 1[36] of the year prior to the beginning of the fiscal year for which the application is being considered. CMS notes if the agency repeals the alternative pathway, as proposed, beginning with the FY 2028 new technology add-on payment applications, in order to be eligible for consideration for the new technology add on payment for the upcoming fiscal year, all applicants would need to receive FDA marketing authorization by May 1 of the year prior to the beginning of the fiscal year for which the application is being considered.

e. Pharmaceutical & Technology Ombudsman (PTO)

The CMS Pharmaceutical & Technology Ombudsman (PTO) (PharmTechOmbud@cms.hhs.gov is a resource to stakeholders to help assist with navigating the different CMS pathways for coverage, coding, and payment. Before contacting the PTO, CMS encourages stakeholders to first review resources available at New Medical Services and New Technologies | CMS and CMS Guide for Medical Technology Companies and Other Interested Parties | CMS.

f. Application Information for New Medical Services or Technologies

Applicants for add-on payments for new medical services or technologies for FY 2028 must submit a formal request, including a full description of the clinical applications of the medical service or technology and the results of any clinical evaluations demonstrating that the new

[34] FDA marketing authorization can include pre-market approval (PMA), 510(k) clearance, the granting of a De Novo classification request, or approval of a New Drug Application (NDA) or Biologics License Application (BLA)
[35] CMS considers FDA marketing authorization as representing that a product has FDA approval or clearance, as well as products that have been granted a De Novo classification request.
[36] CMS finalized a change from July 1 to May 1 in the FY 2024 IPPS/LTCH PPS final rule (88 FR 58948 through 58958) which applies to FY 2025 applications.

medical service or technology represents a substantial clinical improvement, along with a significant sample of data to demonstrate that the medical service or technology meets the high cost threshold. Complete application information will be posted as it becomes available at New Medical Services and New Technologies | CMS.

As is the agency's standard practice, at the time the IPPS proposed rule is published, CMS posts the applications online, including the completed application forms, certain related materials, and any additional updated application information submitted subsequent to the initial application, including (beginning FY 2027) the applicant's analysis of how its application meets the cost criterion. Certain volume, cost, and other information identified by the applicant as confidential is withheld. Applications that are withdrawn prior to the publication of a proposed rule are not publicly posted. In addition to transparency, the public posting of application materials allows CMS to more succinctly address add-on payment requests in the preamble of the IPPS proposed and final rules. The application information is posted at MEARIS™ | Publication | NTAP.

2. Public Input Before Publication of a Notice of Proposed Rulemaking on Add-On Payments

The law requires the Secretary to obtain public input before publication of a notice of proposed rulemaking regarding whether a medical service or technology represents a substantial clinical improvement.[37] As a result, on December 10, 2025, CMS held a virtual town hall meeting for the express purpose of discussing the "substantial clinical improvement criterion" for pending new technology applications.[38] Applicant presentations as well as written comments received by the December 15, 2025 deadline were considered by CMS in the development of the FY 2027 IPPS/LTCH proposed rule.

3. ICD-10-PCS Section "X" Codes for Certain New Medical Services and Technologies

Section "X" codes are ICD-10-PCS codes used to identify new medical services and technologies. Proposals to create, delete, or revise Section "X" codes under the ICD-10-PCS structure will be referred to the ICD-10 Coordination and Maintenance Committee. CMS encourages providers to review the guidelines for ICD-10-PCS Section "X" codes which can be found on the CMS website at: ICD-10 | CMS.

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

In this section of the preamble, CMS addresses the final FY 2027 status of 54 new technology add-on payments approved for FY 2026. CMS reminds the reader that a medical service or technology may be considered new within 2 or 3 years after the point at which data become available which reflects the inpatient hospital code assigned to the new service or technology. CMS' practice has been to begin and end new technology add-on payments on the basis of a fiscal year, generally following a guideline that uses a 6-month window before and after the start of the fiscal year to determine whether to extend an add-on payment for an additional fiscal year.

[37] Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Pub. L. 108-73.
[38] The recording of the virtual town hall is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/newtech.

In the FY 2025 IPPS final rule,[39] CMS finalized a new policy to extend new technology add-on payments for an additional fiscal year when the 3-year anniversary date of the product's entry onto the U.S. market occurs on or after October 1 of that fiscal year. This change is effective beginning with those technologies that are initially approved for new technology add-on payments in FY 2025 or a subsequent year. For technologies that were first approved for new technology add-on payments prior to FY 2025, including for technologies CMS determines to be substantially similar to those technologies, the agency continues to use the midpoint of the upcoming fiscal year (April 1) when determining whether a technology would still be considered "new" for purposes of new technology add-on payments.

Proposals: CMS proposed to continue new technology add-on payments for CONTEPO™ (fosfomycin) for FY 2026. Due to the increasing volume and complexity of circumstances in which applicants assert a delay in commercial availability, CMS proposed that the agency may consider a documented delay in the beginning of a technology's newness period due to commercial availability only until the new technology add-on payment becomes effective for the fiscal year for which the applicant applied for new technology add-on payments. As such, and consistent with this proposal, CMS proposed that the newness period for ZEVTERA® (which was subject to marketing delays) would have commenced on September 30, 2024. CMS invited public comments on its proposal to continue new technology add-on payments for FY 2027 for the technologies listed in Table II.E.-01, as displayed in the proposed rule preamble.

Additionally, CMS proposed to discontinue add-on payments for FY 2027 for the Ceribell Status Epilepticus Monitor in light of the fact that the manufacturer was seeking new technology add-on payments for a related product, the Ceribell Delirium Monitor System for FY 2027 which shares an ICD-10-PCS procedure code (XX20X89). Further, CMS noted that in the FY 2026 IPPS final rule, CMS responded to comments requesting that CMS recognize a delay in commercial availability of the SAINT Neuromodulation System to April 5, 2024, and subsequently extend its new technology add-on payment for FY 2026. After further consideration, and consistent with the proposal to consider a documented delay in the beginning of a technology's newness period due to commercial availability only until the new technology add-on payment becomes effective, CMS proposed to consider the beginning of the newness period for SAINT Neuromodulation System to be September 30, 2023. Because this is more than 3 years, the technology would no longer meet criteria for being new for FY 2027 and add-on payments would be discontinued. CMS invited public comment on its proposal to discontinue new technology add-on payments for FY 2027 for the technologies listed in Table II.E.-02 as displayed in the proposed rule preamble.

Selected Comment/Response: Multiple commenters supported CMS' proposed continuation of new technology add-on payments for FY 2027 for those technologies that were approved for the new technology add-on payment for FY 2026, and which would still be considered "new" for purposes of new technology add-on payments for FY 2027.

[39] FY 2025 IPPS/LTCH PPS final rule (89 FR 69238 through 69242)

Commenters were divided over CMS' proposal to align a technology's "newness period" with its actual commercial availability. Supporters backed the effort to increase transparency but urged a uniform standard that restricts extensions to hurdles beyond a manufacturer's control rather than routine launch activities. Meanwhile, opponents argued that the restrictive cap penalizes responsible launches, shortens critical hospital integration time, and skews Medicare rate-setting data with zero-claim periods—advocating instead for case-by-case reviews and specialized timing rules for low-volume cell and gene therapies. In response, the agency believes its proposed policy preserves case-by-case evaluation flexibility while rejecting any specialized exceptions or transition timelines for specific technology categories, and that it will ensure a predictable framework and prevent technologies from inappropriately receiving four or more years of add-on payments.

In response to updated average cost information submitted by the applicants for the AGENT™ Paclitaxel-Coated Balloon Catheter and CONTEPO™, CMS updated the information in Table II.E.-01 accordingly. The applicant for the AeroPace® System provided additional information on the technology's commercial availability delay and requested that CMS extend the technology's newness date to align with its commercial availability on October 16, 2025.

The applicants for the TOPS™ and DETOUR Systems requested a 12-month extension of their new technology add-on payments (NTAP) because CMS deferred their MS-DRG reassignment requests for FY 2027. CMS disagrees that an extension is warranted for these technologies noting that both the TOPSTM System and the DETOUR System were eligible for new technology add-on payment for three years, from FY 2024 through FY 2026. CMS notes that no comments were received on the proposal to discontinue add-on payments for the SAINT Neuromodulation System.

Final Action: CMS is finalizing:

- Continuation of new technology add-on payments for FY 2027 for the technologies as listed in Table II.E.-01 (reproduced from the final rule preamble below); CMS is finalizing with modifications.
- Discontinuation of new technology add-on payments for FY 2027 for the technologies as listed in Table II.E.-02 (reproduced from the final rule preamble below); CMS is finalizing as proposed.
- For a technology that is not yet available for sale when its new technology add-on payment becomes effective, CMS will consider the newness period to begin on the date preceding the start of the new technology add-on payment for the technology.
    - CMS will consider the beginning of the newness period for ZEVTERA® to commence on September 30, 2024, as proposed.
    - CMS will consider the beginning of the newness period for the AeroPace® System to commence on September 30, 2025.
    - CMS will consider the beginning of the newness period for SAINT Neuromodulation System to be September 30, 2023 and discontinue add-on payments, as proposed.

- Updates to the cost information for AGENT™ Paclitaxel-Coated Balloon Catheter™ and CONTEPO™ (see Table II.E.-01).

TABLE II.E.-01: 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

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	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*	89 FR 69205 through 69208 90 FR 36665 through 36669	$241.39	XXE0X1A
2	*ASTar® System*	*04/26/2024*	*10/01/2024*	*04/26/2027*	89 FR 69208 through 69210 90 FR 36665 through 36669	$97.50	XXE5X2A
3	*Edwards EVOQUE™ Tricuspid Valve Replacement System ("EVOQUE™ System")*	*02/01/2024*	*10/01/2024*	*02/01/2027*	89 FR 69210 through 69213 90 FR 36665 through 36669	$31,850.00	X2RJ3RA
4	*GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device)*	*01/12/2024*	*10/01/2024*	*01/12/2027*	89 FR 69213 through 69215 90 FR 36665 through 36669	$47,238.75	X2VE3SA
5	*LimFlow™ System*	*11/01/2023*	*10/01/2024*	*11/01/2026*	89 FR 69215 through 69218 90 FR 36665 through 36669	$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*	89 FR 69218 through 69221 90 FR 36665 through 36669	$14,950.00	X051329
7	*PulseSelect™ Pulsed Field Ablation (PFA) Loop Catheter*	*12/13/2023*	*10/01/2024*	*12/13/2026*	89 FR 69221 through 69225 90 FR 36665 through 36669	$6,337.50	02583ZF
8	*Symplicity Spyral™ Multi-Electrode Renal Denervation Catheter*	*11/17/2023*	*10/01/2024*	*11/17/2026*	89 FR 69225 through 69228 90 FR 36665 through 36669	$10,400.00	X05133A
9	*TriClip™ G4*	*04/01/2024*	*10/01/2024*	*04/01/2027*	89 FR 69228 through 69230 90 FR 36665 through 36669	$26,000.00	02UJ3JZ

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
10	*VADER® Pedicle Syste*	*02/26/2024*	*10/01/2024*	*02/26/2027*	89 FR 69230 through 69236 90 FR 36665 through 36669	$28,242.50	XRH60FA, XRH63FA, XRH64FA, XRH70FA, XRH73FA, XRH74FA, XRH80FA, XRH83FA, XRH84FA, XRHA0FA, XRHA3FA, XRHA4FA, 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*	89 FR 69236 through 69238 90 FR 36665 through 36669	$5,287.50	XW0335A or XW0435A
12	*ZEVTERA™ (ceftobiprole medocaril); SAB indication*	*09/30/2024*	*10/01/2024*	*09/30/2027*	89 FR 69236 through 69238 90 FR 36665 through 36669	$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 indication*	*12/08/2023*	*10/01/2024*	*12/08/2026*	89 FR 69128 through 69135 90 FR 36665 through 36669	$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
14	*HEPZATO™ KIT (melphalan for injection/hepatic delivery system)*	*01/08/2024*	*10/01/2024*	*01/08/2027*	89 FR 69158 through 69170 90 FR 36665 through 36669	$118,625.00	XW053T9 in combination with 5A1C00Z
15	*LYFGENIA™ (lovotibeglogene autotemcel)*	*12/08/2023*	*10/01/2024*	*12/08/2026*	89 FR 69188 through 69196 90 FR 36665 through 36669	$2,325,000.00	XW133H9 or XW143H9
16	*4WEB Medical Ankle Truss System*	*01/31/2025*	*10/01/2025*	*01/31/2028*	90 FR 36770 through 36773	$15,275.00	XRGJ0B9, XRGK0B9, XRGL0B9, or XRGM0B9
17	*AeroPace® System*	*09/20/2025*	*10/01/2025*	*09/30/2028*	90 FR 36773 through 36776	$23,650.90	X2H13XB
18	*AGENT™ Paclitaxel-Coated Balloon Catheter*	*02/29/2024*	*10/01/2025*	*02/29/2027*	90 FR 36776 through 36779	$4,776.36	XW0J3HA, XW0J3JA, XW0J3KA, XW0J3LA, XW0K3HA, XW0K3JA, XW0K3KA, XW0K3LA, XW0L3HA,

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
							XW0L3JA, XW0L3KA, XW0L3LA, XW0M3HA, XW0M3JA, XW0M3KA, or XW0M3LA
19	*alfapump® system*	*12/20/2024*	*10/01/2025*	*12/20/2027*	90 FR 36779 through 36781	$21,450.00	0W1G3J6 in combination with 0JH80YZ
20	*aprevo®-C cervical interbody fusion device*	*11/15/2024*	*10/01/2025*	*11/15/2027*	90 FR 36781 through 36784	$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*	90 FR 36784 through 36786	$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*	90 FR 36786 through 36792	$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*	90 FR 36792 through 36795	$6,922.50	X27P3TA, X27Q3TA, X27R3TA, X27S3TA, X27T3TA, or X27U3TA
24	*EUROPA™ Posterior Cervical Fusion System*	*11/19/2024*	*10/01/2025*	*11/19/2027*	90 FR 36795 through 36798	$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*	90 FR 36798 through 36803	$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*	90 FR 36803 through 36806	$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*	90 FR 36806 through 36808	$22,685.00	X27339B, X27439B, X27W39B, or X27X39B
28	*MY01 Continuous Compartmental Pressure Monitor*	*04/29/2025*	*10/01/2025*	*04/29/2028*	90 FR 36808 through 36810	$2,112.50	XX2F3W9
29	*PBC Separator with Selux AST System*	*02/15/2024*	*10/01/2025*	*02/15/2027*	90 FR 36810 through 36813	$87.78	XXE5XY9
30	*restor3d TIDAL™ Fusion Cage*	*03/24/2025*	*10/01/2025*	*03/24/2028*	90 FR 36817 through 36819	$18,196.75	XRGK0CA, XRGM0CA, XRGJ0CA, or XRGL0CA

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
31	*ShortCut™*	*09/27/2024*	*10/01/2025*	*09/27/2027*	90 FR 36819 through 36821	$9,750.00	X28F3VA
32	*The WiSE CRT System*	*04/11/2025*	*10/01/2025*	*04/11/2028*	90 FR 36821 through 36823	$41,145.00	X2HN37B in combination with XHH80HB
33	*TriVerity Test*	*01/10/2025*	*10/01/2025*	*01/10/2028*	90 FR 36823 through 36826	$243.75	XXE5XBB
34	*VITEK® REVEAL™ AST System*	*10/21/2024*	*10/01/2025*	*10/21/2027*	90 FR 36826 through 36829	$81.25	XXE5X4A
35	*EMBLAVEO™ (aztreonam-avibactam)*	*02/07/2025*	*10/01/2025*	*02/07/2028*	90 FR 36829 through 36831	$9,000.68	XW033PB or XW043PB
36	*CONTEPO™ (fosfomycin)*	*10/22/2025*	*01/01/2026*	*10/22/2028*	90 FR 36831 through 36834	$4,111.65	XW033WB or XW043WB
37	*AURLUMYN™ (iloprost injection)*	*11/01/2024*	*10/01/2025*	*11/01/2027*	90 FR 36680 through 36687	$28,600.00	XW033QB or XW043QB
38	*BREYANZI® (lisocabtagene maraleucel)*	*03/14/2024*	*10/01/2025*	*03/14/2027*	90 FR 36687 through 36695	$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*	90 FR 36707 through 36717	$21,411.00	XW03388 or XW04388
40	*IMDELLTRA® (tarlatamab-dlle)*	*05/16/2024*	*10/01/2025*	*05/16/2027*	90 FR 36717 through 36727	$7,117.50	XW033NA or XW043NA
41	*TECELRA® (afamitresgene autoleucel)*	*08/01/2024*	*10/01/2025*	*08/01/2027*	90 FR 36753 through 36761	$472,550.00	XW03368 or XW04368

TABLE II.E.-02: DISCONTINUATION OF TECHNOLOGIES APPROVED FOR FY 2026 NEW TECHNOLOGY ADD-ON PAYMENTS NO LONGER CONSIDERED NEW FOR FY 2027

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
1	*CYTALUX® (pafolacianine) (lung indication)*	*06/05/2023*	*10/01/2023*	*06/05/2026*	88 FR 58810 through 58818 89 FR 69120 through 69126 90 FR 36665 through 36669
2	*EPKINLY™ (epcoritamab-bysp) and COLUMVI™ (glofitamab-gxbm)*	*05/19/2023*	*10/01/2023*	*05/19/2026*	88 FR 58818 through 58835 89 FR 69120 through 69126

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
					90 FR 36665 through 36669
3	*Aveir™ AR Leadless Pacemaker*	*06/29/2023*	*10/01/2023*	*06/29/2026*	88 FR 58919 through 58923 89 FR 69120 through 69126 90 FR 36665 through 36669
4	*Aveir™ Dual-Chamber Leadless Pacemaker*	*06/29/2023*	*10/01/2023*	*06/29/2026*	88 FR 58923 through 58925 89 FR 69120 through 69126 90 FR 36665 through 36669
5	*Ceribell Status Epilepticus Monitor*	*05/23/2023*	*10/01/2023*	*05/23/2026*	88 FR 58927 through 58930 89 FR 69120 through 69126 90 FR 36665 through 36669
6	*DETOUR System*	*06/07/2023*	*10/01/2023*	*06/07/2026*	88 FR 58930 through 58932 89 FR 69120 through 69126 90 FR 36665 through 36669
7	*DefenCath® (taurolidine/heparin)*	*11/15/2023*	*01/01/2024*	*11/15/2026*	88 FR 58942 through 58944 89 FR 69120 through 69126 90 FR 36665 through 36669
8	*Phagenyx® System*	*04/12/2023*	*10/01/2023*	*04/12/2026*	88 FR 58935 through 58937 89 FR 69120 through 69126 90 FR 36665 through 36669
9	*REZZAYO™ (rezafungin for injection)*	*07/19/2023*	*10/01/2023*	*07/19/2026*	88 FR 58944 through 58946 89 FR 69120 through 69126 90 FR 36665 through 36669
10	*SAINT Neuromodulation System*	*09/30/2023*	*10/01/2023*	*09/30/2026*	88 FR 58937 through 58939 89 FR 69120 through 69126 90 FR 36670 through 36673
11	*TOPS™ System*	*06/15/2023*	*10/01/2023*	*06/15/2026*	88 FR 58940 through 58942 89 FR 69120 through 69126 90 FR 36665 through 36669
12	*XACDURO® (sulbactam/durlobactam)*	*05/23/2023*	*10/01/2023*	*05/23/2026*	88 FR 58946 through 58948 89 FR 69120 through 69126 90 FR 36665 through 36669

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
13	*RECELL® Autologous Cell Harvesting Device*	*06/07/2023*	*10/01/2025*	*06/07/2026*	90 FR 36813 through 36817

***** RECELL® Autologous Cell Harvesting Device was first approved for new technology add-on payments in FY 2026 and is no longer considered new for FY 2027 because the 3-year anniversary date will occur prior to October 1, 2026. All the rest of the technologies were first approved for new technology add-on payments prior to FY 2025 and are no longer considered new for FY 2027 because the 3-year anniversary date will occur prior to April 1, 2027.

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

Because CMS publicly posts applications for new technology add-on payment on MEARIS, CMS provides a succinct summary of each technology and its application in the proposed and final rules. The publicly posted FY 2027 new technology add-on payment applications and supporting information, including tables listing the ICD-10-CM codes, ICD-10-PCS codes, and/or MS-DRGs related to the analyses of the cost criterion for certain technologies, can be found here: https://mearis.cms.gov/public/publications/ntap.

CMS received 15 applications for new technology add-on payments for FY 2027 under the new technology add-on payment traditional pathway. Of these, 3 applicants were not eligible for consideration for new technology add-on payment because they did not meet the requirements, and 4 applicants withdrew their applications prior to the issuance of the proposed rule. CMS addressed the remaining 8 applications in the proposed rule. Prior to issuance of the final rule, one application (for Orca-T) was withdrawn. HPA has provided a summary table of CMS' final determination for new technology add-on payments for the remaining 7 technologies below. Details for each determination are summarized below the table.

CMS' Final Determination for Technologies Evaluated under the Traditional Pathway for New Technology Add-On Payment for FY 2027			
Technology	**Newness Date**	**Maximum New Tech Add-on Payment for FY 2027**	**Final Determination and Application Link**
COBENFY™ (xanomeline and trospium chloride)	10/09/2024	N/A	Denied: Unable to determine substantial clinical improvement MEARIS™ | Publication | ntap | NTP251006PD218
Command Center Electronic Glycemic Management System	08/04/2017	N/A	Denied: The technology does not meet the newness criterion MEARIS™ | Publication | ntap | NTP251005YD7PG
GAMIFANT® (emapalumab-lzsg)	06/27/2025	$672,756.50	Approved MEARIS™ | Publication | ntap | NTP250926GGG85
RAPIBLYK™ (landiolol)	12/31/1986	N/A	Denied: The technology does not meet the newness criterion. MEARIS™ | Publication | ntap | NTP251006EVR3D
WASKYRA™ (etuvetidigene autotemcel)	Commercial delay	N/A	Denied: Unable to determine newness or substantial clinical improvement. MEARIS™ | Publication | ntap | NTP2510033XJPK
YARTEMLEA® (narsoplimab-wuug)	12/23/2025	$287,079	Approved. MEARIS™ | Publication | ntap | NTP251006R7LMC

CMS' Final Determination for Technologies Evaluated under the Traditional Pathway for New Technology Add-On Payment for FY 2027			
Technology	**Newness Date**	**Maximum New Tech Add-on Payment for FY 2027**	**Final Determination and Application Link**
ZEVASKYN™ (prademagene zamikeracel)	06/15/2025	$2,045,550	Approved. MEARIS™ | Publication | ntap | NTP251003GPVPQ

a. COBENFY™ (xanomeline and trospium chloride)

Bristol Myers Squibb submitted a FY 2027 application for new technology add-on payments for COBENFY™ which is an oral combination drug consisting of xanomeline, a muscarinic agonist, and trospium chloride, a muscarinic antagonist, indicated for the treatment of schizophrenia in adults.

Proposed Rule: CMS expressed concerns regarding whether COBENFY™ met the substantial clinical improvement criterion. Despite the additional studies submitted by the applicant in response to the New Technology Town Hall meeting, CMS continued to question the applicant's assertions. CMS therefore proposed to disapprove new technology add-on payments for COBENFY™ for FY 2027.

Selected Comment/Response: A few commenters expressed support for approving the new technology add-on payments for COBENFY™ citing its benefits for patients and submitted anecdotal evidence for the benefits of COBENFY™ over other medications for schizophrenia. CMS expresses appreciation for the input of commenters and reiterates the need for data to support a substantial clinical improvement. The applicant submitted comments in response to CMS' concerns, questioning CMS' evidentiary standard for 'substantial clinical improvement' and CMS' application of its regulations, as described in more detail in the preamble of the final rule. In response, CMS disagrees that the agency has misapplied the regulations and states it is not imposing evidentiary standards beyond those set forth in §412.87.

Final Action: CMS continues to be unable to determine that COBENFY™ represents a substantial clinical improvement over existing technologies for the reasons discussed in the proposed and final rules, and therefore, CMS is not approving new technology add-on payments for COBENFY™ for FY 2027.

b. Command Center Electronic Glycemic Management System

Glytec, LLC submitted a FY 2027 application for new technology add-on payments for Command Center Electronic Glycemic Management System (Command Center) which is an electronic medical record (EMR)-integrated cloud-based software designed to maintain blood glucose in hospitalized patients by recommending personalized insulin dosing. According to the applicant, the technology utilizes inputs collected from EMRs to direct ongoing insulin dosage management and daily monitoring related glycemic variables (such as labs and diet) during an inpatient stay until insulin is discontinued or the patient is sent home. Per the applicant, direct

per-patient charge for the use of Command Center follows a subscription model. The applicant has submitted a request for a unique ICD-10-PCS code.

Proposed Rule: Based on evidence submitted by the applicant, CMS was unable to establish the technology's newness, stating its belief that the newness period for this technology would have commenced on August 4, 2017, and that the technology is substantially similar to the predicate device. Additionally, CMS was unable to determine whether Command Center met the cost criterion for new technology add-on payment. Finally, CMS raised a number of concerns related to the substantial clinical improvement criterion. Thus, CMS proposed to disapprove new technology add-on payments for Command Center for FY 2027.

Selected Comment/Response: The applicants submitted several comments responding to CMS' concerns. For example, regarding newness, the applicant asserted that CMS' newness criterion turns on the availability of billing data and this technology has never had a billing code to generate such data. In response, CMS disagrees and reiterates its earlier findings related to 'newness' in accordance with its regulations. CMS states that the agency received public comments related to the cost and substantial clinical improvement criteria, however, these are not summarized in the final rule, due to CMS' final determination that this technology does not meet the newness criterion.

Final Action: CMS has determined that the technology does not meet the newness criterion and therefore is not eligible for approval for new technology add-on payments for FY 2027.

c. GAMIFANT® (emapalumab-lzsg)

Sobi, Inc. submitted an FY 2027 application for new technology add-on payments for GAMIFANT® which is an interferon gamma (IFNγ) blocking antibody that targets and neutralizes IFNγ to stop the hyperinflammatory feedback loop of macrophage activation syndrome (MAS). The applicant is seeking new technology add-on payments for GAMIFANT® for its indication for the treatment of adult and pediatric (newborn and older) patients with hemophagocytic lymphohistiocytosis (HLH)/MAS in known or suspected Still's disease, including systemic Juvenile Idiopathic Arthritis (sJIA), with an inadequate response or intolerance to glucocorticoids, or with recurrent MAS.

Proposed Rule: CMS stated its belief that the technology met the newness and cost criterion, but expressed concerns related to the substantial clinical improvement criterion and therefore proposed to disapprove new technology add-on payments for GAMIFANT® for FY 2027.

Selected Comment/Response: The applicant submitted comments supporting CMS' proposed newness date and cost assessment. Additionally, the commenter submitted responses to CMS' concerns related to substantial clinical improvement, in particular, supportive information related to how the technology provides a treatment option for patients who are unresponsive to, or ineligible for, currently available treatments. CMS considered this additional information and agrees with the commenters.

Final Action: CMS is approving GAMIFANT® for new technology add-on payments for FY 2027, with a newness period to commence on June 27, 2025. Cases involving the use of GAMIFANT® that are eligible for new technology add-on payments will be identified by ICD-10-PCS code XW033MA or XW043MA in combination with any of the 18 ICD-10-CM codes listed in a table in the final rule preamble. The maximum new technology add-on payment for a case involving the use of GAMIFANT® is $672,756.50 for FY 2027.

d. RAPIBLYK™ (landiolol)

AOP Health US LLC submitted a FY 2027 application for new technology add-on payments for RAPIBLYK™ which is a beta-1 (β1) adrenergic blocker that inhibits adrenaline and noradrenaline's effects on the heart for short-term reduction of ventricular rate in adults with supraventricular tachycardia (SVT), including atrial fibrillation (AF) and atrial flutter (AFL).

Proposed Rule: In the proposed rule, CMS raised concerns related to the newness criterion; specifically, CMS expressed concerns that RAPIBLYK™ and esmolol are substantially similar to each other. CMS also expressed interest in learning more about the technology's marketing delay. Finally, CMS was unable to determine that RAPIBLYK™ represents a substantial clinical improvement over existing technologies. In light of these issues, CMS proposed to disapprove FY 2027 new technology add-on payments for RAPIBLYK™ for FY 2027.

Selected Comment/Response: The applicant provided information to CMS about the marketing delay and stated that the technology's mechanism of action is different than other similar technologies and treats a different disease and patient population. In addition, the applicant commented on CMS' flexibility to define substantial similarity and recommended CMS apply those criteria consistently with the statute and regulations. In response, CMS disagrees with the applicant and commenters that RAPIBLYK™ has a different mechanism of action (in fact, the mechanism of action that is the same is the one that achieves the therapeutic effect for esmolol) and treats a different disease and patient population. CMS agrees that the agency should apply its long-standing policies consistently when reviewing new technologies for add-on payments, as reflected in its assessment of this technology.

Final Action: Because RAPIBLYK™ is substantially similar to esmolol, CMS considers the beginning of the newness period for RAPIBLYK™ to begin on the date that esmolol became commercially available. Because esmolol has been on the U.S. market since December 31, 1986, the 3-year anniversary of its entry onto the market occurred prior to FY 2027, and therefore, RAPIBLYK™ does not meet the newness criterion and is not eligible for new technology add-on payments for FY 2027.

e. WASKYRA™ (etuvetidigene autotemcel)

Fondazione Telethon submitted an FY 2027 application for new technology add-on payments for WASKYRA™ which is a one-time, cell-based autologous gene therapy indicated for the treatment of pediatric patients 6 months and older and adults with Wiskott-Aldrich Syndrome (WAS) who have a mutation in the WAS gene for whom hematopoietic stem cell transplantation

(HCT) is appropriate and no suitable human leukocyte antigen (HLA)-matched related stem cell donor is available.

Proposed Rule: In the proposed rule, CMS questioned the eligibility of WASKYRA™ to qualify for a new technology add-on payment based on the agency's inability to determine newness, including questions regarding whether the technology was substantially similar to existing technologies. Additionally, CMS was unable to determine that WASKYRA™ represents a substantial clinical improvement over existing technologies. Therefore, CMS proposed to disapprove new technology add-on payments for WASKYRA™ for FY 2027.

Selected Comment/Response: CMS did not receive any comments addressing the agency's questions and concerns. As such, CMS continues to be unable to establish that the technology meets criteria for a new technology add-on payment.

Final Action: CMS is not approving new technology add-on payments for WASKYRA™ for FY 2027.

f. YARTEMLEA® (narsoplimab-wuug)

Omeros Corporation submitted an FY 2027 application for new technology add-on payments for YARTEMLEA® (narsoplimab-wuug) which is a fully human monoclonal antibody designed to treat and alleviate the detrimental consequences of hematopoietic stem cell transplant-associated thrombotic microangiopathy (TATMA) by targeting and inhibiting mannan-binding lectin-associated serine protease 2 (MASP-2), an effector enzyme that activates the lectin pathway of the complement system. CMS notes that the applicant submitted an application for new technology add-on payments for this technology for FY 2022 and FY 2023.

Proposed Rule: CMS did not express concerns related to newness and noted YARTEMLEA® received FDA market authorization on December 23, 2025. Regarding substantial similarity, CMS agreed that YARTEMLEA® has a new mechanism of action and treats a new type of disease or patient population compared to existing technologies. CMS agreed that the technology met the cost criterion. Regarding the substantial clinical improvement criterion, CMS noted that this technology is the first and only FDA-approved treatment option for patients who develop TA-TMA and offers a treatment option for patients who have failed prior treatment with other available therapies including C5 inhibitors and other TA-TMA directed therapies with a one-year overall survival (OS) of 42.7 percent (95% CI: 19.7, 65.8) in adult patients. Therefore, CMS proposed to approve YARTEMLEA® for new technology add-on payments for FY 2027.

Selected Comment/Response: The applicant submitted comments agreeing with CMS' assessment and provided additional cost information.

Final Action: CMS is approving new technology add-on payments for YARTEMLEA® for FY 2027 with a maximum new technology add-on payment of $287,079. Cases involving the use of YARTEMLEA® that are eligible for new technology add-on payments will be identified by ICD-10-PCS code XW03357 or XW04357. CMS considers the beginning of the newness period to commence on December 23, 2025.

g. ZEVASKYN™ (prademagene zamikeracel)

Abeona Therapeutics®, Inc. submitted an FY 2027 application for new technology add-on payments for ZEVASKYN™ which is an autologous cell sheet-based gene therapy which contains functional copies of the collagen type VII alpha 1 chain (COL7A1) transgene for the treatment of adult and pediatric patients with recessive dystrophic epidermolysis bullosa (RDEB).

Proposed Rule: CMS expressed interest in receiving additional information from the technology related to its marketing delay. CMS stated its belief that the technology met newness criteria and was not substantially similar to existing technologies. However, CMS as unable to determine that ZEVASKYN™ represents a substantial clinical improvement over existing technologies, and therefore proposed to disapprove new technology add-on payments for ZEVASKYN™ for FY 2027.

Selected Comment/Response: The applicant submitted information, as requested, regarding the delay in commercial availability. Based on this information, CMS considers the beginning of the newness period to commence on June 15, 2025. In addition, the applicant addressed CMS' questions and concerns related to substantial clinical improvement. For example, the applicant supplied additional detail and data related to use of the technology for treating wounds, and asserted that CMS' comparison with VYJUVEK® and FILSUVEZ® is not scientifically supportable, because these treatments have different mechanisms of action, are categorically distinct, and achieve different clinical outcomes and are thus not interchangeable. As a result, CMS agrees that ZEVASKYN™ represents a substantial clinical improvement over existing technologies because ZEVASKYN™ is a one-time gene therapy for the treatment of large, chronic wounds up to 495 cm2 and significantly reduces pain in patients with RDEB, with a mean change in wound pain from baseline to week 24 of –3.07 points (mean pairwise difference –2.23 [–3.45 to –0.66]; p=0.0002). In contrast, the available data for VYJUVEK® and FILSUVEZ® did not demonstrate statistically significant reductions in pain from baseline (at timepoints beyond 14 days for FILSUVEZ®).

Final Action: CMS is approving new technology add-on payments for ZEVASKYN™ for FY 2027 with a maximum new technology add-on payment of $2,045,550. Cases involving the use of ZEVASKYN™ that are eligible will be identified by any of the following ICD-10-PCS codes: XHR0XGA, XHR1XGA, XHR2XGA, XHR3XGA, XHR4XGA, XHR5XGA, XHR6XGA, XHR7XGA. CMS considers the beginning of the newness period to commence on June 15, 2025.

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

Under alternative Medicare pathways introduced in FY 2021 and FY 2022, FDA-designated Breakthrough Devices, QIDPs, and LPAD products do not need to meet the requirement that it represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries. However, to qualify for a new technology add-on payment, the product must still meet the standard cost criteria and be within the 2-to-3-

year newness period. As discussed in section II.E.7., CMS is finalizing a repeal of the alternative pathway for new technology add-on payment.

Detailed application information and supporting documentation for each application is posted on the CMS MEARIS website: https://mearis.cms.gov/public/publications/ntap. Table 10 (associated with the final rule, but posted on the CMS website at: FY 2027 IPPS Final Rule Home Page | CMS) includes the finalized ICD-10 PCS codes or ICD-10-CM codes that would be used to identify the relevant indication, or exclude cases related to a different technology, for these technologies for purposes of the new technology add-on payment for FY 2027.

CMS received 32 applications for new technology add-on payments for FY 2027 under the new technology add-on payment alternative pathway. Of these, seven applications were not eligible for consideration for new technology add-on payment and three applications were withdrawn prior to the issuance of the proposed rule. The remaining 22 technologies received a Breakthrough Device designation from FDA and were considered by CMS in the proposed rule. Subsequently, prior to issuance of the final rule, five additional applicants (CERAMENT® V, MediBeacon® Transdermal GFR Measurement System, 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. The remaining 17 applications are addressed by CMS in the final rule.

In the proposed rule, CMS noted that it had received multiple applications for subscription-based technologies for FY 2027, and further recognized that there are unique circumstances with respect to determining a cost per case for a technology that uses a subscription to establish its cost. CMS welcomed comments from the public as to the appropriate method to determine a cost-per-case for such technologies, including comments on whether the cost analysis should be updated based on the most recent subscriber data for each year for which the technology may be eligible for add-on payment.

Comment/Response: Commenters expressed mixed views on New Technology Add-on Payments (NTAP) for hospital software, with one opposing its use for enterprise-wide EHR investments and another advocating for clear pathways for establishing costs for AI and subscription-based solutions. In response, CMS indicates recognition that software-based, subscription-based, EHR-integrated, and artificial intelligence-driven technologies may present differently than technologies that are furnished as a more discrete item or service during an inpatient stay. While CMS is not adopting any cost-reporting changes for IT applications or software, the agency may consider whether further analysis of cost-reporting treatment for clinical software or EHR integrated tools would be appropriate in future rulemaking and whether the cost analyses should be updated for each year for which the technology may be eligible for add-on payment.

For this summary, HPA has developed the table below showing CMS' final assessment of the 17 technologies CMS discusses in the final rule for purposes of a new technology add-on payment for FY 2027 under the alternative pathway. A brief summary of each technology follows the table and includes any special considerations discussed by CMS.

Summary of Technologies Evaluated under the Alternative Pathway for New Technology Add-On Payment for FY 2027:

Technology		Newness Date	Final CMS Assessment and Application Link
a	Bayesian Health Sepsis Flagging Device	4/30/2026	Approved with a maximum new technology add-on payment of $61.84 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP25100520EEP
b	BriefCase-Triage: CARE (Clinical AI Reasoning Engine) Multi-Triage CT Body	1/7/2026	Approved with a maximum new technology add-on payment of $137.53 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251004A9NVV
c	CARA System	Pending FDA	Denied; the technology has not received FDA marketing authorization as a Breakthrough Device, therefore it does not qualify for new technology add-on payments for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006TVQL6
d	Ceribell Delirium Monitor System	12/8/2025	Approved with a maximum new technology add-on payment of $2,171 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006WFMK2
e	CMORE® CT System (posterior cervico-thoracic system)	12/8/2025	Approved with a maximum new technology add-on payment of $60,905 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP2510034V5CK
f	GORE® VIABAHN® FORTEGRA Venous Stent	12/19/2025	Approved with a maximum new technology add-on payment of $7,186.40 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006MBT8G
g	Infuse™ Bone Graft	2/13/2026	Approved with a maximum new technology add-on payment of $4,396.60 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP250929NNTP8
h	InVision Precision Cardiac Amyloid	5/21/2025	Approved with a maximum new technology add-on payment of $2,275.00 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251002J7D89
i	Nelli™ Seizure Monitoring System	1/20/2026	Approved with a maximum new technology add-on payment of $975 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP2509294WQJJ
j	NEXUS® Aortic Arch Stent Graft System	4/2/2026	Approved with a maximum new technology add-on payment of $35,880 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP2510006114Y0
k	OmniaSecure™ MRI SureScan™ Lead Model 3930M	1/7/2026	Approved with a maximum new technology add-on payment of $7,796.75 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP250930Q7TFH
l	PearlMatrix™ P-15 Peptide Enhanced Bone Graft	6/18/2025	Approved with a maximum new technology add-on payment of $3,380 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251001VFM4K
m	SAPIEN M3 Transcatheter Mitral Valve Replacement System	12/22/2025	Approved with a maximum new technology add-on payment of $35,100 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251003XXUEG
n	SetPoint System®	8/21/2025	Approved with a maximum new technology add-on payment of $38,675 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006Y987F
o	Spur® Peripheral Retrievable Stent System	5/29/2025	Approved with a maximum new technology add-on payment of $2,596.75 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251001G2LL6
p	Trilogy™ Transcatheter Aortic Valve Regurgitation System	3/17/2026	Approved with a maximum new technology add-on payment of $25,675 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP25100691E86

Technology		Newness Date	Final CMS Assessment and Application Link
q	ViaOne™ Epicardial Access System	3/20/2025	Approved with a maximum new technology add-on payment of $1,300 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251001MFBVW

a. Bayesian Health Sepsis Flagging Device

Bayesian Health, Inc. submitted a FY2027 application for new technology add-on payments for the Bayesian Health Sepsis Flagging Device which is artificial intelligence and machine learning-based Software as a Medical Device (SaMD) intended for use in conjunction with clinical assessments and other laboratory findings to aid the early detection and/or risk prediction of sepsis within the next 4 days.

Cost Criterion Proposal: CMS proposed to approve the Bayesian Health Sepsis Flagging Device for new technology add-on payments for FY 2027, subject to its receipt of FDA marketing authorization for the indication corresponding to the Breakthrough Device designation by May 1, 2026. CMS proposed that the maximum add-on payment for this technology would be $61.84 for FY 2027.

Selected Comment/Response: While most commenters supported CMS' proposal, others raised performance concerns or argued it should be treated as a standard operating cost rather than an add-on payment. CMS clarified that because the technology qualifies under the alternative pathway, it is exempt from proving substantial clinical improvement over existing methods. Furthermore, for subscription-based software like this sepsis flagging device, CMS evaluates eligibility by reviewing the estimated average cost per patient, utilization assumptions, and hospital coding documentation.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing that the maximum new technology add-on payment for a case involving the use of the Bayesian Health Sepsis Flagging Device is $61.84 for FY 2027. The Bayesian Health Sepsis Flagging Device was granted a unique ICD-10-PCS procedure code, XEZZXJC, effective for FY 2027, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on April 30, 2026.

b. BriefCase-Triage: CARE (Clinical AI Reasoning Engine) Multi-Triage CT Body

Aidoc Medical Ltd., Inc. submitted a FY 2027 application for new technology add-on payments for BriefCase-Triage: CARE Multi-Triage CT Body (BriefCase-Triage) which is a radiological triage device used for the analysis of contrast and non-contrast CT images that flags and communicates suspected positive findings for a wide range of clinically actionable, time-sensitive conditions in the abdominopelvic region.

Cost Criterion Proposal: CMS proposed to approve the technology for add-on payments for FY 2027 for its FDA-cleared indication covered by the Breakthrough Device designation with a newness period to commence on January 7, 2026, the date on which BriefCase-Triage received

FDA marketing authorization. CMS proposed a maximum add-on payment of $137.53 for FY 2027.

Selected Comment/Response: The applicant submitted a supporting comment, validating the technology's clinical impact, confirming it is not substantially similar to existing tools, and agreeing with CMS's proposed newness date and cost per case.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing approval of a new technology add-on payments for BriefCase-Triage for FY 2027 with a maximum new technology add-on payment of $137.53 for FY 2027. BriefCase-Triage was granted a unique ICD-10-PCS procedure code, XEZ5XKC, effective for FY 2027, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on January 7, 2026.

c. CARA System

Cara Medical submitted a FY 2027 application for new technology add-on payments for the CARA System which contains software that simulates the path of a patient's cardiac conduction system using anatomical landmarks identifiable on routine CT angiography (CTA) imaging to enable Conduction Guided Intervention (CGI). Per the applicant, CARA augmented fluoroscopy can be used to help the operator visualize, during the procedure, the proximity of his tools and device to the patient's conduction system..

Cost Criterion Proposal: CMS agreed that the CARA System met the cost criterion and proposed to approve the technology for add-on payments for FY 2027, subject to receiving FDA marketing authorization by May 1, 2026. Due to questions regarding cost and indications, the agency sought additional clarifying about the CARA Atlas™ Navigator components, surgical versus interventional cost differences, and the uses of system components. Based on available information, CMS proposed a maximum new technology add-on payment of $10,205.00 for FY 2027.

Selected Comment/Response: The applicant submitted a comment arguing that the CARA System has qualified for alternative pathway add-on payments for FY 2027 based on CMS regulations, claiming the device is "covered by" the FDA's Breakthrough Devices Program and its pending indication matches that designation. CMS rejected this argument because the FDA had not market-authorized the CARA System as a Breakthrough Device by the mandatory May 1, 2026 deadline. CMS clarified that it does not evaluate whether an indication is "covered by" a breakthrough designation until after the FDA formally grants marketing authorization. Consequently, the agency believes it would be inappropriate to determine alternative pathway eligibility before the FDA finalized its own breakthrough device authorization.

Final Action: Because the CARA System did not receive FDA marketing authorization as a Breakthrough Device by the mandatory May 1, 2026 deadline, it does not qualify for new technology add-on payments for FY 2027.

d. Ceribell Delirium Monitor System

Ceribell, Inc. submitted a FY 2027 application for new technology add-on payments for the Ceribell Delirium Monitor System which is comprised of proprietary software, signal acquisition headbands and a recorder. The software utilizes a machine learning model to analyze EEG signals to detect features indicative of delirium. CMS noted that the FDA-cleared indication is different than the indication listed in the application, and that only the use of the Ceribell Delirium Monitor System for patients aged 65 and older, and the FDA Breakthrough Device designation it received for that use, are relevant for purposes of the new technology add-on payment application for FY 2027.

Proposals: CMS proposed to approve the Ceribell Delirium Monitor System for new technology add-on payments with a maximum add-on payment of $2,171 for FY 2027. CMS proposed that the newness period would commence December 8, 2025. Additionally, CMS proposed to exclude certain cases reported in combination with ICD-10-PCS procedure code XX20X89 for patients with status epilepticus which would identify use of the Ceribell Status Epilepticus Monitor, not the Ceribell Delirium Monitor System.

Selected Comment/Response: Several commenters expressed support for CMS' proposals. The applicant submitted a comment agreeing with CMS's proposed approach of utilizing ICD-10-PCS procedure code XX20X89 and excluding the 28 diagnosis codes listed for status epilepticus. The applicant also confirmed CMS' proposed cost estimate. However, a few commenters recommended that CMS reconsider, stating that it's possible to for a patient to have both conditions and it would be inappropriate to exclude delirium from new technology add-on payments for the system based on co-existing conditions, and suggested alternatives such as the establishment of a unique ICD-10-PCS code for the System.

Final Action: CMS is finalizing its proposals without modification. Specifically, CMS is finalizing approval of new technology add-on payments for the Ceribell Delirium Monitor System with a maximum new technology add-on payment for a case involving the use of the Ceribell Delirium Monitor System of $2,171 for FY 2027. The newness period will commence on December 8, 2025. Finally, CMS finalizes the proposal to use the ICD-10-PCS code XX20X89 in combination with ICD-10-CM diagnosis codes describing status epilepticus[40] to identify cases which would not be eligible for new technology add-on payment for FY 2027.

e. CMORE® CT System (posterior cervico-thoracic system)

Icotec ag submitted a FY 2027 application for new technology add-on payments for the CMORE® CT System which is a posterior cervico-thoracic fixation system manufactured from BlackArmor® Carbon/PEEK material for standard posterior fixation of the spinal column which features a variety of screw sizes and types, as well as rod shapes, to accommodate patient anatomy. CMS noted that only the use of the technology for the approved indication that corresponds to the technology's Breakthrough Device designation would be eligible for the new technology add-on payment for FY 2027. Therefore, the CMORE® CT System is only eligible

[40] Table 10.2 can be accessed online: FY 2027 IPPS Final Rule Home Page | CMS

for new technology add-on payment as an adjunct to fusion of the cervical spine (C1 to C7) and the upper thoracic spine (T1 to T3).

Proposals: CMS proposed to approve the CMORE® CT System for add-on payments for its FDA-cleared breakthrough indication with a maximum add-on payment of $60,905 for FY 2027. The newness period would commence on December 8, 2025 which is the date the technology became commercially available. CMS invited public comments on the use of certain ICD-10-PCS procedure codes to identify use of the technology for the Breakthrough Device-designated indication for purposes of a new technology add-on payment, if approved.

Select Comment/Responses: No comments were received by CMS.

Final Action: CMS is finalizing its proposals without modification. Specifically, CMS is finalizing approval of new technology add-on payments for the CMORE® CT System, with a maximum new technology add-on payment for a case involving the use of the CMORE® CT System of $60,905 for FY 2027. The newness period commences on December 8, 2025. The applicant was granted approval for unique ICD-10-PCS procedure codes for the CMORE® CT System beginning in FY 2027. Therefore, cases involving the use of the CMORE® CT System that are eligible for new technology add-on payments will be identified by any of the following ICD-10-PCS procedure codes: XRH10NC, XRH13NC, XRH14NC, XRH20NC, XRH23NC, XRH24NC, XRH40NC, XRH43NC, XRH44NC, XRH60NC, XRH63NC, XRH64NC, in combination with any of the ICD-10-PCS procedure codes listed in Table 10.1. – CMORE® CT System, associated with this final rule.[41]

f. GORE® VIABAHN® FORTEGRA Venous Stent

W.L. Gore & Associates, Inc. submitted a FY 2027 application for new technology add-on payments for the GORE® VIABAHN® FORTEGRA Venous Stent which is an open-structure polymer lattice device providing intraluminal support in the inferior vena cava and, if clinically warranted, the common iliac veins, at the iliocaval confluence in patients with symptomatic vessel obstruction.

Cost Criterion Proposal: CMS proposed to approve the GORE® VIABAHN® FORTEGRA Venous Stent for add-on payments for FY 2027, for the FDA-approved indication covered by the Breakthrough Device designation. The newness period would commence on December 19, 2025, the date on which the technology received FDA marketing authorization. CMS proposed a maximum FY 2027 new technology add-on payment of $7,186.40.

Selected Comment/Response: Multiple commenters expressed support for CMS' proposal. The applicant supported the proposed maximum add-on payment amount.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing approval of a new technology add-on payments for the GORE® VIABAHN® FORTEGRA Venous Stent for FY 2027 with a maximum new technology add-on payment of $7,186.40 for FY 2027. The applicant was granted a unique ICD-10-PCS procedure code, X2723CB, effective

[41] Table 10.1 can be accessed online: FY 2027 IPPS Final Rule Home Page | CMS

for FY 2027, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on December 19, 2025.

g. Infuse™ Bone Graft

Medtronic Sofamor Danek USA, Inc. submitted a FY 2027 application for new technology add-on payments for Infuse™ Bone Graft which is a bone graft material designed to promote bone formation at the site of implantation for transforaminal lumbar interbody fusion (TLIF), at one or two adjacent levels from L2-S1 in the treatment of degenerative disc disease (DDD). It consists of two primary components, recombinant human bone morphogenetic protein-2 (rhBMP-2) and an absorbable collagen sponge which serves as a delivery matrix and scaffold for bone growth.

Proposals: CMS proposed to approve Infuse™ Bone Graft for new technology add-on payments for FY 2027, for the FDA-approved indication covered by the Breakthrough Device designation. CMS considers the beginning of the newness period to commence on February 13, 2026, the date on which Infuse™ Bone Graft received FDA marketing authorization. CMS proposed a maximum FY 2027 new technology add-on payment of $4,396.60. CMS proposed a list of nine relevant ICD-10-PCS procedure codes (specifically: 0SG00AJ, 0SF03AJ, 0SG04AJ, 0SG10AJ, 0SG13AJ, 0SG14AJ, 0SG30AJ, 0SG33AJ, and 0SG34AJ) that CMS believed would be appropriate to report in combination with use of Infuse™ Bone Graft, to identify use of the technology for the Breakthrough Device-designated indication for purposes of an add-on payment, if approved.

Selected Comment/Response: The applicant supported CMS' proposals.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing approval of a new technology add-on payments for Infuse™ Bone Graft with a maximum new technology add-on payment of $4,396.60 for FY 2027. The applicant was granted a unique ICD-10-PCS procedure code, XW0U0CC, effective for FY 2027, which will be used in combination with nine ICD-10-PCS procedure codes (specifically: 0SG00AJ, 0SF03AJ, 0SG04AJ, 0SG10AJ, 0SG13AJ, 0SG14AJ, 0SG30AJ, 0SG33AJ, and 0SG34AJ) to identify cases eligible for new technology add-on payments. The newness period commences on February 13, 2026.

i. InVision Precision Cardiac Amyloid

Invision Medical Technology submitted a FY 2027 application for new technology add-on payments for InVision Precision Cardiac Amyloid (InVision PCA) which is a SaMD machine-learning disease detection algorithm to identify high suspicion of cardiac amyloidosis from routinely obtained echocardiogram videos. The device is designed to assist clinicians in the diagnosis of cardiac amyloidosis.

Cost Criterion Proposal: CMS proposed to approve InVision PCA for new technology add-on payments for FY 2027, for the FDA-approved indication covered by the Breakthrough Device designation. The newness period would commence on May 21, 2025, the date on which the technology received FDA marketing authorization. CMS proposed a maximum FY 2027 new technology add-on payment of $162.50.

Selected Comment/Response: The applicant requested reconsideration of the proposed cost and submitted an updated cost analysis, identifying a final per-patient cost of $3,500.00 reflecting the rarity of the disease, the clinical value to patients, and increased costs associated with Graphics Processing Unit (GPU) computing infrastructure required for the application. In response, CMS notes that the technology would still meet the cost criterion.

Final Action: CMS finalizes its proposal with modification. Specifically, CMS is finalizing approval of a new technology add-on payments for InVision PCA with a maximum new technology add-on payment of $3,500.00 for FY 2027. The applicant was granted a unique ICD-10-PCS procedure code, XEZZXLC, effective for FY 2027, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on May 21, 2025.

i. Nelli™ Seizure Monitoring System

Neuro Event Labs submitted a FY 2027 application for new technology add-on payments for the Nelli™ Seizure Monitoring System which is a prescription-only device that is designed to be used as an adjunct to seizure monitoring in healthcare facilities during periods of rest. Per the applicant, the device utilizes automated analysis of audio and video (media) to identify epileptic and non-epileptic seizure events with a positive motor component.

Cost Criterion Proposal: CMS proposed to approve the Nelli™ Seizure Monitoring System for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation. CMS considers the beginning of the newness period to commence on January 20, 2026, the date on which the technology became commercially available. CMS noted that any new technology add-on payment for the Nelli™ Seizure Monitoring System would be based on only the operating costs of $1,500 for the analysis during inpatient hospital stay, and not any additional capital costs. As a result, CMS proposed that the maximum new technology add-on payment for a case involving the use of the Nelli™ Seizure Monitoring System would be $975 for FY 2027.

Selected Comment/Response: The applicant supported CMS' proposal and also stated that ICD-10-PCS code XXE0X48 (Measurement of brain electrical activity, computer-aided semiologic analysis, new technology group 8), effective October 1, 2022, may be used to identify use of the technology.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing approval of new technology add-on payments for the Nelli™ Seizure Monitoring System with a maximum new technology add-on payment of $975 for FY 2027. ICD-10-PCS procedure code XXE0X48 will be used to identify cases eligible for new technology add-on payments. The newness period commences on January 20, 2026.

j. NEXUS® Aortic Arch Stent Graft System

ENDOSPAN submitted a FY 2027 application for new technology add-on payments for the NEXUS® Aortic Arch Stent Graft System which is a branched endovascular stent graft system

designed specifically for repair of aortic arch pathologies (including aneurysms, chronic dissections, penetrating ulcers, and intramural hematoma) involving Zone 0 ascending aorta and the arch.

Cost Criterion Proposal: CMS proposed to approve the NEXUS® Aortic Arch Stent Graft System for new technology add-on payments for FY 2027, subject to the technology receiving FDA marketing authorization for the indication corresponding to the Breakthrough Device designation by May 1, 2026. CMS proposed a maximum FY 2027 new technology add-on payment of $35,880.

Selected Comment/Response: The applicant submitted a public comment in support of the NEXUS® Aortic Arch Stent Graft System, including a copy of the FDA PMA approval letter. Other commenters also expressed support, and one commenter requested CMS clarify its cost analysis. CMS agrees with the applicant that the NEXUS® Aortic Arch Stent Graft System meets the marketing authorization requirement, and summarizes its cost analysis, which it declines to modify.

Final Action: CMS is finalizing approval of a new technology add-on payments for the NEXUS® Aortic Arch Stent Graft System with a maximum new technology add-on payment of $35,880 for FY 2027. The applicant was granted unique ICD-10-PCS procedure codes, X2VJ3HC and X2VJ3HC, effective for FY 2027. Either code in combination with X2VW3JC will be used to identify cases eligible for new technology add-on payments. The newness period commences on April 2, 2026.

k. OmniaSecure™ MRI SureScan™ Lead Model 3930M

Medtronic submitted a FY 2027 application for new technology add-on payments for the OmniaSecure™ MRI SureScan™ Lead Model 3930M (OmniaSecure™ defibrillation lead) which is an implantable defibrillation lead designed to deliver pacing, sensing, cardioversion, and defibrillation therapy for patients at risk of life-threatening ventricular arrhythmias.

Cost Criterion Proposal: CMS proposed to approve the OmniaSecure™ defibrillation lead for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation. CMS considers the newness period to commence on January 7, 2026, the date on which the OmniaSecure™ defibrillation lead became commercially available. CMS proposed a maximum FY 2027 new technology add-on payment of $7,796.75.

Selected Comment/Response: The applicant supported CMS' proposal and noted that two new ICD-10-PCS codes, X2HV3GB (Insertion of lumenless small diameter defibrillator lead into right ventricle, percutaneous approach, new technology group 11) and X2HM3GB (Insertion of lumenless small-diameter defibrillator lead into ventricular septum, percutaneous approach, new technology group 11) became effective April 1, 2026, to describe procedures involving insertion of the OmniaSecure™ defibrillation lead. In response, CMS does not agree that cases involving X2HM3GB should be eligible for an add-on payment as the FDA Breakthrough Device-designated indication only covers the OmniaSecure™ defibrillation lead when intended for use in the right ventricle.

Final Action: CMS is finalizing approval of a new technology add-on payments for the OmniaSecure™ MRI SureScan™ Lead Model 3930M with a maximum new technology add-on payment of $7,796.75 for FY 2027. The applicant was granted a unique ICD-10-PCS procedure code, X2HV3GB, effective for FY 2026, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on January 7, 2026.

o. PearlMatrix™ P-15 Peptide Enhanced Bone Graft

Cerapedics, Inc. submitted a FY 2027 application for new technology add-on payments for PearlMatrix™ P-15 Peptide Enhanced Bone Graft which is a composite bone graft material consisting of a synthetic peptide, found naturally occurring in human Type I collagen (P-15), adsorbed onto calcium phosphate particles, which are incorporated into a fibrous collagen matrix putty as an inert carrier.

Proposals: CMS proposed to approve PearlMatrix™ P-15 Peptide Enhanced Bone Graft for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation. CMS considers the newness period to commence on June 18, 2025, the date on which the technology received FDA marketing authorization. CMS proposed a maximum FY 2027 new technology add-on payment of $3,380, based on the submitted operating costs. CMS proposed that the relevant ICD-10-PCS procedure codes that would be appropriate to report in combination with the PearlMatrix™ P-15 Peptide Enhanced Bone Graft's unique ICD-10-PCS codes (XW0U0XB, XW0U3XB or XW0U4XB) would be the following: 0SG00AJ, 0SG03AJ, 0SF04AJ, 0SG30AJ, 0SG33AJ, and 0SG34AJ.

Selected Comment/Response: CMS did not receive any comments.

Final Action: CMS finalizes its proposal without modification.

m. SAPIEN M3 Transcatheter Mitral Valve Replacement System

Edwards LifeSciences, LLC submitted a FY 2027 application for new technology add-on payments for the SAPIEN M3 Transcatheter Mitral Valve Replacement System (the SAPIEN M3 TMVR System) which is a transcatheter system designed to allow for replacement of the native mitral valve in patients with symptomatic mitral valve regurgitation or symptomatic mitral stenosis.

Cost Criterion Proposal: CMS proposed to approve the SAPIEN M3 TMVR System for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation with a newness period to commence on December 22, 2025, the date on which the SAPIEN M3 TMVR System received FDA marketing authorization. CMS proposed that the maximum add-on payment would be $35,100 for FY 2027.

Selected Comment/Response: Multiple commenters, including the applicant, expressed support for CMS' proposal.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing approval of a new technology add-on payments for the SAPIEN M3 Transcatheter Mitral Valve Replacement System with a maximum new technology add-on payment of $35,100 for FY 2027. The applicant was granted a unique ICD-10-PCS procedure code, X2RG3FC, effective for FY 2027, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on December 22, 2025.

n. SetPoint System®

SetPoint Medical Corporation submitted a FY 2027 application for new technology add-on payments for the SetPoint System® which is a fully integrated, rechargeable, implantable vagus nerve stimulation system used to treat individuals with moderate to severe rheumatoid arthritis (RA) who have experienced a loss of efficacy, inadequate response, or intolerance to one or more biologic or targeted synthetic disease modifying antirheumatic drugs (DMARDs).

Cost Criterion Proposal: CMS proposed to approve the SetPoint System® for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation with a newness period to commence on August 21, 2025, the date on which the SetPoint System® became commercially available. CMS proposed that the maximum add-on payment would be $38,675 for FY 2027

Selected Comment/Response: A few commenters, including the applicant, submitted public comments that expressed support for CMS' proposal.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing approval of a new technology add-on payments for the SetPoint System® with a maximum new technology add-on payment of $38,675 for FY 2027. The applicant was granted a unique ICD-10-PCS procedure code, X0HQ05C, effective for FY 2027, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on August 21, 2025.

o. Spur® Peripheral Retrievable Stent System

Reflow Medical, Inc. submitted a FY 2027 application for new technology add-on payments for the Spur® Peripheral Retrievable Stent System which is used as an adjunct to percutaneous transluminal angioplasty (PTA) to dilate stenoses in infrapopliteal arteries ranging in diameter from 2.5 mm to 4.5 mm.

Cost Criterion Proposal: CMS proposed to approve the Spur® Peripheral Retrievable Stent System for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation, with a newness period to commence on May 29, 2025, the date on which the technology received FDA marketing authorization. CMS proposed the maximum add-on payment would be $2,596.75 for FY 2027.

Selected Comment/Response: The applicant and other commenters expressed support for CMS' proposal.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing approval of a new technology add-on payments for the Spur® Peripheral Retrievable Stent System with a maximum new technology add-on payment of $2,596.75 for FY 2027. Cases involving the use of this technology that are eligible for new technology add-on payments will be identified by any of the following ICD-10-PCS procedure codes: X2HP38B, X2HQ38B, X2HR38B, X2HS38B, X2HT38B, X2HU38B. The newness period commences on May 29, 2025.

p. Trilogy™ Transcatheter Aortic Valve Regurgitation System

JenaValve submitted a FY 2027 application for new technology add-on payments for the Trilogy™ Transcatheter Aortic Valve Regurgitation System for transcatheter aortic valve implantation which is deployed so that the Transcatheter Heart Valve (THV) expands radially at the native annulus and clips onto the native aortic leaflets to anchor the THV. Per the applicant, the THV is designed to anchor in the diseased regurgitant aortic valve.

Cost Criterion Proposal: CMS proposed to approve the Trilogy™ Transcatheter Aortic Valve Regurgitation System for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation, with a newness period to commence on March 17, 2026, the date on which the technology received FDA marketing authorization. CMS proposed the maximum add-on payment would be $25,675 for FY 2027.

Selected Comment/Response: CMS received several comments that expressed support for its proposal.

Final Action: CMS finalizes its proposal without modification. Specifically, CMS is finalizing approval of a new technology add-on payments for the Trilogy™ Transcatheter Aortic Valve Regurgitation System with a maximum new technology add-on payment of $25,675 for FY 2027. The applicant was granted a unique ICD-10-PCS procedure code, X2RF3LC, effective FY 2027, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on March 17, 2026.

q. ViaOne™ Epicardial Access System

CardioVia Ltd. submitted a FY 2027 application for new technology add-on payments for the ViaOne™ Epicardial Access System (ViaOne™) which is a sterile, single use device, designed to allow safe pericardial access utilizing a proprietary mechanism of entry into the pericardial sac with a blunt tip and a concealed needle.

Proposal: CMS proposed to approve ViaOne™ for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation. Based on statements made by the applicant regarding delayed commercial availability of this product, CMS expressed interest in confirmation regarding the first date of availability for sale of ViaOne™ on the U.S. market (irrespective of purchase volume or when the first sale occurred) in

order to establish the newness period commencement date. CMS proposed that the maximum add-on payment would be $1,300 for FY 2027.

Selected Comment/Response: The applicant submitted additional information regarding the commercial availability of the technology and requested that CMS use June 2026 as the beginning of the newness period for the ViaOne™ Epicardial Access System, rather than the initial expected commercial date of April 27, 2026. The applicant stated its recognition that if further delays in market availability were to occur, the newness period would begin no later than September 30, 2026, consistent with CMS's proposed policy to ensure the newness period begins prior to the new technology add-on payment effective date. In response, CMS reiterates its policy for determining newness and states that in light of insufficient information, the agency will consider the newness date for this technology to be March 20, 2025, the date on which the technology received 510(k) clearance.

Final Action: CMS is finalizing approval of a new technology add-on payments for the ViaOne™ Epicardial Access System with a maximum new technology add-on payment of $1,300 for FY 2027. The applicant was granted a unique ICD-10-PCS procedure code, XEZD3QC, effective for FY 2027, which will be used to identify cases eligible for new technology add-on payments. The newness period commences on March 20, 2025.

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

Through prior rulemaking, CMS established an alternative inpatient new technology add-on payment pathway for certain transformative new devices and certain antimicrobial products.[42] Under this pathway, FDA-designated Breakthrough Devices and QIDPs, and drugs approved under FDA's LPAD are considered to be not substantially similar to existing technology for purposes of the new technology add-on payment. Because of this, such technologies do not need to meet the requirement under §412.87(b)(1) that the technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

Similarly, in the outpatient prospective payment system (OPPS), CMS established an alternative transitional pass-through payment pathway for devices that are part of the FDA's Breakthrough Devices Program and have received FDA marketing authorization for the indication covered by the Breakthrough Device designation.[43] Under this alternative pathway, FDA-designated Breakthrough Devices are not evaluated for substantial clinical improvement under §419.66(c)(2) for the purposes of determining device pass-through payment status.

Since the establishment of the alternative pathways, CMS has developed concerns with the limited evaluation process for alternative pathway applications for new technology add-on and OPPS device pass-through payments. Specifically, CMS stated in the FY 2027 IPPS proposed rule that the agency now believes it is in the best interest of Medicare beneficiaries and taxpayers that new technologies approved for add-on and pass-through payments have demonstrated that

[42] FY 2020 and FY 2021 IPPS final rules (84 FR 42292 through 42297; 85 FR 58737 through 58739).
[43] See the CY 2020 OPPS/ASC final rule (84 FR 61295 through 61296).

they substantially improve the diagnosis or treatment of an illness or injury or improve the functioning of a malformed body part, compared to the benefits of a device or devices in a previously established category or other available treatment (*e.g.*, a substantial clinical improvement). Therefore, CMS proposed to repeal the alternative pathways for the IPPS new technology add-on payment and the OPPS device passthrough applications, and require all applicants for IPPS new technology add-on payments and OPPS device pass-through payments to demonstrate that they meet the same eligibility requirements to receive add-on payments and/or pass-through payments as all other new technologies.

CMS' proposed policy would apply to 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. That is, beginning with applications received for new technology add-on payments for FY 2028 and subsequent fiscal years, all applicants would need to meet all three of the criteria (*i.e.*, the newness, cost, and substantial clinical improvement criteria) as specified at §412.87(b). CMS proposed that technologies that are currently under review for FY 2027 new technology add-on payments under the alternative pathway would remain eligible for consideration for add-on payment under the alternative pathway. Technologies that were previously approved for add-on payments under the alternative pathway would remain eligible for those add-on payments.

Additionally, consistent with the proposed removal of the alternative pathway for certain antimicrobial products currently at §412.87(d), CMS proposed to remove the conditional approval process for a technology for which an application is submitted under the alternative pathway for certain antimicrobial products that does not receive FDA marketing authorization by July 1 prior to the fiscal year for which the applicant applied for new technology add-on payments, as currently reflected at §412.87(f)(3). Accordingly, beginning with the FY 2028 new technology add-on payment applications, in order to be considered for the new technology add on payment for the upcoming fiscal year, all applicants would need to receive FDA marketing authorization by May 1 of the year prior to the beginning of the fiscal year for which the application is being considered, as reflected at §412.87(f)(2). CMS proposed to amend §412.87 to reflect these proposals. CMS also proposed technical corrections to the introductory text at §412.87(d) and §412.88(a)(2)(ii)(A).

Similarly, CMS is proposed that all applications received for OPPS device pass-through payment status on or after October 1, 2026, including all applications received through the remainder of the CY 2028 OPPS application cycle ending on March 1, 2027, and applications received for subsequent calendar years would have to demonstrate that the technology met the requirements currently reflected at §419.66(c)(2)(i). OPPS device pass-through payment applications submitted as of September 30, 2026, for devices that are part of the FDA's Breakthrough Devices Program and received FDA marketing authorization for the indication covered by the Breakthrough Device designation would be evaluated and could be approved under the alternative pathway, provided that all other criteria were met. Existing device category codes established based on the approval, either preliminary or via a final determination made in an OPPS/ASC final rule, including any device category codes established for approved alternative pathway applications received as of September 30, 2026, would continue to be eligible for device pass-through payment status and would remain in effect for at least two years, but no more than

three years, consistent with §419.66(g). Previously existing device category codes that were no longer eligible for device pass-through payment status would remain unchanged. CMS proposed to revise paragraph §419.66(c)(2)(ii) to reflect this proposed policy, effective October 1, 2026.

The agency solicited information on alternate methods that stakeholders believed would more effectively or efficiently accomplish the goal of aligning payment with value by facilitating payment for innovative, high-value technologies that have demonstrated improved Medicare beneficiary health outcomes, such as alternative strategies for leveraging FDA designations.

Unsurprisingly, CMS received numerous responses from the public. HPA has summarized a representative selection of those comments.

Selected Comment/Response: Commenters, including MedPAC, supported CMS's proposal to rescind the alternative pathways to better align Medicare spending with value, with one commenter providing data confirming that an FDA Breakthrough Device designation and subsequent authorization do not automatically prove a technology delivers substantial clinical improvement. By contrast, many commenters opposing the rescission of alternative pathways argued that they are vital for mitigating post-market financial lags, reducing innovator burdens, and ensuring early adoption of crucial Breakthrough Devices. They recommended targeted reforms rather than a full repeal, asserting that CMS's high clinical improvement standards create an unreasonable market barrier and inappropriately transform routine payment evaluations into de facto coverage adjudications. Commenters requested that CMS implement a multi-year transition period or grandfathering provisions to protect technologies currently in the application pipeline and allow companies time to adjust to the traditional pathway requirements. Others stated that CMS had not presented data demonstrating that the alternative pathways have failed to deliver clinical benefit to Medicare beneficiaries, or resulted in inappropriate approvals, excess spending, adverse outcomes, program integrity concerns, or systematic abuse that would warrant a repeal.

In response, CMS rejected the idea that a uniform standard for approving new technologies for add-on payments disadvantages innovation, noting that the alternative pathways may have unintentionally reduced a manufacturer's incentive to generate data showing improved outcomes for Medicare patients. Additionally, CMS rejected the claim that its evaluations have become increasingly stringent, explaining that the growing number of standard-of-care options naturally raises the bar for proving clinical superiority over existing treatments, while clarifying that its regulations remain flexible and do not strictly require direct comparative, peer-reviewed evidence. CMS maintains there is no misalignment between its payment and coverage roles, clarifying that while Medicare coverage requires a device to be "reasonable and necessary" for treatment, the substantial clinical improvement standard is a completely separate, higher threshold used exclusively to determine if a covered technology qualifies for extra incentive payments. CMS rejected commenters' assertion that the agency did not provide an adequate rationale for its proposal. However, CMS agreed that it would be appropriate to adopt a transitional approach to support the technologies already in advanced stages of commercial development or that may already be commercially available, and is therefore finalizing a modification to its proposal.

Final Action for IPPS NTAP: CMS finalizes its proposed policy, with modification to grandfather eligibility under the alternative pathway for certain technologies for a limited period of time. Beginning with 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, 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. Technologies that have previously been approved (including those approved in the FY 2027 IPPS final rule) will remain eligible.

These changes will be reflected in amendments to 42 CFR 412.87, with technical corrections as detailed in the final rule preamble.

In response to comments, 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:

- 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;
- A new medical product that is designated by FDA as a QIDP as of September 30, 2026, and has received marketing authorization for the indication covered by the QIDP designation by May 1, 2028; and
- A new medical product that is approved under FDA's LPAD pathway and used for the indication approved under the LPAD pathway by May 1, 2028.

CMS notes that the conditional approval process for certain antimicrobial products is removed and all future applicants will need to receive FDA marketing authorization by May 1 of the year prior to the beginning of the fiscal year for which the application is being considered, as reflected at §412.87(f)(2), including QIDPs and LPADs that meet the criteria for exception and are eligible to apply under the alternative pathway through FY 2029 as described above.

Final Action for OPPS Pass-Through Payments: Similarly, CMS is finalizing its policy, with modification, that, unless specifically exempted, all applications received for OPPS device pass-through payment status on or after October 1, 2026 will have to demonstrate that the technology met the requirements currently reflected at § 419.66(c)(2)(i). Existing device category codes established based on the approval, either preliminary or via a final determination made in an OPPS/ASC final rule, including any device category codes established for approved alternative pathway applications received as of September 30, 2026, will continue to be eligible for OPPS device pass-through payment status

In response to comments, CMS is finalizing a limited exception such that a new 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, will remain eligible to apply for OPPS device pass-through payment under the alternative pathway through CY 2029.

These changes will be reflected in amendments to 42 CFR 419.66(c)(2)(ii) and will become effective October 1, 2026.

8. Other Comments

CMS notes that public comments requesting structural changes to add-on payment policies, along with feedback on technologies not currently under consideration, were outside the scope of the FY 2027 proposed rule and were therefore not addressed in the final rule.

III. Changes to the Hospital Wage Index for Acute Care Hospitals

A. Background

CMS adjusts a portion of IPPS payments for area differences in the cost of hospital labor—the wage index. Section 1886(d)(3)(E) of the Act requires an annual update to the wage index based on a survey of wages and wage-related costs (fringe benefits) of short-term, acute care hospitals, which the agency collects on Medicare cost reports (CMS Form 2552-10, Worksheet S-3, Parts II, III, and IV). Section 1886(d)(3)(E) of the Act also provides for the collection of data every 3 years on the occupational mix of employees for short-term, acute care hospitals participating in the Medicare program to construct an occupational mix adjustment to the wage index. All changes made to the wage index annually are required to be budget neutral.

B. Labor Market Area Delineations

Hospitals are assigned to labor market areas, and the wage index reflects the weighted (by hours) average hourly wage reported on Medicare cost reports. CMS uses Office of Management and Budget (OMB) Core-Based Statistical Area (CBSA) delineations as labor market areas. Beginning with FY 2025, CMS has been using OMB delineations based on the 2020 Decennial Census, American Community Survey, and Census Population Estimates Program data (OMB Bulletin 23-01).

C. Worksheet S-3 Wage Data

The FY 2027 wage index values are based on data from FY 2023 submitted cost reports. CMS did not propose any changes to the categories of included and excluded costs for FY 2027. CMS based the final rule FY 2027 wage index on data of 3,006 hospitals. The data file used to construct the FY 2027 wage index includes FY 2023 data submitted to CMS as of January 21, 2026.

The wage data includes the wage data for facilities that were IPPS hospitals in FY 2023, inclusive of those facilities that have since terminated their participation in the program if those data did not fail any edits for reasonableness. For the proposed rule, CMS removed the data for seven IPPS hospitals included in the FY 2023 data that converted to CAH status and 2 hospitals that converted to Rural Emergency Hospital (REH) status on or after January 24, 2025 through

January 23, 2026. For the final rule, CMS removed an additional 7 hospitals that converted to CAH/REH status during this period.

General wage index policies are unchanged from prior years. CMS proposed to exclude 68 providers due to aberrant wage data that failed edits for accuracy. Wage data for 8 of these hospitals was restored to calculate the FY 2027 wage index because these hospitals verified their data or improved their data. CMS excluded 1 additional hospital in the final rule with aberrant wage data.

CMS is following its longstanding practice adopted in FY 2012 of allotting the wages and hours data for a multicampus hospital among the different labor market areas where its campuses are located using campus full-time equivalent (FTE) percentages.

CMS has a long-established multistep, 15+ month process for review and correction of the hospital wage data used to create the IPPS wage index for the upcoming fiscal year. The final rule describes this process in detail including when data files were posted and deadlines for hospitals to request corrections or revisions to audit adjustments. A hospital that fails to meet the procedural deadlines does not have a later opportunity to submit wage index data corrections or to dispute CMS' decision on requested changes.

CMS posts the wage index timetable on its website including all the public use files made available during the wage index development process. All deadlines are eastern standard time. The FY 2027 wage index is now complete, For the FY 2028 wage index timetable go to: FY 2028 Wage Index Home Page | CMS.

D. Method for Computing the Unadjusted Wage Index

For the FY 2027 wage index, CMS did not propose any changes to the steps for computing the unadjusted wage index. The final rule includes a detailed listing of these steps. CMS calculates an unadjusted national average hourly wage of $58.89.

E. Occupational Mix Adjustment

Section 1886(d)(3)(E) of the Act requires CMS to collect data every 3 years on the occupational mix of employees for each Medicare participating short-term, acute care hospital to construct an occupational mix adjustment to the wage index. Hospitals were required to submit 2022 occupational mix survey data to CMS by July 1, 2023. The 2022 occupational mix survey data is being used for the occupational mix adjustment applied to FY 2025 through FY 2027 IPPS wage indexes.

CMS reports having occupational mix data for 97 percent of hospitals (2,921 of 3,006) used to determine the FY 2027 final rule wage index. The FY 2027 national average hourly wage, adjusted for occupational mix, is $58.83.

A new measurement of occupational mix is required for FY 2028. The FY 2028 occupational mix adjustment will be based on a new calendar year (CY) 2025 survey. Hospitals were required

to submit their completed CY 2025 surveys to their Medicare Administrative Contractors (MACs) by June 30, 2026. The preliminary, unaudited CY 2025 survey data was posted on the CMS website in mid-July 2026 (FY 2028 Wage Index Home Page | CMS). As with the Worksheet S–3, Parts II and III cost report wage data, CMS and the MACs may revise or verify data elements in hospitals' occupational mix surveys as part of the FY 2028 wage index development process.

F. Geographic Reclassifications

This section describes three different types of geographic reclassifications where a hospital is considered to be in a different area than the area where it is located. These reclassifications are: 1) Urban to rural reclassifications for all IPPS purposes; 2) Medicare Geographic Classification Review Board (MGCRB) reclassifications only for the wage index; and 3) "Lugar" reclassifications where a hospital is in a rural county adjacent to an urban county where a plurality of its workers commute.

1. Urban to Rural Reclassification. Hospitals that meet specific criteria in statute may request that a CMS Regional Office treat an urban hospital as rural for all IPPS payment purposes. Unlike MGCRB reclassifications that are effective based on a fiscal year and only for the wage index, urban to rural reclassifications are effective upon the date the application was submitted to the CMS Regional Office.

Under the statute, hospitals that reclassify from urban to rural are treated as rural for all IPPS purposes. Such hospitals may apply for geographic reclassification under the MGCRB process using the more favorable rural reclassification rules. When a multi-campus hospital is reclassified from urban to rural, the reclassification applies to all the hospital's campuses. In addition, if a multi-campus urban hospital is reclassified as rural, the rural status will apply to all its campuses for such policies as sole community hospitals (SCH), Medicare-dependent, small rural hospitals (MDH) or Rural Referral Center (RRC) status.

An approved urban to rural reclassification remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. For instance, an urban to rural reclassification would no longer be valid if the hospital is no longer located within a rural census tract of an urban county as determined by the Office of Rural Health Policy within the Health Resources and Services Administration. CMS encourages all hospitals and CAHs with active urban to rural reclassifications to review their original reclassification application and determine whether the reclassification status would still apply.

Reclassifications would be considered cancelled for the purposes of calculating the area wage index for any hospital with a CCN listed as terminated as of the date that the hospital ceased to operate with an active CCN. CMS will exclude any hospital with an urban to rural reclassification status from the calculation of the rural wage index if its CCN is listed as terminated 60 days after the proposed rule is on public display with the Office of the Federal Register (known as the "lock-in" date). Any hospital with a CCN listed as terminated is not intended to alter or affect the qualification for CAH, SCH, or REH statuses or to have other effects unrelated to hospital wage index calculations.

2. Geographic Reclassification. Geographic reclassification is a process where hospitals apply to use another area's wage index. To use another area's wage index, the applying hospital must be within a specified distance of the area being requested (15 miles for urban hospitals and 35 miles for rural hospitals) and have wages that are different than their own area and comparable to the wages of the requested area:

- Urban Hospitals: Average hourly wage is at least 108 percent of other hospitals in its geographic area and 84 percent of the requested area.
- Rural Hospitals: Average hourly wage is at least 106 percent of other hospitals in its geographic area and 82 percent of the requested area.

The MGCRB decides whether hospitals meet the criteria for reclassification. Geographic reclassifications are effective for 3 years but may be temporarily withdrawn or terminated. If a hospital accepts a new MGCRB reclassification, any prior ones are permanently terminated.

There are 505 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2027. There are 284 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2025 that will continue for FY 2027. There are 333 hospitals approved for wage index reclassification in FY 2026 that may continue for FY 2027. CMS indicates that there will be 1,118 hospitals (35 percent of all hospitals) in MGCRB reclassification status for FY 2027 (with 302 of these hospitals reclassified back to their urban geographic location. The below explains why a hospital may reclassify out of and back to its home area).

The deadline for withdrawing or terminating a wage index reclassification for FY 2027 approved by the MGCRB is the later of: 1) 45 days from the date of display of the FY 2027 proposed rule (May 25, 2026) or 2) seven calendar days of receiving an Administrator's decision appealing an MGCRB decision.

Ferry Routes and the Proximity Criteria. As indicated above, a hospital must meet specific proximity requirements to qualify for reclassification to use another area's wage index. The rules measure proximity using the shortest route over improved roads. CMS proposed to modify §412.230(c)(1) to include ferry routes when mapping the shortest route. This change would minimize appeals of MGCRB decisions and reduce administrative burden for both CMS and hospitals. One commenter supported this policy that CMS is finalizing without change.

Use of a 3-Year Average Hourly Wage in the Wage Data Comparison. To determine whether a reclassifying hospital meets the average hourly wage requirement, CMS uses a 3-year average of hourly wage for all comparison purposes. CMS has received commentary that the rule is ambiguous with respect to the requirement that a hospital may only reclassify to an area with a higher average hourly wage. For this provision of the regulations, the commenters believe the rules may allow for use of a one year average hourly wage. CMS proposed a minor technical change to §412.230(a)(5)(i) to clarify that a 3-year average hourly wage is necessary for all comparison purposes. There were no public comments. CMS is finalizing this provision without change.

Home Area Reclassification. A hospital that is reclassified from urban to rural under the process described above may also seek an MGCRB reclassification back to the area where it is located. This process allows the hospital to receive the benefits of rural status while continuing to receive the wage index where it is located. As the hospital is reclassifying itself to its own geographic area, it meets the proximity requirements. Such a hospital also must meet the average hourly wage comparison using either the geographic area where it is located or from hospitals in the State's rural areas.

Individual hospitals are required to have at least one year of published average hourly wage data to receive a wage index reclassification. In a rare circumstance, a new hospital would not have an average hourly wage from its first cost report to support an MGCRB application back to the geographic area where it is located. The hospital could cancel its urban to rural reclassification to receive its home area wage index, but the proposed rule indicated that option would have significant financial impacts on the hospital, particularly an urban hospital operating in multiple wage areas. A remote location of such a hospital would be unable to reclassify to its home area if the main hospital has an urban to rural reclassification.

CMS believes this result is inequitable and serves no policy purpose as other hospitals may reclassify back to their home area by virtue of having an average hourly wage to meet the wage data comparison test. For this reason, CMS proposed to waive application of the average hourly wage comparison for hospitals with an urban to rural reclassification and are seeking MGCRB reclassification to their home geographic labor market area. This exception would only be applicable where the inability to obtain a home area reclassification could lead to lower wage index value for the hospital. There were no public comments. CMS is finalizing this provision without change.

3. "Lugar" Counties and Hospitals. A "Lugar" county is a rural county adjacent to one or more urban areas that is deemed to be part of the urban area where the highest number of its workers commute. A Lugar hospital is a hospital located in a Lugar county. A Lugar hospital is treated as reclassified to the urban area where the highest number of its workers commute. This process is automatic and will occur with no action on the part of the hospital.

The outmigration adjustment is a positive adjustment to the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. A hospital can either be reclassified or receive the outmigration adjustment but not both. As a Lugar reclassification occurs automatically, a Lugar hospital must decline its reclassification using the same process as other hospitals to receive the outmigration adjustment (e.g., notify CMS by 45 days from public display of the IPPS proposed rule).

CMS restates the following policies with respect to how Lugar hospitals may decline their urban status to receive the outmigration adjustment:

- Waiving deemed urban status results in the Lugar hospital being treated as rural for all IPPS purposes.
- Waiving deemed urban status can be done once for the 3-year period that the

outmigration adjustment is effective.

- If a Lugar hospital waived its reclassification for 3 years, it must notify CMS to reinstate its Lugar status within 45 days from the date of display of the FY 2027 proposed rule (May 25, 2026).[44]

When applicable, an election to waive Lugar status will result in a cancellation of a hospital's urban to rural reclassification. For the request to be approved, the hospital must terminate any active MGCRB reclassification. All requests, once approved, will remain in effect for the remainder of the 3-year outmigration adjustment period.

In some circumstances, a Lugar hospital may decline its urban reclassification to receive an outmigration adjustment that it would no longer qualify for once it is reclassified as rural. In these circumstances, CMS will decline the Lugar hospital's request and continue to assign it a higher urban wage index (which itself could result in the county requalifying for the outmigration adjustment based on data in the final rule).

CMS did not make any proposals regarding these procedures for cancelling or reinstating Lugar status.

G. Wage Index Floors, Outmigration Adjustment and Other Wage Index Policies

Rural Floor. The rural floor is a provision of statute that prevents an urban wage index from being lower than the wage index for the rural area of the same state. CMS estimates that the rural floor will increase the FY 2027 wage index for 991 urban hospitals requiring a budget neutrality adjustment factor of 0.973492 (-2.65 percent) applied to hospital wage indexes.

CMS received comments on the rural floor that it has addressed in prior rules. There were comments stating that the law indicates the rural floor wage index budget neutrality adjustment is not to be applied to the wage index of hospitals receiving the rural floor. CMS disagrees and believes it has applied the law correctly, e.g., the law establishes that an urban hospital's wage index cannot be lower than the wage index for the rural area of its state but the policy advocated by the commenters would make an urban hospital's wage index higher than the rural area of its state. Also, there is a provision of statute requiring budget neutrality for the rural floor to be applied through a single, uniform nationwide adjustment that applies to all hospitals.

There were also comments expressing concern about rural floor manipulation, particularly by large urban hospitals reclassifying as rural to raise their state's rural floor. CMS responds as it has in prior rules that it expects this trend to continue such that most hospitals (if not all) will be assigned identical wage index values within their states. The response indicates that this trend is a consequence of the law that requires all hospitals reclassified as rural to be treated as rural for all IPPS purposes and for CMS to apply a single, uniform nationwide budget neutrality adjustment for the rural floor.

[44] Requests to waive and to reinstate Lugar status may be sent to wageindex@cms.hhs.gov. CMS requests hospitals include their CCN, and either "waive Lugar" or "reinstate Lugar", in the subject line of these requests.

Imputed Floor. Section 9831 of the American Rescue Plan Act (ARPA) enacted by Congress on March 11, 2021, established an "imputed floor" or a floor on the area wage index in all urban states, urban states with no rural hospitals, Washington, DC and Puerto Rico. The imputed floor provision does not require a budget neutrality offset under the IPPS. CMS is continuing the imputed floor policies unchanged for FY 2027. The rule did not provide the number of hospitals impacted by the policy or the FY 2027 cost of the imputed floor.

Frontier Floor Wage Index. The Affordable Care Act requires a wage index floor for hospitals in the low population density states of Montana, Nevada, North Dakota, South Dakota and Wyoming. CMS indicates that 31 hospitals will receive the frontier floor value of 1.0000 for FY 2027. As all hospitals in Nevada have a wage index of over 1.0, the provision will have no effect on Nevada hospitals. This provision is not budget neutral.

Outmigration Adjustment. CMS proposed to apply the same policies for the FY 2027 outmigration adjustment that it has been using since FY 2012. This provision is not budget neutral.

A commenter stated that hospitals in Middlesex County, New Jersey narrowly missed the eligibility thresholds required to qualify for the out-migration adjustment despite having previously qualified in prior years. The commenter argues that such a marginal shortfall should not be sufficient grounds for withholding the adjustment based on data that is not fully audited. Further, the requirement to have an average hourly wage that is higher than other counties in its CBSA is inequitable as counties with nearly identical labor market conditions can receive different treatment based on negligible differences in the wages being paid. The commenter requested CMS eliminate the average hourly wage comparison requirement to other counties in its CBSA.

CMS responded that the average hourly wage requirement is statutory and it cannot be changed by regulation. With respect to the comment regarding unaudited data, CMS responded that hospitals submit wage data to CMS through the Medicare cost report and should ensure accuracy when submitting their own wage data. For the development of the FY 2027 wage index, CMS also conducted its own review of the wage data.

Cap on Wage Decreases. In the FY 2023 IPPS rule, CMS adopted a 5 percent cap on year-to-year decreases in a hospital's wage index regardless of the circumstances causing the decline. A newly opened hospital is paid the wage index for the area in which it is geographically located for its first full or partial fiscal year without any cap applied as there is no prior wage index upon which to determine the cap. CMS estimates the 5 percent cap on reductions in the wage index will require a budget neutrality adjustment of -0.06 percent for FY 2027.

Low Wage Index Hospital Transition. For FY 2020, CMS adopted a low-wage index policy where it increased wage indexes below the 25th percentile by one-half the difference between the hospital's otherwise applicable wage index and the 25th percentile wage index value. On July 23, 2024, the Court of Appeals for the D.C. Circuit in *Bridgeport Hosp. v. Becerra*[45] held that the

[45] *Bridgeport Hosp. v. Becerra*, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024)

Secretary lacked authority to adopt the low wage index hospital policy for FY 2020 and the related budget neutrality adjustment.

CMS ended the low-wage index policy beginning with FY 2025 and established a transitional adjustment to the wage index for low-wage hospitals. Beginning with the FY 2026 wage index, CMS' transitional adjustment is budget neutral.

For low-wage index hospitals, the transitional policy will apply by comparing the hospital's wage index for FY 2027 to its wage index under the low-wage index policy in FY 2024. If the hospital's wage index decreases by more than 5 percent annually (or 14.2625 percent over three years)[46], the hospital would be eligible for the transitional policy. CMS will apply a budget neutrality adjustment of -0.02 percent for the low wage index transitional policy.

Public comments supported CMS' transition policy and asked that it be extended beyond FY 2027. CMS will consider this comment in future rulemaking.

H. Wage Index Tables

Final wage index Tables 2, 3 and 4 can be found at: FY 2027 IPPS Final Rule Home Page | CMS. Select #2 under FY 2027 Proposed Rule Tables. (The heading appears to be incorrect by referring to the "Proposed Rule Tables" rather than the "Final Rule Tables" as all other headings at this same website refer to information for the final rule.)

I. Labor-Related Share

Section 1886(d)(3)(E) of the Act directs the Secretary to adjust the proportion of the national standardized amount that is attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. The proportion of the standardized amount attributable to wages and wage-related costs is the national labor-related share. The factor that adjusts for the relative differences in labor costs among geographic areas is the wage index. Section 1886(d)(3)(E) of the Act directs the Secretary to employ 62 percent as the labor-related share if that would result in higher payments to the hospital than using the national labor-related share. Application of the 62 percent labor-related share is not subject to wage index budget neutrality.

CMS updates the labor-related share every 4 years. The labor-related share was last updated for FY 2026. CMS is currently using a national labor-related share of 66.0 percent. If a hospital has a wage index of less than 1.0, its IPPS payments will be higher with a labor-related share of 62 percent. If a hospital has a wage index that is higher than 1.0, its IPPS payments will be higher using the national labor-related share of 66.0 percent. Consistent with the statute, CMS is not applying budget neutrality when using the lower 62 percent labor-related share when a hospital has a wage index that is less than 1.0.

[46] Over a 3-year period if a hospital's wage index were decreasing by more than 5 percent each year, this would mean the hospital's wage index for a FY cannot be lower than (0.95*0.95*0.95) times its wage index from three years earlier or 0.857375 which would be a reduction of 14.2625 percent over three years.

One comment indicated that the labor-related share should be higher and include costs that do not vary by the local market. CMS did not propose any changes to the labor-related share and further disagrees with this comment as the labor-related share is intended to establish the portion of a hospital's costs that vary by local area and adjusted by the wage index.

IV. Disproportionate Share (DSH) and Uncompensated Care Payments (UCP)

A. Background

Medicare makes DSH and uncompensated care payments (UCP) to IPPS hospitals that serve more than a threshold percent of low-income patients. Low-income is defined as Medicare eligible patients also receiving supplemental security income (SSI) or Medicaid patients not eligible for Medicare. To determine a hospital's eligibility for DSH and UCP, the proportion of inpatient days for each of these subsets of patients is used.

Prior to FY 2014, CMS made only DSH payments. Beginning in FY 2014, the Affordable Care Act (ACA) required that DSH equal 25 percent of the statutory formula and UCP equal the product of three factors:

- Factor 1: 75 percent of the aggregate DSH payments that would be made under section 1886(d)(5)(F) of the Act without application of the ACA;
- Factor 2: The ratio of the percentage of the population uninsured in a base year prior to ACA implementation to the percentage of the population uninsured in the most recent period; and
- Factor 3: A hospital's uncompensated care costs for a given period relative to uncompensated care costs for that same period for all hospitals that receive Medicare DSH payments.

The statute precludes administrative or judicial review of the Secretary's estimates of the factors used to determine and distribute UCP. UCP payments are only made to hospitals eligible to receive DSH payments that are paid using the national standardized amount (SCHs paid based on hospital specific rates, hospitals not paid under the IPPS and hospitals in Maryland paid under a waiver are ineligible to receive DSH and, therefore, UCP payments).

B. Supplemental Payments: Indian Health Service (IHS), Tribal and Puerto Rico Hospitals

In the FY 2023 IPPS/LTCH PPS final rule (87 FR 49047 through 49051), CMS established a new supplemental payment for IHS/Tribal hospitals and hospitals located in Puerto Rico for FY 2023 and subsequent fiscal years. Specifically, CMS established this payment to help mitigate the impact of the decision to discontinue the use of low-income insured days as proxy for uncompensated care costs for these hospitals. The supplemental payment for a fiscal year is determined as the difference between the hospital's base year amount (what the hospital would have received in 2022 when it used low-income insured days as a proxy) and its uncompensated care payment for the applicable fiscal year (based on using uncompensated care data from

Worksheet S-10).[47] This policy was to prevent undue long-term financial disruption for these providers. If the base year amount is higher than the hospital's uncompensated care payment for the current fiscal year, then the hospital would receive a supplemental payment based on the difference. If it is equal or lower the hospital would not receive a supplemental payment.

The MAC makes a final determination with respect to a hospital's eligibility to receive the supplemental payment for a fiscal year, in conjunction with its final determination of the hospital's eligibility for DSH payments and uncompensated care payments for that fiscal year.

CMS did not propose any changes to this methodology and will calculate these payments consistent with methodology described in the FY 2023 IPPS/LTCH PPS final rule.

C. Uncompensated Care Payments

1. FY 2027 Factor 1

CMS estimates this figure based on the most recent data available. It is not later adjusted based on actual data. CMS used the Office of the Actuary's (OACT) June 2026 Medicare DSH estimates, which were based on the March 2026 update of the HCRIS and the FY 2026 IPPS final rule impact file. Starting with these data sources, OACT applies inflation updates and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year.

OACT's June 2026 Medicare estimate of DSH payments for FY 2027 is $15.767 billion. **The Factor 1 amount is seventy-five percent of this amount, or $11.825 billion.** The final Factor 1 for 2027 is about $587 million less than the final Factor 1 for FY 2026.

The Factor 1 estimate for FY 2027 began with a baseline of $12.898 billion in Medicare DSH expenditures for FY 2023. The table below shows the factors applied to update this baseline to the current estimate for FY 2027.

Factors Applied for FY 2024 through FY 2027 to Estimate Medicare DSH Expenditures Using FY 2023 Baseline

FY	Update	Discharge	Case-Mix	Other	Total	Estimated DSH Payment (in billions)
2024	1.031	1.002	1.0000	1.0279	1.0619	13.696
2025	1.029	1.027	1.0090	0.9936	1.0593	14.508
2026	1.026	1.014	1.0075	0.9674	1.0137	14.707
2027	1.023	1.021	1.0050	1.0215	1.0721	15.767

- The discharge factor represents the increase in the number of Medicare FFS inpatient hospital discharges (based on Medicare claims data adjusted by a completion factor). The

[47] The base year amount is adjusted for a given hospital by one plus the percent change in the total uncompensated care amount between the base and the applicable fiscal year. If the total uncompensated care amount decreased between the base and applicable fiscal year by 10 percent, for example, then the base year uncompensated care amount for a given hospital used in the supplemental payment calculation would decrease by that percentage.

discharge figures for 2026 and 2027 are assumptions based on recent historical experience and assumptions related to how many beneficiaries will be enrolled in MA plans.

- The case-mix column shows the estimated change in case-mix for IPPS hospitals. The 2027 case-mix figures are assumptions based on the 2012 "Review of Assumptions and Methods of the Medicare Trustees' Financial Projections" report by the 2010-2011 Medicare Technical Review Panel.[48]

- The "other" column shows the changes in other factors affecting Medicare DSH estimates, including the difference between the total inpatient hospital discharges (including inpatient rehabilitation facility, inpatient psychiatric facility and LTCH) and the IPPS discharges and various adjustments to the payment rates that have been included over the years but are not reflected in other columns.

The table below shows the factors that are included in the "update" column of the table above.

FY	Market Basket Percentage	Productivity Adjustment	Documentation and Coding	Total Update Percentage
2024	3.3	0.2	0.0	3.1
2025	3.4	0.5	0.0	2.9
2026	3.3	0.7	0.0	2.6
2027	3.2	0.9	0.0	2.3

Comment/Response: As in past years, commenters continue to request greater transparency in the methodology used by CMS and OACT to calculate Factor 1. Several urged CMS to provide greater detail on the calculation of the "Other" component. In addition, a commenter noted that the proposed rule omitted a statement included in prior rulemaking explaining that the "Other" factor accounts for estimated changes in Medicaid enrollment through FY 2023 and another commenter wanted clarification on how CMS adjusted Factor 1 for the assumed Medicaid expansion level in FY 2027.

In its response, CMS disagrees with commenters' assertion regarding the lack of transparency with respect to the methodology and assumptions used in the calculation of Factor 1. It provides additional context that Factor 1 is not estimated in isolation from other projections made by OACT. CMS does not, however, provide a step-by-step explanation and it does not appear as if it can easily provide that level of detail given the nature of how the actuarial calculation is performed and its dependance on data sources that are not available to those trying to replicate the exact values.

Regarding the commenter's concern that the FY 2027 proposed rule did not include a prior statement that the "Other" factor accounts for estimated changes in Medicaid enrollment through FY 2023, CMS refers readers to OACT's FY 2027 Memorandum "Estimate of Medicare DSH Payments Used in Development of Factor 1.[49]" In that memorandum, OACT explains that the "Other" factor includes an

[48] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/technicalpanelreport2010-2011.pdf

[49] Available on the CMS website at: https://www.cms.gov/files/document/fy-2027-final-rule-oact-memo-dsh-factor-1.pdf).

adjustment for the change in Medicaid enrollment in 2023 and that, after examining estimated changes in Medicaid enrollment over the past few years, OACT is making no further explicit adjustments for Medicaid enrollment beyond 2023.

This memorandum also provides additional detail on the "Discharges" column which shows the adjustment for the increase in the number of Medicare fee for-service (FFS) inpatient hospital discharges. Specifically, the adjustments for 2024 and 2025 reflect the net impact of a positive per-beneficiary utilization trend, based on actual claims experience, and the decrease in FFS enrollment that occurred in those years as a growing share of beneficiaries enrolled in MA plans. The estimates for 2026 and 2027 reflect assumptions for per-beneficiary utilization growth, which is positive and reflects a continuation of the recent historical trend, and growth in FFS enrollment, which is estimated to be less negative in these years.

2. FY 2027 Factor 2

Factor 2 adjusts Factor 1 based on the percentage change in the uninsured since implementation of the ACA. For FYs 2014-2017, the statute required CMS to use the Congressional Budget Office's (CBO) estimate of the uninsured rate in the under 65 population from before enactment of the ACA for FY 2013. For FY 2018 and subsequent years, the statute requires Factor 2 to equal the percentage change in the number of individuals who are uninsured from 2013 until the most recent period for which data are available minus 0.2 percentage points for each of fiscal years 2018 and 2019. In 2018, CMS began using uninsured estimates from the National Health Expenditure Accounts (NHEA) in place of CBO data as the source of change in the uninsured population.[50]

CMS estimates that the uninsured rate for the baseline year of 2013 was 14 percent and for CYs 2026 and 2027 is 9.2 percent and 9.5 percent, respectively. As required, the Chief Actuary of CMS certified these estimates.

Using these estimates, CMS calculates the Factor 2 for FY 2027 (weighting the portion of calendar years 2026 and 2027 included in FY 2027) as follows:

- Percent of individuals without insurance for CY 2013: 14 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 = 1-|((0.092-0.14)/0.14)| = 1 - 0.3286 = 0.6714 (67.14 percent)

CMS calculated Factor 2 for the FY 2027 final rule to be 0.6714 or 67.14 percent, and the uncompensated care amount for FY 2027 to be $11.825 billion x 0.6714 = $7.939 billion which is about $226 million more than the FY 2026 UCP total of about $7.713 billion; the percentage

[50]The NHEA estimate reflects the rate of uninsured in the U.S. across all age groups and residents (not just legal residents) who usually reside in the 50 states or the District of Columbia. The NHEA data are publicly available on the CMS website at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/index.html

increase is 2.9 percent. CMS estimates of the change in uncompensated care payment can vary substantially between the proposed and final rule because of a re-estimate of the factors affecting uncompensated care based on updates to the NHEA and the uninsured population. Based on the updated NHEA data, the CY 2027 estimate of the uninsured population, for example, increased from 9.1 percent in the proposed rule to 9.5 percent in the final rule.

The table below shows the Factor 1 and Factor 2 estimates for FY 2026 and the factors for FY 2027.

FY 2027 Final Changes in UCP

($ in billions)

	FY 2026	FY 2027	Change	% Change
Factor 1	$12.412	$11.825	-$0.587	-4.7%
Factor 2	0.6214	0.6714	+0.05	+8.0%
UCP*	$7.713	$7.939	+$0.226	2.9%

* The UCP totals do not include supplemental payments for IHS/Tribal hospitals and Puerto Rico hospitals. In FY 2027, these payments are estimated to account for $109.4 million.

Comment/Response

Most commenters that discussed Factor 2 expressed concern that the proposed rule's FY 2027 uninsured rate is underestimated. Commenters referenced the expiration of the American Rescue Plan's Marketplace enhanced premium tax credits, the implementation of Medicaid work requirements, the projected impact of the Working Families Tax Cut legislation, and other pending or proposed federal policy changes that may restrict Medicaid enrollment and impact the uninsured population in FY 2027. Some commenters continued to express the concern that the NHEA data that CMS proposed to use for Factor 2 does not reflect current trends in the uninsured rate and that it should be replaced with more comprehensive and real-world data sources and calculations or be supplemented with other data sources.

In reply, CMS states that in this final rule, it is updating Factor 2 using the most recently updated NHEA projections that were released in June 2026, which reflect the most recent historical data and updated expectations for the uninsurance rate. These data reflect current law and administrative actions as of April 2026 and reflect all recent, relevant legislative actions. CMS states it continues to believe that the NHEA data and methodology used to estimated Factor 2 for the final rule are transparent and best meet all of CMS' considerations for ensuring reasonable estimates for the rate of uninsurance that are available for each IPPS rulemaking cycle.

3. Factor 3 for FY 2027

a. Background

Factor 3 equals the proportion of hospitals' aggregate uncompensated care attributable to each IPPS hospital (including Puerto Rico hospitals). The product of Factors 1 and 2 determines the total pool available for uncompensated care payments. This result multiplied by Factor 3 determines the amount of uncompensated care payment that each eligible hospital will receive.

CMS uses Worksheet S-10 of the Medicare hospital cost report to determine each hospital's share of uncompensated care costs relative to the national aggregate. It uses a three-year average of the most recent fiscal years for which audited data are available.

b. Methodology for Calculating Factor 3 for FY 2027

For FY 2027, CMS plans to use the same methodology applied in FY 2024 to determine Factor 3 except CMS will be using the most recent 3 years of audited cost reports from FY 2021, FY 2022, and FY 2023. This approach will be used for all eligible hospitals, including IHS/Tribal and Puerto Rico hospitals. CMS uses updated March 2026 HCRIS data to calculate Factor 3 for the final rule.

CMS describes the steps it used to calculate Factor 3 and how it calculated uncompensated care payments for new and newly merged hospitals. Consistent with its past policy, a newly merged hospital's final uncompensated care payment would be determined at cost report settlement where the numerator of the newly merged hospital's Factor 3 would be based on the cost report of only the surviving hospital (that is, the newly merged hospital's cost report) for the current fiscal year.

Consistent with the methodology used in prior years, CMS provides details on the methodology it uses to trim CCRs for hospitals with aberrant uncompensated care cost data. Specifically, the statewide average CCR was applied to a small number of hospitals with potentially aberrant data; this included 12 hospitals for FY 2021 reports, 10 hospitals for FY 2022 reports, and 12 hospitals for FY 2023 reports. In these cases, CMS recalculates the hospitals' uncompensated care costs (Line 30 on Worksheet S-10) using the trimmed CCR (the statewide average CCR (urban or rural, as applicable)).

c. Per Discharge Amount of Interim Uncompensated Care Payments

Consistent with the policy adopted in FY 2014 and applied in each subsequent fiscal year, CMS calculates a per discharge amount of interim uncompensated care by dividing the hospital's total uncompensated care payment amount in the proposed rule year by the hospital's 3-year average of discharges. This per discharge payment amount is used to make interim uncompensated care payments to each projected DSH-eligible hospital. These interim payments are reconciled following the end of the year. As finalized in the 2025 IPPS/LTCH PPS final rule, CMS calculates the per-discharge amount for uncompensated care payments using the average of the most recent 3 years of discharge data.

To reduce the risk of overpayments of interim uncompensated care payments and the potential for unstable cash flows for hospitals and MA plans, CMS continues its voluntary process through which a hospital may submit a request to its MAC for a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the beginning of the fiscal year and/or once during the fiscal year. The hospital would have to provide documentation to support a likely significant recoupment – for example, 10 percent or more of the hospital's total uncompensated care payment or at least $100,000. The only change that would be made would be to lower the per discharge amount either to the amount requested by the hospital or another amount determined by the MAC. This does not change how the total uncompensated care payment amount will be reconciled at cost report settlement.

d. Process for Notifying CMS of Merger Updates and to Report Upload Issues

In the case of hospital mergers, CMS publishes a table on the CMS Web site, in conjunction with the issuance of each fiscal year's proposed and final IPPS rules, containing a list of the mergers known to CMS and the computed uncompensated care payment for each merged hospital. Hospitals had 60 days from the date of public display of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies.

Comment/Response Commenters support for use of a three-year average of Worksheet S-10 data to calculate uncompensated care payment for FY 2027 continues to be mixed. Those commenters in favor believe this approach minimizes year-to-year volatility in uncompensated care payments and provides greater transparency, while those in opposition do not believe this approach adequately acknowledges emerging uncompensated care pressures, particularly those faced by rural hospitals. CMS states that it continues to believe that using a multi-year average of Worksheet S-10 data results in more stable and predictable payments, while mitigating unpredictable swings and single year anomalies in hospital's uncompensated care costs.

CMS also received recommendations for alternative approaches to consider when distributing uncompensated care payments. These recommendations included maintaining the same uncompensated care pool in FY 2027 as in FY 2026, incorporating alternative or additional data sources to more accurately estimate total uncompensated care costs and each hospital's share, publishing interim Factor 3 calculations earlier in each IPPS rulemaking cycle, creating temporary adjustments for states with significant coverage losses, and establishing a supplemental uncompensated care payment for hospitals with large increases in the number of uninsured patients or uncompensated care costs. Another commenter recommended that CMS distribute existing DSH and UC payments based on each hospital's share of the Medicare Safety-Net Index (MSNI) and add $4 billion to the MSNI pool. CMS states, however, that it continues to believe that utilizing Worksheet S-10 data to generate the best estimates of the uncompensated care payments is most conducive to administrative efficiency, finality, and predictability in payments and cites reasons cited in earlier rulemaking (83 FR 41144; 84 FR 42044; 85 FR 58432; 86 FR 44774; 87 FR 48780; 88 FR 58640; 89 FR 68986; and 90 FR 36536).

Commenters also recommended that CMS provide additional clarification of the Worksheet S-10 instructions and related guidance and reconsider certain methodological approaches to improve consistency and accuracy. Specifically, a commenter requested that CMS clarify the Worksheet S-10 instructions for line 29 so that non-Medicare bad debt is not multiplied by the hospital's CCR. Another commenter suggested that CMS reduce reliance on financial assistance policies (FAPs) across uncompensated care categories, citing concerns regarding the complexity and variability associated with coverage denials, non-covered services, medical necessity determinations, out-of-network care, and compliance with state and federal requirements.

In response, CMS states that it continues to believe that its past efforts to refine the Worksheet S-10 instructions and related guidance have improved provider understanding of Worksheet S-10 and have made the instructions clearer. In response to specific concerns related to reliance on FAPs across uncompensated care categories, CMS states it did not mandate eligibility criteria that hospitals use under the hospital's FAPs, as hospitals are able to establish their own policies.

CMS states, however, that it will attempt to address commenters' concerns as may be appropriate through future rulemaking and/or sub-regulatory guidance and subsequent outreach to MACs and providers. Regarding the commenter's request that CMS clarify the instructions for line 29 with respect to whether non-Medicare bad debt is multiplied by the CCR, CMS believes that the Worksheet S-10 instructions are clear and indicate that the CCR will not be applied to the deductible and coinsurance amounts for insured patients approved for charity care and non-reimbursed Medicare bad debt.

Like prior year comments, commenters suggested a standard audit timeline, a more transparent audit process by disclosing criteria used to identify hospitals for audits, and audit protocols published in advance to allow hospitals time and opportunity to respond to audits and address findings through notice and comment rulemaking. In response to commenters' requests regarding audit protocols (see for example, 88 FR 58640), CMS emphasizes that audit protocols are provided to MACs in advance of the audit to ensure consistency and timeliness in the audit process.

Some commenters reiterated their recommendation that CMS use the traditional payment reconciliation process to calculate final payments for uncompensated care costs pursuant to section 1886(r)(2) of the Act. CMS continues to believes, consistent with its position stated in past rulemaking, that applying its best estimates of the three factors used in the calculation of uncompensated care payments to determine payments prospectively is most conducive to administrative efficiency, finality, and predictability in payments (83 FR 41144; 84 FR 42044; 85 FR 58432; 86 FR 44774; 87 FR 48780; 88 FR 58640; and 89 FR 68986). Thus, CMS does not agree with the commenter's suggestion that it should establish a process for reconciling its estimates of uncompensated care payments, which would be contrary to the notion of prospectivity in a payment system.

D. Payment Impacts

The regulatory impact analysis presented in Appendix A of the final rule includes the estimated effects of the changes to uncompensated care payments and supplemental payments for IHS/Tribal hospitals and Puerto Rico hospitals for FY 2027 across all hospitals by geographic location, number of beds, region, teaching status, type of ownership, and Medicare utilization percent. CMS' analysis includes 2,277 hospitals that are projected to be eligible for DSH in FY 2027.

The total amount of uncompensated care payments ($7.939 billion) combined with supplement payments for IHS/Tribal hospitals and Puerto Rico hospitals ($109.4 million) is $8.049 billion. This is a 2.9 percent increase (about $228 million) from FY 2026 payments Changes in FY 2027 payments are driven by a decrease in Factor 1 and an increase in Factor 2.

The variation in the distribution of payments by hospital characteristics is largely dependent on a given hospital's reported uncompensated care costs used in the Factor 3 computation and whether the hospital is eligible to receive the supplemental payment. A percentage change in payments greater than 2.9 percent indicates that hospitals within that category are projected to experience a larger increase in payment compared to the average for all hospitals, and a

percentage change less than 2.9 percent indicates the category of hospitals is projected to receive a larger decrease in payments than the average for all hospitals. The table below shows impacts for selected categories of hospitals, including uncompensated care payments and supplemental payments combined.

Hospital Type	Dollar Difference FY 2026-FY 2027 ($ in millions)	Percent Change (%)
All Hospitals	228	2.9
Urban	248	3.4
Large Urban	203	4.9
Other Urban	45	1.4
Rural	-20	-4.6
Beds: 0-99 (Urban)	-7	-2.2
Beds: 250+ (Urban)	225	4.1
Beds: 0-99 (Rural)	-9	-3.7
Beds: 100 to 249 (Rural)	-12	-7.2
New England (Urban)	7	3.6
Middle Atlantic (Urban)	70	8.1
South Atlantic (Urban)	-14	-1.9
East South Central (Urban)	36	1.9
West North Central (Urban)	5	1.1
West South Central (Urban)	112	6.5
Pacific (Urban)	16	2.3
New England (Rural)	-2	-20.8
Middle Atlantic	2	6.3
East North Central (Rural)	-4	-15.2
Pacific (Rural)	1	7.4
West North Central	-6	-7.5
Puerto Rico	0	0.5
Teaching with 100 or more residents	168	5.2
Teaching with fewer than 100 Residents	51	1.8
Non-Teaching	9	0.5
Voluntary	128	2.9
Proprietary	-14	-1.3
Government	114	5.0

Under the final rule UCP policy, CMS projects that rural hospitals are expected to receive a decrease in uncompensated care payments of 4.6 percent compared to an increase in UCP payments of 3.4 percent for urban hospitals in FY 2027 compared to FY 2026. By region, rural and urban hospitals are projected to receive a varied range of payment changes. Teaching hospitals with 100 or more residents are expected to receive a larger than average increase of 5.2 percent compared with projected increases for teaching hospitals with fewer than 100 residents and nonteaching hospitals of 1.8 percent and 0.5 percent, respectively. Government ownership hospitals are expected to receive a larger than average increase of 5.0 percent, while voluntary hospitals receive the overall average of 2.9 percent, and proprietary hospitals are expected to receive a decrease of 1.3 percent.

V. Other Decisions and Changes to the IPPS

A. Post-Acute Care Transfer Policy

A post-acute care transfer is a hospital discharge occurring prior to the geometric mean length of stay to a post-acute care setting.[51] CMS makes payment to the transferring hospital at:

- Twice the per diem amount for the first day with each subsequent day paid at the per diem amount up to the full MS-DRG payment; or
- 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 (known as the "special payment methodology") for types of cases with large costs early in the stay.

If the MS-DRG's total number of discharges to post-acute care equals or exceeds the 55th percentile for all MS-DRGs and the proportion of short-stay discharges to post-acute care to total discharges in the MS-DRG exceeds the 55th percentile for all MS-DRGs, CMS will apply the post-acute care transfer policy to that MS-DRG and to any other MS-DRG that shares the same base MS-DRG. CMS does not revise the list of DRGs subject to the post-acute care transfer policy annually unless it is also making a change to a specific MS-DRG.

CMS evaluates each new or revised MS-DRG for whether it should be subject to or removed from the post-acute care transfer policy list and subject to the special payment methodology. Based on the changes CMS is making to the MS-DRGs, it proposed to add new or revised MS-DRGs 210, 211, 361, 362, 400, 403, 404, 456, 457, 458, 523, 524, and 525 to the list of MS–DRGs that are subject to the post-acute care transfer policy. Of these, CMS proposed to pay MS-DRGs 362, 400, 404 and 457 using the special payment methodology. CMS also proposed to pay MS-DRGs 463 and 617 using the special payment methodology.

Multiple commenters raised a variety of policy concerns with CMS's proposal to add 13 new or revised MS-DRGs to the post-acute care transfer policy. CMS responded that its analysis of MedPAR data identified these MS-DRGs as having a significant proportion of cases resulting in transfers to post-acute care settings consistent with the criteria for making an MS-DRG subject to the post-acute care transfer policy. The policy adjusts the payment to the transferring hospital to reflect the shorter length of stay and the lower resources the hospital incurs for treating a patient transferred early in a stay to a post-acute care setting. The response adds that of the 13 new or revised MS-DRGs that were proposed to be added to the post-acute care transfer policy, 8 were also proposed to be added to the special payment policy recognizing costs a hospital will have early in the stay for these types of cases.

CMS is finalizing the addition of the new or revised MS-DRGs to the post-acute care transfer policy and special payment policy as proposed.

[51] A post-acute care setting is rehabilitation hospital or unit, a psychiatric hospital or unit, a skilled nursing facility, a hospice or the patient's home with a written plan for home health services from a home health agency, and those services begin within 3 days of the date of discharge.

B. Inpatient Hospital Update

The inpatient hospital update for FY 2027 is calculated by determining the rate of increase in the hospital market basket for IPPS hospitals in all areas, subject to the following reductions:

- The 10-year moving average of economy-wide total factor productivity.
- For hospitals that fail to submit quality information, the FY 2027 inpatient hospital update will be reduced by one quarter of the hospital market basket.
- For a hospital that is not a meaningful EHR user (and to which no exemption applies), the FY 2027 inpatient hospital update will be reduced by three-quarters of the hospital market basket.

CMS proposed a market basket of 3.2 percent with a productivity offset of 0.9 percentage points. Public commenters reiterated many of the same comments made for the last several years with CMS responding as they did in the past. Significant issues include:

Employment Cost Index (ECI). Commenters expressed concern that the ECI may not be adequately capturing employment and labor cost growth in the market basket. CMS responded that the ECI appropriately does not reflect hospital decisions on the mix of labor to use as it is a fixed weight index.

Transparency. A commenter requested CMS provide additional publicly available data on the assumptions and inputs that go into developing a market basket update. CMS provided a detailed response on the publicly available information it provides that can be used to replicate its calculation of the market basket.

Rebase the Market Basket More Frequently. A commenter requested CMS rebase the market baskets at least every three years to ensure the market basket reflects the appropriate mix of services provided to Medicare beneficiaries. CMS rebased and revised the market basket to reflect a 2023 base year in the FY 2026 IPPS. Therefore, it is reflective of hospital's most recent cost structure and input prices.

Market Basket is Too Low. Several commenters expressed concern that the proposed update fails to account for the costs of contract labor, workforce shortages, administrative costs from prior authorization and claims denials, tariffs and their effect on pharmaceuticals and supply costs among many other variables. Comments noted that proposed update was below the Consumer Price Index (CPI), which suggests prices are growing more rapidly than reflected in CMS' market basket forecast. Others cited negative hospital margins by MedPAC, AHA data showing underpayments to hospitals, Kaiser Family Foundation information that Medicare payments have not accommodated market increases for at least the last 10 years indicators that the market basket is too low.

CMS responded that market basket is designed to measure price inflation for IPPS hospitals and would not reflect increases in costs associated with changes in the volume or intensity of input goods and services. The market basket may differ from other overall inflation indexes such as the

CPI as it measures a different mix of products, services, or wages. The response reiterates those made in prior years about how the market basket is constructed consistent with the statute and that it is calculated by IHS Global Insight, Inc. (IGI)— a nationally recognized economic and financial forecasting firm. IGI. considers all macroeconomic factors that influence pricing trends when determining the market basket.

Forecast Error Correction. Several commenters recommended that CMS consider adopting a prospective forecast error correction policy for FY 2027 if CMS again underestimates hospital inflation in a period of economic uncertainty and instability. CMS responded that over long periods, its forecast of the hospital market basket has generally averaged close to the historical measures. While the SNF PPS includes a forecast error adjustment, it was adopted very early in the payment system. Forecast errors have been consistently addressed within the SNF PPS throughout its history.

Productivity Adjustment. Several comments object to application of the productivity adjustment and cite OACT's own analysis that hospitals cannot achieve the same level of productivity as the general economy. Other commenters requested CMS provide more information so the productivity estimates can be replicated. There were also comments indicating that CMS should increase the market basket for periods of negative productivity as well as decrease it at other times.

CMS responded that section 1886(b)(3)(B)(xi) of the Act requires the application of the productivity adjustment. The response again provided detailed publicly available information that the public can use to replicate its calculation of the productivity adjustment. CMS further added that the statutory language in section 1886(b)(3)(B)(xi)(I) of the Act requires that the Secretary reduce (not increase) the market basket percentage increase by changes in economy-wide productivity.

CMS is finalizing the market basket and productivity adjustment using the most recent available data. Using a 2023 base year, IGI's 2nd quarter 2026 forecast (with historical data through the 1st quarter of 2026) of the hospital market basket is 3.2 percent. IGI's 2nd quarter 2026 forecast of total factor productivity is 0.9 percent.

Four different scenarios that may apply to a hospital, depending on whether it submits quality data and/or is a meaningful EHR user, are shown in the following table.

FY 2027	Scenario 1: Hospital Submitted Quality Data and is a Meaningful EHR User	Scenario 2: Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Scenario 3: Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Scenario 4: 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	0.0	0.0	-0.8	-0.8
Adjustment for Failure to be a Meaningful EHR User	0.0	-2.4	0.0	-2.4
Productivity Adjustment	-0.9	-0.9	-0.9	-0.9

FY 2027	Scenario 1: Hospital Submitted Quality Data and is a Meaningful EHR User	Scenario 2: Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Scenario 3: Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Scenario 4: Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Applicable Percentage Increase	**2.3**	**-0.1**	**1.5**	**-0.9**

For updates to the hospital-specific rate for SCHs and MDHs, CMS will adopt the same four possible applicable percentage increases shown in the table above (although the MDH program is set to expire on December 31, 2026, if it is not extended by Congress).

Puerto Rico hospitals are not subject to the quality reporting provisions but do receive EHR subsidies and may be subject to a penalty for not being meaningful users of EHR technology equal to ¾ of the market basket (before application of total factor productivity).

C. Rural Referral Centers (RRCs)

RRCs are hospitals that are either geographically rural or treated as rural for IPPS purposes and are subject to special rules for the DSH payment adjustment and geographic reclassification. To qualify as an RRC, a hospital must have more than 275 beds or meet case-mix, discharge and other criteria for the federal fiscal year that ends at least one year prior to the beginning of the cost reporting period for which the hospital seeks RRC status.

CMS annually revises case mix index (CMI) and discharge criteria to qualify for RRC status. For FY 2027, CMS proposed to use FY 2025 data to set the CMI criteria. Commenters supported CMS' proposal that is being finalized without change. To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2026, a hospital may qualify as an RRC if the hospital is rural or treated as rural and has:

- 275 beds or more; or
- More than 5,000 discharges (3,000 for an osteopathic hospital) in its cost reporting period that began during FY 2023, and a CMI greater than or equal to the lower of 1.778 (national urban hospital CMI excluding teaching hospitals) or the CMI for the hospital's region shown in the below table.

Census Region	CMI Value
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

The median regional CMIs in the final rule reflect the March, 2026 update of the FY 2025 MedPAR with bills received through March 31, 2026. A hospital seeking to qualify as an RRC should get its hospital-specific CMI value (not transfer-adjusted) from its MAC.

D. Low-Volume Hospitals (LVH)

Section 1886(d)(12) of the Act provides a payment in addition to a hospital's IPPS payment for each qualifying LVH beginning in FY 2005. To qualify as an LVH, the hospital must be more than a distance specified in the statute from another IPPS hospital and have fewer than a statutory specified number of discharges. The table below shows the statutory and regulatory criteria for a low-volume hospital and how the additional payment is calculated.

Fiscal Year	Distance Criteria	Discharge Criteria	Payment Methodology
2005 - 2010	25 miles	200 Total Discharges	25%
2011 - 2018	15 miles	1,600 Medicare Discharges	Medicare Discharges<200=25%; Declining Linear Adjustment Up to 1,600
2019 – 2026 and the 1st quarter of FY 2027	15 miles	3,800 Total Discharges	Total Discharges<500=25%; Declining Linear Adjustment up to 3,800 discharges applied to each Medicare Discharge
2nd quarter of FY 2027 and later	25 miles	200 Total Discharges	25%

Absent statutory intervention, only hospitals with fewer than 200 total discharges will be eligible for the LVH adjustment after December 31, 2026. As shown in the above table, the payment adjustment for a qualifying LVH will be 25 percent for each Medicare discharge beginning January 1, 2027 for hospitals with fewer than 200 total discharges.

Several commenters expressed concern about the repeated sunset of the more permissive criteria to be an LVH indicating that hospitals made business decisions in reliance on the low-volume adjustment since current criteria took effect in FY 2019. There were many other comments asking CMS to support an extension of the current LVH criteria. Many comments requested clarification on how CMS would handle any legislation that extends the current LVH hospital payment policy while urging CMS to expeditiously process claims and provide instructions to MACs for any subsequent extensions, especially those made retroactively. Those comments indicated that MA plans do not make payments retrospectively until after CMS issues instructions to the MACs.

CMS responded that once legislation is enacted, it will evaluate the most appropriate approach to implement changes to the law, including issuing instructions to the MACs and communicating with affected hospitals. As with past extensions, CMS will implement any subsequent extensions as quickly and seamlessly as possible.

Several commenters object to CMS establishing a qualifying criterion of less than 200 discharges to be an LVH rather than the 800 discharges specified in statute. CMS reiterates its prior response that while the statute allows an LVH to be one with fewer than 800 discharges, it also authorized CMS to determine the empirical relationship between low number of discharges and standardized cost per case to determine the LVH adjustment. CMS performed several regression

analyses and found the data only supported an adjustment for hospitals with less than 200 total discharges (see 69 FR 49101 through 49102 for more detailed analysis of this finding).

CMS proposed to continue the past process for hospitals to apply for LVH status. Hospitals must submit a written request for LVH status to their MACs by September 1, 2026, that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria. Hospitals must use the latest submitted Medicare cost report for discharge information. Use of a web-based mapping tool may be used to demonstrate that the mileage criterion has been met.

If a hospital's written request for LVH status for FY 2027 is received after September 1, 2026, CMS proposed that any approval will be effective prospectively within 30 days of the date of the MAC's determination. A hospital that qualified for the LVH payment adjustment for FY 2026 may continue to receive the LVH adjustment for the 1st quarter of FY 2027 without reapplying if it meets both the discharge criterion and the mileage criterion applicable for the 1st quarter FY 2027. In this case, the hospital must send written verification that is received by its MAC no later than September 1, stating that it meets the discharge mileage criterion for 1st quarter of FY 2027.

For the portion of FY 2027 beginning January 1, 2027, a hospital must submit a written request for LVH status to its MAC by December 1, 2026, that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria for LVH status to be effective January 1, 2027. If a hospital's written request for LVH status for FY 2027 is received after December 1, 2026, CMS proposed that any approval will be effective prospectively within 30 days of the date of the MAC's determination.

A hospital that qualified for the LVH adjustment for FY 2026 that will continue to qualify for LVH status on or after January 1, 2027, may continue to receive a low-volume hospital payment adjustment without reapplying if it meets both the discharge criterion and the mileage criterion. In this case, the hospital must send written verification that is received by its MAC no later than December 1, stating that it meets the discharge and mileage criterion effective January 1, 2027.

A hospital may submit a single written request for LVH status to its MAC for both the portions of FY 2027 by September 1, 2026. CMS did not receive any comments on these process issues that it is finalizing without modification.

E. Medicare-Dependent Small Rural Hospitals (MDH)

Section 1886(d)(5)(G) of the Act provides special payments under the IPPS to an MDH through December 31, 2026. Beginning with discharges occurring on or after January 1, 2027, all hospitals that previously qualified for MDH status will no longer be eligible for this special payment methodology. While the MDH program was set to expire many times previously, it has always been extended by Congress.

When the MDH program was set to expire at the end of FY 2012, CMS revised the SCH regulations to allow MDHs to apply for SCH status in advance of the expiration of the MDH program. However, if an MDH classifies as a SCH in anticipation of the MDH program

expiration, it would have to reapply for MDH classification and meet the criteria specified in 42 CFR §412.108(a) and (b).

Commenters requested CMS implement any potential retroactive restoration and/or extensions of the MDH program expeditiously to avoid significant financial strain to affected hospitals and potential lower Medicare reimbursement from MA plans. CMS responded that, as with past extensions, it will evaluate enacted legislation to determine the most appropriate approach to implement changes to the law, including issuing instructions to the MACs to reinstate MDH status to eligible hospitals and communicating with affected hospitals expeditiously.

F. Indirect and Direct Graduate Medical Education

1. Background

Medicare pays hospitals for direct graduate medical education (DGME) and indirect medical education (IME) costs based on the number of full-time equivalent (FTE) residents they train. Generally, the greater the number of FTE residents a hospital counts, the greater the amount of Medicare DGME and IME payments the hospital will receive. Since 1997, the law has limited the number of residents a hospital may count for DGME and IME (other than dental and podiatric residents) to the amount they counted in 1996.

For IME, the hospital's payment adjustment is based on a complex formula specified in statute. For DGME, the hospital's payment equals the product of a per resident amount (PRA), the number of residents and the Medicare's share of the hospital's total inpatient days. For DGME, a resident is weighted at 0.5 FTE for training beyond an "initial residency period." Generally, this means that the resident has completed an initial board certification and is engaged in subspecialty training.

2. Prohibiting Unlawful Discrimination in Approved Medical Residency Programs and Nursing and Allied Health Education (NAH)

To receive DGME and IME payments from Medicare, a hospital's training program must be an "approved medical residency training program." Under 42 CFR §415.152, a graduate medical education program may be an approved medical residency training program if it is accredited by one of several national accrediting bodies or the resident's training leads toward a board certification included in the American Board of Medical Specialties (ABMS) for allopathic medicine (or the equivalent for osteopathic medicine).

In the 2026 OPPS rule, CMS finalized regulatory changes that accrediting organizations may not use accreditation criteria that promote or encourage discrimination based on race, color, national origin, sex, age, disability, or religion or proxies for those characteristics. For FY 2027, CMS proposed the same policy for medical residency programs and NAH health education programs that receive reasonable cost payment under 42 CFR §413.85. CMS believes such a policy is necessary to ensure that, even in the absence of discriminatory accreditation standards, individual

programs do not implement policies that constitute unlawful discrimination under Federal law. The effective date of the policy would be October 1, 2026.[52]

Several commenters supported these proposals and requested that CMS expand conscience protections to additional services beyond abortion such as procedures for contraception, sterilization, assisted suicide, euthanasia, or, as it is referred to in the rule "sex-rejecting interventions (what advocates call 'gender affirmative care')."

Other commenters supported the overall goal of prohibiting unlawful discrimination but expressed concern about definitional issues and enforcement standards for these proposals. The absence of objective and administrable standards, duplication of established accreditation and civil rights requirements, lack of clearly delineated responsibilities, and unresolved questions about due process would increase compliance risks and create payment uncertainty for hospitals according to the commenters. Some commenters emphasized the importance of a diverse physician workforce in achieving positive health outcomes, especially among vulnerable groups, and stated that ignoring identity-based characteristics in the selection process could disadvantage qualified applicants from marginalized backgrounds.

CMS responded that a non-exhaustive list of unlawful policies and practices that are prohibited under these regulations are included in the Attorney General's Guidance for Recipients of Federal Funding Regarding Unlawful Discrimination (June 29, 2025). Section B.1 of that guidance includes discussion of the prohibited use of proxies for protected characteristics, including examples of potentially unlawful proxies. CMS disagrees with commenters who advocated using identity-based characteristics, or proxies for such characteristics, as selection criteria in residency training programs. Such race-conscious elements of diversity, equity and inclusion policies are generally impermissible under Federal law. CMS is unpersuaded by commenters' arguments that such policies are necessary for achieving positive health outcomes.

Several commenters urged CMS to rely on existing Federal civil rights laws to address concerns related to unlawful discrimination and defer to the medical community and accrediting organizations to develop evidence-based standards that safeguard patient safety and promote an effective learning environment. CMS disagrees stating that its policy is necessary to ensure that, even in the absence of discriminatory accreditation standards, individual residency programs do not implement policies that constitute unlawful discrimination under Federal law.

CMS is finalizing its proposals without modification. Additionally, CMS emphasizes that regardless of the inclusion of explicit language in the GME regulations, no entity or individual may be forced to act contrary to objections protected by Federal conscience and nondiscrimination statutes.

[52] In the impact section of the rule, CMS states "we believe that, as of October 1, 2026, no approved programs or accrediting bodies would continue to or newly engage in unlawful discrimination on the basis of race or other protected characteristics".

3. Criteria for New Residency Programs

Since 1997, the law has limited the number of residents a hospital may count for DGME and IME (other than dental and podiatric residents) to the amount they counted in 1996. A hospital with no residents in its most recent cost reporting period ending on or before December 31, 1996, has an FTE cap for IME and DGME of zero.

The law authorizes CMS to establish rules for applying the IME and DGME caps in the case of medical residency training programs established on or after January 1, 1995. The current rules allow FTEs in new medical residency programs to be counted for IME and DGME for five years before the cap is established beginning in the 6th year after the first residency program is created. A Rural hospital can receive an adjustment to its IME and DGME FTE caps for any new medical residency program it creates even if it is already a teaching hospital with a cap.

42 CFR §413.79(l) defines a "new medical residency training program" as a "medical residency that receives initial accreditation by the appropriate accrediting body or begins training residents on or after January 1, 1995." To be considered a "new" program for which new cap slots would be created, a previously non-teaching hospital would have to ensure that the program meets three primary criteria:

- The residents are new,
- The program director is new, and
- The teaching staff are new.

In rulemaking for FY 2025, CMS proposed to define the above three criteria with more specificity but did not finalize its proposals. CMS' current policy indicates that it would consider a program to be new for cap adjustment purposes if the "overwhelming majority" of the residents and staff are not coming from previously existing programs in that same specialty.

The proposed rule indicated that the definition of a "new" program eligible to receive additional Medicare-funded GME slots has taken on increasing significance because of the increasing frequency of hospitals reclassifying from urban to rural areas. Among the other benefits available to an urban hospital reclassifying as rural is its ability to receive an IME cap adjustment for any new medical residency program created. An urban to rural reclassified hospital cannot receive the same benefit for DGME cap adjustments as a different section of the law applies.

CMS reviewed its FY 2025 proposals on this topic in the proposed rule as well a request for comments on potential criteria for defining a new medical residency program that it did after completing the FY 2025 IPPS final rule. Based on those public comments, CMS believes that it should not restrict the ability of new residency programs to hire experienced faculty and program directors. CMS believes that considering the previous training experience of residents should provide a sufficient guardrail to ensure that existing programs are not being transferred between hospitals inconsistent with the statutory purposes of establishing the caps.

As indicated below where CMS modifies its proposed rule policies for this final rule, effective

October 1, 2026, CMS will no longer consider the previous employment of the faculty or program director in determining whether a residency program should be considered new for cap-building purposes. In addition to the program receiving initial accreditation from the appropriate accrediting body on or after January 1, 1995, CMS proposed that at least 90 percent of the individual resident trainees (not FTEs) must not have previous training in the same specialty as the new program. CMS would evaluate whether the 90 percent threshold is met during the entire 5-year cap building period.

The proposed rule distinguished between a resident that was accepted, enrolled and participated in an internal medicine residency program from a resident who was not enrolled in an internal medicine program but who may have done a rotation in internal medicine as part of the requirements for a different specialty. Also, an individual who enters a subspecialty training program after having previously completed an initial board residency would be counted as a new resident.

CMS proposed to create a limited exception to the counting rules for certain residents admitted via the National Resident Matching Program (the Match) or other third-party resident matching programs whose results are binding on hospitals. The proposal would exclude from the count of trainees—both numerator and denominator of the 90 percent calculation—any individuals with previous experience training in another program in the same specialty who enter the new program as first-year residents through the Match or another binding third-party resident matching program or are displaced from a closed program. However, such residents could continue to be counted as new residents for determining DGME and IME payment and establishing the cap at the end of the 5-year cap building window.

Residents displaced from a closed program would also be excepted from the 90 percent determination of whether a residency program is new or not. These residents may continue to be counted as residents above the cap but not on the cost report lines for new residents and instead on the lines for displaced residents. Displaced residents would not be counted for determining a hospital's cap at the end of the cap building period.

Comments were overwhelmingly supportive of the proposals to no longer consider the previous employment of the faculty or program director in determining whether a residency program should be considered new for cap-building purposes. There were also many commenters supportive of CMS' proposal to require that at least 90 percent of the individual resident trainees (not FTEs) must not have previous training in the same specialty, in addition to receiving initial accreditation from the appropriate accrediting body for the program to be considered new..

There were some commenters that were not supportive of the 90 percent threshold. These commenters suggested several alternatives to the 90 percent criterion CMS rejected these alternatives stating that 90 percent is consistent with "overwhelming majority" and is established precedent when receiving temporary cap adjustment for taking over a hospital's closed residency program. The 10 percent allowance for residents that are not new would address specific situations that concerned commenters such as hardship situations.

Several commenters asked CMS to apply the revised criteria to programs still in their five-year cap-building period as of October 1, 2026, rather than the proposed effective date of new programs that start on or after October 1, 2026. CMS agreed with the comment and is modifying its final rule policy accordingly.

There was a comment indicating that it is burdensome to wait until the end of the 5 year cap building period to determine whether a program is new. By the time the hospital with the new program files its cost report in which the newness and cap calculation would be determined, there are already five or six previous cost reporting periods where the hospital had claimed FTE counts for residents in the new programs and for which the final settlements have been issued. If there is an adverse finding on the "newness" of a program, the earliest of these cost reporting periods may no longer be subject to reopening. The commenter recommended that the determination of newness should be made at the time of the review of the first cost reporting period where the hospital is claiming FTE residents in the new program. The assessment of the newness generally does not need to be made in the second through the fifth years of a new program's existence unless there is evidence of a program transfer.

CMS disagrees. The MAC will need to review the previous training experience of each individual trainee and determine the newness of the residency program prior to calculating the IME and DGME cap adjustments for the hospital. The hospital is responsible for maintaining and providing the training history of each of those residents and furnishing that documentation to the MAC in an orderly and auditable format at the end of the 5-year period. Much of this information should be the same or like documentation needed to establish and record the resident's Initial Residency Period (IRP) under 42 CFR 413.79(a) in the Intern and Resident Information System (IRIS).

Several commenters opposed the proposed exclusion of displaced residents accepted into new small or rural programs from cap-building, asserting that not infrequently, rural hospitals, unlike urban counterparts, rely on displaced residents to fill positions. Other commenters were concerned that excluding displaced residents from cap-building could serve as a disincentive to new programs from accepting them. One commenter also expressed concern about CMS's specification of the clause "in the same specialty," noting that if the displaced resident would be transferring from a different specialty, concerns about duplicating the resident slot under the resident cap at another hospital would still be present.

CMS responded that to the extent that the proposed guardrail on displaced residents serves as a disincentive for some new programs to accept these residents, hospitals closing or closing their programs may opt to lend FTE cap slots to receiving hospitals under 42 CFR 413.79(h). Regarding the comment limiting the displaced resident to being "in the same specialty," CMS agrees with the commenter and will exclude any resident admitted into the new program from another program who meet the definition of a "displaced resident" from the numerator and from the denominator of the calculation used to determine the proportion of new vs. experienced residents regardless of whether the resident is the same specialty or changed specialties.

CMS also proposed an exception to the 90 percent requirement for small residency programs defined as those accredited for 16 or fewer residents. For these programs, CMS did not propose an alternative threshold to 90 percent but only that these programs must have an initial accreditation after January 1, 1995.

One commenter requested that this proposal should be abandoned because it will be ineffective in preventing an urban to rural reclassified hospital from establishing new programs for IME as most subspecialty training programs are not more than 16 residents. Another commenter recommended that in determining the 16-resident limit for a small program, the exception should be based on the size of the accredited residency program, not on the number of residents reported.

CMS responded that it shares the commenters' concerns regarding urban hospitals' possible use of rural reclassifications to obtain increased cap limits but indicates that it is a result of the statute, not CMS' policy. Any program exception for small programs must apply for IME purposes to urban to rural reclassified hospitals under section 1886(d)(8)(E). CMS agrees that the 16-resident exemption is based on the accredited size of the program, not based on FTEs or individual residents in the new program.

One commenter requested that CMS define a small program as a program that is accredited for five or fewer residents per program year to avoid discriminating against training programs that are four to five years. CMS does not believe it is necessary to adopt the commenter's suggestion as 16 is sufficient to apply to 3, 4, and 5-year programs.

There would be no restrictions on commingling of residents under these new proposed rules as CMS had previously considered in the FY 2025 IPPS rule. The 90 percent threshold would only be determined based on new residents in the new medical residency program. In addition, CMS would allow a hospital to have two or more residency programs in the same specialty if the second or subsequent program has separately received initial accreditation and at least 90 percent of the individual trainees (not FTEs) entering the program during the five-year cap building period are new. The programs would not be required to have separate program directors and staff as is current policy for a program to be considered new. CMS did not receive any comments on this proposal.

After considering the comments, CMS is finalizing the proposed policy with the modifications that the effective date will be for programs that are still in their five year cap building period as of October 1, 2026 and that the policy not to count displaced residents will apply all displaced residents, not just those in the same specialty.

4. DGME and IME Payments Following a Hospital Merger

CMS is not proposing any new policies following a hospital merger but is clarifying the methodology for calculating DGME and IME payments for the surviving provider in rulemaking. A detailed and complex description of the methodology followed in the proposed rule and again in the final rule and is not repeated here. Public commenters expressed support for CMS' transparency regarding the payment methodology applied following hospital mergers.

5. Notice of Closure of a Teaching Hospital

Section 5506 of the Affordable Care Act authorizes the Secretary to redistribute residency slots of a hospital that trained residents in an approved medical residency program after its closure.

CMS is notifying the public of the following hospital closures:

Available Resident Cap FTEs

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME Resident Cap	DGME Resident Cap
360055	Insight Hospital and Medical Center Trumball	Warren, OH	49660	October 10, 2025	75.11	76.93
240063	M Health Fairview St. Joseph's Hospital	Saint Paul, MN	33460	July 1, 2022	13.36	13.38

Application Process for Available Resident Slots

The application period for hospitals to apply for slots under section 5506 is 90 days following notification to the public of a hospital closure. Therefore, hospitals must apply to the CMS Central Office **no later than October 29, 2026** to be eligible to receive slots from these closed hospitals.

CMS will only accept applications submitted via MEARIS™ (MEARIS™ (cms.gov)). Applications submitted through any other method will not be considered. CMS has not established a deadline for when it will issue the final determinations to hospitals that receive slots under section 5506. However, CMS reviews all applications received by the deadline and will notify applicants of its determinations as soon as possible.

G. Nursing and Allied Health Education (NAH)

1. Nursing and Allied Health Education Medicare Advantage Payments

Medicare pays for provider-operated nursing and allied health education programs on a reasonable cost basis. Under the reasonable cost payment methodology, a hospital is paid Medicare's share of its reasonable costs. Provisions of law enacted in 1999 and 2000 required that CMS include Medicare Advantage (MA) utilization in determining the Medicare share of reasonable cost nursing and allied health education payments. These additional payments for nursing and allied health education attributed to MA utilization are funded through a reduction to analogous payments made to teaching hospitals for DGME and limited to $60 million per year.

CMS uses cost reporting periods ending in the fiscal year that is 2 years prior to the calendar year for which the MA nursing and allied health education payments are being determined to determine each eligible hospital's share of the $60 million pool. Each hospital's payment is based on its relative share of national nursing and allied health education payments and MA utilization.

In the FY 2027 IPPS proposed rule, CMS provided the MA nursing and allied health education payments and reduction in MA DGME payments for 2025. CMS proposed using the 3rd quarter 2025 update of the 2023 HCRIS projected forward two years to estimate 2025 payments. For 2025, CMS proposed to distribute the maximum $60 million in nursing and allied health education MA payments with an offset of 2.33 percent to MA DGME payments. These figures are the result of applying the statutory formula, which leads to capped payments of $60 million for nursing and allied health education MA payments.

CMS received support from commenters for its proposed policy and one out of scope comment asking CMS not to make the payments at all, which CMS cannot do as it is merely implementing a statutory provision as required. For the final rule, CMS is updating the distribution methodology based on the 1st quarter 2026 update of the 2023 HCRIS to estimate 2025 payments. CMS will distribute the maximum $60 million and in nursing and allied health MA payments with an offset of 2.34 percent to MA DGME payments.

2. No Longer Listing Accrediting Bodies

CMS provides examples of recognized accrediting bodies in the regulations text that an NAH program can use to be an approved NAH program. Given the evolving nature of the field and the large number of additional accrediting bodies active across various disciplines, CMS proposed to eliminate the partial list of accrediting bodies that are provided as examples of those that can accredit an NAH program for it to be considered an approved program. The regulations will maintain the requirement to be accredited by a recognized national professional organization for the particular activity.

A few commenters stated that the removal of the examples could create uncertainty for hospitals and auditors. These commenters stated CMS should provide a clear standard for determining whether an accrediting body is the recognized national professional organization for the activity. CMS disagrees. While many programs are accredited by organizations other than those currently listed in the regulations text, CMS is not aware of, nor have the commenters cited, instances in which a program has been disapproved because of uncertainty over whether an accreditor is nationally recognized. CMS is finalizing its proposal without modification.

3. Allocation of Indirect Costs to NAH Education Cost Center

Background.

A hospital's reasonable costs for NAH education are net of revenues received from tuition, student fees, sale of textbooks, etc., referred to below as revenues received from students. Separately, the Medicare cost report instructions indicate how indirect costs are allocated to individual cost centers. On November 17, 2017, CMS issued cost reporting instructions that revenues from students should be subtracted from the costs of NAH education prior to allocating indirect costs. On February 9, 2024, the U.S. District Court for the District of Columbia issued a ruling on behalf of five plaintiff hospitals finding that CMS' cost report instruction was

inconsistent with 42 CFR §413.85 that requires revenues from students to be subtracted from the cost of educational activities after the indirect cost allocation is completed.

In the FY 2026 IPPS proposed rule, CMS proposed to modify 42 CFR §413.85(d)(2)(ii) to indicate that revenues received from students is subtracted before completing the indirect cost allocation effective October 1, 2025. In a circumstance where revenue from students reduces direct NAH costs to zero, there would be no indirect costs to allocate to the NAH cost center. However, CMS' proposal would have allowed a hospital to seek permission from their MAC to employ a different allocation method to mitigate the reduction in reasonable cost payment for NAH education in accordance with PRM 15-1, chapter 23, section 2313.

The proposed rule indicated that this alternative allocation of indirect costs would focus on only those costs that are directly related to the operation of approved educational activities under 42 CFR §413.85. CMS provided examples of costs directly related to approved educational activities as those costs that the hospital would not have in the absence of an educational program. Such costs would not include nursing supervisors who oversee floor nurses and student nurses or costs that benefit the hospital as a whole (e.g., admissions or patient registration) and would also exclude the costs of a related organization (such as a home office).

CMS received many comments objecting that its proposed policy was inconsistent with general cost-finding principles and would result in the NAH education cost centers receiving less than their share of institutional overhead. Due to the number and nature of the comments, CMS decided not to finalize the proposed changes and said it expects to revisit the treatment of NAH education costs in future rulemaking.

After considering the public comments on the FY 2026 IPPS rule, CMS continues to believe that correct accounting procedures require the deduction of tuition and other revenue from the direct costs of a provider's approved educational activities prior to the allocation of overhead. However, CMS is modifying FY 2026 proposal to ensure that the deduction of revenue does not inappropriately reduce the allocation of overhead to the NAH cost centers when hospitals allocate administrative and general costs using accumulated cost as the default statistical basis. CMS also proposed to clarify the nature of allowable indirect costs of approved educational activities and to refine the cost reporting procedures to ensure that hospitals appropriately allocate overhead costs to the NAH cost centers.

CMS' proposals involve detailed cost accounting instructions for how to report costs on different worksheets and columns of the Medicare cost report. Worksheet A is where hospitals accumulate direct costs while Worksheet B is where the indirect cost allocation is done. The first proposal would have hospitals subtract revenues received from students from total NAH costs on Worksheet A-8. Hospitals would then add those revenues back to NAH costs on Worksheet B-1 only for the overhead allocation.

The proposed rule indicates that this procedure would result in the NAH cost center receiving its share of administrative and general expenses in the indirect allocation without NAH costs being used in subsequent steps of the indirect cost allocation that allocate costs for non-patient care cost centers like NAH to other patient care cost centers on the Medicare cost report. CMS states

this procedure is consistent with other non-patient cost centers like interest expense and cafeteria, which have adjusted costs respectively for investment revenue and revenue from the sale of food and beverages before the shares of expenses in these non-patient care costs are allocated to patient care cost centers.

Several commenters supported CMS' proposal while other commenters expressed concern that the proposal to deduct tuition and revenue prior to stepdown would be inconsistent with general cost-finding principles and result in under-allocation of legitimate overhead costs to the NAH cost centers. A few commenters stated that the procedure would impose significant administrative burden on hospitals, especially those with multiple NAH education programs. The commenters requested that CMS make the procedure optional, provide detailed cost reporting instructions, allow for a two-year transition period and extend audit protections to hospitals that make a good-faith effort to comply with the requirements.

CMS disagrees that the proposal is inconsistent with general cost finding principles. As Medicare's share of allowable costs is determined based on the hospital's Medicare utilization, it is necessary to remove any of those costs that are not generally allowable to Medicare prior to the stepdown process. Such generally unallowable costs include indirect expenses that are recovered through related non-patient care revenue.

The proposal was intended to facilitate the removal of unallowable costs at the appropriate stage of the cost reporting process while ensuring that the NAH cost centers continue to receive their fair share of the hospital's A&G costs. CMS believes use of the reconciliation column on Worksheet B-1 accomplishes these goals without imposing a significant administrative or compliance burden on hospitals as it results in only one additional step that hospitals must complete prior to the allocation of indirect costs on Worksheet B, Part I.

CMS intends to issue revisions to the cost report instructions to reflect the procedure for utilizing the reconciliation column as described in this final rule effective October 1, 2026. The proposal is being finalized with a minor modification discussed further below to state that indirect costs are limited to those costs that are "directly attributable" to the approved educational activities.

The second proposal clarified that indirect costs may only be allocated to the NAH education cost center to the extent those costs benefit the hospital's nursing and allied health education programs. For this purpose, CMS proposed to require providers with approved NAH education programs componentize—fragment or subscript—their general service cost center as follows:

- Indirect costs that provide a benefit to the hospital's NAH programs, and
- Indirect costs that do not provide a benefit to NAH.

Only those indirect costs that provide a benefit to the hospital's NAH would be allocated through the indirect cost allocation to the NAH cost center to be reimbursed reasonable costs. Costs in the second category would be deleted from the indirect cost allocation so that those costs are allocated to the departments that they serve but not to the NAH cost centers. Further, as the regulations prohibit a hospital from receiving reasonable cost payment for related party costs (such as a home office), the provider would have to further distinguish between administrative

costs incurred directly by the hospital and a related party. CMS notes that the componentization of general service cost centers is consistent with longstanding Medicare cost reporting procedures as described in the Provider Reimbursement Manual (CMS Pub. 15-1, chapter 23, section 2307(B)).

Some commenters assert, by definition, indirect costs cannot be attributed to a specific activity. By restricting indirect costs to those incurred "as a consequence of" a hospital's NAH programs, CMS would effectively prevent any indirect costs from flowing to the NAH cost centers. For similar reasons, commenters opposed requiring providers to componentize (subscript) their general service cost centers to distinguish between functions that provide a benefit to their NAH programs and those that do not. Commenters emphasized that NAH programs benefit from many hospital functions even when those functions are not exclusively or primarily educational, and that a hospital's shared institutional overhead cannot readily be disaggregated in the manner CMS proposed. In addition, commenters warned that overly granular componentization of general service costs would introduce subjectivity and uncertainty into the cost reporting process and result in significant administrative burden.

CMS disagrees that its proposed clarification conflicts with the nature of indirect costs and standard cost reporting principles. The statistical basis used to allocate a general service cost center must reflect the cause-and-effect relationship between the cost and the activities or services receiving the allocation. CMS maintains that because the A&G cost center comprises multiple discrete overhead functions, it is reasonably possible to identify and evaluate each of those functions separately to determine whether such a cause-and-effect relationship exists with respect to the hospital's other cost centers, including NAH.

For these reasons, CMS disagrees that accurate allocation of overhead costs at the level of detail proposed would introduce subjectivity into the cost reporting process or invite inconsistent treatment by the MACs. CMS is finalizing its clarification that the NAH cost centers may only receive a proportional share of the costs associated with those overhead functions that provide a benefit to the hospital's NAH education programs. However, based on commenters' concerns regarding administrative burden, CMS is not finalizing its proposal that, if a hospital operates approved NAH education programs, it must componentize its general service cost centers to distinguish between those overhead functions that provide a benefit to its NAH programs and those that do not. Nevertheless, CMS emphasizes that even in the absence of a specific componentization requirement, hospitals must continue to ensure that only allowable indirect costs are allocated to the NAH cost centers.

There were several comments on the allocation of a supervisor's costs between clinical care and educational activities. CMS acknowledged that the portion of a supervisor's compensation allocated to educational activities is a direct NAH cost that must be supported by adequate documentation such as a detailed time report or time study (e.g., it is a not a non-allowable NAH cost as there would be nursing supervisors even in the absence of the educational program).

Many commenters objected to CMS policies concerning related party costs, and especially home office costs, for purposes of NAH pass-through payment. The commenters stated that there is no justification for treating related party costs differently for purposes of allocation to NAH versus

other cost centers. For NAH, commenters argued that related party costs prohibit redistribution of costs from a related educational institution, not a home office. Disallowing home office costs would be treating the "administrative portion" of the hospital inconsistently depending on whether it is freestanding or co-located with the rest of the hospital. Several commenters expressed concern that NAH education programs could be deemed non-provider-operated simply because the programs depend on centralized administrative resources such as payroll processing, accounting systems, human resources support, etc., even if the hospital directly controls and operates its NAH programs, as required under §413.85(f).

CMS believes these comments distinguish two separate but related issues: allowance of related party costs and whether an NAH program is provider operated. Under existing §413.85(d)(2)(ii), a provider's total allowable education costs do not include patient care costs, costs incurred by a related organization, or costs that constitute a redistribution of costs from an educational institution to a provider or costs that have been or are currently being provided through community support. Separately, the regulations at §413.85(f) specify the requirements that a provider must meet to be considered the operator of an approved NAH education program.

CMS reiterates its rule on related party costs. Hospitals must continue to ensure that only allowable direct and indirect costs are included in the NAH cost centers. Allowable costs generally do not include indirect costs incurred by a related organization (66 FR 3367).

CMS further states that many cases, central offices or other related entities may be providing consolidated non-clinical and administrative functions. A corporate headquarters (historically referred to as a "home office") is a related organization to the hospital; it is not the hospital itself. Therefore, its costs may not be directly reimbursed by Medicare. As a home office is a related organization and not the provider itself, it may not be considered the operator of an approved NAH education program if it is incurring costs (such as salary costs) associated with the NAH education program, holding the W-2s of the teaching staff and residents, operating payroll, or providing other administrative functions. These factors would be evidence that the hospital itself is not "directly" incurring the costs or controlling the teaching staff or students.

H. Payment Adjustment for Certain Immunotherapy Cases

In some cases, CAR-T cell or other immunotherapy patients may be part of a clinical trial where the high-cost therapy product is furnished to the hospital at no cost. Beginning with FY 2021, CMS adopted a differential payment for these cases to recognize hospitals' lower costs. CMS has also excluded CAR-T cases from the relative weight calculation where the hospital has no costs for the CAR-T product.

The initial situations where CMS adopted this policy included clinical trial cases where the hospital received the drug at no cost and expanded access use (also known as compassionate use) of the immunotherapy. CMS also applies this policy to other situations where the hospital does not have a cost for the immunotherapy product.

CMS proposed to adopt these same policies for FY 2027. Using the March 2026 update of the FY 2025 MedPAR data for determining the FY 2027 IPPS relative weights, the average costs of

cases assigned to MS-DRG 018 that are identified as clinical trial cases were 16 percent of the average costs of the cases assigned to MS-DRG 018 that are identified as non-clinical trial cases. Accordingly, CMS is adjusting the payment for MS-DRG 018 by applying an adjustor of 0.16 to the full payment amount in those situations where the hospital does not have a cost for the CAR-T or other immunotherapy product.

I. Hospital Readmissions Reduction Program (HRRP)

1. Background

The HRRP is established under section 1886(q) of the Act.[53] Under the HRRP, hospitals with disproportionately high numbers of readmissions for selected common conditions and procedures (conditions that are high volume and high expenditure) have their adjusted operating base DRG payments reduced by up to 3 percent. There are currently six conditions/procedure-specific 30-day risk-standardized unplanned readmission measures included in the HRRP measure set (collectively referred to as the HRRP measure set). Excess Readmission Ratios (ERRs) are calculated for each hospital and condition combination, and each hospital's weighted average ERR is compared to the median ERR of its peer group. Peer group assignment is determined by hospitals' proportions of Medicare inpatients who are full-benefit Medicare and Medicaid dual eligible beneficiaries. From the ERR comparisons, an adjustment factor is derived for each hospital that ranges from 1.0 (no payment reduction) to 0.9700 (3 percent payment reduction).

The estimated percentage of hospitals that will be penalized under the previously finalized measure set for HRRP for the FY 2027 HRRP is 83.26 percent (2,358 of the 2,832 eligible hospitals),[54] with total penalties for all such penalized hospitals estimated to be 0.48 percent of total payments for such hospitals.[55]

2. HRRP Measures

a. Summary of Previously Adopted Measures

The HRRP measure set for the FY 2027 program year includes the following: (i) acute myocardial infarction (AMI); (ii) chronic obstructive pulmonary disease (COPD); (iii) heart failure (HF); (iv) pneumonia (PN); (v) coronary artery bypass graft surgery (CABG); and (vi) elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA).

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[53] CMS provides sources for the legislative and regulatory histories of the HRRP. The program's regulatory requirements are under §§412.152 through 412.154. Details of the program's methodology are available for download at https://qualitynet.cms.gov/inpatient/hrrp/resources. General information about the Program is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program and https://qualitynet.cms.gov/inpatient/hrrp.

[54] A hospital is eligible to receive a penalty if it has 25 or more eligible discharges for at least one measure during the applicable period (i.e., between January 1, 2022, and December 31, 2023). The results shown in Table I.G.6-01 of the rule include 2,832 non-Maryland hospitals estimated as eligible to receive a penalty during the performance period based on the most recently available data at the time of publication of the final rule.

[55] See Table V.I.-06 of the final rule.

b. Adoption of Sepsis Readmission Measure

Final Action. CMS finalizes the addition of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization (Sepsis Readmission) measure to the measure set, with modifications to delay implementation by one year and use two years of "early reports." As finalized the phased-in approach will use "early look" reports for FY 2028 and FY 2029 (instead of only FY 2028, as proposed) before the measure begins to be used in the FY 2030 payment adjustment (rather than the 2029 payment adjustment, as proposed).

Background. Sepsis is a life-threatening condition that is a leading cause of hospitalizations, readmissions, and mortality in the United States. Infection is the leading cause of sepsis-related readmissions. CMS describes how sepsis readmissions are both high cost and high volume with around 50 percent of total hospital costs for sepsis stays in 2020 and 2021 being associated with stays billed to Medicare. Sepsis readmissions are also often preventable. CMS discusses studies showing that quality improvement initiatives could reduce sepsis readmission rates by incentivizing evidence-based interventions such as care coordination, medication reconciliation, patient education, and timely post-discharge follow-up.

Overview of Measure. Therefore, CMS finalizes adding to the HRRP the Sepsis Readmission measure, which calculates hospital-level 30-day all-cause risk-standardized readmission rates (RSRR) for sepsis. The measure tracks hospital-level rates of sepsis readmission, including both FFS and MA beneficiaries in its cohort. CMS believes this measure addresses a critical gap in health care quality as sepsis poses a public health challenge with variation in hospital readmission rates following an index sepsis hospitalization. The agency believes that this measure could provide hospitals with actionable feedback and reduce preventable readmissions.

- *Measure Numerator*. Medicare FFS or MA beneficiaries aged 65 and older who were discharged from the hospital with a principal diagnosis of sepsis (including post-procedural sepsis) who were then readmitted to an acute care hospital for any cause within 30 days. Must have been enrolled in FFS or MA during the index admission and for the 12 months before date of admission, discharged alive from a non-federal short-term acute care hospital, and not transferred to another acute care facility. Planned readmissions are excluded from numerator.
- *Measure Denominator*. All FFS or MA beneficiaries aged 65 and older, hospitalized at non-federal short-term acute care hospitals who are discharged alive following a principal diagnosis of sepsis (including post-procedural sepsis) and with a continuous 12-month Medicare enrollment period before the index hospitalization.
- *Excluded Index Admissions*. (i) admissions during which patients leave against medical advice, (ii) admissions for patients without at least 30 days post-discharge enrollment in FFS or MA, (iii) admissions resulting in patients discharged to hospice, (iv) sepsis admissions captured in pneumonia readmission measure, and (v) sepsis admissions within 30 days of an eligible sepsis index admission (excluded because they are considered readmissions, not index admissions).
- *Risk Adjustment*. Measure includes risk adjustments for age, comorbid diseases, and indicators of patient frailty. Also adjusts for aggressiveness of the infectious organism

causing sepsis, a transplant recipient indicator, and clinical markers of severe sepsis. Risk adjustment does not include complications that arise during the index hospitalization.

Calculation. The sepsis RSRR is calculated according to the same methodology used for the current measures in the HRRP—that is, as the ratio of the number of predicted readmissions based on the hospital's performance with its observed case mix to the number of expected readmissions based on the average national level of performance with the hospital's case mix, multiplied by the national observed readmission rate.

As with the current measures in the HRRP, the measure ratio is calculated using hierarchical logistic regression. The measure method produces an adjusted actual (i.e., predicted) number in the numerator and an expected number in the denominator. The denominator is the sum of all patients' expected probabilities of readmission taking into account their risk factors and the risk of readmission at an average hospital with similar case mix. The numerator for each hospital is calculated by estimating the probability of readmission for each patient at that hospital and summing that over the hospital's patients to get the actual adjusted number of readmissions.

Data Submission, Early Look, and Public Reporting. The Sepsis Readmissions measure uses Medicare administrative data (FFS Part A and B claims, hospital-submitted MA claims, and MA organization-submitted encounter data). Consistent with the policy finalized for readmission measures in the FY 2026 IPPS/LTCH PP final rule, CMS would use 2 years of claims data to calculate the measure.

CMS finalizes, with modification, its proposal to provide hospitals an "early look" report of their Sepsis Readmission measure results and estimated payment adjustment that will not be applied but provides insight into what it would be (if it did apply for that program year). Instead of one "early look" for the FY 2028 program year, as it had proposed, CMS is finalizing "early look" reports for the FY 2028 and FY 2029 program years. During the early look periods, data will not be used for payment adjustment and will not be made publicly available; confidential reports will be provided to hospitals with their measure and program results. Public reporting and the payment adjustment will begin with the FY 2030 program year (instead of FY 2029 program year, as proposed).

CMS publicly reports readmission measures results annually for each applicable condition for each applicable hospital on the Compare tool[56] or successor website and on the Provider Data Catalog.[57]

Payment Reductions. The HRRP payment adjustment factor is the greater of (i) 1 minus the ratio of aggregate payments for excess readmissions for the applicable condition to aggregate payments for all discharges or (ii) the applicable floor adjustment factor.[58] As finalized, when sepsis is included as an applicable condition (beginning for the FY 2030 program year, after the early look program years), excess readmissions for sepsis will be included in the calculation of

[56] The compare tool is available at https://www.medicare.gov/care-compare.
[57] The Provider Data Catalog is available at https://data.cms.gov/provider-data.
[58] The adjustment factor is defined in section 1886(q)(3) of the Act. Subparagraph (C) of that section specifies that the floor adjustment factor for FY 2015 and each subsequent FY is 0.97.

aggregate payments for excess readmissions. Table V.I.-05 of the rule shows the estimated total Medicare savings with and without the Sepsis Readmission measure in the HRRP. With the measure included in the measure set (as compared to the current measure set without the measure), the estimated average payment reduction per penalized hospital increased (i.e., payments were further reduced) by approximately $63,500 and total estimated Medicare savings increased by $169,651,338. Table V.I.-06 of the rule compares the current measure set to the measure set with the newly finalized Sepsis Readmission measure included and assesses the impact (by hospital characteristics) on payment reductions resulting from such inclusion.

Comments/Responses. Several commenters supported the adoption of the Sepsis Readmission measure because they believe it will improve quality, coordination, and safety. Many commenters expressed concern that the proposal would not provide enough time for hospitals to review the methodology, receive feedback, validate performance, and understand how patient complexity is addressed. Some commenters suggested extending the "early look" reports for at least an additional year and other commenters suggested delaying implementation until the FY 2031 program year. In response, CMS is finalizing its proposal with modification to initially adopt the measure with early looks for the FY 2028 program year (applicable period of July 1, 2024 to June 30, 2026) and FY 2029 program year (applicable period of July 1, 2025 to June 30, 2027). Then, beginning with the FY 2030 program year (applicable period of July 1, 2026 to June 30, 2028), the measure will be used in the HRRP for payment adjustment.

Several commenters expressed concerns about the inclusion of the measure because sepsis diagnosis is broad and includes patients with diverse clinical presentations, which makes it difficult to apply a uniform definition. Some commenters recommended delaying implementation of any sepsis-related measure until there is national alignment on sepsis definitions. CMS does not believe complete uniformity across sepsis measurement frameworks is needed for adoption of the measure and notes that the measure has undergone rigorous development, testing, and validation.

J. Hospital Value-Based Purchasing Program (HVBP)

1. Background

a. Program Overview[59]

CMS calculates the HVBP incentive payment percentage for a hospital based on its Total Performance Score (TPS) for a specified performance period. A hospital's incentive payment adjustment factor for a fiscal year combines a uniform 2 percent contribution to the program's incentive payment funding pool (i.e., a reduction to each hospital's base operating DRG payments) with a performance-based, hospital-specific incentive payment percentage derived from the hospital's TPS. The adjustment factor may be positive, negative or result in no change in the payment rate that would apply to the hospital absent the program.

[59] Further detail on the program's requirements may be found under §§412.160 through 412.168. Additional information on the program is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing and https://qualitynet.cms.gov/inpatient/hvbp.

The HVBP Program measure set is specified by CMS through rulemaking for each program (i.e., payment) year. Each hospital's TPS is calculated by summing the greater of the hospital's achievement or improvement points for each measure then creating domain scores that themselves are summed as the TPS. Finally, CMS converts the hospital TPS into a value-based incentive payment percentage through a linear exchange function, under which the sum of all hospitals' payments will equal the total amount of dollars contributed to the VBP funding pool.

For the HVBP, CMS finalizes, as proposed, modifications to five condition-specific and procedure-specific mortality measures beginning with the FY 2032 program year. CMS also summarizes (as discussed in section IX.B of the summary) comments received in response to its request for information (RFI) on measuring emergency room access and timeliness in the Hospital Inpatient Quality Reporting Program (HIQRP) and HVBP.

b. FY 2025 Program Year Payment Details

The estimated amount of base operating MS-DRG payment reductions for the FY 2027 program year (and also the amount available for the FY 2027 HVBP incentive payments) is approximately $1.9 billion, based on the March 2026 update of the FY 2025 MedPAR file.[60]

c. Estimated Impact Analysis

The estimated impact analysis of base operating DRG payment amounts resulting from the FY 2027 HVBP is shown in Table I.G.8-01 of the rule. The estimates were calculated using the FY 2026 program year's TPSs, which are the most recently available scores that hospitals were given an opportunity to review and correct. The analysis shows that for the 2,448 hospitals, there is an average net percent positive payment adjustment of 0.132 percent, and the number of hospitals with a positive percent change in base operating DRG (51.7 percent) is higher than those with a negative change (48.3 percent).

2. HVBP Measures

CMS finalizes, as proposed, adoption of substantive measure updates to five condition-specific and procedure-specific mortality measures included in the Clinical Outcome domain, beginning with the July 1, 2028, through June 30, 2030, performance period for the FY 2032 program year. This policy corresponds to the finalized adoption of the measures, with the same finalized updates, in the HIQRP beginning with the FY 2028 payment determination. The finalized updates are discussed in section IX.B.2.

[60] The agency published proxy value-based incentive payment adjustment factors in Table 16 of the rule associated with the proposed rule, calculated using historical baseline and performance periods for the FY 2026 HVBP, and by using the March 2026 update to the FY 2025 MedPAR file. The proxy adjustment factors will not be used to adjust hospital payments. CMS intends to add a Table 16B on the CMS website in Fall 2026 to display the actual value-based incentive payment adjustment factors, exchange function slope, and estimated amount available for the FY 2027 HVBP.

a. Summary of Previously Adopted Quality Measures for the HVBP

Table V.J.1 in the rule shows the previously adopted measures for the FY 2027 program year and Table V.J.2 in the rule shows the previously adopted measures for the FY 2028 through FY 2032 program years. The table below consolidates the information.

Measure	CBE[61]	2027	2028-2032
Clinical Outcomes Domain			
Acute Myocardial Infarction (AMI) 30-day mortality rate (MORT-30-AMI)	0230	X	X**
Heart Failure (HF) 30-day mortality rate (MORT-30-HF)	0229	X	X**
Pneumonia (PN) 30-day mortality rate (MORT-30-PN)	0468	X	X**
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate (MORT-30-COPD)	1893	X	X**
Coronary Artery Bypass Graft (CABG) 30-day mortality rate (MORT-30-CABG)	2558	X	X**
Hospital Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP-HIP-KNEE)	1550	X	X***
Safety Domain			
NHSN Central Line Associated Blood Stream Infection (CLABSI)	0139	X	X
NHSN Catheter Associated Urinary Tract Infection (CAUTI)	0138	X	X
Colon and Abdominal Hysterectomy Surgical Site Infections (SSI)	0753	X	X
NHSN Methicillin-Resistant *Staphylococcus Aureus* (MRSA) Bacteremia	1716	X	X
Clostridium Difficile Infection (CDI)	1717	X	X
Severe Sepsis and Septic Shock: Management Bundle (SEP-1)	0500	X	X
Person and Community Engagement Domain			
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Communication with Nurses Communication with Doctors Responsiveness of Hospital Staff* Communication About Medicines Discharge Information Care Transition* Cleanliness and Quietness of Hospital Environment Overall Rating of Hospital	0166 0228	X	X*
Efficiency and Cost Reduction Domain			
Medicare Spending per Beneficiary (MSPB)	2158	X	X

* In the FY 2025 IPPS/LTCH PPS final rule, the updated HCAHPS measure was adopted into the HVBP Program beginning with the FY 2030 program year (89 FR 69508-69511). The Care Transition and Responsiveness of Hospital Staff dimensions will be included in the survey but not scored for FYs 2027-2029 and will not be included in the survey beginning with FY 2030.
** CMS finalizes in section IX.B.2 modifications to the MORT–30–AMI, MORT–30–HF, MORT–30–PN, MORT–30–COPD, and 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 HVBP beginning with the FY 2033 program year (90 FR 36943 through 36948). The updated COMPHIP-KNEE measure will include MA beneficiaries in the measure cohort and a reduced reporting period from 3 to 2 years.

[61] Consensus-based entity identifier number for endorsed measures.

3. Baseline and Performance Periods for the FY 2028 Through FY 2032 Program Years

The table below combines information shown in Tables V.J.3 through V.J.7 to show the baseline and performance periods previously adopted for the FY 2028 through FY 2032 program years and reflecting the finalized changes to the mortality measures beginning with the baseline and performance periods for the FY 2032 program year, which are finalized in section IX.B.2 of the rule.

Baseline and Performance (Perf.) Periods by Measure for the FYs 2028 Through 2032 Program (Prog.) Years										
Measure	Baseline Period / FY 2028 Prog. Year	Perf. Period / FY 2028 Prog. Year	Baseline Period / FY 2029 Prog. Year	Perf. Period / FY 2029 Prog. Year	Baseline Period / FY 2030 Prog. Year	Perf. Period / FY 2030 Prog. Year	Baseline Period / FY 2031 Prog. Year	Perf. Period / FY 2031 Prog. Year	Base-line Period / FY 2032 Prog. Year	Perf. Period / FY 2032 Prog. Year
Person and Community Engagement Domain										
HCAHPS	1/1/24–12/31/24	1/1/26–12/31/26	1/1/25-12/31/25	1/1/27-12/31/27	1/1/26-12/31/26	1/1/28-12/31/28	1/1/27-12/31/27	1/1/29-12/31/29	1/1/28-12/31/28	1/1/30-12/31/30
Safety Domain										
NHSN Measures *	1/1/24–12/31/24	1/1/26–12/31/26	1/1/25-12/31/25	1/1/27-12/31/27	1/1/26-12/31/26	1/1/28-12/31/28	1/1/27-12/31/27	1/1/29-12/31/29	1/1/28-12/31/28	1/1/30-12/31/30
SEP-1	1/1/24–12/31/24	1/1/26–12/31/26	1/1/25-12/31/25	1/1/27-12/31/27	1/1/26-12/31/26	1/1/28-12/31/28	1/1/27-12/31/27	1/1/29-12/31/29	1/1/28-12/31/28	1/1/30-12/31/30
Clinical Outcomes Domain										
Mortality measures^	7/1/18–6/3/21**	7/1/23–6/30/26	7/1/19-6/30/22 **	7/1/24-6/30/27	7/1/20-6/30/23	7/1/25-6/30/28	7/1/21-6/30/24	7/1/26-6/30/29	7/1/24-6/30/26 #	7/1/28-6/30/30 #
COMP-HIP-KNEE	4/1/18–3/31/21 **	4/1/23–3/31/26	4/1/19-3/31/22 **	4/1/24-3/31/27	4/1/20-3/31/23 **	4/1/25-3/31/28	4/1/21-3/31/24	4/1/26-3/31/29	4/1/22-3/31/25	4/1/27-3/31/30
Efficiency and Cost Reduction Domain										
MSPB	1/1/24–12/31/24	1/1/26–12/31/26	1/1/25-12/31/25	1/1/27-12/31/27	1/1/26-12/31/26	1/1/28-12/31/28	1/1/27-12/31/27	1/1/29-12/31/29	1/1/28-12/31/28	1/1/30-12/31/30
Source: Tables V.J.3 through V.J.7 in the rule, excerpted and combined by HPA										

* NHSN measures include CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, CDI, and MRSA Bacteremia
^ Mortality measures include MORT-30-AMI, MORT-30-HF, MORT-30-COPD, MORT-30-CABG, and MORT-30-PN
** These baseline periods are impacted by the Extraordinary Circumstances Exception (ECE) granted on March 22, 2020. Qualifying claims will be excluded from the measure calculations for January 1, 2020-March 31, 2020 (Q1 2020) and April 1, 2020-June 30, 2020 (Q2 2020) from the claims-based complication and mortality measures. See the FY 2022 IPPS/LTCH PPS final rule (86 FR 45297-45299).
# In section IX.B.2 of the rule, CMS is finalizing modifications to the mortality measures beginning with the FY 2032 program year, including a reduced performance period from 3 to 2 years, as reflected in the table.

4. Performance Standards for the HVBP Program

The previously established performance standards for the Clinical Outcomes domain and Efficiency and Cost Reduction domain as well as the newly estimated performance standards for the Safety domain measures are shown in Table V.J.8 of the rule for the FY 2029 program year. The previously established performance standards for the Clinical Outcomes domain and Efficiency and Cost Reduction domain for the FY 2030 and FY 2031 program years are shown in Tables V.J.10 and V.J.11, respectively, in the rule. The newly established performance

standards for the FY 2032 program year for the Clinical Outcome domain and Efficiency and Cost Reduction domain are shown in Table V.J.12 of the rule. Since the performance standards for the MSPB measure (the only measure in the Efficiency and Cost Reduction domain) are based on performance period data, CMS is unable to provide numerical equivalents for the standards at this time.

CMS reviews its finalized modifications adopted in the FY 2025 IPPS/LTCH PPS final rule to the scoring of the HCAHPS Survey for the FY 2027 through FY 2029 program years. During that period, the (i) Responsiveness of Hospital and (ii) Care Transition dimensions will be excluded from scoring while the updated survey is publicly reported under the HIQRP for one year. Scoring was modified to score hospitals on only the remaining 6 HVBP dimensions of the survey during that period. Specifically, scoring is modified such that the achievement points (0-10) and improvement points (0-9) are calculated for each of the 6 remaining dimensions, the larger of which is summed up across the dimensions, resulting in a base score of 0-60 points (as compared to 0-80 points). That score will then be multiplied by 8/6 to establish the normalized HCAHPS base score, ranging from 0-80 points. HCAHPS consistency points (ranging from 0-20) are calculated without change and added to the normalized base score (as is currently) for a total score that ranges from 0-100 points. The estimated performance standards for the 6 unchanged dimensions for the FY 2029 program year are shown in Table V.J.9 of the rule.

K. Hospital-Acquired Conditions Reduction Program (HACRP)

The HACRP was implemented beginning in FY 2015. Under the program, a 1.0 percent reduction in IPPS payments is made to hospitals that are identified as being in the worst performing quartile nationally based on a set of six HAC-related measures. CMS utilizes the "Winsorized Z-Score Method" for determining individual measure performance scores to mitigate outlier effects. The Total HAC Score is calculated as the equally weighted average of the Winsorized z-scores. The distribution of Total HAC Scores for all hospitals is used to define the top quartile of hospitals (i.e., worst performers), members of which will be subject to the HACRP's penalty. Payment reductions are applied at the claim level. Performance data are reported confidentially to hospitals for review and correction, following which hospital-level results are publicly reported on the CMS Provider Data Catalog website at https://data.cms.gov/provider-data/.

Requirements of the HAC Program are codified at §§412.170 through 412.172. More information on the HAC Program is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program and https://qualitynet.cms.gov/inpatient/hac.

CMS estimates that for the FY 2027 HACRP, out of 2,891 hospitals, 721 hospitals will be included in the worst-performing quartile (and subject to the program's penalty).[62]

[62] See Table I.G.8-01 in the rule.

There are currently the following 6 measures in the HACRP for FY 2027 and subsequent years: [63]

- 5 Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) hospital-associated infection (HAI) measures:
    - Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (CBE 0138);
    - Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure (CBE 1717);
    - Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure (CBE 0139);
    - Colon and Abdominal Hysterectomy Surgical Site Infection (SSI) Outcome Measure (CBE 0753); and
    - Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia Outcome Measure (CBE 1716); and
- The CMS PSI 90 measure (CBE 0531).

In the FY 2027 IPPS/LTCH PPS proposed rule, CMS had not made any proposals or updates for the HACRP.

L. Rural Community Hospital Demonstration Program

1. Background

The Rural Community Hospital Demonstration program allows up to 30 rural community hospitals to receive reasonable cost payment for covered inpatient hospital services furnished to Medicare beneficiaries. The program has been in place since January 1, 2005, with a statutory expiration date that has been extended three times, most recently by section 128 of the Consolidated Appropriations Act, 2021 (CAA 2021). Expiration of the program for individual hospitals will vary based on the hospital's cost reporting period and when it began participating in the program but will generally be 5 years from when the program was last extended or the hospital first began participating. The period of participation for the last hospital under the CAA, 2021 authority would extend until June 30, 2028. As of March 2026, there were 27 hospitals participating in the demonstration; however, elsewhere in the final rule CMS stated that it believes 22 hospitals may participate in the demonstration at the beginning of FY 2027.

The statute requires CMS to make the demonstration program budget neutral by applying an adjustment to IPPS rates that affects all hospitals rather than only demonstration program participants. CMS describes the budget neutrality calculation in detail. In summary, CMS compares reasonable cost payments to what IPPS payments would have been in the absence of the demonstration. IPPS rates are adjusted for the difference. Interim reasonable cost payments from as submitted cost reports are initially used and then later reconciled as cost reports become final. CMS must also account for differences in actual and estimated costs for the demonstration

[63] Technical specifications for the CDC NHSN HAI measures can be found at http://www.cdc.gov/nhsn/acute-care-hospital/index.html and at https://qualitynet.cms.gov/inpatient/measures/hai/resources. Technical specifications for the CMS PSI 90 measure can be found at https://qualitynet.cms.gov/inpatient/measures/psi/resources.

in past fiscal years after finalized data have been reported. It applies any difference to the estimated budget neutrality adjustment for the demonstration for the upcoming fiscal year.

2. FY 2027 Budget Neutrality Adjustment

CMS continues to use its general budget neutrality methodology applied in previous years for the hospitals currently participating in the program with cost report end dates in CY 2024. However, CMS indicates that timing issues arose with the addition of 11 new hospitals in 2025, and it is still not yet able to finalize the estimated FY 2027 costs of the demonstration at this time. For the same reason, the agency says it is unable to determine the actual costs for the demonstration for FY 2021. Thus, CMS did not propose to apply a budget neutrality offset in the FY 2027 IPPS/LTCH PPS proposed rule for FY 2027.

Instead, CMS will apply budget neutrality offsets for both FYs 2027 and 2028 to the national IPPS rates in the FY 2028 IPPS/LTCH PPS proposed rule.

CMS believes all the historical "as submitted" cost reports needed for the estimated costs of the demonstration for FYs 2027 and 2028 will be available before the FY 2028 IPPS/LTCH PPS proposed rule. Similarly, CMS indicates it will be able to determine the actual costs for the demonstration for FYs 2021 and 2022 from finalized cost reports before next year's proposed rule. CMS will apply the difference between the actual and estimated costs for the demonstration during those fiscal years to the estimated costs of the demonstration when determining the FY 2027 and FY 2028 budget neutrality offsets for FY 2028.

VI. Changes to the IPPS for Capital-Related Costs

National Capital Federal Rate for FY 2027. For FY 2026, CMS established a national capital Federal rate of $524.15. CMS proposed a national capital Federal rate of $545.22 for FY 2027. The final FY 2027 capital rate is $540.03

Update Factor:

For FY 2027, CMS will increase the national capital Federal rate by 3.4 percent based on the capital input price index (CIPI) of 3.1 percent plus a forecast error correction of 0.3 percentage points.

CMS is not adopting any change to the capital update for intensity. For FY 2027, CMS projects a 0.5 percent increase in total case mix. CMS estimates that the real case mix increase will equal 0.5 percent for FY 2027. The net adjustment for change in case mix is the difference between the projected increase in case mix and the real increase in case mix (e.g., increases in case mix due to improved coding are removed from the capital update). As projected less real case mix is 0.0 percent, CMS is applying an adjustment for case mix change in the FY 2027 capital update framework.

The reclassification and recalibration adjustment accounts for the difference between the budget neutrality adjustment that CMS applied in FY 2025 compared to what it would be based on later

data. CMS is not making an adjustment for FY 2025 reclassification and recalibration in the update framework for FY 2027.

CMS makes a forecast error correction if the forecast CIPI used for the update in a past year (FY 2025 for FY 2027) differs from the actual CIPI based on later information by more than 0.25 percentage points. The CIPI used in the FY 2025 update was 2.6 percent. Its later determined level was 2.9 percent or a difference of 0.3 percentage points. As the 0.3 percentage point difference is more than the 0.25 percentage point threshold for making a forecast error correction adjustment, CMS is making an adjustment to the capital update for forecast error correction of 0.3 percentage points.

Table 1 below shows the elements of update to the capital rate under the capital update framework.

Table 1 CMS FY 2027 UPDATE FACTOR TO THE CAPITAL FEDERAL RATE		
FY 2023-based CIPI		3.1
Intensity		0.0
Case mix Adjustment Factors:		
Projected Case Mix Change	0.5	
Real Across DRG Change	0.5	
Net Case mix Adjustment (Projected - Real)		0.0
Effect of FY 2025 Reclassification and Recalibration		0.0
Forecast Error Correction		0.3
Total Update		3.4

Other Adjustments:

For FY 2026, CMS estimated that outlier payments would be 3.84 percent of total capital IPPS payments. For FY 2027, CMS estimates that outlier payments will be 3.26 percent of total capital payments and 3.23 percent after subtracting 0.03 percentage points for outlier reconciliation. Therefore, the FY 2027 outlier adjustment factor is 0.9677 (-3.23 percent), compared to 0.9616 (-3.84 percent) in FY 2026. The net change is (0.9677/0.9616) or 0.63 percent. Thus, the outlier adjustment increases the FY 2027 capital federal rate by 0.63 percentage points.

The geographic adjustment factor (GAF) is a function of the hospital wage index. As such, CMS has been reflecting changes to the wage data as well as its policy changes to the wage index in the budget neutrality adjustment. To determine the GAF budget neutrality factors, CMS compares estimated aggregate capital Federal rate payments based on the MS-DRG classifications and relative weights in combination with the GAFs.

CMS has determined a net GAF budget neutrality adjustment in two steps:

- Isolate the impact of the change to the wage index (including changes to wage data, geographic reclassification and the rural floor but excluding the 5 percent cap on wage index decreases and the transitional exception for low-wage index hospitals).
- Isolate the impact of the 5 percent cap on wage index decreases and the transitional adjustment for low-wage index hospitals.

The first step in the GAF budget neutrality adjustment is retained on the capital rate from year to year. As explained in the FY 2022 IPPS final rule, CMS believes it would be technically more appropriate to remove the past year's budget neutrality adjustment determined in step 2 before applying the new payment year adjustment.

To remove the prior year budget neutrality adjustment for the 5 percent cap on the wage index and the transitional adjustment for low-wage index hospitals, CMS divides the capital Federal rate by 0.9989, which was the effect of the 5 percent cap and transitional adjustment in FY 2026.

CMS then continues with its 2-step approach to determining GAF budget neutrality as follows:

- Isolate the impact of the change to the wage index (e.g., without the 5 percent cap on reductions to the wage index and the transitional adjustment for low-wage index hospitals). CMS determined a budget neutrality adjustment of 0.9916 for this factor for FY 2027.
- Isolate the impact of the 5 percent cap and the transitional exception for low-wage hospitals. CMS determined a GAF budget neutrality factor of 0.9990 for FY 2027.

CMS also incorporates an adjustment for FY 2027 MS-DRG changes and recalibration inclusive of a 10 percent cap on the reduction in the relative weights and the associated budget neutrality adjustment. The adjustment for DRG reclassification and recalibration prior to applying the 10 percent cap on reductions to the DRG relative weights is 0.9987. The incremental adjustment for the 10 percent cap on reductions to the DRG relative weights is 0.9997. The total adjustment is 0.9984 (0.9987 x 0.9997 or -0.16 percent) for DRG reclassification and recalibration.

The combined adjustment due only to the wage index in step 1 above and for changes for MS-DRGs and recalibration is 0.9901 (0.9916 x 0.9984, or -0.99 percent). The wage index and transitional exception for low-wage index hospitals of 0.9990 (or -0.01 percent) is then applied.

Final Rule Calculation:

The final rule includes the following chart to show how each of the factors and adjustments affect the computation of the FY 2027 national capital Federal rate compared to the FY 2026 national capital Federal rate.

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

	FY 2026	FY 2027	Change	Percentage Change
Update Factor[1]	N/A	1.0340	1.0340	3.4
GAF/DRG Adjustment Factor[1]	N/A	0.9901	0.9901	-0.99
WI Cap/Transitional Exception[2]	0.9989	0.9990	1.0001	0.01
Outlier Adjustment Factor[2]	0.9616	0.9677	1.0063	0.63
Capital Federal Rate	$524.15	$540.03	1.0303	3.03

[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 GAF/DRG budget neutrality adjustment factor for FY 2027 is a net change of 0.9901 or -0.99 percentage points.
[2] The outlier adjustment factor and the lowest quartile adjustment factors are 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 FY 2027 outlier adjustment factor is 0.9677/0.9616, or 1.0063 (or 0.63 percent). The net change to the wage index cap and transitional exception is 0.9990/0.9989 or 1.0001 (0.01 percent).

Considering the update factor and the budget neutrality adjustments, CMS is adopting a national capital Federal rate for FY 2027 of $540.03, a 3.03 percent increase over the FY 2026 rate of $524.15.

VII. Changes for Hospitals Excluded from the IPPS

A. Rate-of-Increase

Most hospitals are paid under prospective payment systems. Some hospitals, however, continue to be paid based on reasonable costs subject to a per discharge limit updated annually under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Hospitals that continue to be paid reasonable costs subject to a limit include 11 cancer hospitals, children's hospitals, and hospitals located in the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands and one hospital classified as an extended neoplastic disease care hospital. Religious non-medical health care institutions are also paid reasonable costs subject to a limit.

The annual update to the TEFRA limit is based on IGI's 2026 2nd quarter forecast of the hospital market basket for FY 2027 with historical data through the 1st quarter of 2026 and is 3.2 percent.

B. Report on Adjustment Payments

TEFRA hospital cost limits may be adjusted for specific factors after the hospital submits its Medicare cost report. Section 4419(b) of Pub. L. 105-33 requires the Secretary to publish a report annually in the *Federal Register* describing the total amount of adjustment payments made to excluded hospitals and hospital units. Total adjustment payments made to IPPS-excluded hospitals during FY 2025 were $92,696,418, as shown by hospital type in the below table.

Class of Hospital	Number	Excess Cost Over Ceiling	Adjustment Payments
Cancer Hospitals	5	$162,316,893	$91,599,402
Children's Hospitals	8	$5,357,347	$1,097,016
Total	13	**$1,67,674,150**	**$92,969,418**

C. Critical Access Hospitals (CAHs)

The Frontier Community Health Integration Project (FCHIP) Demonstration[64] is designed to develop and test new models of care by permitting enhanced reimbursement for telemedicine, nursing facility, ambulance, and home health services. Ten CAHs in Montana, Nevada, and North Dakota participated in the 3-year demonstration beginning August 1, 2016. Section 129 of the CAA, 2021 extended the FCHIP for another five years in the cost reporting year beginning January 1, 2022. Among the 10 CAHs eligible to participate in the demonstration project in the extension period, five have elected to continue their participation.

The demonstration was intended to be budget neutral through reduced transfers and admissions to other health care providers that offset any increase in payments under the waivers. However, if that is not the case, CMS would recoup any additional expenditures attributable to the FCHIP through a reduction in payments to all CAHs nationwide beginning with FY 2020. CMS found that the initial period of the demonstration was budget neutral and no reduction in payments to CAHs was necessary.

For the extension period, CMS proposed the same application of budget neutrality if the demonstration is found to increase costs—through an adjustment to payments for all CAHs nationwide. However, CMS adopted a policy to make this adjustment in a single fiscal year rather than over three fiscal years as was its policy for the initial period (although the budget neutrality adjustment was unneeded for the initial period). CMS believes a one-year period is a more efficient timeframe for the government to conclude the demonstration's operational requirements (such as analyzing claims data, cost report data and/or other data sources) to adjudicate the budget neutrality payment recoupment process due to any excess cost that occurred because of the demonstration extension period.

CMS did not propose to make any budget neutrality adjustment in FY 2027 for the FCHIP demonstration project.

VIII. Long-Term Care Hospital Prospective Payment System (LTCH PPS)

A. Background

1. Dual Payment Structure

Since FY 2016, LTCHs have been paid under a dual-rate payment structure. An LTCH case is either paid at the "LTCH PPS standard Federal payment" when the criteria for site neutral payment rate exclusion are met or a "site neutral payment rate" when those criteria are not met. Site neutral

[64] The FCHIP Demonstration was authorized by section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275).

cases are paid an IPPS comparable amount. The criteria for exclusion from the site neutral payment remain the same for FY 2027:

- Case cannot have a principal diagnosis relating to a psychiatric diagnosis or rehabilitation (the DRG criterion).
- Case must be immediately preceded by discharge from an acute care hospital that included at least 3 days in an intensive care unit (the ICU criterion).
- Case must be immediately preceded by discharge from an acute care hospital and the LTCH discharge must be assigned to an MS-LTC-DRG based on the beneficiary's receipt of at least 96 hours of ventilator services in the LTCH (the ventilator criterion).

To be paid the LTCH PPS standard Federal payment, the case must meet the DRG criterion and either the ICU or ventilator criterion.

CMS finalizes updates for LTCHs using a process that is consistent with prior regulatory policy and that cross-links to relevant IPPS provisions. For FY 2016 and FY 2017, the site neutral payment rate was a blend of the LTCH PPS standard Federal rate and the IPPS comparable amount. Section 51005 of the BBA 2018 extended the transitional blended payment rate (50 percent LTCH standard Federal payment and 50 percent IPPS comparable amount) for site neutral payment cases for an additional 2 years. The FY 2019 IPPS final rule made conforming changes to the regulations to implement the extended transitional blended payment, and it removed the 25-percent threshold policy.[65] The FY 2020 IPPS/LTCH PPS final rule implemented payment adjustments for discharges from LTCHs that do not maintain the requisite discharge payment percentage and the process by which those LTCHs may have the payment adjustment discontinued.

2. Criteria for Classification as an LTCH

A hospital must have an average Medicare inpatient length of stay (ALOS) of greater than 25 days to be paid under the LTCH PPS. Starting with cost reporting periods beginning on or after October 1, 2015, discharges of enrollees of Medicare Advantage (MA) plans and site neutral payment rate discharges are excluded from the calculation of the ALOS for all LTCHs. Before a hospital may be classified as an LTCH, it must first be a Medicare participating hospital (typically an IPPS hospital) and during the sixth month period before its conversion to an LTCH (referred to as the qualifying period), it must demonstrate that it has the requisite ALOS for 5 consecutive months during that qualifying period.

Summary of Changes to LTCH PPS Rates for FY 2027*	
Standard Federal Rate, FY 2026	$50,824.51
Final Rule Update Factors	
Update per Section 1886(m)(3)(C) of the Act (including MFP reduction)	+2.3%
Penalty for hospitals not reporting quality data (including MFP reduction)	-2.0%
Net update, LTCHs reporting quality data	+2.3% (1.023)

[65] The 25-percent threshold policy applied a payment adjustment for Medicare patient LTCH discharges when the number of such patients originating from any single referring hospital was greater than the applicable threshold for given cost reporting period.

Summary of Changes to LTCH PPS Rates for FY 2027*	
Net update LTCHs not reporting quality data	+0.3% (1.003)
Final Rule Adjustments	
Final area wage index budget neutrality adjustment	1.002679
Final Standard Federal Rate, FY 2027	
LTCHs reporting quality data $50,824.51 × 1.023 × 1.002679)	$52,132.76
LTCHs not reporting quality data ($50,824.51 × 1.003 × 1.002679)	$51,113.55
Final Fixed-loss Amount for High-Cost Outlier (HCO) Cases	
LTCH PPS standard Federal payment rate cases	$78,936
Site neutral payment rate cases (same as the IPPS fixed-loss amount)	$49,346
Impact of Policy Changes on LTCH Payments in FY 2027	
Total estimated impact	+2.2% (~ $54 million)
*More detail is available in Table IV, "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for LTCH PPS Standard Federal Payment Rate Cases for FY 2027". Table IV does not include the impact of site neutral payment rate cases. **LTCH site neutral payment rate cases are paid a rate that is based on the lower of the IPPS comparable per diem amount or 100 percent of the estimated cost of the case.	

B. MS-LTC-DRGs and Relative Weights

1. Background

Similar to FY 2026, the annual recalibration of the MS-LTC-DRG relative weights for FY 2027 is determined using data only from claims qualifying for LTCH PPS standard Federal rate payment and claims that would have qualified if that rate had been in effect. The MS-LTC-DRG relative weights are not used to determine the site neutral payment rate and site neutral payment case data are not used to develop the relative weights.

2. Patient Classification into MS-LTC-DRGs

CMS applies the same MS-DRG classification system used for the IPPS payments to the LTCH PPS in the form of MS-LTC-DRGs. Other MS-DRG system updates are incorporated into the MS-LTC-DRG system for FY 2027 since the two systems share an identical base. MS-DRG changes are described elsewhere in this summary and details can be found in section II.C. of the preamble of the final rule. Other changes to the MS-DRGs that affect assignments under GROUPER Version 44 are discussed in section II.C of the final rule, including changes to the Medicare Code Editor (MCE) software and the ICD-10-CM/PCS coding system, which apply to the LTCH PPS for FY 2027.

3. Development of the FY 2027 MS-LTC-DRG Relative Weights Methodology

For FY 2027, as it did for FY 2026, CMS uses its historical 11-step methodology for calculating the relative weights, as described in the FY 2021 IPPS/LTCH PPS final rule,[66] subject to a 10-

[66] 85 FR 58898 through 58907

percent cap on the reduction to an MS-LTC-DRG's relative weight in a given year, which was added as a permanent policy in the FY 2023 IPPS/LTCH PPS final rule.[67]

CMS uses three different categories of MS-LTC-DRGs based on volume of cases within specific MS-LTC-DRGs to determine relative weights:

- MS-LTC-DRGs with at least 25 applicable LTCH cases in the data used to calculate the relative weight, which are each assigned a unique relative weight;
- MS-LTC-DRGs that contain between 1 and 24 applicable LTCH cases (i.e., low-volume MS-LTC-DRGs) that are grouped into quintiles and assigned the relative weight of the quintile; and
- No-volume MS-LTC-DRGs that are cross-walked to other MS-LTC-DRGs based on the clinical similarities and assigned the relative weight of the cross-walked MS-LTC-DRG.

CMS uses applicable LTCH cases to establish the same volume-based categories to calculate the FY 2027 MS-LTC-DRG relative weights.

Selected Comments/Responses. Commenters expressed concerns about the methodology's accuracy and its impact on payment, including that the methodology has resulted in fewer standard Federal payment rate cases as well as a concentration of more clinically acute patient population in a narrow set of MS-LTC-DRGs. They believe the methodology no longer captures the true cost of care for these cases. Specifically, they argue that case severity varies widely within individual DRGs and that a rising share of cases now qualifies for outlier payments because of this structural misalignment, with that structural misalignment being a contributing factor to recent increases in the fixed-loss amount. In response, CMS states that it has found no evidence to conclude that the MS-LTC-DRG structure is a major driver of the recent increases to the fixed-loss amount or to payment inaccuracy.

a. Relative Weights Source Data

The FY 2027 relative weights are derived from the March 2026 update of the FY 2025 MedPAR file. These data are filtered to identify LTCH cases that met the established site neutral payment exclusion criteria or had the dual rate LTCH PPS payment structure applied to those cases at the time of discharge. CMS uses these data and Version 44 of the GROUPER in establishing the FY 2027 MS-LTC-DRG relative weights in the final rule.

CMS notes that section 3711(b)(2) of the CARES Act provided a waiver of the application of the site neutral payment rate for LTCH cases admitted during the COVID-19 PHE period. Thus, all LTCH PPS cases in FY 2023 with admission dates on or before May 11, 2023 (the COVID-19 PHE expiration date) were paid the LTCH PPS standard Federal rate regardless of whether the discharge met the statutory patient criteria. For purposes of setting rates for LTCH PPS standard Federal rate cases for FY 2027 (including MS-LTC-DRG relative weights), CMS identifies FY 2025 cases that meet the statutory patient criteria depending on date of admission as follows. First, it uses LTCH PPS cases in the FY 2025 MedPAR file with an admission date after May 11, 2023, that met the criteria for exclusion from the site neutral payment rate under §412.522(b) and were

[67] 87 FR 49162

paid the LTCH PPS standard Federal rate in FY 2025 (based on the claim payment amount). Second, it also uses LTCH PPS cases in the FY 2025 MedPAR file with an admission date on or before May 11, 2023, that would have met the criteria for exclusion from the site neutral payment rate if the CARES Act waiver had not been in effect; for these cases, CMS uses its historical process for identifying cases that would have met the criteria for exclusion from the site neutral payment rate rather than how those cases were paid in FY 2025.

The filtered data are trimmed to exclude all-inclusive rate providers, Medicare Advantage claims (which are identified based on the presence of a GHO Paid indicator value of "1" in the MedPAR files), and demonstration project participants, which yields "applicable LTCH data." CMS notes that no data were reported in the December 2025 update of the FY 2025 MedPAR file from any LTCH paid in accordance with a demonstration project.

b. Remove Cases With a Length of Stay of 7 Days or Less

CMS removes cases with a length of stay of 7 days or less from applicable LTCH cases.

c. Volume-related Adjustments

CMS accounts for low-volume MS-LTC-DRG cases using its quintile methodology when calculating relative weights. Generally, if an MS-LTC-DRG has 1-24 cases, it is assigned to one of five quintiles based on average charges. CMS assigns the low-volume MS-LTC-DRGs to specific low-volume quintiles by sorting them in ascending order by average charge.

For the final rule, it identified 244 such MS-LTC-DRGs in the claims, and the quintiles each contained at least 48 MS-LTC-DRGs (244/5 = 48 with a remainder of 4). CMS uses its historical methodology to assign each remainder low-volume MS-LTC-DRG to the low-volume quintile that contains an MS-LTC-DRG with an average charge closest to that of the remainder low-volume MS-LTC-DRG. In cases where these initial assignments of low-volume MS-LTC-DRGs to quintiles results in nonmonotonicity within a base-DRG, CMS makes adjustments to the resulting low-volume MS-LTC-DRGs to preserve monotonicity.

CMS then determines a relative weight and (geometric) average length of stay for each quintile; each quintile's weight and length of stay are then assigned to each MS-LTC-DRG within that quintile.[68]

d. Remove Statistical Outliers

Consistent with its historic methodology, CMS removes statistical outlier cases from the LTCH cases with a length of stay of at least 8 days. It defines statistical outliers as cases that are outside of 3.0 standard deviations from the mean of the log distribution of both charges per case and the charges per day for each MS-LTC-DRG. After removing statistical outlier cases and cases with a length of stay of 7 days or less in each set of claims, CMS has applicable LTCH cases that have a

[68] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html for these low-volume MS-LTC-DRGs.)

length of stay greater than or equal to 8 days, which it refers to as "trimmed applicable LTCH cases."

e. Adjust Charges for Short Stay Outliers

The effect of short stay outlier (SSO) cases (i.e., those with a length of stay of five-sixths or less of the average for that MS-LTC-DRG) is adjusted for by counting an SSO case as a fraction of a discharge based on the ratio of the length of stay of the SSO case to the average length of stay for the MS-LTC-DRG for non-SSO cases.

f. Hospital-Specific Relative-Value Methodology (HSRV)

CMS continues to use its HSRV methodology in FY 2027 to mitigate relative weight distortions due to nonrandom case distribution across MS-LTC-DRGs and charge variation across providers. Generally, the HSRV methodology scales each LTCH's average relative charge value by its case mix.

g. Adjustment for Nonmonotonically Increasing Relative Weights

Each MS-LTC-DRG contains one, two or three severity levels; resource utilization and relative weights typically increase with higher severity. CMS continues to believe that using nonmonotonic relative weights to adjust payments would result in inappropriate payments; this is because payment for cases in the higher severity level in a base MS-LTC-DRG (generally expected to have higher resource use and costs) would be lower than payment for cases in a lower severity level within the same base MS-LTC-DRG (which are generally expected to have lower resource use and costs).

When relative weights decrease as severity increases in a DRG ("nonmonotonic"), CMS combines severity levels within the nonmonotonic MS-LTC-DRG for purposes of computing a relative weight to assure that monotonicity is maintained. Table 11 (listed in section VI. of the Addendum to the final rule) notes any adjustments made for nonmonotonicity.

h. Determination of Relative Weights for MS-LTC-DRGs with No Applicable LTCH Cases

If an MS-LTC-DRG has zero cases after data trims are applied (415 of these MS-LTC-DRGs are identified for the final rule), CMS cross-walks that no-volume MS-LTC-DRG to another MS-LTC-DRG based on clinical similarities in resource use intensity and relative costliness to assign an appropriate relative weight. If the MS-LTC-DRG that is similar is a low-volume DRG that has been assigned to one of the five quintiles noted above, then the zero volume MS-LTC-DRG is assigned to that same quintile.

CMS removes from this total the 11 transplant, 2 "error" and 15 psychiatric or rehabilitation MS-LTC-DRGs. This results in 387 no-volume MS-LTC-DRGs, for which CMS assigns relative weights based on clinical similarity and relative costliness to one of the remaining 353 MS-LTC-DRGs[69] for which it calculates relative weights based on the trimmed applicable LTCH cases in the FY 2025 MedPAR file data. When necessary, adjustments are made to account for

[69] 768 - 415 = 353

nonmonotonicity. The preamble includes an example of this methodology for determining the relative weights for the FY 2027 MS-LTC-DRGs with no applicable LTCH cases.[70] The agency notes that this system is dynamic and that it is entirely possible that the number of MS-LTC-DRGs with no volume would vary in the future.

CMS assigns a 0.0000 relative weight for each of the following:

- The 11 transplant MS-LTC-DRGs (since no LTCH has been certified by Medicare for transplantation coverage);
- The 2 "error" MS-LTC-DRGs (998 and 999) (which cannot be properly assigned to an MS-LTC-DRG group); and
- The 15 psychiatric and rehabilitation MS-LTC-DRGs (because these MS-LTC-DRGs would never include any LTCH cases meeting the site neutral payment rate exclusion criteria).

i. Budget Neutrality

Annual updates to the MS-LTC-DRG classifications and relative weights are done in a budget neutral manner. CMS uses its existing methodology to achieve budget neutrality for the FY 2027 MS-LTC-DRG relative weights update, including for the application of a 10-percent cap on relative weight decreases. It applies two budget neutrality factors to determine the MS-LTC-DRG relative weights for FY 2027; one before the application of the 10-percent cap (referred to as the "uncapped relative weights") and the other after the application of that cap.

(1) Normalizing the Relative Weights

CMS normalizes relative weights using its established methodology. This is designed to ensure that the recalibration of the MS-LTC-DRG relative weights neither increases nor decreases the average case-mix index. In determining the MS-LTC-DRG relative weights for FY 2027, each recalibrated MS-LTC-DRG uncapped relative weight is multiplied by the normalization factor in the first step of the budget neutrality methodology, which produces "normalized relative weights."

(2) Budget neutrality for uncapped relative weights.

As noted above, to determine budget neutrality adjustments for the update of the MS-LTC-DRG classifications and relative weights before applying the 10-percent cap (or the uncapped relative weights), CMS uses its established two-step budget neutrality methodology.

First, it applies its normalization factor to the recalibrated relative weights. To do so, it uses the applicable LTCH cases from LTCH discharges from the FY 2025 MedPAR file, and groups them using Version 44 of the GROUPER and the recalibrated FY 2027 MS-LTC-DRG uncapped relative weights to calculate the average case-mix index. Next, it groups the same applicable LTCH cases using the FY 2026 GROUPER (Version 43) and the FY 2026 MS-LTC-DRG relative weights to calculate an average case-mix index. Finally, it computes the ratio of these average

[70] The list of the no-volume MS-LTC-DRGs and the MS-LTC-DRGs to which each was cross-walked for FY 2027 is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html.

case-mix indexes by dividing the average case-mix index for FY 2026 by the average case-mix index for FY 2027. As a result, in determining the MS-LTC-DRG relative weights for FY 2027, each recalibrated MS-LTC-DRG uncapped relative weight is multiplied by a normalization factor of 1.27345 in the first step of the budget neutrality methodology, which produces "normalized relative weights."

Next, CMS determines the first budget neutrality adjustment factor (for uncapped relative weights) by calculating the ratio of estimated aggregate FY 2027 LTCH PPS standard Federal payment rate payments for applicable LTCH cases before reclassification and recalibration to estimated aggregate payments for FY 2027 LTCH PPS standard Federal payment rate payments for applicable LTCH cases after reclassification and recalibration. CMS calculates a budget neutrality factor of 1.0055356, which is applied to each uncapped normalized relative weight.

(3) MS-LTC-DRG Cap Budget Neutrality Factor

Under its policy to limit reductions in relative weights to 10 percent in a given year, the 10-percent cap is only applied to the relative weights for MS-LTC-DRGs with at least 25 applicable LTCH cases. For any MS-LTC-DRG where the FY 2026 relative weight would otherwise have been reduced by more than 10 percent, CMS calculates a capped FY 2027 MS-LTC-DRG relative weight equal to 90 percent of that MS-LTC-DRG's FY 2026 relative weight.

(4) Budget Neutralize Application of the 10-percent Cap Policy

CMS uses its established 3-step methodology to determine the budget neutrality adjustment factor for its 10-percent cap on relative weight reductions as follows:

- It simulates estimated total FY 2027 LTCH PPS standard Federal payment rate payments for applicable LTCH cases using the capped relative weights for FY 2027 (determined in Step 10) and GROUPER Version 44;
- It simulates estimated total FY 2027 LTCH PPS standard Federal payment rate payments for applicable LTCH cases using the uncapped relative weights for FY 2027 (determined in Step 9) and GROUPER Version 44; and
- It calculates the ratio of the estimated total payments.

The budget neutrality adjustment factor for the 10-percent cap is 0.9978875. To determine the FY 2027 MS-LTC-DRG relative weights, CMS multiplies each capped relative weight by the budget neutrality factor to meet the budget neutrality requirement.

Extensive discussion of the entire 11-step process to determine MS-LTC-DRG relative weights is provided in the final rule (pages 986 through 1006 of the display copy of the final rule).

C. Payment Rates and Other Changes for FY 2027

1. Overview LTCH PPS Standard Federal Payment Rates

As noted earlier, only LTCH discharges meeting the site neutral payment rate exclusion criteria are paid based upon the LTCH PPS standard Federal payment rate. The LTCH PPS uses a single payment rate to

cover both operating and capital-related costs, so the LTCH market basket includes both operating and capital cost categories.

2. FY 2026 LTCH PPS Standard Federal Payment Rate Annual Market Basket Update

CMS adopted the 2022-based LTCH market basket for use under the LTCH PPS beginning in FY 2025 because it is primarily based on the Medicare cost report data submitted by LTCHs and, CMS believes, appropriately reflects the cost structure of LTCHs. The agency uses the 2022-based LTCH market basket to update the LTCH PPS standard Federal payment rate for FY 2027.

The update to the 2022-based LTCH market basket is 3.2 percent (based on IGI's second quarter 2026 forecast of the 2022-based LTCH market basket) less 0.9 percentage points for multifactor productivity (renamed by BLS to be the total factor productivity (TFP)), which results in an update factor of 1.023 to the FY 2026 LTCH PPS standard Federal payment rate. For LTCHs failing to submit data to the LTCH Quality Reporting Program (QRP), the annual update IS further reduced by 2.0 percentage points (PP). CMS notes that the "other adjustment" under section 1886(m)(4)(F) of the Act does not apply for FY 2027. The LTCH updates for FY 2027 are as follows:

Factor	Full Update	Reduced Update for Not Submitting Quality Data
LTCH Market Basket	3.2%	3.2%
Multifactor Productivity	-0.9 PP	-0.9 PP
Quality Data Adjustment	0.0	-2.0 PP
Total	2.3%	0.3%

3. Area Wage Levels and Wage-Index

a. Labor Market Areas

CMS adopted the revised labor market area delineations announced in OMB Bulletin No. 23-01[71] (issued on July 21, 2023) effective for FY 2025 under the LTCH PPS, which it uses for FY 2027. The FY 2027 LTCH PPS wage index values in Tables 12A and 12B listed in section VI. of the Addendum reflect the revisions to the CBSA-based labor market area under OMB Bulletin No. 23-01. CMS provides a supplemental data file that includes an updated county-to-CBSA crosswalk reflecting the revisions to the CBSA-based labor market area delineations, which is posted at https://www.cms.gov/medicare/payment/prospective-payment-systems/long-term-carehospital/other-files-download.

[71] https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf.

b. Labor-related Share

CMS finalizes a FY 2027 labor-related share of 73.0 percent based on IGI's second quarter 2026 forecast of the 2022-based LTCH market basket. This is based on the sum of the labor-related portion of operating costs[72] (69.1 percent) and capital costs (3.9 percent).

c. Wage Index for FY 2027 for the Standard Federal Rate

To determine the applicable area wage index values for the FY 2027 LTCH PPS standard Federal payment rate, CMS utilizes the same data it uses to compute the FY 2027 acute care hospital inpatient wage index, which uses wage data for cost reporting periods beginning during FY 2023.

One commenter objected to using unadjusted FY 2023 cost report data because pandemic-driven labor costs, especially contract labor, were unusually high and not representative of expected labor costs in FY 2027. CMS does not see how changes due to the COVID–19 PHE differentially impacted the wages paid by individual hospitals and notes the commenter did not provide data or examples to support their contention. It finalizes its proposal to use FY 2023 cost report data.

The FY 2027 standard Federal payment rate area wage index values are calculated consistent with the "urban" and "rural" geographic classifications, but they do not take into account IPPS geographic reclassifications under sections 1886(d)(8) and 1886(d)(10) of the Act. CMS apportions the wage data for multicampus hospitals with campuses located in different labor market areas to each CBSA where the campus or campuses are located, consistent with the IPPS policy.

To determine area wage index values for areas where there are no IPPS wage data, CMS uses its existing methodology. In these cases, the LTCH PPS wage index value for urban CBSAs with no IPPS wage data is determined by using an average of all the urban areas within the state, and the LTCH PPS wage index value for rural areas with no IPPS wage data is determined by using the unweighted average of the wage indices from all the CBSAs that are contiguous to the rural counties of the state. CMS notes there are no IPPS wage data for the urban area of Hinesville, GA (CBSA 25980) or for rural North Dakota (CBSA 35).

d. Permanent Cap on Wage Index Decreases

Standard Federal Payment Rate. The FY 2023 IPPS/LTCH PPS final rule established a permanent policy to apply 5-percent cap on any decrease in an LTCH's wage index from the LTCH's final wage index from the prior fiscal year by reason of large wage index decreases (87 FR 49440 through 49442). CMS believes the policy provides increased predictability in LTCH wage indexes and payments, and it mitigates significant payment reductions due to changes in wage index policy, such as the adoption of revised CBSAs. To ensure budget neutrality, it includes this policy in the determination of the area wage level budget neutrality factor.

[72] Operating costs include the following cost categories: wages and salaries; employee benefits; professional fees; labor-related; administrative and facilities support services; installation, maintenance, and repair services; and all other labor-related services.

Under this policy, an LTCH's wage index will not be less than 95 percent of its wage index for the prior fiscal year. New LTCHs that became operational during the prior Federal fiscal year would be subject to the LTCH PPS wage index cap whereas LTCHs that become operational on or after the first day of the fiscal year to which this final rule applies would not be subject to the cap (even when other LTCHs in the same geographic area are receiving a wage cap). CMS notes that approximately 32 LTCHs are expected to receive the 5-percent cap on wage index decreases in FY 2027.

IPPS Comparable Amount. CMS calculates an "IPPS comparable amount" to determine payments for short-stay outliers and the site neutral payment rate. Additionally, an "IPPS equivalent amount" is calculated for LTCHs that do not meet the applicable discharge payment percentage. Calculation of these amounts includes adjustments to the IPPS operating and capital standardized amounts by the applicable IPPS wage index for non-reclassified hospitals in the same geographic area as the LTCH. CMS adopted, beginning with FY 2023, the application of a permanent 5-percent cap on decreases in an LTCH's applicable IPPS comparable wage index from its applicable IPPS comparable wage index in the prior year. Historically, CMS has not budget neutralized changes to LTCH PPS payments that result from the annual update of the IPPS wage index for non-reclassified IPPS hospitals. Consistent with this approach, the cap on decreases in an LTCH's applicable IPPS comparable wage index is not applied in a budget neutral manner.

e. Budget Neutrality Adjustments for Changes to the LTCH PPS Standard Federal Payment Rate Area Wage Level Adjustment

CMS computes the wage index as it has in prior years, which includes ensuring that any changes to the area wage index values or the labor-related share are implemented in a budget neutral manner. As noted above, the 5-percent cap on wage index decreases is included in the determination of the area wage level budget neutrality factor. CMS determined a FY 2027 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor of 1.002679.

4. Cost of Living Adjustment for Alaska and Hawaii

To account for higher living costs in Alaska and Hawaii, a cost of living adjustment (COLA) is provided to LTCHs in those states that is applied to the non-labor related share of the standard Federal payment rate. The COLA is determined by comparing Consumer Price Index (CPI) growth in Anchorage, Alaska and Honolulu, Hawaii to that of the average U.S. city published by the Bureau of Labor Statistics (BLS) and is updated every four years. The COLAs were last updated in FY 2022.

Effective for FY 2027, CMS finalizes its proposal to adjust non-labor related costs for LTCHs located in Alaska and Hawaii using the Overseas Cost-of-Living Allowance data published by the Department of Defense.[73] CMS also finalizes its proposal to no longer cap the COLA factors for Alaska and Hawaii at 25 percent.

[73] Overseas Cost-of-Living Allowance | COLA | Defense Travel Management Office

FY 2027 COLA Adjustment Factors: LTCHs Located in Alaska and Hawaii

Area	FY 2022 through FY 2026	FY 2027
Alaska:		
City of Anchorage and 80-kilometer (50-mile) radius by road	1.22	1.28
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.22	1.32
City of Juneau and 80-kilometer (50-mile) radius by road	1.22	1.36
Rest of Alaska	1.24	1.44
Hawaii		
City and County of Honolulu	1.25	1.20
County of Hawaii	1.22	1.32
County of Kauai	1.25	1.26
County of Maui and County of Kalawao	1.25	1.24

5. Adjustment for High-Cost Outlier (HCO) Case Payments

CMS includes an adjustment to account for cases in which there are extraordinarily high costs relative to the costs of most discharges. Section 1886(m)(7)(A) of the Act requires CMS to reduce the LTCH standard Federal payment rate by 8 percent for high-cost outliers (HCOs). Section 1886(m)(7)(B) requires CMS to set an outlier threshold such that estimated outlier payments equal 99.6875 percent of the 8 percent estimated aggregate payments for standard Federal payment rate cases (that is, 7.975 percent). Under the HCO policy, an LTCH receives 80 percent of the difference between the estimated cost of the case and the HCO threshold, which is the sum of the LTCH PPS payment for the case and the fixed-loss amount for that case.

a. Determining LTCH CCRs

CMS calculates the estimated cost of an LTCH case by multiplying the LTCH's overall CCR by the Medicare allowable charges for the case. Generally, an LTCH's overall CCR is computed based on the sum of LTCH operating and capital costs as compared to total Medicare charges, with those values determined from either the most recently settled cost report or the most recent tentatively settled cost report, whichever is from the latest cost reporting period. However, in some cases, an alternative CCR is used, such as the statewide average CCR, a CCR that is specified by CMS, or one that the hospital requests. The LTCH's calculated CCR is then compared to the LTCH total CCR ceiling (which is 3 standard deviations from the national geometric average CCR). If the LTCH's CCR exceeds the LTCH total CCR ceiling, it is assigned the applicable statewide CCR.

CMS uses its established methodology for determining the LTCH total CCR ceiling based on IPPS total CCR data from the March 2026 update of the Provider Specific File (PSF). Thus, it establishes an LTCH total CCR ceiling of 1.342 under the LTCH PPS for FY 2027 for HCO cases under either payment rate and for the site neutral payment rate.

CMS also uses its established methodology for determining the LTCH statewide average CCRs for urban and rural hospitals, based on the most recent complete IPPS total CCR data from the March 2026 update of the PSF. They are effective for discharges occurring on or after October 1, 2026, through September 30, 2027.

Payments for HCO cases are reconciled at cost report settlement based on the CCR that was calculated based on the cost report coinciding with the discharge.

b. High-Cost Outlier Payments for LTCH PPS Standard Federal Payment Rate Cases

As noted above, CMS establishes a fixed-loss amount so that total estimated outlier payments under the LTCH PPS for Federal standard payments are projected to equal 7.975 percent of total estimated payments under the LTCH PPS for Federal standard payment cases. When the dual rate LTCH PPS payment structure was implemented beginning in FY 2016, the historical LTCH PPS HCO policy continued to apply to LTCH PPS standard Federal payment rate cases and the data used under that policy was limited to LTCH cases that would have been LTCH PPS standard Federal payment rate cases if the statutory changes had been in effect at the time of those discharges.

(1) Established Methodology

Historically, CMS estimates outlier payments and total LTCH PPS payments for each LTCH PPS standard Federal payment rate case using claims data from the MedPAR files. Because there is a lag in the availability of claims data, CMS inflates charges from the claims data by a uniform factor based on the historical growth in charges for LTCH PPS standard Federal payment rate cases. The inflated charges are then multiplied by each provider's best available CCR, which is adjusted by a factor calculated from historical changes in the average case-weighted CCR for LTCHs. In accordance with §412.525(a)(2)(ii), the applicable fixed-loss amount for LTCH PPS standard Federal payment rate cases results in estimated total outlier payments being projected to be equal to 7.975 percent of projected total LTCH PPS payments for LTCH PPS standard Federal payment rate cases.

(2) Change Request 14233

CMS issued Change Request 14233 on September 22, 2025, to expand the criteria MACs apply for identifying cost reports that MACs must refer to CMS for approval of outlier reconciliation. Specifically, MACs were directed to also identify for CMS any instances where: (1) the actual CCR is found to be plus or minus 20 percent or more (an increase from the 10 percent or more standard under the July 2003 instructions) from the CCR used during that time period to make outlier payments, and (2) the total outlier payments exceeded $500,000 for that cost reporting period. Looking at FY 2023 cost reports, CMS found that for most of the cost reports that would have met the expanded criteria, LTCHs increased their charges during their cost reporting period at rates that far exceeded their costs. Using the most recent data available for this rule, CMS determined that LTCHs, on average, increased their charges approximately 17 percent from FY 2024 to FY 2025.

(3) Fixed-loss Amount for LTCH PPS Standard Federal Payment Rate Cases

Background. CMS does not believe its historical methodology, which relies on the most recently available data, would accurately estimate outlier payments for LTCHs in FY 2027. Further, it does not find that a 17-percent increase in average charges is a reliable indicator to forecast

future annual increases in charges to estimate outlier payments in FY 2027. Similarly, it does not believe the historical changes in LTCHs' CCRs observed from cost reporting periods subject to only the original (pre- Change Request 14233) criteria can be used to reliably predict future CCR levels for purposes of estimating outlier payments in FY 2027. The agency concludes that it lacks the information needed to reasonably quantify the magnitude that a behavioral change would have on charging practices and outlier payment trends in FY 2027. Using a variety of assumptions in the proposed rule, CMS estimated fixed-loss amounts ranging from $67,000 (a decrease of roughly $12,000 compared to the current fixed-loss amount) to $109,000 (an increase of roughly $30,000 compared to the current fixed-loss amount).

Proposed Rule Policy. For FY 2027, CMS proposed to maintain the fixed-loss amount at its FY 2026 level ($78,936); it believes this 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.

Final Action. CMS finalizes its proposal, without modification, to establish a FY 2027 fixed-loss amount for LTCH PPS standard Federal payment rate cases of $78,936, which would result in estimated outlier payments projected to be equal to 7.975 percent of estimated FY 2027 payments for such cases.

Selected Comments/Responses. While some support was expressed for maintaining the FY 2026 fixed-loss amount for another FY, commenters nonetheless asked CMS to resume its pre-FY 2022 methodology where the charge inflation factor was set equal to the market basket update. Alternatively, CMS was encouraged to use a charge inflation assumption based on IPPS data and to set the FY 2027 fixed-loss amount as the lower of the FY 2026 amount or the amount derived using the IPPS charge inflation assumption. CMS rejects both these suggestions because they would result in high cost outlier payments that significantly exceed the statutory target.

Some commenters asserted that LTCH charge growth will return to levels more consistent with IPPS hospitals as the effects of the COVID-19 PHE continue to subside. CMS cites evidence to the contrary, namely that it estimates LTCHs increased their charges on average by 17 percent from FY 2024 to FY 2025, while IPPS hospitals increased their charges on average by 7 percent over the same period. Some commenters disagreed with the agency's estimate of LTCH charge increases, but CMS asserts the historical FY 2023 cost report data discussed in the proposed rule demonstrate increased LTCH charges at rates that greatly exceeded their growth in costs during that period.

The agency was urged to account for anticipated outlier reconciliation recoupments under the expanded reconciliation criteria when calculating the fixed-loss amount as it currently does for the IPPS. CMS agrees that incorporating an estimate of reconciled outlier dollars for the fiscal year into its methodology for determining the fixed-loss amount would improve its accuracy, but it is unclear how to do so accurately in part because of the many factors determining whether a case will be an outlier case. It notes that rather than trying to predict which claims or hospitals may be subject to outlier reconciliation, it incorporates an estimate of outlier reconciliation dollars based on actual outlier reconciliation amounts reported in historical cost reports in its methodology. However, it welcomes recommendations on how to account for the potential

impact of reconciliation in the determination of the fixed-loss amount for LTCH PPS standard Federal payment rate cases for future rulemaking.

A number of stakeholders argue that the dual payment rate structure has contributed significantly to the increases in the fixed-loss amount in recent years. Because CMS only uses cases that would have been paid the standard Federal rate, the claims dataset used in the calculation is smaller and thus more susceptible to year-to-year fluctuations. They also assert that the dual payment rate structure has incentivized LTCHs to prioritize higher-acuity admissions through the ICU and Ventilator Criterion exceptions to site-neutral payment, making these patients more likely to qualify for outlier payments. They suggested applying a non-budget neutral cap on future increases to the fixed-loss amount. CMS agrees with these comments but notes that adopting a non-budget neutral cap would result in fixed-loss amounts that exceed the statutory target of 7.975 percent.

One commenter asked CMS to disclose its projected FY 2026 LTCH high-cost outlier expenditures and assess proximity to the approximately 8 percent outlier target, as it had done in earlier proposed rules. CMS explains that the deviation from its normal practice is because the historical data currently available for projecting LTCH high-cost outlier payments are subject to significant uncertainty.

c. High-Cost Outlier Payments for Site Neutral Payment Rate Cases

CMS continues to believe that the most appropriate fixed-loss amount for site neutral payment rate cases is the IPPS fixed-loss amount. For FY 2027, CMS finalizes a fixed-loss amount for site neutral payment rate cases of $49,346.

CMS also applies a budget neutrality factor of 0.949 for site neutral payment rate cases for FY 2027. Consistent with the policy adopted in FY 2019, the HCO budget neutrality adjustment is not applied to the HCO portion of the site neutral payment rate amount. CMS estimates that HCO payments for site neutral payment rate cases would be 5.1 percent of the site neutral payment rate payments.

6. IPPS DSH and Uncompensated Care Payment Adjustment Methodology

The calculations of the "IPPS comparable amount" (under the SSO policy at §412.529) and the "IPPS equivalent amount" (under the site neutral payment rate at §412.522) include an applicable operating Medicare DSH and uncompensated care payment amount. For FY 2027, the DSH/uncompensated care amount is equal to 75.36 percent of the operating Medicare DSH payment amount, based on the statutory Medicare DSH payment formula prior to the amendments made by the ACA, adjusted to account for reduced payments for uncompensated care resulting from expansion of the insured population under the ACA.

D. Impacts

CMS projects that the overall impact of the finalized payment rates and factors for all LTCHs will result in an increase of 2.2 percent (or approximately $54 million) in aggregate payments.

Based on the FY 2025 LTCH cases that were used for the analysis in this final rule, roughly 7 percent of those cases were classified as site neutral payment rate cases. Thus, approximately 93 percent of LTCH cases meet the patient-level criteria for exclusion from the site neutral payment rate in FY 2027, which will be paid based on the LTCH PPS standard Federal payment rate for the full year. Total estimated LTCH PPS payments for these LTCH PPS standard Federal payment rate cases in FY 2027 will increase by approximately 2.2 percent (or approximately $54 million), which is solely due to the projected 2.3 percent annual update to the LTCH PPS standard Federal payment rate.

Some commenters expressed concern that the projected increase in payments for LTCH PPS standard payment rate cases for FY 2027 is insufficient to address the financial pressures facing LTCHs because they do not keep pace with actual cost growth driven by workforce shortages, increased reliance on contract labor, elevated pharmaceutical and supply costs, and rising patient acuity. CMS acknowledges those concerns. It also notes that the final estimated increase in aggregate payments of 2.2 percent is lower than the 2.3 percent under the proposed rule estimate.

CMS estimates that aggregate FY 2027 LTCH PPS payments will be approximately $2.490 billion, as compared to estimated aggregate FY 2026 LTCH PPS payments of approximately $2.436 billion.

Table IV "Impact of Payment Rate and Policy Changes to LTCH PPS Payments for LTCH PPS Standard Federal Payment Rate Cases for FY 2027" in the final rule shows the detailed impact by location, participation date, ownership type, region, and bed size for LTCH PPS standard Federal payment rate cases only; it does not include a detailed impact on payments for site neutral payment rate cases. Selected excerpts from that table are shown below.

Summary of Impact of Changes to LTCH PPS Standard Federal Payment Rate Cases for FY 2027*		
	Number of LTCHs	**Estimated Percent Change in Payments per Discharge**
All LTCH providers	319	2.2%
By Location:		
Rural	16	1.7%
Urban	302	2.2%
By Ownership Type:		
Voluntary	52	1.8%
Proprietary	258	2.2%
Government	8	3.7%
By Region		
New England	9	2.3%
Middle Atlantic	20	3.4%
South Atlantic	60	2.0%
East North Central	46	1.7%
East South Central	32	1.3%
West North Central	22	2.2%
West South Central	81	1.7%
Mountain	25	2.7%
Pacific	23	3.0%

Summary of Impact of Changes to LTCH PPS Standard Federal Payment Rate Cases for FY 2027*		
	Number of LTCHs	**Estimated Percent Change in Payments per Discharge**
*More detail is available in Table IV on page 2665 of the display copy.		

IX. Quality Data Reporting Requirements for Specific Providers

A. Overview

In this section, CMS provides finalized decisions and summarizes and responds to comments relating to its proposals (including crosscutting quality program proposals) relating to the Hospital Inpatient Quality Reporting Program (HIQRP), PPS-Exempt Cancer Hospital Quality Reporting Program (PCH QRP), Long-Term Care Hospital Quality Reporting Program (LTCH QRP), and Medicare Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (CAHs).

B. Crosscutting Quality Program Proposals and RFIs

1. Adoption of Advance Care Planning Electronic Clinical Quality Measure (eCQM) in HIQRP, PCH QRP, and Medicare Promoting Interoperability Program

Final Action. CMS finalizes its proposal to adopt the Advance Care Planning eCQM in the HIQRP and Medicare Promoting Interoperability Program as part of the eCQM measure set, from which a hospital can self-select measures to report to meet the eCQM reporting requirement, beginning with the 2028 reporting period/FY 2030 payment determination. CMS also finalizes its proposal to adopt the eCQM for the PCH QRP, but with a modification to provide an initial voluntary reporting period for the 2028 reporting period/FY 2030 program year followed by mandatory reporting of a full year's data (and public display) beginning with the 2029 reporting period/FY 2031 program year.[74] During the voluntary period, PCHs will receive confidential data through the Hospital Quality Reporting System.

Background. CMS describes that engagement in advance care planning remains low. Even though CMS authorized, beginning in 2016, Medicare payment to reimburse practitioners for time devoted to advance care planning services under specific codes, those codes were billed for less than 6 percent of Medicare FFS patients during the three years after the codes were introduced. CMS believes there is a need to keep care aligned with the goals and values of patients and for caregivers and clinicians to have clear guidance in cases in which patients are unable to communicate their preferences.

Overview of Measure. The Advance Care Planning eCQM calculates the proportion of adult patients with one or more inpatient hospitalizations during the measurement period who, by the time of hospital discharge for at least one encounter, have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the

[74] In the proposed rule, CMS had proposed mandatory reporting of the eCQM for PCHs beginning for the 2028 reporting period/FY 2030 program year.

patient's electronic health record (EHR). The measure is calculated as a proportion by dividing the number of patients who meet the numerator criteria by the number of eligible patients who meet the denominator criteria.

- *Numerator*. All adult patients with one or more inpatient encounters during the measurement period who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the patient's EHR by the time of hospital discharge during at least one of the inpatient encounters in the measurement period. The numerator comprises any of the following:
    - Advance care planning document evidenced by designated health care agent (health care proxy or medical power of attorney for health care), advance directive or living will, or a portable medical order (medical order for life sustaining treatment, physician order for life sustaining treatment, or do not resuscitate), or
    - Documentation that an advance care planning discussion with a documented decision occurred during the measurement period.
- *Denominator*. All patients aged 18 years and older at the start of the measurement period who are discharged from an inpatient hospitalization during the measurement period.[75]
- *Exclusions.* None.

Data Sources, Submission, and Public Reporting. The eCQM uses data extracted from EHRs. It is designed to be calculated by the hospital or PCH's certified health information technology using patient-level data and then be submitted by the facility to CMS. Testing across a variety of inpatient hospital types showed the measure had a high level of feasibility, validity, and reliability. CMS believes these findings are applicable to PCHs as well and will monitor implementation and measure performance and consider refinements if setting-specific issues are identified.[76]

CMS finalizes, for the HIQRP and Medicare Promoting Interoperability Program, its proposal to adopt the eCQM as part of the eCQM measure set, from which a hospital can self-select measures to report to meet the eCQM reporting requirement, beginning with the 2028 reporting period/FY 2030 payment determination. For the PCH QRP, CMS finalizes, with modification, to adopt the eCQM. The modification for the PCH QRP is to include a voluntary reporting period for the 2028 reporting period/FY 2030 program year followed by mandatory reporting of a full year's data (and public display) beginning with the 2029 reporting period/FY 2031 program year.

Comments/Responses. Many commenters supported adoption of the measure because they believe it will contribute to aligning care with patient preferences. Several commenters recommended updating the numerator to include only patients who have documentation of their goals created or revised during the current admission to ensure the documentation is representative of current, ongoing care planning. CMS, however, believes that prior advance care planning may remain applicable over time and each hospital should establish review processes

[75] The measurement period is a 12-month period that would run from January 1 through December 31 of each applicable CY.
[76] Further discussion of CMS' finalized policies to introduce eCQM reporting and submission requirements under the PCH QRP is under section IX.D.5 of the summary.

with the patient to determine applicability to the patient's care. Therefore, CMS believes the numerator should not be limited in that way.

Several commenters stated that the measure is not appropriate for the acute inpatient setting because effective discussions depend on the type of care relationships more commonly developed in outpatient and primary care settings. CMS believes advance care planning conversations should be addressed across multiple settings The agency notes that the Merit-based Incentive Payment System (MIPS) under the physician fee scheduled includes an Advance Care Plan clinical quality measure but also observes that not all patients have the same access to primary care. Therefore, CMS believes it is important to include a related measure in the inpatient setting as well.

Many commenters thought the denominator was too broad and should not include younger populations. CMS points to the technical expert panel's conclusion that the measure was appropriate for all patients 18 years and older because serious illness can occur at any age. Several commenters noted that the eCQM should ensure that an individual's religious or cultural beliefs can be honored that might conflict with providing an advance directive, such as through a measure exception. CMS states it does not intend for the measure to force conversations about end-of-life care for those who are not ready to have those conversations. The measure is designed so that if a patient does not wish to name a health care proxy or make an advance care planning decisions, the hospital may satisfy the numerator where a conversation took place but no advance care plan or proxy was documented.

Several commenters stated that further testing and evaluation of the eCQM was needed across a broader scope of EHRs and hospital types. CMS emphasizes that eCQMs, like all measure types, undergo rigorous testing. Many commenters raised concerns about time needed for hospitals to modify EHR templates and workflows and train staff. CMS acknowledges the initial resources needed but believes that in the long run eCQMs will help reduce burden of manual abstraction and reporting. CMS recognizes that for the PCH QRP specifically additional time to operationalize eCQM reporting and submission requirements may be needed since eCQMs will be an entirely new measure type for PCHs. Therefore, as discussed above, CMS is finalizing its policy with a modification to provide for a voluntary reporting period before mandatory reporting begins for the PCH QRP.

2. Adoption and Modifications to Five Mortality Measures in the HIQRP and HVBP

Background. The following five mortality measures were initially included in the HIQRP, but beginning with the FY 2014 program year, were adopted into the HVBP under the Clinical Outcomes domain and subsequently were removed from the HIQRP:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization (MORT–30–AMI) measure;[77]
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (MORT–30–HF) measure;[78]

[77] 76 FR 26495 through 26511.
[78] 76 FR 26495 through 26511.

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT–30–PN) measure;[79]
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT–30–COPD) measure;[80] and
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT–30–CABG) measure.[81]

The five current measures are endorsed by the Consensus-Based Entity (CBE) and CMS will submit the modified measures for endorsement for the Spring 2028 cycle.[82]

Final Action. CMS finalizes, without modification, its proposal to adopt modified versions of these measures in the HIQRP beginning with the FY 2028 payment determination and then include the modified versions of these measures in the HVBP (and remove them from the HIQRP) beginning with the FY 2032 payment determination. The modified mortality measures will be publicly reported in the HIQRP for at least one year before adoption into the HVBP, as required under section 1886(o)(2)(C)(i) of the Act.

Overview of Updates. The following two substantive modifications are being made to each of the five mortality measures:

- Expand the measure inclusion criteria to include MA beneficiaries (in addition to FFS beneficiaries, which are currently included); and
- Shorten the performance period from three to two years.

The initial performance period in the HIQRP for each of the measures will be July 1, 2024, through June 30, 2026, for the FY 2028 payment determination, and the final performance period in the HIQRP will be July 1, 2027, through June 30, 2029, for the FY 2031 payment determination. The initial performance period for the measures in the HVBP will be July 1, 2028, through June 30, 2030, for the FY 2032 Program Year.

Each of the measures will continue to measure 30-day all-cause mortality. Each measure will continue to be calculated by (i) determining the ratio of the number of predicted deaths (i.e., adjusted number of deaths at a specific hospital based on its patient population) to the number of expected deaths (i.e., the number of deaths if an average quality hospital treated the same patients) for each hospital, and (ii) multiplying the ratio by the national observed mortality rate.

Data Source, Submission, and Public Reporting. All five measures are calculated using administrative data from the Medicare FFS claims or hospital-submitted MA claims, and MA organization-submitted encounter data. Patient enrollment status is obtained from the Medicare Enrollment Database. The modified measures will be calculated and publicly reported on an annual basis using a rolling 24 months of prior data for the measurement period. Measure results

[79] Adopted at 76 FR 26495 through 26511; modified at 81 FR 56994 through 56996.
[80] 80 FR 49557 through 49558.
[81] 81 FR 56996 through 56998.
[82] In the proposed rule, CMS had stated the measure would be submitted for the Spring 2026 review cycle.

will be publicly reported on the Compare tool beginning in July 2027, or as soon as feasible, for the HIQRP.

Technical Updates. CMS provides notification of technical updates to the risk adjustment methodology for the five modified mortality measures, beginning with the FY 2028 payment determination, to the HIQRP and beginning with the FY 2032 program year in the HVBP. The technical updates are to use individual International Classification of Diseases (ICD-10) codes instead of hierarchical condition categories (HCC) to improve the measures' risk adjustment methodology. Table IX.B.9 in the rule summarizes improvements to the risk adjustment models' performance for the five modified mortality measures when ICD-10-based risk variables are used instead of HCC-based risk variables.

Comments/Responses. Many commenters supported the modifications to the measures because they believe the updates will improve the measures' reliability and the accuracy of performance data.

Many other commenters did not support adopting the modified measures into the HIQRP and the HVBP because of concerns about data collection and reporting challenges and variation between MA and FFS. Many commenters did not support modification of the measures in the HVBP because of concerns about how the inclusion of MA data, due to differences in MA populations and plan designs, would affect measure performance and hospital scores (resulting in payment consequences). CMS believes there is benefit in providing a more complete picture of the quality of care provided to all Medicare beneficiaries. The agency has found that including MA patient data in measures improves measure reliability and increases the number of hospitals and beneficiaries included in the measures. CMS intends to provide hospitals with measure performance data with the expanded measures' patient cohort via annual confidential hospital-specific reports beginning with the FY 2028 payment determination and via annual Provider Participation Summary Reports under the HVBP beginning with the FY 2032 program year. Further, CMS internal analyses using 2 years of data (2022 and 2023) showed no statistical difference in the average risk-standardized mortality rates across the condition and procedure-specific measures for the FFS-only and MA-only beneficiaries.

3. RFI: Measuring Emergency Care Access and Timeliness in the HIQRP and HVBP

Background. Emergency department (ED) boarding is holding a patient in the ED after the patient is admitted or placed into observation status. CMS describes how ED boarding rates are increasing, which causes safety risks for patients and worsening working conditions for health care personnel. The agency further describes how long ED wait times is one of the most cited reasons for leaving an ED without being evaluated for care, and discusses concerns about the quality and timeliness of care in the ED.

ED efficiency could be tied to various hospital-wide operational processes, including inpatient bed management, staffing and procedures scheduling, discharge planning and poste-acute care (PAC) access, and diagnostic and consult turnaround. CMS describes several examples of interventions that have been suggested to improve ED boarding times (e.g., real-time monitoring and predictive capabilities within health information technology systems, enabling holiday and

weekend discharges, strengthening triage and ED teams, cross-departmental initiatives, and other administrative and organizational strategies).

Overview of Emergency Care Access & Timeliness eCQM. CMS provides an overview of the Emergency Care Access & Timeliness eCQM, which was finalized in the 2026 OPPS/ASC final rule for adoption in the Hospital Outpatient Quality Reporting Program (HOQRP), beginning with voluntary reporting for the 2027 reporting period followed by mandatory reporting beginning with the 2028 reporting period/2030 payment determination and in the Rural Emergency Hospital Quality Reporting Program (REH QRP) as an optional alternative measure beginning with the 2027 reporting period/2029 program determination.

The overall score for the eCQM represents the proportion of ED encounters associated with patients of all ages, for all payers, that experience at least one of the numerator events described below during a 12-month performance period.

- *Denominator*. All ED encounters associated with patients of all ages, for all payers, during a 12-month performance period; patients can have multiple encounters during a performance period and each encounter would be eligible to contribute to the measure calculation.
- *Numerator*. Any ED encounter in the denominator where the patient experiences any of the following (an event can contribute only once to the numerator):
    - Patient wait time longer than 1 hour after arrival to the ED until placement in a treatment room or dedicated treatment area that allows for audiovisual privacy during history-taking and physical exam.
    - Patient left the ED without being evaluated.
    - Patient boarding time in the ED (measured from a decision to admit (order) to ED to ED departure for admitted patients) longer than 4 hours.
    - Patient ED length of stay (LOS) (time from ED arrival to ED physical departure, measured by the ED departure timestamp) longer than 8 hours.
- *Exclusions*. ED encounters with ED observation stays are excluded from components #3 and #4, but are included in the denominator; patients who have a "decision to admit" after an ED observation stay are excluded from criteria #3.

The measure score is first calculated at the individual ED level as the proportion of ED encounters where *any* one of the four numerator outcomes occurred. The overall score is then standardized by ED case volume using z-scores (which indicates how many standard deviations a data point is from the mean of a normal distribution). The volume-adjusted z-score for the eCQM shows how an ED's performance compares to the average for similar-volume EDs. If a CMS Certification Number (CCN) has more than one ED, the volume-adjusted z-scores are combined as a weighted average for the CCN.

The results of the eCQM are stratified into four groups: two by age (18 and older and under 18) and two by mental health diagnoses (with and without).

RFI on Potential Future Use in the HIQRP and HVBP. CMS recognizes that access to care and timeliness is an issue that is not specific to setting, but the quality programs are divided to

monitor the inpatient and outpatient settings separately. The agency is considering how best to measure care access and timeliness in its quality reporting and value-based purchasing programs. It could consider adopting the existing eCQM (described above) into the HIQRP and HVBP (which would promote aligning access and timeliness measurement at a systems-level) or it could adopt a modified version more specific for the inpatient setting.

Therefore, in the FY 2027 IPPS/LTCH PPS proposed rule, CMS sought comment on the potential use of the Emergency Care Access & Timeliness eCQM into the HIQRP and HVBP. In the final rule, CMS summarizes the comments it received.
Many commenters expressed concerns related to the use of the eCQM in the HIQRP and HVBP, noting many reasons for prolonged wait times that are outside of a hospital's control and suggesting further refinements and technical and conceptual development would be needed. Many commenters also believed the measure would be duplicative, increase administrative burden, increase the risk of payment adjustments for the same measure, and add complexity. Some commenters supported the inclusion of the measure and believe that continuity of the measure across settings could help address causes of ED boarding. Many commenters addressed barriers and challenges related to improving bed availability and reducing ED boarding, including workforce shortages, post-acute care bed availability, and prior authorization requirements.

Many commenters raised concerns about unintended consequences, such as incentivizing hospitals to convert patients to observation status to avoid poor scores or disincentivizing hospitals from accepting direct admissions from other facilities.

CMS does not respond to comments but states it will take them into account for future development and consideration of the measures for the HIQRP and HVBP.

4. RFI: Potential Future Use of Adult Community-Onset Sepsis Standardized Mortality Ratio Measure in the HIQRP

Background. Sepsis is a life-threatening condition that is the leading cause of mortality, hospitalization, and readmission in the United States. CMS describes how the lack of a definitive diagnostic test and wide variation in diagnosis and coding practices make it difficult to track the incidence of sepsis and outcomes. The agency believes that a measure that assesses the community-onset sepsis standardized mortality ratio is necessary to produce timely and clinically meaningful comparisons across hospitals.

The agency reviews its work to advance the use of digital quality measures (dQMs), including through the use of the Fast Healthcare Interoperability Resources® (FHIR) standard to exchange health care information across different systems in a consistent, structured, and reusable format. The Adult Community-Onset Sepsis Standardized Mortality Ratio measure is an FHIR-based dQM that was reviewed in the 2025 PRMR process and is being tested at hospitals participating in a Centers for Disease Control and Prevention (CDC) pilot program that is testing dQMs.

Overview of Adult Community-Onset Sepsis Standardized Mortality Ratio measure. This measure provides hospitals with a nationally benchmarked metric of community-onset sepsis

mortality outcomes. It assesses the annual risk-adjusted standardized mortality ratio (SMR) of adult patients with community-onset sepsis who died during their hospitalization or were discharged to hospice.

- *Numerator*. Number of annually observed adults with community-onset sepsis who died during hospitalization or were discharged to hospice. Exclusions: patients under 18 years of age, patients whose length of hospitalization is greater than 120 days, patients with prior enrollment in hospice, and patients transferred to another acute care hospital.
- *Denominator*. Number of annually predicted adults with community-onset sepsis who died during hospitalization or were discharged to hospice.
- *Risk-Adjustment.* Risk-adjustment model incorporates baseline patient characteristics (age, sex), comorbidities, and clinical data (vital signs, laboratory values, positive blood cultures and COVID-19 tests, body mass index, and infection source per ICD-10 codes).

The measure was considered by the PRMR Hospital Committee in its January 2026 meeting. The committee reached consensus (81 percent) to recommend adoption of the measure in the HIQRP but did not reach consensus (only 57 percent voted to recommend) for inclusion in the HVBP.

CMS indicates that it will submit the measure to the CBE for endorsement in a future endorsement cycle.

RFI on Potential Future Use in HIQRP. In the FY 2027 IPPS/LTCH PPS proposed rule, CMS sought comment on the potential future use in the HIQRP of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure. In the final rule, CMS summarizes comments it received.

Commenters expressed many concerns, including about the measure's feasibility and implementation burden, cautioned about adding a sepsis measure that could increase burden without improving outcomes, and noted factors beyond the control of an inpatient facility that have an impact on sepsis outcomes. Some commenters recommended changes to the measure, including a higher case minimum, clear definitions of sepsis, and certain exclusions.

Many commenters raised concerns about including the Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the HVBP because of inadequate considerations of pre-hospital influences, lack of standardized national definition of sepsis, the presence of the current Severe Sepsis and Septic Shock: Management Bundle (SEP-1) in the program, and potential unintended consequences such as disincentivizing palliative are and hospice. Many commenters recommended that CMS not use the current SEP-1 because it is outdated and no longer reflects best practice.

Many commenters addressed challenges and burden related to using FHIR for reporting the Adult Community-Onset Sepsis Standardized Mortality Ratio measure and noted the need for pilot testing and demonstrations of feasibility across diverse EHRs, hospitals, and clinical settings.

CMS does not respond to comments but states it will take them into account for future development and consideration of the measures for the HIQRP and HVBP.

C. Hospital Inpatient Quality Reporting Program (HIQRP)

CMS finalizes changes to the HIQRP, including:

- To adopt (i) The Excess Days in Acute Care After Hospitalization for Diabetes (Diabetes EDAC) measure and (ii) the Hospital Harm—Postoperative Venous Thromboembolism eCQM (in addition to the cross-program adoption of the Advance Care Planning eCQM and the five modified mortality measures, which is discussed in detail in sections IX.B.1 and IX.B.2, respectively);
- To remove (i) Venous Thromboembolism Prophylaxis (VTE-1) eCQM; (ii) Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM; and (iii) Discharged on Antithrombotic Therapy (STK-02) eCQM;
- To make substantive updates to three excess days in acute care (EDAC) measures to expand the inclusion criteria to include MA beneficiaries and shorten the performance period to two years.
- To make changes to the reporting and submission requirements for eCQMs and structural measures in the measure set.

In addition, the agency summarizes comments received in response to its RFI on modifications to the Birthing Friendly Hospital Designation to expand the designation criteria.

CMS estimates that the policies finalized in the rule will result in, across 3,050 IPPS hospitals, as compared to the currently approved information collection burden estimates, a total increase in information collection burden: (i) for the 2028 and 2029 reporting periods of approximately 6,100 hours at a cost of $335,866, and (ii) beginning with the 2030 reporting period, of approximately 8,133 hours at a cost of $447,803.[83]

CMS reviews that historically, an average of 100 hospitals that participate in the HIQRP do not receive the full market basket rate update factor increase for failure to meet the Program requirements, and anticipates that number to remain approximately the same for FY 2027.

1. Background

The HIQRP[84] is a pay-for-reporting program. Hospitals that do not submit specified quality data or fail to meet all program requirements are subject to a one-fourth reduction in their annual payment update (APU).[85] Additional information on the Program is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalRHQDAPU and https://qualitynet.cms.gov/inpatient/iqr.

[83] See Tables XII.B-01 and XII.B-02 in the rule.
[84] The HIQRP regulations are under 42 CFR 412.140.
[85] Prior to FY 2015, hospitals that did not submit the required data in accordance with HIQRP requirements were subject to a 2.0 percentage point reduction to their annual applicable percentage increase (market basket percentage increase) for the applicable FY. Starting with FY 2015, hospitals in noncompliance with the HIQRP reporting requirements are instead subject to a one-fourth reduction to their annual applicable percentage increase (market basket percentage increase). See Section 1886(b)(3)(B)(viii) of the Act.

2. Considerations in Expanding and Updating Quality Measures

Section 1890A(a)(2) of the Act requires CMS to make public certain quality and efficiency measures being considered for adoption through rulemaking. The CBE, which is currently Battelle, convenes the Partnership for Quality Measurement (PQM) as part of the pre-rulemaking and measure endorsement process, consistent with these requirements.

3. New Measures for the HIQRP Measure Set

For the HIQRP measure set, in addition to the newly finalized cross-program proposals to adopt the Advance Care Planning eCQM and the five modified mortality measures (discussed in detail in sections IX.B.1 and IX.B.2, respectively), CMS finalizes, without modification, its proposals to adopt:

- The Excess Days in Acute Care After Hospitalization for Diabetes (Diabetes EDAC) measure; and
- The Hospital Harm—Postoperative Venous Thromboembolism eCQM.

a. Adoption of Excess Days in Acute Care After Hospitalization for Diabetes Measure

Final Action. CMS finalizes, without modification, its proposal to adopt the Diabetes EDAC measure beginning with the July 1, 2025, through June 30, 2027, performance period, associated with the FY 2029 payment determination

Background. About one-third of Americans age 65 years or older is estimated to have diabetes, which is one of the most expensive conditions billed to Medicare. CMS describes how hospitals that practice diabetes management interventions, such as care transition teams, diabetes educator appointments, and medication reconciliation, can improve diabetes care and reduce diabetes-related costs. There are no publicly reported measures in the HIQRP on post-discharge care utilization for patients hospitalized for diabetes.

Overview of Measure. The Diabetes EDAC measure is a risk adjusted outcome measure that assesses the number of days a patient spends in acute care within 30 days of discharge from an inpatient hospitalization for a diagnosis of diabetes mellitus with complications. The measure is intended to improve the quality of care-transitions for individuals hospitalized for diabetes. CMS observes that hospital performance shown in testing of the measure[86] indicated there is meaningful variation in the distribution of measure scores.

Measure Calculation. The final risk adjusted Diabetes EDAC measure score represents excess days in acute care per 100 discharges and is reported as a rate. The score is calculated as the difference ("excess" days) between a hospital's predicted days (i.e., the average number of days a patient spent in acute care after adjusting for the risk factors) and expected days (i.e., the average number of risk adjusted days in acute care a patient would have been expected to spend

[86] Hospital-level performance rates are shown in Table IX.C.1 of the rule.

if discharged from an average-performing hospital with the same case mix), per 100 discharges. The measure result is then multiplied by 100.

- *Numerator*. Number of days a patient spends in acute care for any cause, within 30 days of discharge from the index hospitalization for diabetes. Utilization is measured in days; each ED visit counts as one full day, regardless of duration; observation stays are measured in hours and rounded to the nearest whole day. Planned readmissions (such as scheduled follow-ups, elective surgeries, or chemotherapy) are excluded.
- *Denominator*. Includes index admissions for patients who meet all of the following (i) principal discharge diagnosis of diabetes; (ii) enrolled in Medicare FFS or MA for the 12 months before the date of admission and during the index admission; (iii) aged 65 or older; (iv) discharged alive from a non-federal short-term acute care hospital; and (v) not transferred to another acute care facility.
- *Exclusions*. Hospitalizations without at least 30 days of post-discharge enrollment in FFS or MA, those discharged against medical advice, and diabetes admissions within 30 days of discharge from a prior diabetes index admission.
- *Risk-adjustment.* Adjusts for age, comorbidities (present at admission or within prior 12 months), severity of illness, and frailty based on clinical status at the index admission. Excludes complications arising during hospitalization.

Data Sources, Submission, and Public Reporting. The measure uses FFS claims data and MA encounter data. The existing EDAC measures in the HIQRP use a 3-year performance period, but CMS in section IX.C.5 of the rule is finalizing its proposal to add MA beneficiaries to the measure cohorts and shorten the performance periods to 2 years. In alignment, CMS finalizes a 2-year performance period for the Diabetes EDAC measure. The performance period for the FY 2029 payment determination will include data for index admissions occurring between July 1, 2025, and June 30, 2027. The measure (aggregated data) will be publicly reported through the Compare tool beginning in July 2028, or as soon as feasible. Confidential feedback reports to hospitals will include payer information on a patient level.

Comments/Responses. Many commenters supported the adoption of the measure, believing that it improves inpatient diabetes management, discharge planning, outcomes, patient education, care transition planning and effectiveness, and access to diabetes support.

Similar concerns were raised regarding including MA beneficiaries in the measure cohort as were raised (and discussed in the cross-programs finalized policies above) with respect to the addition of MA beneficiaries in the existing EDAC measures. CMS again asserts that inclusion of MA beneficiaries is not only important for measure reliability but also important to provide more complete information and assessment of care given the increasing proportion of the Medicare population represented by MA beneficiaries.

Several commenters did not support the proposal because they were concerned the measure may not be sufficiently attributable to inpatient hospital care, noting that people hospitalized for diabetes often have complex comorbidities, complications, and care needs involving a number of specialists. CMS believes the needs of this population emphasizes the importance of the measure and notes that the measure is risk-adjusted for clinically relevant factors. The agency recognizes

that diabetes care is impacted by much more than the inpatient setting, but also states that hospitals play an important role in discharge planning, medication reconciliation, patient education, care coordination, and connecting patients to resources.

b. Adoption of the Hospital Harm—Postoperative Venous Thromboembolism eCQM

Final Action. CMS finalizes, without modification, its proposal to adopt the Hospital Harm—Postoperative VTE eCQM, a risk-adjusted outcome measure, as an eCQM option for hospital selection beginning with the CY 2028 reporting period/FY 2030 payment determination and then as a mandatory eCQM beginning with the 2030 reporting period/FY 2032 payment determination. The eCQM is also being finalized for adoption in the Medicare Promoting Interoperability Program, as discussed in section IX.F.9.

Background. Postoperative venous thromboembolism (VTE) includes deep vein thrombosis (a blood clot in the deep veins) and pulmonary embolism (when a blood clot lodges in the lungs). VTE is considered a leading cause of preventable death following surgery. CMS reviews the adverse health consequences and long-term complications that are caused by non-fatal postoperative VTE. The agency also discusses how hospital care processes can reduce the risk of hospital-acquired VTE.

There are two VTE eCQMs in the current HIQRP measure set, both of which are process measures that hospitals may self-select: Venous Thromboembolism Prophylaxis (VTE-1) eCQM and Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM. CMS believes that a single comprehensive outcome measure instead of these two process measures will reduce burden. In section IX.C.4, the agency finalizes its corresponding proposal to remove the VTE-1 and VTE-2 eCQMs with the adoption of the Hospital Harm—Postoperative VTE eCQM.

Overview of Measure. The Hospital Harm—Postoperative VTE eCQM assesses the proportion of inpatient hospitalizations for patients at least 18 years of age who have at least one surgical procedure performed inside the operating room (OR) during the admission and have a postoperative VTE during hospitalization or during the 30 days after the first surgical procedure. The goal of the measure is to encourage hospitals to implement processes to reduce the occurrence of postoperative VTE.

Measure Calculation. The measure uses a risk-adjusted measure score to reflect the performance of a hospital relative to the average hospital with patients with the same characteristics. The measure is calculated by: (i) determining the observed rate by dividing the measure numerator by denominator, (ii) determining the hospital's expected VTE event rate (based on case mix) by applying the risk adjustment model); and (iii) dividing the observed rate by the expected rate.

- *Numerator*. Number of inpatient hospitalizations for adult patients who had a surgical procedure performed in the OR during the hospitalization and experienced a VTE within 30 days of the surgical procedure.
- *Denominator*. Number of adult patients who had a surgical procedure in the OR during an inpatient hospitalization.

- *Exclusions*. Cohort excludes inpatients encounters for patients with obstetric-related diagnosis, a VTE diagnosis present on admission, acute brain or spinal injury of hemorrhage present on admission, extracorporeal membrane oxygenation during the inpatient encounter, thrombectomy procedure before or on the same day as the first surgical procedure, intracranial or spinal surgery where the patient was discharged less than five days after the end of the surgery, and inpatient encounters with a duration of stay of fewer than 2 days.
- *Risk Adjustment*. Accounts for age, sex, and the following 8 clinical factors: bleeding disorders, cancer, catheter insertion, history of VTE, obesity, respiratory operations, stroke, and vascular surgeries.

Data Source, Submission and Public Reporting. The measure is calculated by hospitals' certified health IT using patient-level data and is then submitted by hospitals to CMS.

Pre-Rulemaking. The measure was included on the 2025 Measures Under Consideration List (MUC List) and reviewed by the Pre-Rulemaking Measure Review (PRMR) Hospital Committee during its January 2026 meeting. Only 35 percent of members recommended adopting the measure into the HIQRP while 65 percent voted against recommending its inclusion. Concerns were raised regarding the 30-day timeframe, potential overlap with the PSI 12 measure, potential unintended consequences, technical implementation within EHR systems, the measure's ability to meaningfully advance quality, need for methodological refinements (specifically for clearer diagnostic criteria for VTE), and lack of CBE endorsement.[87]

To address these concerns, in the FY 2027 IPPS/LTCH PPS proposed rule, CMS noted that it was proposing that the eCQM be an optional measure that hospitals may select as one of the three self-selected eCQMs to be reported (in addition to the three required eCQMs) for the first two years of its inclusion in the HIQRP. It also referred to details in section IX.C.3.b(3)(c) of the preamble of the proposed rule for details on the measure testing, noted that it conducts ongoing monitoring and evaluation to identify unintended consequences, and stated that the 30-day post-discharge assessment window is a common window for assessing adverse events from a hospital admission and is the window used for other HIQRP quality measures. Further, CMS responded that since the Committee had met, the CBE endorsed the measure on February 4, 2026 (CBE #5325e), with the condition that by the next measure maintenance review in 5 years the developer explores other risk factors that may impact post-discharge VTE.

With respect to the concern raised about overlap with the PSI 12 measure, which is a claims-based measure of perioperative pulmonary embolism (PE) and deep vein thrombosis (DVT) rate included in the PSI-90 composite measure, CMS believes that the eCQM captures a broader population since it captures care provided to all patients rather than only Medicare patients (as the PSI 12 measure does) and that the Hospital Harm—Postoperative VTE eCQM may be a replacement for the PSI 12 measure in the future.

[87] Sections 1886(b)(3)(B)(viii)(IX(bb) and 1866(k)(3)(B) of the Act provide that the Secretary may specify a measure that is not CBE-endorsed in the case of a specified area or medical topic determined appropriate by the Secretary for which there is not a feasible and practical measure that has been endorsed by the CBE.

The agency acknowledged that the Hospital Harm—Postoperative VTE eCQM relies on capturing data regarding an imaging procedure to diagnose the VTE and initiation of anticoagulant therapy within 24 hours of the imaging procedure within the same EHR system in which the qualifying surgery was documented and that this may cause systems with multiple EHRs to appear to perform better on the measure because they capture fewer post-discharge VTE events. CMS stated that since many numerator-qualifying VTE events occur during the initial hospitalization, and approximately 75 percent of patients with post-surgical complications return to their discharging hospital, the agency believes that the majority of data on postoperative VTEs would be available within the reporting hospital's EHR.

Comments/Responses. Many commenters supported adoption of the measure, some because it is an eCQM and they believe that eCQMs can improve the timeliness of quality data, and others because they believe VTE is an important topic to address with an outcome measure to improve care. Many other commenters raised various concerns, including regarding burden with adopting multiple eCQMs across quality reporting programs, whether an eCQM can accurately and completely capture post-discharge VTEs, data element validity testing that had been limited to two vendor systems, unintended consequences, and lack of clear diagnostic criteria for VTE. Many commenters were concerned that the measure was not recommended by the PRMR Hospital Committee. CMS points to its responses included in the FY 2027 IPPS/LTCH PPS proposed rule addressing the concerns raised by the committee (discussed in the pre-rulemaking provision above).

4. Removals from the Measure Set

CMS finalizes its proposals to remove the following 3 measures beginning with the 2028 reporting period/FY 2030 payment determination:

- Venous Thromboembolism Prophylaxis (VTE-1) eCQM;[88]
- Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM;[89] and
- Discharged on Antithrombotic Therapy (STK-02) eCQM.[90]

a. Removal of Two Venous Thromboembolism eCQMs

The VTE-1 and VTE-2 eCQMs are optional measures for hospitals to self-select. CMS finalizes removal of these two measures from the HIQRP beginning with the 2028 reporting period/FY 2030 payment determination, under measure removal factor 5[91] – the availability of a measure that is more strongly associated with desired patient outcomes for the particular topic. Their removal corresponds with the newly finalized adoption of the Hospital Harm–Postoperative VTE eCQM (discussed under section IX.C.3).

The VTE-1 eCQM assesses the proportion of patients admitted to the hospital who received VTE prophylaxis or have documentation of why it was not given. The VTE-2 eCQM measures the

[88] Adopted in the FY 2014 IPPS/LTCH PPS final rule.
[89] Adopted in the FY 2014 IPPS/LTCH PPS final rule.
[90] Adopted in the FY 2014 IPPS/LTCH PPS final rule.
[91] The HIQRP's measure removal factors are under 42 CFR 412.140(g)(2) and (3).

proportion of patients admitted or transferred to the intensive care unit who received VTE prophylaxis or have documentation of why it was not given. In comparison, the Hospital Harm–Postoperative VTE eCQM is an outcome measure that evaluates the incidence of postoperative VTE events, assessing the success of the VTE prophylaxis strategies measure by the VTE-1 and VTE-2 measures.

Under section IX.F.9 of the rule, CMS is also finalizing removal of the VTE-1 and VTE-2 eCQMs from the Medicare Promoting Interoperability Program.

Comments/Responses. Many commenters supported removal of the VTE-1 and VTE-2 eCQMs and believed that replacing those two eCQMs with the Hospital Harm–Postoperative VTE eCQM would reduce burden and focus on patient outcomes. Many other commenters believed that retaining the two eCQMs, even with the addition of the third eCQM would provide a more complete clinical picture that could help hospitals understand systemic failures that lead to VTEs.

b. Removal of Discharged on Antithrombotic Therapy eCQM

The STK-02 eCQM is an optional measure that hospitals may self-select. It assesses the proportion of patients hospitalized with ischemic stroke who are prescribed or continue antithrombotic therapy at the time of hospital discharge. CMS finalizes its proposal to remove the measure from the HIQRP beginning with the 2028 reporting period/FY 2030 payment determination under measure removal factor 1 – measure performance is so high and unvarying among hospitals that meaningful distinctions and improvements can no longer be made (i.e., the measure is "topped out").

CMS points to other clinical outcome measures in the HIQRP that address quality of care for stroke patients, including the Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Acute Ischemic Stroke (MORT-30-STK) measure, the Anticoagulation Therapy for Atrial Fibrillation (STK-03) eCQM, and the Antithrombotic Therapy by the End of Hospital Day Two (STK-05) eCQM.

Under section IX.F.9 of the rule, CMS is also finalizing removal of the STK-02 eCQM from the Medicare Promoting Interoperability Program.

5. Modifications to Current Measures in HIQRP Measure Set

CMS finalizes its proposal for modifications to the following three excess days in acute care (EDAC) quality measures beginning with the July 1, 2024, through June 30, 2026, performance period, associated with the FY 2028 payment determination:

- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (AMI Excess Days);
- Excess Days in Acute Care after Hospitalization for Heart Failure (HF Excess Days); and
- Excess Days in Acute Care after Hospitalization for Pneumonia (PN Excess Days).

Since these measures were adopted, the proportion of MA beneficiaries has increased to over 50 percent. CMS believes assessing care transitions for all Medicare beneficiaries (not only FFS) is important and that inclusion of the broader population will make the measures more reliable. The agency also believes a shorter performance period will provide more timely and actionable data.

Therefore, the agency is finalizing, as proposed, two substantive updates to the EDAC measures:

- Expand the measure inclusion criteria to include MA beneficiaries (in addition to FFS beneficiaries); and
- Shorten the performance period from 3 years to 2 years.

Measure Calculation. Each of the modified AMI, Heart Failure, and Pneumonia EDAC measures continue to assess the number of days the patient spends in acute care within 30 days post-discharge from an inpatient hospitalization with a principal diagnosis of AMI, heart failure, or pneumonia, respectively. For each measure, the hospital-level 30-day all-cause EDAC is risk-adjusted and calculates the difference (i.e., excess days) between a hospital's predicted days and expected days per 100 discharges.

- *Numerator*. Number of days the patient spends in acute care within 30 days of discharge from an eligible index hospitalization for AMI, heart failure, or pneumonia, as applicable. Days in acute care is defined as days spent in an ED, an observation stay, or admitted as an unplanned readmission for any cause to a short-term acute care hospital within 30 days from discharge from the index hospitalization. ED visits are counted as one whole day; observation stays are counted by hours and rounded up to the nearest whole day.
- *Denominator*. Patients must meet all of the following to be included in the measure cohort: (i) have a principal discharge diagnosis of AMI, heart failure, or pneumonia, as applicable; (ii) be enrolled in FFS or MA for 12 months before admission and enrolled in Part A of MA during index admission; (ii) be at least 65 years old; (iv) be discharged alive from non-federal acute care hospital or Veterans Health Administration hospital; and (v) not be transferred to another acute care facility.

Data Source, Submission, and Public Reporting. The modified EDAC measures are calculated using FFS claims data and MA encounter data and will be calculated and publicly reported on an annual basis using 24 months of prior data for the measurement period.

Pre-Rulemaking. The modified measures were included on the 2025 MUC and considered by the PRMR Hospital Committee during its January 2026 meeting. Consensus was reached to recommend all three modified EDAC measures for inclusion in the HIQRP.

The Heart Failure EDAC (CBE #2880) and Pneumonia EDAC (CBE #2882) measures were last endorsed in the Spring 2021 CBE review cycle and are planned for maintenance review in the Fall 2027 cycle. The updated AMI EDAC (CBE #2881) measure, which included the addition of MA beneficiaries, was most recently submitted to the CBE's Endorsement and Maintenance Cost and Efficiency Committee in the Spring 2025 review cycle and received endorsement with the condition for the measure developer to empirically explore the differences with outpatient

visits and post-hospitalizations for MA beneficiaries compared to FFS beneficiaries when the measure returns in five years for maintenance endorsement (Spring 2030).

Technical Updates. CMS provides notification of technical updates to the EDAC measures' risk adjustment methodology to use individual ICD-10 codes instead of the current practice of grouping ICD-10 codes from the HCC system into clinically relevant categories. These updates begin with the FY 2028 payment determination.

Comments/Responses. Many commenters supported the modifications, noting that including MA enrollees will provide a more complete assessment of hospital performance and that shortening the performance period will provide more recent and actionable data. Many other commenters expressed concern that including MA enrollees in the cohorts for the measures would affect comparability and reliability because of concerns about the completeness and consistency of MA encounter data. However, CMS has found in its internal studies that there were not significant differences between the MA and FFS populations. Plus, the agency notes that the inclusion of the MA population increases the size of the measures' cohorts which leads to more hospitals being able to reach the minimum threshold for reporting and receiving results.

Several commenters noted that utilization trends for MA enrollees are affected by plan benefit structures, payment delays, inappropriate denials, prior authorization requirements, post-acute network limitations, differences in patient populations, and other distinctions as compared to FFS. Some of the commenters stated that these effects on utilization trends may subject hospitals to unfair comparisons based on the markets they serve rather than the care they provide. CMS acknowledges the differences, but states that unplanned readmissions, ED visits, and observation stays are adverse events from a patient's perspective regardless of the benefit or payment policy involved. CMS believes it is important to provide transparency on the quality of transitions in care by collectively measuring these events for all Medicare beneficiaries,

6. Summary of Previously Finalized and Newly Finalized HIQRP Measures

Table IX.C.5 of the rule shows the previously finalized and newly finalized HIQRP measures for each of the FY 2028 through FY 2031 payment determinations. Information from that table and Tables IX.C.8 and IX.C. 9 in the rule (relating to reporting and submission requirements) is included in the table below (with formatting and presentation changes).

Previously Finalized and Newly Finalized HIQRP Measures by Payment Determination Year				
	2028	**2029**	**2030**	**2031**
Chart-Abstracted Process of Care Measures				
Severe sepsis and septic shock: management bundle Composite Measure) (CBE #500)	X	X	X	X
Electronic Clinical Quality Measures				
STK-2 Antithrombotic therapy for ischemic stroke (CBE #0435e)^ STK-3 Anticoagulation therapy for Afib/flutter (CBE #0436e) STK-5 Antithrombotic therapy by end of hospital day 2 (CBE #0438e) VTE-1 VTE prophylaxis (CBE #0371)^	Report 4 calendar quarters of data for a total of 8 eCQMs: Safe Use of Opioids AND Cesarean Birth	Report 4 calendar quarters of data for a total of 9 eCQMs: Safe Use of Opioids AND Cesarean Birth	Report 4 calendar quarters of data for a total of 14 eCQMs: Safe Use of Opioids AND Cesarean Birth	Report 4 calendar quarters of data for a total of 14 eCQMs: Safe Use of Opioids AND

Previously Finalized and Newly Finalized HIQRP Measures by Payment Determination Year				
	2028	**2029**	**2030**	**2031**
VTE-2 ICU VTE prophylaxis (CBE #0372)^ Safe Use of Opioids (CBE#3316e) HH-HYPO Hospital Harm-Severe Hypoglycemia (CBE #3503e) HH-HYPER Hospital Harm-Severe Hyperglycemia (CBE #3533e) Hospital Harm Opioid Related Adverse Events HH-ORAE (CBE# 3501e) PC-02 Cesarean Birth (CBE# 0471e) PC-07/SMM Sever Obstetric Complications (CBE# 3687e) MCS Malnutrition Care Score (CBE #3592e)* HH-PI Hospital Harm-Pressure Injury (CBE #3498e)** HH-AKI Hospital Harm-Acute Kidney Injury (CBE #3713e)** IP-ExRad Excessive Radiation Does or Inadequate Image Quality for Diagnostic CT in Adults (CBE# 3663e) HH-FI Hospital Harm-Falls with Injury (CBE#4120e)* HH-RF Hospital Harm-Postoperative Respiratory Failure (CBE#4130e)* HH-VTE Hospital Harm—Postoperative Venous Thromboembolism (CBE#5325e)*** ACP Advance Care Planning***	AND Severe Obstetric Complications AND HH-HYPO AND HH-HYPER AND 3 of the following eCQMs: STK-2 STK-3 STK-5 VTE-1 VTE-2 HH-ORAE MCS HH-PI HH-AKI IP-ExRad HH-FI HH-RF	AND Severe Obstetric Complications AND HH-HYPO, HH-HYPER, and HH-ORAE AND 3 of the following eCQMs: STK-2 STK-3 STK-5 VTE-1 VTE-2 MCS HH-PI HH-AKI IP-ExRad HH-FI HH-RF	AND Severe Obstetric Complications AND MCS*, HH-HYPO, HH-HYPER, HH-ORAE, HH-PI, HH-FI,* HH-RF* and HH-AKI AND 3 of the following eCQMs: STK-3 STK-5 IP-ExRad HH-VTE*** ACP***	Cesarean Birth AND Severe Obstetric Complications AND MCS*, HH-HYPO, HH-HYPER, HH-ORAE, HH-PI, HH-FI,* HH-RF* and HH-AKI AND 3 of the following eCQMs: STK-3 STK-5 IP-ExRad HH-VTE*** ACP***
National Healthcare Safety Network Measures				
Healthcare Personnel Influenza Vaccination (CBE #0431)	X	X	X	X
CAUTI-onc (CBE #0138)	X	X	X	X
CLABSI-onc (CBE #0139)	X	X	X	X
Claims-Based Measures				
Mortality/Complications				
Hospital 30-Day, All-Cause, Risk Standardized Mortality- Rate Following Acute Ischemic Stroke	X	X	X	X
Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA and/or TKA (COMP-HIP-KNEE) (CBE # 1550)	X	X		
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization (MORT–30–AMI) (CBE #0230)^^	Adopted	X	X	X
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (MORT–30–HF) (CBE #0229)^^	Adopted	X	X	X

Previously Finalized and Newly Finalized HIQRP Measures by Payment Determination Year				
	2028	**2029**	**2030**	**2031**
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT–30–PN) (CBE #0468)^^	Adopted	X	X	X
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT–30–COPD) (CBE #1893)^^	Adopted	X	X	X
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT–30CABG) measures (CBE #2558)^^	Adopted	X	X	X
Coordination of Care				
Excess days in acute care after hospitalization for AMI (AMI Excess Days) (CBE #2881) ^^^	X	X	X	X
Excess days in acute care after hospitalization for HF (HF Excess Days) (CBE #2880)^^^	X	X	X	X
Excess days in acute care after hospitalization for PN (PN Excess Days) (CBE #2882)^^^	X	X	X	X
Excess Days in Acute Care after Hospitalization for Diabetes^^^^		Adopted	X	X
Claims and Electronic Data Measures (Hybrid)				
Hybrid HWR (all-cause readmission) (CBE #2879e)	X	X	X	X
Hybrid HWM (all-cause mortality) (CBE #3502e)	X	X	X	X
Patient Safety				
30-day Risk Standardized Death Rate among Surgical Inpatients with Complications (Inpatient Surgical Complications Mortality Rate) (CBE #4125)	X	X	X	X
Patient Experience of Care				
HCAHPS survey (CBE #0166) (0228)	X	X	X	X
Patient-Reported Outcome Performance Measure (PRO-PM)				
Hospital-Level THA/TKA PRO-PM (CBE 3559)	X	X	X	X
Structural Measures				
Maternal Morbidity	X	X	X	X
Age Friendly Hospital	X	X	X	X
Patient Safety	X	X	X	X
* Finalized modification from self-selected to mandatory reporting beginning with the FY 2030 payment determination.				

Previously Finalized and Newly Finalized HIQRP Measures by Payment Determination Year				
	2028	2029	2030	2031
** These eCQMs will be mandatory rather than among the list for self-selection beginning for the 2030 payment determination. *** Finalized for adoption beginning with the FY 2030 payment determination as self-selected eCQMs. HH-Postoperative VTE will become mandatory after 2 years of self-selected reporting beginning with the FY 2032 payment determination, at which point there will be a total of 15 eCQMs reported. ^ Finalized for removal beginning with the FY 2030 payment determination. ^^ Finalized for adoption for the FY 2028 payment determination through the FY 2031 payment determination. ^^^ CMS finalizes modifications to the AMI EDAC, HF EDAC, and PN EDAC measures beginning with the FY 2028 payment determination. ^^^^ Finalized for adoption in the rule beginning with FY 2029 payment determination.				

7. Future Considerations

a. RFI: Birthing-Friendly Hospital Designation Modification to Expand Designation Criteria

In the FY 2027 IPPS/LTCH PPS proposed rule, CMS sought input on potential modifications to the Birthing-Friendly Hospital Designation (the Designation), specifically on (i) the inclusion of the Cesarian Birth eCQM and Severe Obstetric Complications eCQM in the criteria for awarding the Birthing-Friendly Hospital Designation; and (ii) a modified scoring methodology for the expanded designation.

The Designation is a publicly reported display on the Compare tool on Medicare.gov to identify hospitals with high-quality maternal care and a commitment to improving maternal health outcomes. The designation is currently given to hospitals that report yes for the attestation-based Maternal Morbidity structural measure (i.e., that hospital is participating in a structured Perinatal Quality Improvement (QI) collaborative and implementing patient safety practices or bundles as part of the QI initiatives).

CMS is considering potential modifications to the Designation that would include hospital performance on the Cesarian Birth eCQM and Severe Obstetric Complications eCQM (both of which are mandatory under the HIQRP and Medicare Promoting Interoperability Program). The Cesarian Birth eCQM assesses the proportion of cesarian deliveries to women giving birth for the first time who delivered at 37 weeks of gestation or later with a live (single) baby in a vertex position. The Severe Obstetric Complications eCQM is a risk-standardized measure that assesses severe maternal morbidity events and mortality during delivery hospitalizations for patients between the ages of 8 and 65 years of age delivering stillborn or a live birth at 20 weeks gestation or more.

To be eligible for the expanded Designation, a hospital would need to have attested positively to the current Maternal Morbidity structural measure as a threshold requirement. Weighted scores for each of the two eCQMs under consideration would be aggregated into a composite score for each hospital. The Cesarean Birth eCQM would be assigned a 45 percent weight and the Severe Obstetric Complications eCQM a 55 percent weight. Hospitals would be grouped into four peer groups by hospital delivery volume and a k-means statistical clustering algorithm would be applied within each group to assign hospitals with similar composite scores to one of three clusters representing levels of maternal care quality. Each cluster would receive a number of

birthing-friendly icons (similar to a star rating) with hospitals in the lowest performing cluster receiving one icon, middle performing cluster receiving two icons, and top performing cluster receiving three icons.

In the FY 2027 proposed rule, the agency sought feedback on expanding the Designation to include the Cesarean Birth and Severe Obstetric Complications eCQMs, the described scoring methodology, and the described tiered approach to awarding Birthing-Friendly Hospital Designation Icons.

Comments/Responses. In the final rule, CMS summarizes comments it received.

Many commenters supported updating the Designation because of the importance of obstetric care. Other commenters did not support developing a scoring or tiering system using available measures because they had concerns about the appropriateness of those measures. Many commenters specifically expressed concerns about the Cesarean Birth eCQM, including that it does not appropriately distinguish between medically necessary and elective cesarean births and that it lacks sufficient risk adjustment. Many commenters supported inclusion of the Severe Obstetric Complications eCQM, while some suggested incorporating risk adjustment for social and clinical risk factors.

Several commenters expressed concern about the scoring framework CMS described, specifically expressing concern regarding the k-means clustering and that it would be difficult for patients to interpret and hospital to use. Many commenters supported peer grouping and establishing minimum case volumes, while other commenters thought a minimum case volume may signal that quality is not important at hospitals that treat small volumes of labor and delivery patients.

Many commenters expressed that the described Designation may be difficult for patients and their families to understand Some commenters recommended other quality measures and quality measure concepts to include in the scoring for the Designation, which CMS lists in the discussion.

CMS does not respond to comments in the final rule but states it will take the feedback into account for future development of the Birthing-Friendly Hospital Designation.

8. Form, Manner, and Timing of Quality Data Submission[92]

CMS finalizes changes to the reporting and submission requirements for eCQMs and structural measures, as discussed in further detail below.

[92] Data submission requirements, specifications manual, measure methodology reports, and submission deadlines are posted on the QualityNet website at https://qualitynet.cms.gov. The Annual Update for the Hospital Quality Reporting Programs (which contains updated measures specifications for the year prior to the reporting period) and implementation guidance documents are available on the Electronic Clinical Quality Improvement Resource Center website at http://ecqi.healthit.gov.

a. Requirements for eCQMs

Table IX.C.8 of the rule summarizes the previously finalized eCQM reporting and submission policies for the 2026 reporting/FY 2028 payment determination and subsequent years. Information from that table is also reflected in the HIQRP measure set summary table under section IX.C.6 above.

Mandatory Reporting of Malnutrition Care Score eCQM. The Malnutrition Care Score eCQM was finalized in the FY 2023 IPPS/LTCH PPS final rule for adoption in the HIQRP measure set as an eCQM which a hospital could self-select beginning with the CY 2024 reporting period/FY 2026 payment determination. CMS finalizes its proposal to shift the eCQM from the self-select option to mandatory beginning with the 2028 reporting period/FY 2030 payment determination, in alignment with its strategy to transition to fully digital quality measurement.

Mandatory Reporting of Hospital Harm eCQMs. CMS describes hospital harms as a significant source of morbidity, mortality, and cost. There are currently seven eCQMs in the measure set that address different types of and various aspects of preventable hospital harm. Five of those eCQMs are mandatory and two are currently self-select.

The agency is finalizing, with modification, its proposal that beginning with the 2028 reporting period/FY 2030 payment determination, Hospital Harm eCQMs that have not yet been finalized for mandatory reporting will become mandatory in the third year of reporting (i.e. after two years of self-selected reporting). The modification is to publicly report data on the more research-focused Provider Data Catalog for the first year of mandatory reporting before moving it to the more consumer-focused Care Compare site, including Star Ratings, beginning with the second year of mandatory reporting.

Under this policy:

- The two remaining self-select Hospital Harm eCQMs (Hospital Harm—Falls with Injury eCQMand the Hospital Harm—Postoperative Respiratory Failure) will begin mandatory reporting in the 2028 reporting period/FY 2030 payment determination.
- The newly finalized Hospital Harm— Postoperative VTE eCQM, finalized for adoption in section IX.C.3 of the rule, will become mandatory to report beginning with the 2030 reporting period/FY 2032 payment determination, after being available for 2 years of self-selected reporting.
- Any newly adopted Hospital Harm eCQM in the HIQRP will become mandatory for reporting after 2 years of self-selected reporting in the program.

Comparable updates to the reporting requirements for Hospital Harm eCQMs in the Medicare Promoting Interoperability Program are discussed in section IX.F.9.

Summary of Changes to the eCQM Reporting and Submission Requirements. If a hospital does not have patients that meet the denominator criteria for any of the eCQMs, the hospital will submit a zero denominator declaration, which allows the hospital to meet the reporting requirements for that eCQM.

Table IX.C.10 of the rule summarizes the eCQM reporting and submission requirements for the 2028 reporting period/FY 2030 payment determination and subsequent years. Information from that table is also reflected in the HIQRP measure set summary table under section IX.C.6 above.

Comments/Responses. Many commenters supported the modifications to the eCQM reporting and submission requirements as a step in transitioning all quality measure reporting to digital quality measures (dQMs). Many commenters supported transitioning specifically the Malnutrition Care Score eCQM to mandatory reporting because they believe that nutrition care is a low-cost, high-impact intervention and encouraged CMS to advance additional nutrition quality measures, such as in post-acute care settings and pay-for-performance programs.

Many commenters raised concerns about the pace and scale of mandatory eCQM implementation and suggested a more phased approach that would allow additional time for staff training, validation, monitoring, and performance improvement before mandatory reporting begins. Commenters also raised concerns about hospitals with limited health IT resources. CMS acknowledges concerns with the timeline and required resources, but believes hospitals have notice and can plan accordingly since its proposal provides a predictable timeline by providing two years of self-selected reporting before a Hospital Harm eCQM becomes mandatory. In response to concerns raised about potentially inaccurate data being public facing, CMS states it will publicly report data for Hospital Harm eCQMs on the more research-focused Provider Data Catalog for the first year of mandatory reporting before moving the measures to the consumer-focused Care Compare site, including Star Ratings, beginning with the second year of mandatory reporting.

Some commenters recommended offering voluntary incentivized FHIR-based dQM reporting as an alternative to mandatory eCQM reporting. CMS indicates it will consider this feedback as it develops policies related to future FHIR-based dQM reporting and points to the RFI on potential FHIR timelines that is included in the 2027 Physician Fee Schedule proposed rule (91 FR 44151 through 44154).

b. Data Submission and Reporting Requirements for Structural Measures

CMS finalizes, without modification, its proposal to update the reporting requirements for the Maternal Morbidity Structural measure beginning with the 2026 reporting period/FY 2028 payment determination. Currently the attestation-based measure asks whether the hospital participates in a perinatal quality improvement collaborative program and if it has implemented patient safety practices or bundles related to maternal morbidity to address complications. Under the newly finalized update a hospital answering "yes" will also need to report the name of the perinatal quality improvement collaborative program to successfully report all requirements of the measure.

D. PPS-Exempt Cancer Hospital Quality Reporting Program (PCH QRP)

1. Background; Overview

The PCH QRP applies to hospitals meeting the description of PPS-exempt cancer hospital (PCH) as defined at section 1886(d)(1)(B)(v) of the Act. The Program has 11 participants that focus on

the care of oncology patients and are paid on a cost basis, subject to a per discharge limit (target amount), rather than through a prospective payment system (PPS). The program requires quality reporting by PCHs, and measure data are publicly available, but the results have no associated payment consequences.

In addition to the finalized cross-program proposal discussed in section IX.B.1 to adopt the Advance Care Planning eCQM, CMS is also finalizing for the PCH QRP its proposals to adopt the Malnutrition Care Score eCQM and remove the COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP COVID-19 Vaccine) measure. In addition, CMS finalizes its proposal for reporting and submission requirements for eCQMs in the PCH QRP.

Across all PCHs, CMS estimates, compared to the currently approved information collection burden estimates, (i) beginning for the FY 2028 program year, a reduction in the total annual information collection burden of between 88 hours at a savings of $4,972 and 99 hours at a savings of $5,801, attributable to the finalized removal of the HCP COVID-19 Vaccine measure, and (ii) an increase, attributable to the finalized adoption of the Advance Care Planning eCQM and Malnutrition Care Score eCQM, in the total information collection burden of 8 hours at a cost of $440 for the FY 2030 program year and of 15 hours at a cost of $826 beginning for the FY 2030 program year.

2. Adoption of Malnutrition Care Score eCQM

Final Action. CMS finalizes, with modification, to adopt the Malnutrition Care Score eCQM in the PCH QRP. The modification provides for voluntary reporting for the 2028 reporting period/FY 2030 program year followed by mandatory reporting of a full year's data beginning with the 2029 reporting period/FY 2031 program year (in comparison to beginning mandatory reporting with the 2028 reporting period/FY 2030 program year, as proposed). For the voluntary period, PCHs will receive confidential data through the Hospital Quality Reporting System to allow for chances to identify and address deficiencies before public display. CMS will publicly report measure information beginning with the 2029 reporting period/FY 2031 program data as soon as it is feasible.

Background. Malnutrition is a common and high-risk condition that encompasses both undernutrition and overnutrition. CMS describes how malnutrition can be more prevalent among hospitalized patients with cancer and is associated with adverse clinical outcomes and increased health costs. The agency believes there is an opportunity for reduced complications and lengths of stay if PCHs identify malnutrition early in the patient admission process and address it with interventions in the patient's cancer treatment plan.

Overview of Measure. The Malnutrition Care Score eCQM (previously known as the Global Malnutrition Composite Score eCQM) assesses the percentage of adults aged 18 years and older at the start of the eligible encounter, with a length of stay that is at least 24 hours, who received optimal malnutrition care appropriate to the specific patient's level of malnutrition risk and severity. This eCQM is included in the HIQRP and Medicare Promoting Interoperability Program.

Measure Calculation.[93] The eCQM has four components, which are scored separately: (i) screening for malnutrition risk at admission; (ii) completing a nutrition assessment for patients who screened for risk of malnutrition; (iii) appropriate documentation of malnutrition diagnosis in patients' medical record if risk of moderate or severe was indicated; and (iv) development of nutrition care plan for malnourished patients.

- *Numerator*. Four components that are individually scored at the encounter level for patients 18 and older admitted to a PCH; each component that is not documented gets a value of 0 and each that is documented gets a value of 1; then all values are summed to total the numerator.
- *Denominator*. Total eligible occurrences of the 4 components for patients aged 18 and older admitted to a PCH. Only exclusion is patients whose length of stay is less than 24 hours.

Data Sources, Submission, and Reporting. The eCQM would be calculated by certified health IT using patient-level data and then submitted by the PCH to CMS.

Comments/Responses. Many commenters supported the adoption of the eCQM, including for the reason that addressing nutrition is a low-cost way to improve patient outcomes, and noted the importance of malnutrition care specifically for cancer patients. Commenters encouraged CMS to provide incentives for effective care transitions and sustainable patient access to outpatient services so that care plans are carried out in post-acute care settings.

Several commenters expressed concern about the ability to implement eCQMs in the PCH QRP under the proposed timeframe. Some commenters raised concerns about publicly reporting the eCQMs immediately after the first required reporting period because they did not believe there would be sufficient opportunity to validate data accuracy before public display. Acknowledging that eCQMs will be entirely new to the PCH QRP and that additional time may therefore be needed to ensure the accuracy of publicly reported data and implement workflow and other needed changes, CMS is finalizing its proposal with a modification to delay mandatory reporting by one year (as compared to its proposal) and provide for a voluntary reporting period before mandatory reporting begins.

3. Removal of COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP COVID-19 Vaccine) Measure

In the FY 2022 IPPS/LTCH PPS final rule, CMS adopted the HCP COVID-19 Vaccine measure into the PCH QRP measure set.[94] The measure requires PCHs to report the COVID-19 vaccination status of HCP through the National Healthcare Safety Network (NHSN).

CMS is finalizing, without modification, its proposal to remove, beginning for the 2026 reporting period/FY 2028 program year, this measure under measure removal factor 2, which provides for

[93] Table IX.D.1 of the rule provides details on the numerator and denominator cohort for each component.
[94] 86 FR 45428-45434.

removal of a measure that does not align with the current clinical guidelines or practice.[95] Specifically, the latest CDC COVID-19 vaccination recommendations are based on shared clinical (also referred to as individual-based) decision-making, where there is not a default decision to vaccinate for a defined population. Therefore, CMS describes that both receipt and nonreceipt of the vaccination would be consistent with the latest recommendations. This differs from the guidance that had been in place when the measure had been finalized for inclusion, which had provided for well-defined parameters for populations to receive the vaccination.

PCHs will not need to report CY 2026 HCP COVID-19 Vaccination measure data to meet the PCH QRP requirements for the FY 2028 program year. Any 2026 data on the measure received by CMS will not be used for PCH QRP compliance or public reporting.

CMS has already removed this measure from the Hospital Inpatient Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, the Ambulatory Surgical Center Quality Reporting Program, the Hospital Outpatient Quality Reporting Program, and the Inpatient Rehabilitation Facility Quality Reporting Program. In section IX.E.3 of the rule, CMS discusses its policy to remove the measure from the LTCH QRP.

Comments/Responses. A few commenters supported the proposal for reasons such as the measure no longer aligns with current clinical guidance and the proposal would reduce burden. Some commenters opposed the proposal for reasons such as vaccination being an important strategy for protecting cancer patients who are a vulnerable population and concern about the proposal resulting in reduced transparency and accountability for infection prevention efforts.

4. Summary of Previously Finalized and Newly Finalized PCH QRP Measures for FY 2028 Program Year and Subsequent Years

CMS summarizes the PCH QRP's previously established and newly finalized measure set, in table IX.D.3 of the rule. The table below shows information provided in that table.

PCH QRP Measures for FY 2028 through FY 2031 Program Years (PY)				
Measure	**FY 2028 PY**	**FY 2029 PY**	**FY 2030 PY**	**FY 2031 PY**
NHSN Safety and Healthcare Associated Infection (HAI)				
American College of Surgeons – CDC (ASC-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (includes SSIs following Colon/Abdominal Hysterectomy Surgery) (CBE #0753)	X	X	X	X
NHSN CDI (CBE #1717)	X	X	X	X
NHSN MRSA bacteremia (CBE #1716)	X	X	X	X
Influenza vaccination coverage among health care personnel CBE #0431)	X	X	X	X

[95] See section 412.24(d)(3)(i) of title 42, CFR, for factors used to evaluate whether a measure should be removed from the PCH QRP.

PCH QRP Measures for FY 2028 through FY 2031 Program Years (PY)				
Measure	**FY 2028 PY**	**FY 2029 PY**	**FY 2030 PY**	**FY 2031 PY**
COVID-19 vaccination coverage among HCP ** Removal finalized beginning for 2026 reporting period/FY 2028 program year*				
NHSN CLABSI (CBE #0139)	X	X	X	X
NHSN CAUTI (CBE #0138)	X	X	X	X
Patient Safety Structural Measure	X	X	X	X
Claims-Based End-of-Life				
Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (CBE #0210)	X	X	X	X
Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (CBE #0215)	X	X	X	X
Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (CBE #0216)	X	X	X	X
Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (CBE #0213)	X	X	X	X
Patient Engagement / Experience of Care				
HCAHPS (CBE #0166)	X	X	X	X
Documentation of Goals of Care Discussions Among Cancer Patients	X	X	X	X
Claims-Based Outcome Measures				
Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy	X	X	X	X
30-Day Unplanned Readmissions for Cancer Patients (CBE #3188)	X	X	X	X
Surgical Treatment Complications for Localized Prostate Cancer	X	X	X	X
eCQMs				
Advance Care Planning ** Finalized with voluntary reporting for 2028 reporting period/FY 2030 PY and mandatory reporting beginning with 2029 reporting period/FY 2031 PY*			Voluntary	X
Malnutrition Care Score (CBE #3592e) ** Finalized with voluntary reporting for 2028 reporting period/FY 2030 PY and mandatory reporting beginning with 2029 reporting period/FY 2031 PY*			Voluntary	X

5. Updates to Form, Manner, and Timing of Quality Data Submission

CMS finalizes, as proposed, its policies establishing eCQM data submission and reporting requirements for the Program, which apply to the newly finalized Advance Care Planning eCQM and Malnutrition Care Score eCQM.

a. Maintenance of Technical Specifications

CMS finalizes, as proposed, its policy for maintaining technical specifications for eCQMs. PCHs will be required to use the eCQM electronic measure specifications and implementation guidance for the applicable reporting period, which is available on the eCQI Resource Center website.[96] As with the HIQRP, the technical specifications for eCQMs for the PCH QRP will be contained in the Annual Update for Hospital Quality Reporting Programs (Annual Update). Measure specifications for eCQMs will be updated on an annual basis through the Annual Update process.

b. Data Submission and Reporting Requirements for eCQMs

CMS intends to transition fully to digital quality measures (dQMs) and towards that goal is expanding the use of eCQMs in its reporting programs while it supports the phased conversion to FHIR and dQMs. The newly finalized Advance Care Planning and Malnutrition Care Score eCQMs are the first eCQMs included in the PCH QRP.

CMS finalizes, beginning with the 2028 reporting period/FY 2030 program year, eCQM submission and reporting requirements for the PCH QRP that would align with such requirements in other CMS quality reporting programs.

eCQM Reporting and Data Submission Requirements. CMS codifies at §412.24(g) that PCHs must use health IT certified to the ONC Health IT Certification Program certification criteria, as adopted and updated at 45 CFR 170.315(c), to calculate, export, and submit results for the eCQMs under the PCH QRP. The agency also finalizes its proposal that health IT will not need to be recertified each time the eCQMs' specifications are updated to a more recent version.

The standard file format used for eCQM submission in CMS quality programs is the Quality Reporting Document Architecture (QRDA) standard. CMS is aligning the PCH QRP with other quality reporting programs by (i) requiring PCHs submit eCQM data through the QRDA Category I file format; (ii) permitting PCHs to use third parties to submit QRDA I files; and (iii) permitting PCHs to either use abstraction or pull the data from non-certified sources to input the data into certified health IT to report in this format.

CMS finalizes, as proposed, its policy that a PCH could meet the eCQM reporting requirements by any of the following:

- *Submitting data via QRDA I files*.
- *Submitting a zero-denominator declaration*. A PCH will submit a zero in the denominator for an eCQM if the PCH's health IT is certified to the eCQM but the PCH does not have patients that meet the denominator criteria. In this case, a zero in the denominator is a successful submission for the eCQM.
- *Submitting a case threshold exemption*. A PCH using certified health IT will be exempt from reporting on an eCQM if the PCH has 5 or fewer applicable inpatient encounters or discharges per quarter or 20 or fewer applicable inpatient encounters of discharges per

[96] https://ecqi.healthit.gov

year (Medicare and non-Medicare combined) that meet the eCQM's patient population denominator criteria for the reporting period.

The eCQM submission deadline under both the HIQRP and Medicare Promoting Interoperability Program is by the end of two months following the end of the calendar year reporting period. CMS finalizes the same eCQM submission deadline for the PCH QRP. For example, for the mandatory 2029 reporting period/FY 2031 program year, PCHs will need to submit eCQM data by February 28, 2030.

c. Review and Corrections Period for eCQM Data Submitted

CMS finalizes for the PCH QRP (as exists under the HIQRP) a review and corrections period for eCQM data that runs concurrently with the data submission period.

E. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

1. Background and Overview

The LTCH QRP is a pay-for-reporting quality program implemented in FY 2014.[97] LTCHs submit data to CMS on the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) patient assessment instrument using the Internet Quality Improvement Evaluation System (iQIES). The LCDS requires reporting of multiple standardized patient assessment data elements (SPADES) that are interoperable and are common to post-acute care (PAC) providers.[98] An LTCH that fails to meet the program's quality data reporting requirements is subject to a 2.0 percentage point reduction in the annual update factor. Information about many aspects of the program is available through the LTCH QRP website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting.[99]

CMS finalizes (i) removal of 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, and (ii) revisions to the LTCH QRP data submission deadlines. The agency also summarizes comments received to its RFI on future measure concepts for the LTCH QRP.

CMS estimates a total annual information collection burden reduction across 318 LTCHs of 4,473 hours for annual savings of about $203,060 beginning for the FY 2028 LTCH QRP compared to the currently approved information collection burden estimates, attributable to the removal of the two measures.

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[97] The program is authorized under section 1886(m)(5) of the Act and the regulatory program requirements are under 42 CFR 412.560.

[98] Post-acute care providers required to report SPADEs are long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies.

[99] For a detailed discussion of considerations used for the selection of quality measures for the LTCH QRP, see FY 2016 Inpatient Prospective Payment System (IPPS)/LTCH PPS final rule (80 FR 49728), and for a detailed discussion of the factors used for removal of measures, see FY 2019 IPPS/LTCH PPS final rule (83 FR 41624 through 41634).

2. General Considerations Used for Selection of Measures; Quality Measures Currently Adopted

The 18 quality measures adopted for the FY 2027 LTCH QRP are shown in Table IX.E.-01 of the rule. No new measures had been proposed, but two are being finalized for removal. Information from that table is provided below, with additional information to reflect the finalized removals for the FY 2028 LTCH QRP.

Quality Measures Adopted for the LTCH QRP

Measure Title	FY 2027	FY 2028
NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure (CBE #0138)	X	X
NHSN Central line-associated Blood Stream Infection (CLABSI) Outcome Measure (CBE #0139)	X	X
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	X	X
Compliance with Spontaneous Breathing Trial (SBT) by Day 2 of the LTCH Stay	X	X
Ventilator Liberation Rate	X	X
Influenza Vaccination Coverage among Healthcare Personnel (CBE #0431)	X	X
NHSN Facility-Wide Inpatient Hospital-onset Clostridium Difficile Infection (CDI) Outcome Measure (NQF #1717)	X	X
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (CBE #0674)	X	X
Change in Mobility among Long-Term Care Hospital Patients Requiring Ventilator Support (CBE #2632)	X	X
Medicare spending per beneficiary MSPB-PAC LTCH	X	X
Discharge to Community PAC LTCH	X	X
Potentially Preventable Readmissions 30 Days Post LTCH Discharge	X	X
Drug Regimen Review Conducted with Follow-up (DRR)	X	X
Transfer of Health Information to the Provider – PAC Measure (TOH-Provider)	X	X
Transfer of Health Information to the Patient – PAC Measure (TOH-Patient)	X	X
COVID-19 Vaccination Coverage among Healthcare Personnel	X	*Removed*
Discharge Function (DC Function) Measure	X	X
COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	X	*Removed*

3. Removal of COVID-19 Vaccine HCP Measure

In the FY 2022 IPPS/LTCH PPS final rule, CMS adopted the HCP COVID-19 Vaccine measure into the LTCH QRP measure set.[100] The measure requires LTCHs to report the COVID-19 vaccination status of HCP through the NHSN.

CMS finalizes, without modification, its proposal, beginning with the FY 2028 LTCH QRP, to remove this measure under measure removal factor 3, which provides for removal of a measure that does not align with the current clinical guidelines or practice.[101] Specifically, the latest CDC COVID-19 vaccination recommendations are based on shared clinical (also referred to as individual-based) decision-making, where there is not a default decision to vaccinate for a

[100] 86 FR 45438-45446.

[101] See section 412.560(b)(3) of title 42, CFR, for factors used to evaluate whether a measure should be removed from the LTCH QRP.

defined population. Therefore, CMS describes that both receipt and nonreceipt of the vaccination would be consistent with the latest recommendations. This differs from the guidance that had been in place when the measure had been finalized for inclusion, which had provided for well-defined parameters for populations to receive the vaccination.

LTCHs will not need to report CY 2026 HCP COVID-19 Vaccine measure data to meet the LTCH QRP requirements for the FY 2028 LTCH QRP. Any 2026 data on the measure received by CMS will not be used for LTCH QRP compliance or public reporting. The measure data will be publicly reported for the last time with the September 2026 Care Compare refresh on Medicare.gov, based on data from Q4 of 2025.

CMS has already removed this measure from the Hospital Inpatient Quality Reporting Program, the Inpatient Psychiatric Facility Quality Reporting Program, the Ambulatory Surgical Center Quality Reporting Program, the Hospital Outpatient Quality Reporting Program, and the Inpatient Rehabilitation Facility Quality Reporting Program. In section IX.D.3, CMS also finalizes removal of the measure from the PCH QRP.

Comments/Responses. Some commenters supported removal of the measure because of confusion around current clinical guidance and belief that the measure no longer aligns with current guidelines and practice. Other commenters expressed concerns about the LTCH patient population having medically complex characteristics that make it more vulnerable and at increased risk of severe COVID-19 outcomes. Commenters expressed that HCP vaccination remains an important infection prevention strategy and that measurement and public reporting of vaccination rates promote accountability, transparency, and vaccination efforts. CMS reiterates the changing clinical guidance and its belief removal is appropriate based on measure removal factor 3.

4. Removal of COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date (Patient/Resident COVID-19 Vaccine) Measure

The Patient/Resident COVID-19 measure was adopted beginning with the FY 2026 LTCH QRP.[102] The assessment-based process measure reports the percent of stays in which patients in an LTCH are up to date on their COVID-19 vaccinations per the CDC's latest guidance.

CMS finalizes, without modification, its proposal, beginning with the FY 2028 LTCH QRP, to remove this measure under measure removal factor 3, the measure does not align with current clinical guidelines or practice. Similar to the newly finalized proposal to remove the HCP COVID-19 vaccine measure, CMS points to the latest CDC COVID-19 vaccination recommendations, which are based on shared clinical decision-making and do not provide a default recommendation. Therefore, CMS believes the Patient/Resident COVID-19 Vaccine measure no longer aligns with current clinical guidelines or practice.

CMS will remove the Patient's COVID-19 vaccination is up to date data element (O0350) from the LCDS as of October 1, 2028, because sooner removal is not technically feasible, but LTCHs will not be required to collect or submit the measure data beginning with patients discharged on

[102] 88 FR 59243-59250.

or after October 1, 2026. The measure data will be publicly reported for the last time with the September 2026 Care Compare refresh on Medicare.gov, based on data from Q4 of 2025.

CMS has already removed this measure from the Home Health QRP and Inpatient Rehabilitation Facility QRP.

Comments/Responses. Similar views were expressed regarding removal of the Patient/Resident COVID-19 measure as were expressed (and discussed above) regarding the removal of the HCP COVID-19 vaccine measure.

5. RFI: LTCH QRP Measure Concepts Under Consideration for Future Years

In the FY 2027 IPPS/LTCH PPS proposed rule, CMS sought input on the importance, relevance, appropriateness, and applicability of the quality measure concept of advance care planning for future years in the LTCH QRP. CMS described that advance care planning facilitates shared decision-making by documenting resident preferences and furthering care consistent with goals throughout care transitions. CMS stated that it will prioritize evidence-based outcome measures that promote person-centered care practices.

In the final rule, CMS summarizes comments it received. Several commenters supported the measure concept of advance care planning. Several commenters provided recommendations for measure specifications and development. A few commenters expressed concerns about the measure concept in the LTCH setting because of the clinical instability of many LTCH patients. Some commenters provided feedback on other future measure concepts, such as patient reported outcome measures and successful care transitions. CMS does not respond to comments but states it will take feedback into consideration for future measure development efforts.

6. Form, Manner, and Timing of Data Submission under the LTCH QRP[103]

CMS describes that one goal of public reporting of data collected under the LTCH QRP and other quality reporting programs is to provide consumers with the most current information in order to facilitate informed decision-making. CMS believes that the time between when data on measures is collected and submitted, and when the data are made publicly available (about 9 months) may be too long for those purposes. CMS further believes that if the data submission timeframe were reduced from its current 4.5-month timeframe to 45 days, the lag between the end of the data collection period and public reporting could be reduced by up to 3 months.

CMS finalizes its proposal, beginning with the FY 2029 LTCH QRP, that LTCHs be required to complete their data submissions and make corrections, as necessary, to their assessment data and CDC NHSN data no later than the 15th day of the second month after the end of the calendar quarter, except if such 15th day falls on a Friday, weekend, or Federal holiday the deadline would be delayed until the next business day. The finalized data submission deadline is approximately within 45 days of the end of the quarter. According to an analysis conducted by CMS on the potential impact of shortening the data submission timeframe, CMS identified that 98.36 percent of all LCDS assessments were submitted to CMS within a 45-day period. According to another

[103] The current policies for reporting LTCH QRP data can be found at 42 CFR §412.560(b).

analysis conducted by CMS, 88 percent of all LTCHs submitted CDC NHSN data within a 45-day period.

The specific data submission deadlines for LCDS data affecting the FY 2029 payment determination are shown in Table IX.E.-02 of the rule; the deadlines for CDC NHSN LTCH QRP measures affecting such payment determination are shown in Table IX.E.-03 of the rule. Information from both tables is shown below, reflecting the finalized policies. Similar calendar year data submission deadlines will apply for future years.

Data Collection Timeframe and Data Submission Deadlines for LCDS Data Affecting FY 2029 Payment Determination

Calendar Year (CY) Quarter	Data Collection Timeframe	Final Data Submission Deadlines for FY 2029 Payment Determination
CY 2027 Quarter 1	January 1 – March 31, 2027	May 17, 2027
CY 2027 Quarter 2	April 1 – June 30, 2027	August 16, 2027
CY 2027 Quarter 3	July 1 – September 30, 2027	November 15, 2027
CY 2027 Quarter 4	October 1 – December 31, 2027	February 15, 2028

Data Collection Timeframe and Data Submission Deadlines for CDC NHSN LTCH QRP Measures Affecting FY 2029 Payment Determination

Measure	Data Collection Timeframe	Final Data Submission Deadlines for FY 2029 Payment Determination
- CAUTI - CLABSI - CDI	January 1 – March 31, 2027	May 17, 2027
	April 1 – June 30, 2027	August 16, 2027
	July 1 – September 30, 2027	November 15, 2027
	October 1 – December 31, 2027	February 15, 2028
Influenza Vaccination Coverage among HCP	October 1, 2027 – March 31, 2028	May 15, 2028

F. Medicare Promoting Interoperability Program

1. Background

A hospital that is not identified as a meaningful user of certified electronic health record technology (CEHRT) under the Medicare Promoting Interoperability Program (PIP) is subject to an update factor reduction equal to three quarters of the market basket.[104] A critical access hospital that is not identified as a meaningful user of CEHRT is subject to a payment reduction to 100 percent of reasonable costs, from the 101 percent of reasonable costs it might have otherwise earned.[105] In the following provisions of this section, the term hospital includes a critical access hospital unless otherwise noted.

CMS finalizes the following changes to the Medicare PIP program:

- To revise the definition of CEHRT based on ONC's HTI-5 proposed rule;[106]

[104] See section 1886(b)(3)(B)(ix) of the Act.
[105] See section 1814(l)(4) of the Act.
[106] See the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity proposed rule (90 FR 60970) (HTI-5 proposed rule).

- To remove attestations related to ONC Direct Review and ONC-Authorized Certification Body (ONC-ACB) Surveillance;
- To remove the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure starting with the 2029 EHR reporting period;[107]
- To modify the Electronic Prior Authorization measure;
- To adopt the Unique Device Identifiers (UDIs) for Implantable Medical Devices measure within the Public Health and Clinical Data Exchange objective;
- To adopt two new eCQMs in alignment with the Hospital Inpatient Quality Reporting Program (HIQRP); and
- To remove three eCQMs in alignment with the HIQRP.

2. ONC Health IT Certification Program Proposed Updates Relevant to the Medicare Promoting Interoperability Program

a. Background

In the HTI-5 proposed rule, ONC proposed to remove 34 certification criteria and revise 7 certification criteria. ONC believes removing or revising these criteria would reduce burden and costs for health IT developers and clinicians, partly due to the decreased necessity to maintain ongoing conformance with certain certification requirements (90 FR 60973).

CMS summarizes in Table IX.F.-01 of the final rule (reproduced below with minor editorial changes) the potential impact on Medicare PIP participants of the ONC proposed certification criteria removals and revisions. As of August 4, 2026 (the date of publication of the FY 2027 IPPS/LTCH PPS final rule in the *Federal Register*), ONC has not finalized the HTI-5 proposed rule.

TABLE IX.F.-01. HTI-5 PROPOSED REMOVALS OR REVISIONS OF CERTIFICATION CRITERIA REFERENCED IN CEHRT DEFINITION FOR THE MEDICARE PROMOTING INTEROPERABILITY PROGRAM

ONC Health IT Certification Criteria as defined in the following sections of Title 45 CFR 170.315	Remove/Revise	Effective Date (ED)	Relevance to the CEHRT Definition for the Medicare Promoting Interoperability Program
Patient Demographics and Observations - (a)(5)	Revise	ED of HTI-5 final rule.	Specified in Base EHR definition.
Implantable Device List – (a)(14)	Remove	ED of HTI-5 final rule.	Specified in Base EHR definition.
Decision Support Interventions – (b)(11)	Revise	ED of HTI-5 final rule.	Specified in Base EHR definition.
Direct Project – (h)(1)	Remove	ED of HTI-5 final rule.	Specified in Base EHR definition.

[107] In the final rule, CMS delayed the effective date of this provision by one year.

ONC Health IT Certification Criteria as defined in the following sections of Title 45 CFR 170.315	Remove/Revise	Effective Date (ED)	Relevance to the CEHRT Definition for the Medicare Promoting Interoperability Program
Direct Project, Edge Protocol, and XDR/XDM – (h)(2)	Remove	ED of HTI-5 final rule.	Specified in Base EHR definition.
Family Health History – (a)(12)	Remove	January 1, 2027.	Specified in CEHRT definition.
Patient Health Information Capture – (e)(3)	Remove	January 1, 2027.	Specified in CEHRT definition.
Automated Numerator Recording – (g)(1)	Remove	January 1, 2027.	Specified in CEHRT definition.
Automated Measure Calculation – (g)(2)	Remove	January 1, 2027.	Specified in CEHRT definition.
Transitions of Care – (b)(1)	Revise	January 1, 2027.	Specified criterion for the Support Electronic Referral Loops by Sending Health Information, Support Electronic Referral Loops by Receiving and Reconciling Health Information, HIE Bi-Directional Exchange, and Enabling Exchange Under TEFCA measures.
Clinical Information Reconciliation and Incorporation – (b)(2)	Remove	January 1, 2027.	Specified criterion for the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure.
View, Download, and Transmit to 3rd party – (e)(1)	Revise	ED of HTI-5 final rule.	Specified criterion for the Provide Patients Access measure.
Transmission to public health agencies—Electronic Case Reporting – (f)(5)	Revise	ED of HTI-5 final rule.	Specified criterion for the Electronic Case Reporting measure.
Transmission to public health agencies—Antimicrobial Use and Resistance Reporting – (f)(6)	Revise	ED of HTI-5 final rule.	Specified criterion for the Antimicrobial Use Surveillance and Antimicrobial Resistance Surveillance measures.
Transmission to public health agencies—Health Care Surveys – (f)(7)	Remove	January 1, 2027.	Specified criterion for the Public Health Registry measure.
Application Access—Patient Selection – (g)(7)	Remove	January 1, 2027.	Specified criterion for the Provide Patients Access and HIE Bi-Directional Exchange measures.
Application Access—All Data Request – (g)(9)	Remove	January 1, 2027.	Specified criterion for the Provide Patients Access and HIE Bi-Directional Exchange measures.

Changes to certification criteria in the HTI-5 proposed rule would affect certification criteria referenced in the definition of CEHRT, including the definition of BASE EHR. If the HTI-5 proposed rule is finalized as proposed, then removal of these criteria from the ONC Health IT Certification Program and the Base EHR definition would remove requirements on hospitals to

use CEHRT that includes those functionalities. ONC proposed removals of certification criteria from the BASE EHR definition include "implantable device list," "transport methods and other protocols—direct project," and "transport methods and other protocols—Direct Project, Edge Protocol, and XDR/XDM," and revisions to criteria in the BASE EHR definition would apply to "patient demographics and observations" and "decision support interventions". Table IX.F.-07 in this final rule contains a complete list of the Medicare PIP objectives and measures and their relevant ONC Health IT certification criteria, including the impact to individual certification criteria if the HTI-5 proposals are finalized.

With respect to the Public Health Registry Reporting measure, ONC proposed removing the only certification criterion "transmission to public health agencies—health care surveys" that supports the measure. If the removal of the criterion is finalized, there will be no specific certification criteria identified for this measure, and CMS says that a hospital could use any available data exchange standard specified in 45 CFR part 170 subpart B to meet the measure.

For the Electronic Case Reporting measure, ONC proposed revising the criterion "transmission to public health agencies—electronic case reporting" identified as supporting this measure. For the Antimicrobial Use Surveillance and Antimicrobial Resistance Surveillance measures, ONC proposed revising the criterion "transmission to public health agencies—antimicrobial use and resistance reporting" identified as supporting these measures. CMS notes that if ONC's proposed updates are finalized, requirements for health IT products certified to these criteria would also be revised. Hospitals would still have to use health IT certified to these criteria to report the Electronic Case Reporting, Antimicrobial Use Surveillance, and Antimicrobial Resistance Surveillance measures.

Similarly, while ONC proposed removing certain certification criteria for "safety-enhanced design," "quality management system," and many criteria related to privacy and security functionality, CMS states that hospitals would still be required to ensure the privacy and security of patients' electronic health information under HIPAA and other applicable laws.

b. Updates to the Definition of Certified Electronic Health Record Technology in the Medicare Promoting Interoperability Program

In order to be consistent with modifications to ONC health IT certification criteria proposed in the HTI-5 proposed rule that impact the definition of CEHRT, CMS proposed removing references to the following certification criteria from the definition of CEHRT at 42 CFR 495.4 for the Medicare PIP effective January 1, 2027: "family health history," "patient health information capture," "automated numerator recording," and "automated measure calculation".

CMS does not believe it must rely on ONC to finalize its proposed revisions for CMS to finalize changes to its regulatory definition of CEHRT for the Medicare PIP. CMS believes the functionalities reflected in the criteria for "family health history" and "patient health information capture" are fully embedded in certified health IT and are widely available and used by hospitals. CMS notes that health IT developers that support customers participating in the Medicare PIP will have to continue supporting reporting of numerators and denominators for certain Medicare

PIP measures, including the Electronic Prescribing measure and Providing Patients Access to Their Health Information measure.

Final Action. The proposal is finalized without modification.

Selected Comments/Responses. Commenters supporting the proposal believe these health IT functionalities are already mature, broadly implemented, and embedded in certified health IT products and workflows; they also emphasized the importance of alignment with the HTI-5 proposed rule. Those opposed to the proposal stated that CMS should wait until ONC finalizes the HTI-5 proposed rule to support consistency and predictability in compliance across HHS programs.

Some commenters objected to the removal of the "family health history" and "patient health information capture" certification criteria because there is no guarantee that these functionalities will continue to be offered within health IT products. CMS disagrees and foresees minimal impacts on data consistency because it believes there are multiple avenues to fully implement and broadly support family health history data and the patient health information capture through standards without having to retain references to those criteria in the CEHRT definition.

Similarly, some commenters did not support removing references to "automated numerator recording" and "automated measure calculation" certification criteria due to fears of inconsistency, data errors, and increased audit risk for eligible hospitals by reason of a clearly defined measure calculation standard. CMS notes that developers must still support reporting of numerators and denominators for certain Medicare Promoting Interoperability Program measures and that the proposal reduces burden on developers. The agency suggests hospitals work closely with their vendors to ensure that current functionality is retained because ultimately hospitals are responsible for the accuracy of information submitted. Some commenters suggested CMS establish a monitoring mechanism for the changes made by vendors related to numerator recording and measure calculation, noting that reducing developer burden should not inadvertently penalize or burden organizations while they adjust to this technology no longer being certified by ONC. CMS "appreciates" the suggestion but only indicates it plans to collaborate with ONC "to identify opportunities for technical support" to facilitate the transition away from ONC certification of this functionality. CMS does not anticipate any impact on hospitals. CMS also expects health IT developers to retain these capabilities in their Health IT Modules despite the absence of certification criteria.

One commenter asked if CMS intends for the functional, clinically useful data elements in these criteria to be retained or removed. CMS does not intend for any of the data elements to be removed, noting that clinically useful data elements that support the Medicare PIP would still be retained in the CEHRT definition as many of the criteria of the Base EHR definition continue to require these data elements.

3. Removal of ONC Direct Review and ONC-ACB Surveillance Attestations

CMS proposed removing the mandatory ONC Direct Review attestation and the optional ONC-ACB Surveillance attestation from the Medicare PIP beginning with the EHR reporting period in 2026. CMS states that the changes would be effective with the data submission period beginning January 1, 2027, because neither attestation requires any specific action to occur within the EHR reporting period.

Final Action. The proposal is finalized without modification. Thus, hospitals will not have to report on these attestations by the March 1, 2027, submission deadline, and there will be no effect on their FY 2028 payment determination or FY 2026 cost reimbursement, respectively. Nonetheless, CMS encourages hospitals to continue participating in oversight processes when ONC, or an ONC-ACB, requests assistance.

Selected Comment. CMS reports that commenters largely supported the proposal, applauding reductions in unnecessary reporting and administrative burden while streamlining program requirements.

4. Removal of the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures

a. Background

The Health Information Exchange (HIE) objective includes five measures: (i) Support Electronic Referral Loops by Sending Health Information, (ii) Support Electronic Referral Loops by Receiving and Reconciling Health Information, (iii) HIE Bi-Directional Exchange, (iv) Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA), and (v) Electronic Prior Authorization. The objective's goal is to encourage and leverage electronic health information interoperability on a broader scale and promote health IT-based care coordination.

Currently, hospitals must satisfy the HIE objective using one of three reporting options:

1. Report on the Support Electronic Referral Loops by Sending Health Information measure AND the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure, or
2. Report on the HIE Bi-Directional Exchange measure, or
3. Report on the Enabling Exchange Under TEFCA measure.

The Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure are each worth 15 points within the HIE objective, and a hospital may receive up to a maximum of 30 points by reporting on both measures. Hospitals must also attest "Yes" on the Electronic Prior Authorization measure beginning with the EHR reporting period in 2027 to meet all requirements for the HIE objective.

Two ONC health IT certification criteria support the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure: (i) the "transitions of care" certification criterion (45 CFR 170.315(b)(1)) and (ii) the "clinical information reconciliation and incorporation" certification criterion (45 CFR 170.315(b)(2)). In the HTI-5 proposed rule, ONC proposed reducing the scope of the "transitions of care" certification criterion to focus requirements on enabling the receipt of a C-CDA document to position the criterion for a future evolution to receipt of Fast Healthcare Interoperability Resources® (FHIR®)-formatted data. It also proposed removing the "clinical information reconciliation and incorporation" certification criterion based on widespread adoption of the criterion by industry.

b. Removal of the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures

CMS proposed removing 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 2028. Under the proposal, hospitals would fulfill requirements in the HIE objective by attesting "Yes" to either the HIE Bi-Directional Exchange measure or the Enabling Exchange Under TEFCA measure, as well as attesting "Yes" or claiming an Exclusion on the Electronic Prior Authorization measure. CMS proposed maintaining the same scoring policy for these two measure options; attesting "Yes" to either the HIE Bi-Directional Exchange or Enabling Exchange Under TEFCA measure would result in a maximum score of 30 points. Additionally, hospitals would be required to meet the Electronic Prior Authorization measure requirement.

c. Final Action

CMS finalizes the proposals with a one-year delay to the effective date. CMS will remove the measures beginning with the EHR reporting period in 2029, rather than beginning with the EHR reporting period in 2028 as proposed.

d. Selected Comments/Responses

CMS agrees with comments that indicated the proposal to remove these measures would (i) streamline reporting, (ii) reduce the complexity of multiple measure reporting options for the HIE objective, (iii) focus program performance on measures that assess the adoption of newer health information technologies and more comprehensive methods of information sharing, and (iv) eliminate outdated or duplicative measures. The agency notes that a majority of hospitals have been successfully reporting either the HIE Bi-Directional Exchange measure or the Enabling Exchange Under TEFCA measure and that these measures of participation in a network-based exchange are more comprehensive indicators of meaningful health information exchange.

CMS was asked to provide (i) implementation support during the transition, (ii) flexibility, (iii) hardship exceptions, or (iv) transitional policies for hospitals that do not currently have

established HIE or TEFCA relationships, particularly small, rural, critical access, low-resourced, underserved, and inner-city hospitals. The agency responds that significant hardship exceptions are available though they are limited to 5 years.

Many commenters sought additional time for the transition as hospitals may face barriers related to readiness, vendor implementation timelines, costs, staffing constraints, technical onboarding, and operational delays. CMS is sympathetic to these concerns and, as noted above, delays removal of the measures until the EHR reporting period in 2029.

Support was expressed for the agency's goal of focusing on broader-scale interoperability approaches by prioritizing pathways that leverage HIEs and Qualified Health Information Networks (QHINs) under TEFCA. However, these stakeholders recommended continued investment in TEFCA infrastructure and governance and that CMS and ONC ensure TEFCA supports practical use cases such as admission, discharge, and transfer (ADT) notifications, transitions of care for long-term and post-acute care, and pharmacy interoperability.

Commenters who opposed the proposal noted that C-CDA-based exchange remains widely used and continues to provide an important interoperability floor for eligible hospitals that have not fully adopted alternative exchange pathways, such as FHIR-based exchange or TEFCA. They believe moving away from these standards would jeopardize interoperability. CMS acknowledges the importance of the continued use of C-CDA-based exchange and the importance of maintaining an interoperability baseline, and it states that removing the measures will not prohibit eligible hospitals and CAHs from continuing to use C-CDA-based exchange where it remains clinically or operationally appropriate.

Other commenters lamented the removal of these measures because they feared it would weaken referral reconciliation, incorporation of clinically relevant information into care workflows, and closed-loop interdisciplinary care coordination during transitions of care. CMS responds that the HIE Bi- Directional Exchange and Enabling Exchange Under TEFCA measures support broader access to longitudinal patient information across exchange networks and care settings, which can support referral communication, reconciliation of clinical information, incorporation of relevant information into care workflows, and care coordination across health care providers.

It was recommended that CMS continue recognizing State-designated HIE networks that support bidirectional exchange as acceptable for purposes of this measure, which CMS confirms. It also notes that hospitals may also meet the measure through participation in other bi-directional exchange networks that meet these attributes.

5. Updates to the Electronic Prior Authorization Measure

a. Background

The Electronic Prior Authorization measure under the HIE objective was adopted in the Medicare PIP in the 2024 CMS Interoperability and Prior Authorization final rule with the following specifications:

Measure Description for Eligible Hospitals and Critical Access Hospitals in the Medicare PIP—Electronic Prior Authorization. For at least one hospital discharge and medical item or service (excluding drugs) ordered during the EHR reporting period, the prior authorization is requested electronically from a Prior Authorization API using data from CEHRT.

- Reporting Requirement. The eligible hospital or CAH would be required to report a yes/no response for the measure or (if applicable) report an exclusion. To meet this measure, the eligible hospital or CAH must attest "yes" to requesting a prior authorization electronically via a Prior Authorization API using data from CEHRT for at least one hospital discharge and medical item or service (excluding drugs) ordered during the EHR reporting period or (if applicable) report an applicable exclusion.
- Exclusions. Any eligible hospital or CAH that:
  (1) Does not order any medical items or services (excluding drugs) requiring prior authorization during the applicable EHR reporting period; or
  (2) Only orders medical items or services (excluding drugs) requiring prior authorization from a payer that does not offer an API that meets the Prior Authorization API requirements during the applicable EHR reporting period.

Eligible hospitals and CAHs are required to report the measure beginning with the 2027 EHR reporting period, but the measure will not be scored for the EHR reporting period in 2027.

b. Modification of the Electronic Prior Authorization Measure Beginning with the EHR Reporting Period in 2027

CMS proposed several changes to the measure description. Under the proposal, CMS would revise the phrase "using data from CEHRT" to "using CEHRT" to clarify that the requirement is to use health IT certified to specific certification criteria included in the definition of CEHRT for this measure. CMS also proposed changing "hospital discharge" to "hospital encounter" to clarify that a prior authorization request may occur at any time during the hospital encounter, rather than be associated temporally with the discharge. No changes were proposed to the exclusion criteria. The text for the measure description would read as follows:

> *For at least one medical item or service (excluding drugs) ordered during a hospital encounter that occurs within the EHR reporting period, the prior authorization is requested electronically through a Prior Authorization API using CEHRT.*

Final Action. The proposed changes are finalized without modification. CMS notes that it is "very strongly considering" further modifying the Electronic Prior Authorization measure in the FY 2028 IPPS/LTCH PPS proposed rule to align its requirements with the proposed modifications for MIPS eligible clinicians in the 2027 PFS proposed rule, if finalized. This would include a proposal to revise the measure to focus on submitting a prior authorization request based on a complete prior authorization workflow as reflected in the combined use of the functionality found in each of the three ONC health IT certification criteria described immediately below.

Selected Comments/Responses. Support was expressed for revising the measure language from "hospital discharge" to "hospital encounter" because it would better reflect the intent of the measure and likely prior authorization workflows within hospitals. Some commenters appreciated the proposal to modify the measure to require the use of CEHRT because of the flexibility of being able to use different combinations of certified Health IT Modules to meet the measure. Other commenters, however, opposed the requirement to use CEHRT because it could limit practical software implementation options, increase burden, and force duplicative connections across systems. CMS responds that hospitals may use any combination of Health IT Modules to fulfill the measure action and that nothing would prohibit intermediaries from supporting electronic prior authorization exchange in other ways separate from the capabilities reflected in the electronic prior authorization certification criteria.

A commenter sought clarification on several issues, including clear numerator and denominator definitions and noted that it would be difficult for hospitals to operationalize and demonstrate compliance with the measure without them. CMS responds that educational and guidance resources, "as appropriate and feasible," will be available to clarify implementation details. Clarification was requested on what constitutes a successful prior authorization request for purposes of attestation, including whether a request should count as successful when a payer responds that no prior authorization is required and whether a request is satisfied when the request is made and a response is received, or only when additional information is subsequently submitted to the payer. CMS states that the measure only applies to medical items and services for which prior authorization is required. Additionally, to attest "Yes" for the measure in 2027, the hospital must first query a Prior Authorization API to request the prior authorization and receive a response that the request is satisfied, approved, or denied.

Some commenters objected to conditioning successful participation on certification or API-version requirements that may not yet be fully testable or broadly available, noting that payers are currently investing in version 2.1 implementation and that CRD 2.2 test tools were released in early June 2026. They believe 12 to 18 months are needed for development, certification, and deployment, and most hospitals won't be using version 2.2 until late 2027 or 2028. CMS acknowledges that some hospitals will have difficulty deploying technology that uses version 2.2 of the Da Vinci IGs, which is why the measure is finalized as an optional for 2027.

Noting that CMS had not specified for audit purposes how hospitals would document which certified Health IT Modules were used to satisfy the Electronic Prior Authorization measure, a commenter cautioned that this would cause uncertainty for hospitals and would increase administrative burden. CMS responds that hospitals should indicate the certified health IT that they used to complete the measures and objectives of the Medicare PIP as part of the CMS EHR Certification ID submitted to meet program requirements.

c. Health IT Certification Criteria to Support the Electronic Prior Authorization Measure

In the HTI-4 final rule, ONC finalized three ONC health IT certification criteria for electronic prior authorization, based on the following FHIR IGs:

- "Provider prior authorization API—coverage requirements discovery" (45 CFR 170.315(g)(31));
- "Provider prior authorization API—documentation templates and rules" (45 CFR 170.315(g)(32)); and
- "Provider prior authorization API—prior authorization support" (45 CFR 170.315(g)(33)).

CMS finalizes its proposals to require the use of health IT certified to these certification criteria for the Electronic Prior Authorization measure.

d. Making the Electronic Prior Authorization Measure a Bonus Measure for the EHR Reporting Period in 2027

CMS believes hospitals require more time for procurement, integration, and testing to operationalize standards-based electronic prior authorization capabilities that support the Electronic Prior Authorization measure. Additional implementation complexity will likely arise from the changes in Prior Authorization API standards requirements.

CMS proposed making the measure, with the proposed measure updates, optional and eligible for 10 bonus points for hospitals that attest "Yes" to the measure for the EHR reporting period in 2027.

Final Action. The proposal is finalized without modification. A hospital attesting "No" to the measure for the EHR reporting period in 2027 will not earn any bonus points, but attesting "No" will not also result in the hospital failing to meet the measure, which is significant because failing to meet minimum program requirements would mean the hospital would not be considered a meaningful EHR user for the EHR reporting period in 2027. Additionally, no exclusions are available.

Selected Comments/Responses. Support was expressed for the additional time before the measure is required, especially for small, rural, or under-resourced hospitals. Some commenters objected to the proposal to require reporting in 2028 because it would impose a new certification-based compliance requirement too quickly despite limited certified module deployment and evolving IGs; they recommended an additional delay. CMS says it will monitor implementation, but it believes one year of optional reporting should suffice. CMS disagrees with those commenters who recommended requiring hospitals to report and score the measure for the EHR reporting period in 2027.

e. Required Reporting of the Electronic Prior Authorization Measure Beginning with the EHR Reporting Period in 2028

Because CMS finalizes its proposal to make the Electronic Prior Authorization measure an optional measure for the EHR reporting period in 2027, it also finalizes its proposal to delay requiring hospitals to report on the measure until the EHR reporting period in 2028. CMS also finalizes its proposal that the measure would remain unscored for the EHR reporting period in 2028 and subsequent years, which would allow time for hospitals to adjust to the new electronic

prior authorization workflow using Prior Authorization APIs without undue focus on scoring implications in the Medicare PIP.

To meet the measure requirements, hospitals must request a prior authorization electronically using CEHRT to send a request through a payer's Prior Authorization API for at least one medical item or service (excluding drugs) ordered during a hospital encounter that occurs within the EHR reporting period in order to attest "Yes" to the measure. Alternatively, the hospital must claim an applicable exclusion.

A "No" response to the measure for the EHR reporting period in 2028 and subsequent years means the hospital does not meet the measure requirements, which further means it will not meet minimum program requirements nor be considered a meaningful EHR user for an EHR reporting period, and thus be subject to a downward payment adjustment.

Selected Comments/Responses. CMS says it received broad support for making the Electronic Prior Authorization measure a bonus measure in 2027 and requiring it beginning in 2028. Commenters explained that additional time was needed for implementation, testing, validation, integration, and workflow redesign, and they emphasized the clinical and technical complexity of electronic prior authorization workflows, including dependencies on EHR vendors, certified technology, and payer readiness. Some commenters requested an additional delay before reporting on the measure is mandatory, noting that FHIR standards, APIs, and IGs are still maturing and may not yet be sufficiently tested across real-world settings. CMS says it understands that implementation will require technical build, testing, configuration, staff training, workflow redesign, and coordination with health IT developers, payers, and other external partners. However, it believes making the measure mandatory in 2028 provides for a reasonable transition period. CMS says it will monitor hospitals' implementation experience and coordinate with ONC and other CMS components as standards, IGs, and payer-facing requirements continue to mature.

Several commenters emphasized the importance of holding payers accountable for timely, meaningful decisions; they suggested that CMS should require faster payer turnaround times, address large gaps between initial denials and appeal overturns, curb "deny first, appeal later" practices, and consider the patient care consequences of delayed prior authorizations. Arguing that these comments are outside the scope of its proposals, CMS nonetheless tries to assure stakeholders that payer practices are being addressed through various HHS efforts.

f. Request for Information on Future Potential Performance-Based Measure of Electronic Prior Authorization

CMS sought comments on potential future updates that could be made to this measure to incentivize providers to use electronic prior authorization for a more substantial set of the electronic prior authorization requests that they submit over the course of an EHR reporting period. The agency's goal is to drive consistent adoption of certified health IT capabilities that support the complete electronic prior authorization workflow over time by requiring hospitals to address a wider array of prior authorization requests that require more complex interactions with payers. Comment was specifically sought on barriers and challenges small, rural, or otherwise

under-resourced hospitals might face reporting a performance-based electronic prior authorization measure.

Comments in response to this RFI addressed similar concerns raised in other comments to the Electronic Prior Authorization measure proposals in the proposed rule. CMS was urged to move cautiously before adopting a performance-based measure, to use a phased-in approach, and to avoid performance thresholds until payer APIs, EHR functionality, IGs, certification tools, and health care provider workflows are mature and tested. Commenters also noted that hospital performance measurement will necessarily depend heavily on factors outside hospital control. These stakeholders recommended clearer measure specifications for attribution, numerator and denominator construction, qualifying workflows, payer errors, exclusions, and whether checking if prior authorization is required should count as a meaningful electronic action.

6. Adoption of the Unique Device Identifiers for Implantable Medical Devices Measure in the Public Health and Clinical Data Exchange Objective

a. Background

The Food and Drug Administration (FDA) established a unique device identification system for medical devices that is intended to help reduce medical errors, identify adverse events, facilitate rapid notice and follow-up care during recalls, and improve care coordination across providers. Under that system, a Unique Device Identifier (UDI) is a standard identifier that adequately identifies a medical device from manufacturing through distribution to patient use and is comprised of the Device Identifier (UDI-DI) and the Production Identifier (UDI-PI). The UDI-DI identifies the version or model of a device, and the UDI-PI contains production information about a device such as lot or batch number, serial number, expiration and manufacturing dates, and distinct identification codes for human cellular or tissue-based products. Device labelers must include UDIs on device labels and packages in both human readable form and machine-readable form and must submit device identification information to FDA's Global Unique Device Identification Database (GUDID).[108]

CMS believes that UDIs should be integrated into data sources throughout the healthcare system to fully realize the benefits of the UDI system. It notes hospitals have widely adopted health IT capabilities to capture UDIs, and the "implantable device list" certification criterion (which is currently included in the Base EHR definition) requires Health IT Modules certified to the criterion to record and allow a user to access a list of UDIs associated with a patient's implantable devices.

b. Adoption of Unique Device Identifiers for Implantable Devices Measure Beginning With the EHR Reporting Period in 2027

The agency proposed adopting the following measure entitled "Unique Device Identifiers for Implantable Medical Devices measure" under the Public Health and Clinical Data Exchange objective.

[108] FDA's Global Unique Device Identification Database is accessible from two public portals, AccessGUDID435 and OpenFDA.

Measure Description: The eligible hospital or CAH uses CEHRT during the EHR reporting period to electronically capture and store, as one or more discrete data elements within the patient's electronic health record, the complete Unique Device Identifier (UDI), which includes the device identifier and, when present on the device label, the production identifier, for each implantable medical device subject to UDI requirements used for patient care delivery.

Reporting Requirements: "Yes" or "No" attestation.

Exclusion: The eligible hospital or CAH implanted five or fewer medical devices subject to UDI requirements during the calendar year of the applicable EHR reporting period.

Under the proposal, beginning with the EHR reporting period in 2027, hospitals would be required to attest "Yes" or "No" to meet measure requirements or claim an applicable exclusion. Hospitals not providing a "Yes" or "No" attestation would fail to meet minimum program requirements and thus would be subject to a downward payment adjustment. However, a "No" attestation would satisfy the measure requirements.

No points would be assigned to this measure; it would be one of seven measures required to satisfy the Public Health and Clinical Data Exchange objective.

The proposed measure would only apply to implantable medical devices subject to UDI requirements under 21 CFR 801.20(a) and 21 CFR part 830, subpart E, which covers most implantable medical devices. Some devices, such as investigational devices, devices for research use only, and custom devices, are exempt from UDI requirements and thus would also be exempt from this measure.

Final Action. The proposal is finalized without modification.

Selected Comments/Responses. CMS indicates that many stakeholders supported the proposed measure because standardized UDI capture in EHRs would improve post-market surveillance; reduce patient safety risks; and enable faster, more accurate public health responses.

Clarification was requested on whether hospitals could use CEHRT alone or in combination with integrated non-CEHRT systems to capture, validate, reconcile, exchange, and transmit complete, structured UDI data into the EHR. In response, CMS says that the measure's requirement for a hospital to use CEHRT to electronically capture complete UDI information is intended to refer to the ultimate capture and storage of this information; intermediate steps or systems used outside of CEHRT to capture this information are permissible as long as the complete UDI is ultimately captured and stored in CEHRT.

CMS also clarifies that "each implantable device" and "implantable medical devices" refer to medical devices that are subject to UDI requirements and implanted by the hospital in a procedure performed during the EHR reporting period. The measure assesses facility-level

compliance, and the facility's duty to store UDIs within CEHRT applies to all eligible implantable devices implanted during the EHR reporting period in order for the eligible hospital or CAH to attest "Yes" to the measure.

Those opposed to the proposal urged CMS to delay implementation of mandatory reporting and provide a multi-year transition period before requiring full participation or moving toward performance-based measurement. Noting that the measure requires only a "Yes" or "No" attestation, CMS disagrees that hospitals or other parties require additional time to report the measure. The agency also observes that hospitals already have obligations to capture UDI information for implantable devices at 21 CFR 821.30 and that the measure only assesses whether that information is stored in CEHRT as structured data.

Some commenters were concerned that the proposed measure would lead to future requirements to include device identifiers on claims. CMS responds that this measure includes no such requirement and confirms the UDI measure does not establish a requirement to report UDI or device identifier information on Medicare claims or cost reports.

ONC's proposal to remove the implantable device list ONC health IT certification criterion raised concerns among stakeholders who believe maintaining the implantable device list criterion would help ensure referential integrity and improve GUDID data quality over time. CMS acknowledges the concern, but it believes health IT functionality related to UDI access, storage, and exchange will be maintained because other ONC certification criteria continue to reference or support exchange of UDI for implantable devices, including the "standardized API for patient and population services" criterion.

c. Future Direction of the Unique Device Identifiers for Implantable Devices Measure and Additional Options for Utilizing UDI

CMS intends to consider additional modifications to the measure in future rulemaking to further promote the appropriate capture of UDIs within the EHR. It sought public comments on performance measures and additional UDI options.

Consistent with earlier comments, stakeholders recommended a cautious, gradual approach before adopting performance-based requirements. Suggestions were made for possible future measures based on the percentage of implant procedures, encounters, selected procedure codes, or covered devices for which complete UDI data are captured and stored as structured data. It was also noted that non-sterile, tray-based, small, consigned, multi-component, and unpackaged devices are especially difficult to capture; commenters recommended phased implementation, exceptions, and collaboration with manufacturers and vendors to improve labeling, validation, and data quality.

7. Overview of Scoring Methodology

The minimum scoring threshold that hospitals must meet to satisfy the requirement to report on the objectives and measures of meaningful use for the EHR reporting period in 2026 and subsequent years is 80 points.

Table IX.F.-02 of the final rule (shown below with slight stylistic modifications) includes the scoring methodology beginning in 2027, reflecting previously adopted policies and policy proposals finalized in this rule.

TABLE IX.F.-02: PERFORMANCE-BASED SCORING METHODOLOGY FOR EHR REPORTING PERIOD IN 2027

Objective	Measures	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of (PDMP)	10 points	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	15 points	Required (eligible hospitals and CAHs must choose one of the three reporting options)
	-AND-		
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	15 points	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points	
	-OR-		
	Enabling Exchange under TEFCA	30 points	
	Electronic Prior Authorization*	10 points (*bonus*)	Optional
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required
Public Health and Clinical Data Exchange	<u>Report the following 7 measures:</u> • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Laboratory Reporting • Antimicrobial Use Surveillance • Antimicrobial Resistance Surveillance • Unique Device Identifier**	25 points	Required
	<u>Report one of the following measures:</u> • Public Health Registry Reporting • Clinical Data Registry Reporting • Public Health Reporting with TEFCA	5 points (*bonus*)	Optional

Notes: The Security Risk Analysis measure, SAFER Guides measure, and Information Blocking attestation required by section 106(b)(2)(B) of MACRA are required but will not be scored. Reporting eCQMs is required but will not be scored. Eligible hospitals and CAHs must also submit their level of active engagement for measures under the Public Health and Clinical Data Exchange objective. Participants may spend only one EHR reporting period at Option 1: Pre-production and Validation level per measure and must progress to Option 2: Validated Data Production level for the following EHR reporting period. See the FY 2023 IPPS/LTCH PPS final rule (87 FR 49337) for more details about active engagement. In section IX.F.3 of the final rule, CMS removes the ONC Direct Review and ONC-ACB Surveillance attestations for the EHR reporting period in 2026 and subsequent years.

Objective	Measures	Maximum Points	Required/Optional
* In section IX.F.5.d of the final rule, CMS finalizes the Electronic Prior Authorization measure as an optional bonus measure for 2027 EHR reporting period. ** In section IX.F.6 of the final rule, CMS adopts the Unique Device Identifier measure beginning with the EHR reporting period in 2027.			

Table IX.F.-03 of the final rule (shown below with slight stylistic modifications) includes the scoring methodology beginning in 2028, reflecting previously adopted policies and policy proposals finalized in this rule.

TABLE IX.F.-03: PERFORMANCE-BASED SCORING METHODOLOGY FOR EHR REPORTING PERIOD IN 2028

Objective	Measures	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of (PDMP)	10 points	Required
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information*	15 points	Required (eligible hospitals and CAHs must choose one of the three reporting options)
	-AND-		
	Support Electronic Referral Loops by Receiving and Reconciling Health Information*	15 points	
	-OR-		
	Health Information Exchange Bi-Directional Exchange	30 points	
	-OR-		
	Enabling Exchange under TEFCA	30 points	
	Electronic Prior Authorization**	Unscored	Required
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required
Public Health and Clinical Data Exchange	<u>Report the following 7 measures:</u> • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Laboratory Reporting • Antimicrobial Use Surveillance • Antimicrobial Resistance Surveillance • Unique Device Identifier***	25 points	Required
	<u>Report one of the following measures:</u> • Public Health Registry Reporting • Clinical Data Registry Reporting • Public Health Reporting with TEFCA	5 points (*bonus*)	Optional

Objective	Measures	Maximum Points	Required/Optional
Notes: The Security Risk Analysis measure, SAFER Guides measure, and Information Blocking attestation required by section 106(b)(2)(B) of MACRA are required but will not be scored. Reporting eCQMs is required but will not be scored. Eligible hospitals and CAHs must also submit their level of active engagement for measures under the Public Health and Clinical Data Exchange objective. Participants may spend only one EHR reporting period at Option 1: Pre-production and Validation level per measure and must progress to Option 2: Validated Data Production level for the following EHR reporting period. See the FY 2023 IPPS/LTCH PPS final rule (87 FR 49337) for more details about active engagement. In section IX.F.3 of the final rule, CMS removes the ONC Direct Review and ONC-ACB Surveillance attestations for the EHR reporting period in 2026 and subsequent years. * In section IX.F.4 of the final rule, CMS removes the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measures for the EHR reporting period in 2029 and subsequent years. Eligible hospitals and CAHs must choose one of the two reporting options beginning with the EHR reporting period in 2029. ** In section IX.F.5 of the final rule, CMS makes the Electronic Prior Authorization optional in the 2027 EHR reporting period and required, but unscored, starting with the EHR reporting period in 2028. *** In section IX.F.6 of the final rule, CMS adopts the Unique Device Identifier measure beginning with the EHR reporting period in 2027.			

Table IX.F.-04 of the final rule shows how points will be redistributed for the EHR reporting period in 2027, and Table IX.F.-05 shows how points will be redistributed for the EHR reporting period in 2028 and subsequent years if an exclusion were claimed. CMS did not propose to change the point redistribution policy. The tables indicate that:

- If an exclusion for the e-Prescribing measure is claimed, the 10 points are redistributed to the HIE objective;
- If an exclusion for the Query of PDMP measure is claimed, the 10 points are redistributed to e-Prescribing measure; and
- If an exclusion for all seven Public Health and Clinical Data Exchange measures is claimed, the 25 points are redistributed to the Provide Patients Electronic Access to Their Health Information.
- For the EHR reporting period in 2028, Table IX.F.-05 clarifies there is no redistribution of points for an exclusion to the Electronic Prior Authorization measure in part because the measure is unscored for that reporting period.

8. Overview of Objectives and Measures

Table IX.F.-06 of the final rule lists the objectives and measures for the Medicare PIP for the EHR reporting period in 2027 as revised to reflect the proposals finalized in this rule as well as changes that go into effect for the EHR reporting period beginning with 2028. For measures that have differing information between the EHR reporting period in 2027 and the EHR reporting period in 2028 and subsequent years, the applicable year is noted in the measure column.

Table IX.F.-07 of the final rule lists the ONC Health IT certification criteria required to meet specific objectives and measures.

9. Clinical Quality Measurement for Eligible Hospitals and CAHs Participating in the Medicare Promoting Interoperability Program

Hospitals must report on clinical quality measures selected by CMS using CEHRT (referred to as eCQMs) as part of satisfying the definition of being a meaningful EHR user under the Medicare PIP.[109]

a. Adoption and Removal of eCQMs

Beginning with the 2028 reporting period, CMS proposed to adopt and remove the same eCQMs for the Medicare PIP as it does for the HIQRP, as follows.[110]

- Adopt the following two eCQMs in the Medicare PIP eCQM measure set from which hospitals may self-select to report: (i) Hospital Harm – Postoperative Venous Thromboembolism and (ii) Advance Care Planning.
- Remove the following three eCQMs from the Medicare PIP eCQM measure set: (i) Discharged on Antithrombotic Therapy, (ii) Venous Thromboembolism Prophylaxis eCQM, and (iii) Intensive Care Unit Venous Thromboembolism Prophylaxis.

Final Action. The proposals are finalized without modification.

Commenters were supportive of the agency's efforts to align eCQM reporting requirements and the eCQM measure set for the Medicare PIP with similar requirements under the Hospital Inpatient Quality Reporting Program.

b. Modification of the eCQM Reporting and Submission Requirements

Hospitals are currently required to annually report data for each required eCQM and three self-selected eCQMs for the 2026 reporting period and subsequent years. CMS did not propose changes to its previously finalized policy that progressively increases the number of mandatory eCQMs a hospital must report for the 2026 or 2027 reporting period. To align with the HIQRP, CMS proposed the following changes to the reporting and submission requirements for eCQMs for the Medicare PIP beginning with the 2028 reporting period.

Hospital Harm eCQMs. Beginning with the 2028 reporting period, the hospital harm eCQMs would become mandatory for reporting after 2 years of self-selected reporting. For example, the Hospital Harm – Falls with Injury eCQM and the Hospital Harm – Postoperative Respiratory Failure eCQM would become mandatory for reporting beginning with the 2028 reporting period (but would continue to be available as self-selected measures for the 2027 reporting period). The proposed Hospital Harm – Postoperative VTE eCQM would be available for self-selected reporting for the 2028 and 2029 reporting periods and would become mandatory for reporting

[109] See sections 1814(l)(3)(A) and 1886(n)(3)(A) of the Act for these requirements applied to CAHs and hospitals, respectively.
[110] See summary sections IX.B.1., IX.C.3., IX.C.4., and IX.C.8.c. for a detailed discussion of the policies.

beginning with the 2030 reporting period. (See the summary of section IX.C.8.c. above for more detailed information.)

Other eCQMs. The Malnutrition Care Score eCQM would continue to be available as a self-selected measure for the 2027 reporting period but would become mandatory for the 2028 reporting period.

Final Action. The proposals are finalized without modification. Table IX.F.-08 of the final rule summarizes the Medicare PIP eCQM reporting requirements, and Table IX.F.-09 summarizes the previously and newly finalized eCQMs available for hospitals to report under the Medicare PIP for the specified reporting periods, including whether the measure is mandatory or self-selected.

X. Other Provisions

A. Transforming Episode Accountability Model (TEAM)

1. Background

Under its 1115A waiver authority, in the IPPS final rule for FY 2025 (89 FR 68986), CMS finalized a mandatory 5-year episode-based payment model (January 1, 2026 – December 31, 2030) to evaluate participating hospitals' performance on cost and quality metrics for five surgical episode categories: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion. CMS proposed this model within the CMMI strategic refresh framework[111] and developed it in light of the agency's experience with the Bundled Payments for Care Improvement (BPCI) Initiative, the BPCI Advanced Model, and the Comprehensive Care for Joint Replacement (CJR) Model, as well as comments received in response to the Episode-based Payment Model request for information (RFI) published in July 2023.[112] TEAM is expected to improve on these prior models and produce greater success in improving patient outcomes and lower costs by reducing fragmentation of care. In this final rule, CMS modifies TEAM by:

- Adding new Medicare Severity Diagnosis Related Groups (MS-DRGs) to the spinal fusion episode category.
- Adjusting episode attribution.
- Adjusting the measurement performance periods for certain quality measures.
- Adjusting the construction of the Composite Quality Score (CQS) baseline period.
- Capturing Ambulatory Payment Classification (APC) and MS-DRG changes in preliminary target prices.
- Adjusting the construction of the prospective normalization factor.

In addition, in the proposed rule CMS issued two requests for information: 1) information that would inform a potential decision to include ambulatory surgical centers (ASCs) in TEAM as early as calendar year 2028, and 2) information that would inform a potential CMS decision to

[111] Innovation Center Strategy Refresh: https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper
[112] https://www.federalregister.gov/documents/2023/07/18/2023-15169/request-for-information-episode-based-payment-model

allow certain physician-owned hospitals (POHs) to voluntarily opt into TEAM. CMS summarizes responses to those RFIs in this final rule.

TEAM participants are acute care hospitals paid under the IPPS, as defined in section 1886(d)(1)(B) of the Act. Participation is mandatory for hospitals selected to participate in order to avoid selection issues that arise in voluntary models.[113]

TEAM participants exclusively (and not other providers and suppliers involved in the care provided during an episode) bear sole financial accountability for performance under the model. In the case of episodes involving multiple hospitalizations, financial accountability falls to the TEAM participant that initiated the episode.

There are three tracks in TEAM, defined by varying levels of potential risk and reward. Track 1 is available only in Performance Year (PY) 1 for all TEAM participants and would have only upside financial risk with quality adjustment applied to positive reconciliation amounts. Track 2 is available in PYs 2 through 5 to a limited set of TEAM participants, including safety net hospitals, and has two-sided financial risk with quality adjustment to reconciliation amounts. Lastly, Track 3 is available in PYs 1 through 5 for all TEAM participants and has two-sided financial risk with quality adjustment to reconciliation amounts. CMS permits a one-year glide path to two-sided risk for TEAM participants in an effort to ensure that TEAM participants have time to prepare for two-sided financial risk. All TEAM participants are allowed to select between one of two tracks for the first performance year of TEAM.

TEAM episodes include non-excluded Medicare Parts A and B items and services and begin with an anchor hospitalization or anchor procedure and end 30 days after hospital discharge. TEAM participants will continue to bill Medicare FFS as usual for items and services delivered to beneficiaries in an episode but will receive preliminary target prices for episodes prior to each performance year. Target prices will be based on three years of baseline data, prospectively trended forward to the relevant performance year, and calculated at the level of Medicare Severity Diagnosis Related Group/Healthcare Common Procedure Coding System (MS-DRG/HCPCS) episode type and region. Target prices will also include a discount factor and risk adjustment. Participants will receive reconciliation (final) target prices that will incorporate a capped retrospective trend factor adjustment and a capped normalization factor. Performance in the model will be assessed by comparing TEAM participants' actual Medicare FFS spending during a performance year to their reconciliation target price as well as by assessing performance on selected quality measures. TEAM participants may earn a payment from CMS, subject to a quality performance adjustment, if their spending is below the reconciliation target price. TEAM participants may owe CMS a repayment amount, subject to a quality performance adjustment, if their spending was above the reconciliation target price.

[113] Maryland hospitals under the Total Cost of Care (TCOC) model are excluded from participating in TEAM.

2. TEAM Provisions of this Final Rule

a. Episodes

TEAM tests five episode categories, identified in Table X.A.-01 (reproduced with modifications, below), that represent high-expenditure, high-volume care delivered to Medicare beneficiaries. These episode categories also generally have a greater proportion of spending in the post-acute period relative to the anchor hospitalization or procedure, that present a greater opportunity to improve care transitions for beneficiaries and reduce unnecessary hospitalizations and emergency care. Episodes are initiated by an anchor hospitalization, identified by an MS-DRG, or an anchor outpatient procedure, identified by a HCPCS code.[114]

TABLE X.A.-01: EPISODE CATEGORIES AND CORRESPONDING CODES THAT INITIATE AN ANCHOR HOSPITALIZATION OR ANCHOR PROCEDURE

Episode Category	Anchor Hospitalization Trigger Code (MS-DRG)	Anchor Procedure Trigger (HCPCS)
Coronary Artery Bypass Graft	231, 232, 233, 234, 235, or 236	Not Applicable
Lower Extremity Joint Replacement	469, 470, 521, or 522	27447, 27130, or 27702
Major Bowel Procedure	329, 330, or 331	Not Applicable
Surgical Hip Femur Fracture Treatment	480, 481, or 482	Not Applicable
Spinal Fusion	402, 426, 427, 428, 429, 430, 447, 448, 450, 451, 471, 472, 473, **523, 524, or 525**	22551, 22554, 22612, 22630, or 22633

Generally, CMS assesses MS-DRG classification changes on an annual basis with the fiscal year IPPS rulemaking cycle. These changes may result in the addition, modification, or deletion of MS-DRGs. Since inpatient episodes in TEAM rely on MS-DRG codes to identify when an anchor hospitalization is initiated, any changes to the MS-DRGs included in TEAM may affect episode volume and ultimately the number of beneficiaries included in the model. As described in section II.C of the preamble of this final rule, there are changes to certain MS-DRGs that affect the spinal fusion episode category in TEAM. Specifically, three new MS-DRGs are being added to better classify beneficiary acuity and resource utilization for a subset of spinal fusion procedures. Given these new spinal fusion DRGs, and consistent with its proposal in the IPPS/LTCH proposed rule for FY 2027, **CMS now makes conforming changes in TEAM, specifying at §512.525(d)(4)(i) that starting on October 1, 2026, MS-DRGs 523, 524, and 525 will be added to the spinal fusion episode category that would initiate a spinal fusion anchor hospitalization. CMS also modifies §512.505 to update the spinal fusion definition to include these three new MS-DRGs.**

Selected comments: CMS indicates that comments in response to its proposal to add three new spinal fusion DRGs to the TEAM Spinal Fusion episode category were mixed. "A few" commenters supported the inclusion of these DRGs, but even some of those who supported the proposal expressed concerns about how the change would be implemented. Other commenters opposed including these DRGs in TEAM, arguing that their inclusion would create undue

[114] HCPCS (Healthcare Common Procedure Coding System).

administrative burden with no clear clinical rationale, that adding DRGs to the model mid-stream is unduly disruptive, or (most significantly), arguing that procedures covered by these DRGs are extremely complex and costly, and that their inclusion in setting a target price for a TEAM spinal fusion episode would result in target prices that would penalize the high-acuity medical centers that often provide these services. Nonetheless, **CMS is finalizing without modification the proposal at §512.525(d)(4)(i) to add MS-DRGs 523, 524, and 525 to the spinal fusion episode category**.

CMS also proposed changes in the TEAM episode attribution methodology. In section X.C. of the preamble of this final rule, the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model is being finalized as an expanded phase II model test under section 1115A(c) of the Act. Both TEAM and CJR-X test LEJR episodes; however TEAM tests a 30-day post-discharge period episode length while CJR-X tests a 90-day post-discharge period episode length. Given the model similarities and the agency's desire to assess differences in outcomes between these two episode durations, the CJR-X model excludes TEAM participants from participating in CJR-X. While this exclusion would prevent a TEAM participant from being a CJR-X participant, it does not address instances where a beneficiary is in a CJR-X episode and receives care at a TEAM participant during the CJR-X 90-day post-discharge period. Therefore, CMS proposed at §512.537(b)(4) that if a beneficiary in a CJR-X episode has a procedure performed at a TEAM hospital that would initiate a TEAM episode during the CJR-X 90-day post-discharge period, then that procedure would *not* initiate a TEAM episode or be attributed to the TEAM participant and the spending from that procedure would be included in the CJR-X episode.

Selected comments: CMS states that "many commenters supported the proposed episode attribution policy;" some requested operational clarifications. After consideration of public comments, **CMS is finalizing without modification the proposal at §512.537(b)(4) to not attribute an episode to a TEAM participant if the beneficiary is in a CJR-X episode and has a procedure performed at a TEAM participant that would initiate an episode during the CJR-X 90-day post-discharge period**.

b. Quality Measures

TEAM incorporates quality measures that focus on care coordination, patient safety, and patient reported outcomes (PROs), which CMS believes represent areas of quality that are particularly important to patients undergoing acute procedures. Where possible, CMS has attempted to align TEAM quality measures with those used in ongoing models and programs to minimize participant burden.

The current set of quality measures used in TEAM is summarized in the table below.

TEAM QUALITY MEASURES BY PERFORMANCE YEAR

FY 2025 IPPS/ LTCH PPS Finalized TEAM Quality Measures		
Performance Year 1	All Inpatient Episodes	Hybrid Hospital-Wide All-Cause Readmission measure (CMIT ID #356); claims only for PY1 and full hybrid for PY2-PY5

Performance Year 1	All Inpatient Episodes	CMS Patient Safety and Adverse Events Composite (CMIT ID #135)
Performance Year 1	Lower Extremity Joint Replacement Episodes	Hospital-Level Total Hip and/or Knee Arthroplasty (THA/THK) Patient Reported Outcome Based Measure (CMIT ID #1618)
Performance Year 2-5	All Inpatient Episodes	Hospital Harm – Fall with Injury (CMIT ID #1518)
Performance Year 2-5	All Inpatient Episodes	Hospital Harm – Postoperative Respiratory Failure (CMIT ID #1788)
Performance Year 2-5	All Inpatient Episodes	Thirty-Day Risk – Standardized Death Rate among Surgical Inpatients with Complications (Inpatient Surgical Compilations Mortality Rate)) (CMIT ID #134)
Performance Year 3-5	All outpatient LEJR and Spinal Fusion Episodes	Information Transfer Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) (CMIT ID #1797)

CMS asserts that TEAM aims to, whenever possible, align with existing reporting requirements so as not to introduce additional burden to participants. In the FY 2025 IPPS/LTCH PPS final rule (89 FR 68986), CMS finalized the Hospital Harm – Falls with Injury, Hospital Harm – Postoperative Respiratory Failure, and Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications (ISCMR), with the intent of aligning these measures with the performance periods used in the Hospital Inpatient Quality Reporting IQR) Program. However, CMS did not propose or finalize the specific measurement performance periods for these measures within TEAM.

Thus, in this year's proposed rule, CMS proposed to establish measurement performance periods for these three quality measures. For Hospital Harm—Falls with Injury, and Hospital Harm—Postoperative Respiratory Failure, the agency proposed alignment with the Hospital IQR Program's calendar year reporting requirements, utilizing a one-year measurement performance period. For ISCMR, CMS proposed alignment with the Hospital IQR Program's two-year rolling measurement performance period. CMS details the specific performance periods in Table X.A.-02 of this final rule.

Selected comments: Commenters expressed concern about changing performance periods in the middle of a performance year, and concerns about using "untested" measures.[115] Despite these concerns, **CMS is finalizing without modification the proposal to apply measurement performance period timeframes to TEAM performance years 2 through 5 for the Hospital Harm—Falls with Injury and Hospital Harm—Postoperative Respiratory Failure, and ISCMR quality measures**. CMS summarizes its finalized changes to the CQS baseline periods, that would begin with TEAM PY2, in Table X.A.-02 of the final rule, reproduced below.

[115] That is, using measures prior to their being required under mandatory reporting.

TABLE X.A.-02: FINALIZED QUALITY MEASUREMENT PERFORMANCE PERIODS

Quality Measure	PY2 Performance Period	PY3 Performance Period	PY4 Performance Period	PY5 Performance Period
Hospital Harm—Falls with Injury (CMIT ID #1518)	January 1, 2027 through December 31, 2027	January 1, 2028 through December 31, 2028	January 1, 2029 through December 31, 2029	January 1, 2030 through December 31, 20230
Hospital Harm—Postoperative Respiratory Failure (CMIT ID #1788)	January 1, 2027 through December 31, 2027	January 1, 2028 through December 31, 2028	January 1, 2029 through December 31, 2029	January 1, 2030 through December 31, 2030
Thirty-day Risk—Standardized Death Rate among Surgical Inpatients with Complications (ISCMR) (CMIT ID #134)	July 1, 2024 through June 30, 2026	July 1, 2025 through June 30, 2027	July 1, 2026 through June 30, 2028	July 1, 2027 through June 30, 2029

CSM also proposed changes to the TEAM Composite Quality Score (CQS) baseline period methodology. In the FY 2025 IPPS/LTCH PPS final rule (89 FR 68986), CMS established fixed CQS baselines for calculating CQS performance that would remain constant throughout the model's duration, using calendar year (January – December) CQS baseline periods for all quality measures. In this year's IPPS/LTCH proposed rule, CMS proposed two changes to the CQS baseline methodology:

- CMS proposed at §512.547(a)(1)-(3) replacing the current fixed CQS baseline approach with a sliding historical CQS baseline methodology for all quality measures except the CMS PSI-90 measure which applies only in TEAM PY1 and therefore does not require advancement of baseline periods beyond that performance year.
- CMS proposed at §512.547(a)(1)-(3) to update the baseline periods from a calendar year to a July to June period for the Hybrid HWR, CMS PSI-90, THA/TKA PRO-PM, and the ISCMR measures, consistent with the Hospital IQR and HAC programs requirement of July – June measurement periods.

Selected comments/response: CMS states that many commenters supported the proposal to update the CQS baseline periods from a calendar year to a July to June period for the Hybrid HWR, CMS PSI-90, THA/TKA PRO-PM, and the ISCMR measures. Some of these commenters noted that doing so would reduce administrative burden on participants and reduce confusion. Some commenters supported the proposal to adopt sliding historical CQS baseline periods, but "a few" commenters opposed this proposal, raising concerns about the potential for increased year-to-year variability, and transparency and predictability of price targets under TEAM. In light of these comments, **CMS is finalizing with modification the proposal at §512.547(a) to change the CQS baseline methodology in TEAM to using a concurrent CQS baseline period starting in PY 1**. **CMS is also finalizing without modification the proposed change from calendar year to July to June timeframe for the Hybrid HWR, CMS PSI-90, THA/TKA PRO-PM, and ISCMR measures.** The finalized concurrent measurement periods

and CQS baseline periods for all seven quality measures are shown in Table X.A.-03 of the final rule.

c. Pricing Methodology

As finalized in the FY 2025 IPPS/LTCH PPS final rule (89 FR 68986), TEAM participants will be provided with target prices for each MS-DRG/HCPCS episode type. These target prices will be calculated using three years of rolling baseline episode spending, trended forward, with two additional historical years to the performance year, at the level of MS-DRG/HCPCS episode type and region, with updates to be made using the performance year data during the reconciliation process.

Because TEAM uses three years of rolling baseline episode spending (with two additional historical trend years) to construct target prices for a given performance year, changes in the MS-DRG or HCPCS-APC mappings and weights after the baseline period and either prior to or during the performance year may result in target prices that do not appropriately reflect episode spending in the performance year. Additionally, any new code established prior to or during the performance year that did not exist in the baseline period would not have a target price. Therefore, in the FY 2026 IPPS/LTCH PPS final rule (90 FR 36536), CMS finalized the definition of a scaling factor at §512.505 and methodology at §512.540(a)(2)(i) through (iii) to account for changes to MS-DRGs and HCPCS between the baseline period and the performance year. However, in this course of preparing this year's IPPS/LTCH proposed rule, CMS determined that this methodology does not completely mitigate the potential for disconnects between the target prices and changes in the MS-DRGs, APCs, or HCPCS codes that compose the TEAM episodes subsequent to the establishment of episode target prices.

To avoid these inconsistencies CMS proposed to update the definitions at §512.505 and the pricing methodology at §512.540(b)(7) to add an APC update factor to the calculation of the prospective trend factor and at §512.545(f)(1) to the retrospective trend factor, to ensure the final target price and reconciliation amounts align with payment rates and weights that are applied during each performance year.

Selected comments: CMS reports that many commenters expressed support for the APC update factor proposal; some of these commenters asserted that the application of the APC update factor should help ensure target prices more accurately reflect APC weight changes between calendar years.[116] CMS did not report any comments opposed to the proposed APC update factor. Therefore, **CMS is finalizing without modification the proposal at §512.505 to add an APC update factor definition and without modification the proposal at §512.540(b)(7) and §512.545(f)(1) to add an APC update factor to the calculation of the prospective trend factor**.

For reasons similar the APC update factor discussed above, to account for changes in MS-DRG mapping and weights between the first and second fiscal years in a TEAM performance year,

[116] Of note: "A couple commenters suggested that if the APC update factor is applied starting in PY1, it should only be applied in cases where it results in favorable adjustments for TEAM participants."

CMS proposed updates to the definitions at §512.505 and the pricing methodology at §512.540, §512.545, and §512.550, to adjust the target price and reconciliation amount accordingly.

Selected comments/response: CMS indicates that as with the APC update factor, many commenters expressed support for the MS-DRG update factor proposal. Some commenters expressed the need for clear and timely visibility and communication into any updates associated with IPPS/LTCH changes prior to the start of the applicable performance year, especially with respect to the transparency in calculating TEAM episode target prices.

Lastly, CMS proposed that TEAM participants would not be accountable for episodes with anchor end dates in the fourth quarter of the performance year that are initiated by anchor hospitalizations that would have been assigned a non-TEAM MS-DRG in the first three quarters of the performance year.

After consideration of the public comments, CMS is finalizing without modification the proposals at §512.505 to add definitions for MS-DRG update factor and updated prospective trend factor and at §512.540(b)(7) to add MS-DRG update factors in the calculation of the prospective trend factor. CMS also finalizes without modification the proposals at §512.545 to specify the FY MS-DRG(s) that each reconciliation target price component reflects for episodes with anchor end dates in the fourth quarter of the performance year. Lastly, the agency is finalizing without modification the proposals at §512.550(c) to add a step to assign a first fiscal year MS-DRG to performance year episodes with anchor end dates in the fourth quarter and modify the calculations to the assigned first and second fiscal year MS-DRG/HCPCS episode type.

In the FY 2025 IPPS/LTCH PPS final rule (89 FR 68986) that established TEAM, a normalization factor was included in the calculation of preliminary and reconciliation target prices to ensure that the average benchmark price after risk adjustment does not exceed the average benchmark price prior to risk adjustment. The FY 2026 IPPS/LTCH PPS final rule (90 FR 36536) revised the language at §512.505 to clarify that the prospective normalization factor will be calculated using the benchmark prices rather than using preliminary target prices. In the proposed rule, CMS proposed, starting with performance year 2, to update the definition at §512.540(b)(6) to calculate the prospective normalization factor at the MS-DRG/HCPCS episode type and region level based on the applicable episodes in the baseline period. Specifically, CMS proposed to update §512.540(b)(6)(i) to apply the risk adjustment coefficients to all applicable baseline year episodes, rather than restricting application to the most recent baseline year episodes, in the calculation of the risk adjustment multiplier.

Selected comments: CMS indicates that some commenters supported, and a commenter "did not oppose," [!] the proposed update to the prospective normalization factor construction. A few of the commenters agreed with CMS' assertion that the proposed methodology update would improve the predictive accuracy of the prospective normalization factor. Thus, after consideration of the public comments, **CMS is finalizing without modification the proposals at §512.540(b)(6) and (b)(6)(i) to calculate the risk adjustment multiplier and normalization factor using the baseline period clinical episodes starting with performance year 2**.

d. Ambulatory Surgical Center (ASC) Episode Request for Information

CMS is exploring ASC participation in TEAM, beginning as early as CY 2028 (that is, Performance Year 3). CMS previously solicited public comment on inclusion of ASCs in LEJR focused models (85 FR 10537) in the Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing proposed rule. Since that time, CMS notes that the health care landscape has changed, and more procedures, including certain procedures that initiate episodes in TEAM, are being performed more regularly in the ASC setting. Therefore, in this year's proposed rule, CMS solicited additional public feedback on inclusion of ASC episodes in TEAM.

Towards that end, CMS asked for information in response to the following questions:

Participation and Financial Accountability

- What operational challenges would ASCs face participating in an episode-based payment model such as TEAM? Are there any unique challenges to treating patients in an ASC compared to IP/OP hospital settings? How might these challenges impact model participation?
- What steps could CMS take to support ASC readiness to participate in episode-based payment models such as TEAM?
- What programmatic waivers may be necessary to ensure ASCs have successful participation in TEAM?
- What entity should be held financially accountable for episodes initiated at ASCs?
- How should CMS account for financial and ownership relationships between hospitals and ASCs or both?
- What barriers are there to partnerships between hospitals and ASCs that are not owned by hospitals?
- What opportunities, if any, exist for ASCs to achieve efficiency gains under TEAM? What model features could support or enhance these opportunities?

Episode Construction

- What additional surgical episode types should CMS consider if TEAM is modified to include the ASC setting?

Risk Adjustment and Target Pricing

- If CMS incorporates ASCs into multi-setting episode types, how can CMS adapt the beneficiary-level risk adjustment methodology to ensure appropriate site-of-service decisions?
- Could including ASCs in TEAM create barriers to care for any Medicare beneficiaries? What could CMS do to mitigate this?

Model Overlap

- How should CMS handle TEAM ASC episode overlap with other value-based care initiatives or payment models focused on the same procedures at either ASCs or hospitals?

Quality Measures

- What quality measures would reasonably capture performance and outcomes of TEAM ASC episodes?
- On what quality metrics can ASCs and hospital outpatient departments be fairly compared?
- What opportunities, if any, exist for quality improvement at ASCs for procedures included in (or suggested for inclusion in) TEAM?

Selected comments/response: CMS indicates that the agency received "many thoughtful and wide-ranging comments" in response to the Ambulatory Surgical Center (ASC) Episodes RFI. Due to the breadth of topics covered in the ASC Episodes RFI and public comments, as well as the variety of viewpoints expressed in response to this RFI, CMS is not responding to specific comments submitted. CMS is conducting an in-depth review of the comments received, and this may help to inform potential future rulemaking proposals.

e. Hospital with Physician Ownership Request for Information

A hospital with physician ownership (POH) is any hospital in which a physician, or an immediate family member of a physician, has an ownership or investment interest in the hospital. Ownership or investment interest may be through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in the hospital.[117]

Section 1877 of the Social Security Act (the Act) (42 U.S.C. 1395nn), also known as the physician self-referral law (and commonly referred to as the "Stark" law) prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship, unless the requirements of an applicable exception are satisfied. It also prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third-party payor) for any improperly referred designated health services.

Section 1877(d) of the Act sets forth exceptions related to ownership or investment interests held by a physician (or an immediate family member of a physician) in an entity that furnishes designated health services. Section 6001(a) of the Affordable Care Act effectively eliminated the exceptions for physician ownership or investment in hospitals.[118]

[117] 42 CFR 411.351 and 411.254(b).
[118] Hospitals with physician ownership or investment and a Medicare provider agreement on December 31, 2010, are grandfathered and able to continue using an exception for rural providers, if applicable, and an exception that applies in the case of physician ownership of whole hospitals.

In the IPPS/LTCH proposed rule for FY 2027, CMMI considered initiating a voluntary opt-in period to allow POHs located in core-based statistical areas (CBSAs) not selected for TEAM inclusion to participate in the Model. CMS noted that TEAM is a mandatory model, and allowing voluntary participation could have cost and evaluation implications. Therefore, CMS requested feedback on the following questions:

- Should CMS allow a voluntary opt-in period to include POHs in TEAM; why or why not?
- Should the option to participate in TEAM be limited to those POHs that are grandfathered under the Affordable Care Act to use the rural provider or whole hospital exception to the physician self-referral law?
- Should POHs that wish to voluntarily opt into TEAM be required to meet the geographic eligibility criteria described previously and in 42 CFR 512.515 and be subject to participation requirements described in 42 CFR 512.510?
- What inclusion criteria, if any, should be added for POHs opting to participate in TEAM?
- What programmatic waivers may be necessary to ensure POHs have successful participation in TEAM (for example, restrictions on expansion of facility capacity, service limitations, etc.)? Provide justification for any waiver that you believe may be necessary. Please explain how the waiver will not undermine the TEAM model by allowing Medicare payment for services furnished by POHs where such payments are not currently allowed because the POHs are not grandfathered in to use the rural provider or whole hospital exception to the physician self-referral law.
- Waivers of law, if provided and necessary to test a model, are temporary and generally end when the model expires or the participant's agreement is terminated.
- How will POHs continue any successful actions taken under TEAM once they must comply with all applicable statutes and regulations, including the physician self-referral law?
- How can CMS ensure that, upon the termination of TEAM and any associated waivers specific to POHs, if granted, that POHs remain compliant with existing mandates? For example, if TEAM waives Section 6001(a)(3) of the Affordable Care Act to allow a POH to expand beyond its baseline number of operating rooms, procedure rooms, and beds (as defined at 42 CFR 411.363(a)) without requesting an expansion from the Secretary as required at 42 CFR 411.362(b)(2), how can CMS ensure that the POH reduces its facility capacity to its baseline number of operating rooms, procedure rooms, and beds?
- What additional program integrity requirements should CMS consider to avoid beneficiary steering, cherry-picking, and lemon-dropping and ensure beneficiary choice is not compromised if waivers are offered to POHs?
- Should any episode categories be excluded from episode initiation, or should any items and services be excluded from target prices for POHs in TEAM? If so, include evidence to support this exclusion.
- What episode categories, beyond the episode categories currently tested in TEAM, should CMS consider testing for POHs?

Selected comments/response: CMS states that "the vast majority of commenters" supported allowing hospitals with physician ownership to voluntarily opt in to participate in TEAM. CMS agrees with commenters that allowing additional POHs to participate in TEAM can support the

goals of the model by expanding the number of hospitals participating in episode-based accountability, increasing the number of Medicare beneficiaries who may receive care under value-based care arrangements, and supporting continued investment in care redesign, care coordination, and improved transitions of care. CMS also agrees with commenters who asserted that POH participation may generate useful evidence about physician-led delivery models. Other commenters supported or did not oppose consideration of POH participation, but stressed that CMS should proceed with caution. These commenters discussed concerns related to appropriate utilization, patient selection, program integrity safeguards, and beneficiary choice.

It is worth noting, however, that some commenters opposed allowing POHs to voluntarily participate in TEAM, raising concerns about selective patient mix, negotiating leverage, profits for physician owners, and program integrity. Other commenters expressed concerns about the potential for POH participation through a voluntary opt-in to harm rural or underserved communities. Commenters opposing voluntary POH participation in TEAM generally believed that allowing POH participation through a voluntary opt-in could create inequities for mandatory participants and could distort TEAM's cost, quality, and evaluation results.

After consideration of the public comments received, CMS states that the agency intends to propose in future rulemaking a policy to allow POHs not located in mandatory CBSAs to participate in TEAM. CMS recognizes, however, the concerns that limited-service hospitals could raise issues related to overutilization, patient steering, cherry-picking, lemon-dropping, conflicts of interest, and impacts on full-service hospitals. CMS indicates that the agency takes these concerns seriously and intends to consider these issues when proposing POH participation and monitoring policies in future rulemaking.

B. Provider-Based Location Criteria

The provider-based rules (42 CFR §413.65) establish criteria that an entity must meet to be consider "provider-based" or a part of a provider. For off-campus facilities to be provider-based, they must be no more than 35 miles from the main provider or they must demonstrate that they serve the same patient population as the main provider.

An off-campus provider-based facility may satisfy the "same patient population" test as the main provider by submitting records showing that, during the immediately preceding 12-month period, and for each subsequent 12-month period, that either:

- At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider; or
- At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (referred to by CMS as the "referral-based test").

The referral-based test is intended to provide access to services beyond 35 miles from the main provider in situations where the patient may be unable to receive continuation of acute care because of the lack of access to acute care services. CMS has concerns that the referral-based test could provide significant payment advantages for a remote location of an IPPS-exempt hospital a

considerable distance from the main provider. If such a remote location could meet the referral-based test, it would be paid for inpatient services based on the reasonable costs subject to a limit rather than under the IPPS.

Alternatively, it would not matter if the same hospital created a provider-based remote location or a separate hospital more than 35 miles from the main provider if both sites are paid under the IPPS. In the case of an IPPS hospital, there is no payment advantage from having an additional remote site versus creating a separate hospital that is not provider-based. For this reason, it is not necessary for the referral-based test to apply to inpatient sites as there is already an option outside of the provider-based rules to create inpatient care where there may be a lack of access for patients needing referral to a site distant from the main provider. For these reasons, CMS proposed to limit the application of the referral-based test to outpatient departments only and not allow it for inpatient sites of care.

Commenters argued that the proposal contradicts the agency's own longstanding policy that explicitly applied the referral-based test to both inpatient and outpatient provider-based facilities. These commenters requested that CMS withdraw the policy or grandfather facilities that would not meet the new requirement. The comments indicated CMS policy would risk significant potential harm to patient access — particularly in rural and underserved communities—where remote specialty inpatient locations would routinely refer patients to a large, better equipped tertiary hospital for additional treatment.

CMS responded that the commenters did not provide a specific example of an existing facility that would be negatively affected by its proposal. The rule indicates that the policy is intended to address a scenario where payments to an IPPS excluded hospital would be increased by obtaining provider-based status for a remote location. Rather than being a remote location of an existing IPPS excluded hospital, this hospital could enroll as a new IPPS hospital to serve the needs of the community where it is located without needing to receive reasonable cost payment. The referral arrangements that concern the provider would continue to be permitted—provider-based status is not a requirement to refer a patient to a hospital irrespective of the payment system under which it is paid.

One commenter argued that CMS' proposal is inconsistent with the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554). As section 404(b) of BIPA codified the 75 percent referral test as written, the commenter indicates that CMS cannot change it through regulation. CMS responded that it is maintaining the 75 percent tests and only updating the regulation to address an attempt by an IPPS-excluded hospital to increase Medicare payments by obtaining provider-based status for a remote location in proximity to IPPS hospitals. Only the referral based test is limited to off-campus outpatient

departments. The other 75 percent test remains available to both off-campus inpatient and outpatient departments.

CMS is finalizing its policy as proposed

C. Comprehensive Care for Joint Replacement Expanded (CJR-X) Model

1. Overview of Expansion of the Comprehensive Care for Joint Replacement (CJR) Model

CMS provides a brief historical overview of the Comprehensive Care for Joint Replacement (CJR) Model, a mandatory alternative payment model tested by CMMI between April 1, 2016, and December 31, 2024. The model as originally fielded applied to all acute care hospitals in 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, CMS in this final rule is expanding the model to all eligible acute care hospitals nationwide, under the auspices of Comprehensive Care for Joint Replacement – Expanded (CJR-X). All eligible acute care hospitals would be required to participate in the CJR-X model beginning January 1, 2028, three months later than originally proposed.[119]

The CJR Model tested quality and spending accountability for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery. Specifically, the CJR Model was a retrospective bundled payment model where CMS provided participant hospitals with a target price for each CJR episode type (based on the MS-DRG assigned to the hospitalization and the presence or absence of a hip fracture in the original CJR Model and the MS-DRG or HCPCS code assigned to the hospitalization or procedure in the CJR Extension), prior to the start of each CJR Model performance year (PY).

CMS discusses changes to the CJR model that occurred during its fielding, most notably those changes to episodes necessitated by the removal of certain procedures from the Inpatient Only (IPO) list – total knee arthroplasty (TKA) effective January 1, 2018, and total hip arthroplasty (THA) effective January 1, 2020. In light of these changes, CMS issued a proposed rule titled "Medicare Program: Comprehensive Care for Joint Replacement Model Three-Year Extension and Changes to Episode Definition and Pricing" which appeared in the February 24, 2020 *Federal Register* (85 FR 10516). This rule proposed to extend the CJR Model for an additional three CJR Model PYs with modifications that included adding outpatient TKAs and THAs to the episode definition, adjusting the target price methodology and risk adjustment, and simplifying the reconciliation process. CMS also discusses changes to the model as a result of the COVID-19 Public Health Emergency (PHE) in November of 2020 (85 FR 71142).

[119] CMS continues to not describe CJR-X as "permanent" or "indefinite." Interestingly, some commenters on the scope of the model noted that in the proposed rule, CMS did not specify an end date for CJR-X, leading one commenter to assert that "Innovation Center authority is limited to models of defined duration, and the proposal to implement CJR-X without any end date and with only the prospect of unilateral termination is unlawful." In the preamble language around Table K-CL.-01 discussing the effects of CJR-X, CMS notes that its estimates of projected savings under the model "represent a portion of the potential savings to Medicare that CJR-X may produce since the model does not have an end date."

CMS notes that CJR achieved small, but statistically insignificant program savings during its first four years of operation, but exhibited substantial losses in performance year (PY) 5, which coincided with the COVID-19 PHE. CMS finalized its proposed 3-year extension of the model (which also included certain policy changes) in May of 2021 (86 FR 23496). CMS reports that CJR produced $112.7 million in net savings in PYs 6 and 7, while maintaining quality of care.[120] CMS states that given this performance, in the IPPS / LTCH proposed rule for 2027, the agency proposed to expand the CJR model to all eligible acute care hospitals nationwide. The proposed extension includes minor changes based on CMMI's experience with the Transforming Episode Accountability Model (TEAM), and it also excludes TEAM participants from CJR-X until TEAM has been completed.

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

a. Scope of Proposed Model

In the IPPS / LTCH proposed rule for 2027, CMS proposed at §512.630(a) that CJR-X would begin on October 1, 2027, and would continue on a fiscal year basis (§512.605) to align with Medicare's IPPS payment policies. CMS considered, but did not propose, both a CY performance year basis for CJR-X, and a later start date.

Selected comments/response: CMS indicates that numerous commenters recommended that CMS delay the implementation of CJR-X. Some commenters recommended that CMS align CJR-X performance and reporting periods with the calendar year. Commenters stated that calendar-year alignment would simplify data management, abstraction workflows, validation processes, cross-program analytics, resource allocation, and budgeting. Commenters noted that overlapping or conflicting timelines across programs increase the risk of data errors and administrative burden.

CMS was persuaded by their arguments, and recognized that "mandatory participation in a nationwide episode-based payment model requires substantial preparation and that hospitals may need time to develop operational, clinical, financial, and data infrastructure to support successful participation." In response to these comments, **CMS is finalizing at §512.630(a) to start CJR-X on January 1, 2028 rather than the proposed October 1, 2027 start date. CMS is also finalizing at §512.605 that performance years will be based on the calendar year rather than the fiscal year**.

b. Participants

Consistent with the CJR Model, CMS proposed that hospitals would be the model participants in CJR-X. For the purposes of CJR-X, CMS proposed to define the term "hospital" at §512.605 to mean a hospital as defined in section 1886(d)(1)(B) of the Act, which includes only acute care hospitals and excludes certain specialty hospitals, such as psychiatric and cancer hospitals.

[120] Comprehensive Care for Joint Replacement Model – Seventh Annual Report (https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-py7-annual-report)

Although the CJR Model was confined to certain geographic areas, CMS proposed at §512.610(a) that CJR-X participation would be mandatory for all acute care hospitals nationwide, provided they meet the proposed "CJR-X participant" definition. To meet this definition, hospitals must provide services under both the IPPS and the OPPS.[121] However, CMS proposed at §512.610(b)(1) to exclude hospitals that are TEAM participants from CJR-X, and proposed at §512.610(b)(2) to exclude acute care hospitals in the State of Maryland because of Maryland's unique rate-setting authority.

Selected comments/response: CMS indicates that commenters were generally supportive of its proposals regarding CJR-X participants and exclusions. Some commenters recommended that CMS permit physician group practices (PGPs), physician-owned hospitals (POHs), and others that have participated in bundled payment models and other APMs to manage or initiate episodes in CJR-X, as convening or collaborative participants, but CMS declined to act on these suggestions. Some commenters recommended that additional types of hospitals be excluded from CJR-X (*e.g.*, rural, low-volume hospitals, or other types of hospitals with fragile financial resources). CMS declined to expand the list of excluded hospital types, pointing to other financial protections the agency is finalizing as part of CJR-X. Commenters were mixed regarding supporting or opposing mandatory models generally, with those opposing suggesting that CJR-X be implemented as a voluntary, or opt-in model. Again, CMS declined to accommodate these suggestions.

After consideration of the public comments received, **CMS is finalizing without modification its proposal at §512.605 to define "hospital" as defined in section 1886(d)(1)(B) of the Act. CMS is finalizing with modification the "CJR-X participant" definition at §512.605 to be a hospital located in any of the 50 States, District of Columbia, or U.S. Territories that initiates LEJR episodes and is eligible to be paid under both the IPPS and OPPS, and the proposal at §512.610(a)(1) that CJR-X participation is mandatory for any hospital that meets the CJR-X participant definition**. **CMS also finalizes its proposal at §512.610(b) to exclude TEAM participants and Maryland hospitals from CJR-X.**

c. Beneficiary Population

CMS proposed at §512.620(a) that the beneficiaries whose care would be included in CJR-X would include those who meet the following beneficiary inclusion criteria at the time of their admission for an anchor procedure or anchor hospitalization:

- Is enrolled in Medicare Part A and Part B;
- Has Medicare as their primary payer;
- Is not eligible for Medicare on the basis of end-stage renal disease, as described at §406.13;
- Is not enrolled in any managed care plan (for example, Medicare Advantage, Health Care Prepayment Plans, cost-based health maintenance organizations);

[121] This definition excludes, for example, Indian Health Service hospitals because they are not paid under the OPPS, and hospitals participating in the Rural Community Hospital Demonstration, Critical Access Hospitals, and Rural Emergency Hospitals, all of which are not paid under the IPPS.

● Is not covered under a United Mine Workers of America health plan, which provides health care benefits for retired mine workers; and
● Is in an episode, as defined at §512.605.

CMS proposed that if a beneficiary ceases to meet the inclusion criteria at some point in the CJR-X episode, the episode would be cancelled.

In the proposed rule, CMS asserted that beneficiaries would not be able to opt out of CJR-X when they receive care from a CJR-X participant. However, CMS proposed at §512.622(a)(1) that every CJR-X participant must provide written notification to each CJR-X beneficiary of his or her inclusion in the CJR-X model, and proposed the required content of such notification at §512.622(a)(4). Lastly, CMS proposed at §512.622(b) that CJR-X participants must require every CJR-X collaborator to provide written notice, to applicable CJR-X beneficiaries that describes the existence of a sharing arrangement with the CJR-X participant and the basic quality and payment incentives under the model, no later than the time at which the beneficiary first receives an item or service from the CJR-X collaborator during an episode. In addition, CMS proposed at §512.622(b) that CJR-X participants would have to require every CJR-X collaborator to provide written notice to applicable CJR-X beneficiaries describing the existence of a sharing arrangement with the CJR-X participant and the basic quality and payment incentives under the model.

Selected comments/response: CMS indicates that several commenters requested that CMS clarify and explicitly require that beneficiaries meet the inclusion criteria throughout both the clinical episode period and the 180-day lookback period used for risk adjustment. CMS accommodated these requests. Commenters asked for clarifications regarding the exclusion of ESRD beneficiaries and beneficiaries enrolled in Medicare Advantage.

CMS is finalizing with modification the proposed beneficiary inclusion criteria at §512.620(a) as follows:

"An individual is a CJR-X beneficiary if, based on a 180-day lookback period that ends on the day prior to an anchor procedure or anchor hospitalization, the individual—

- **Is enrolled in Medicare Parts A and B;**
- **Has Medicare as their primary payer;**
- **Is not eligible for Medicare on the basis of having end stage renal disease, as described at §406.13 of this chapter;**
- **Is not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations);**
- **Is not covered under a United Mine Workers of America health care plan; and**
- **Is in an episode."**

Regarding the proposed notification requirements, CMS notes that many commenters opposed or recommended narrowing the proposed CJR-X beneficiary notification requirements. Commenters stated that requiring hospitals and collaborators to provide CJR-X-specific written notices would create unnecessary administrative burden, duplicate existing patient education and

discharge communications, and provide little practical value to beneficiaries because CJR-X is mandatory and beneficiaries cannot opt out, and that the notifications had the potential to create beneficiary confusion. In response, the agency said it believes it necessary that beneficiaries are aware of the model, how it would or would not impact their care, and their continued beneficiary rights, including their freedom of choice to choose providers, suppliers, and services. Other commenters supported the proposed notification requirements. Thus, **CMS is finalizing the beneficiary notification requirements for CJR-X at §§512.622(a), 512.622(b), and 512.622(d) as proposed**.

d. Episode

In the proposed rule, CMS proposed to define "episode" to mean all Medicare Part A and B items and services described in §512.625(b) (excluding the items and services described in §512.625(c)) that are furnished to a CJR-X beneficiary during the period that begins on the date of the beneficiary's admission to an anchor hospitalization or the date of the anchor procedure, and ends on the 90th day following the date of discharge from the anchor hospitalization or anchor procedure, with the date of discharge or date of the anchor procedure itself being counted as the first day in the 90-day post-discharge period. This episode definition aligns with the CJR Model and with TEAM, at §510.2 and §512.505, respectively.

CMS proposed to identify lower extremity joint replacement (LEJR) episodes by certain MS-DRGs and HCPCS codes included on claims. Specifically, IPPS discharges under MS-DRG 469, 470, 521, or 522; and OPPS claims for HCPCS codes 27130 or 27447, would trigger LEJR episodes in CJR-X.

The proposed CJR-X episode would cover most Part A and Part B services provided during the episode, including, but not limited to:

- Physicians' services
- Inpatient hospital services, including services paid through IPPS operating and capital payments
- Inpatient psychiatric facility (IPF) services
- Long-Term Care Hospital (LTCH) services
- Inpatient Rehabilitation Facility (IRF) services
- Skilled Nursing Facility (SNF) services
- Home Health Agency (HHA) services
- Hospital outpatient services
- Outpatient therapy services
- Clinical laboratory services
- Durable medical equipment
- Part B drugs and biologics except for those excluded under §512.625(c) as proposed
- Hospice services
- Certain Part B professional claims dated in the three days prior to an anchor hospitalization

CMS proposed to exclude from episodes certain Part A and B items and services that are clinically unrelated to an LEJR procedure (*e.g.*, oncology services, trauma services, major diagnostic categories such as pregnancy, newborns, and Human Immunodeficiency Virus, IPPS new technology add on payments, and other specified services). CMS also discusses at length its proposed exclusion of certain Part B payments for high-cost drugs and biologics, low-volume drugs, and blood clotting factors for hemophilia patients billed on outpatient, carrier, and durable medical equipment claims for episodes in the baseline period and initiated in the performance years.[122]

CMS proposed at §512.630(d) to end episodes 90 days after discharge from the anchor hospitalization or anchor procedure and that day 1 of the 90-day post-acute portion of the episode is the date of the anchor procedure or the date of discharge from an anchor hospitalization.

Similar to the CJR Model, CMS proposed that once an episode begins, the episode would continue until the end of the episode, unless the episode is cancelled for certain reasons. Proposed reasons for terminating an episode are:

- The beneficiary ceases to meet requirements for inclusion in CJR-X,
- instances in which an episode anchor hospitalization occurs within three days of starting an episode triggered by an anchor procedure (in this event, the latter episode would be cancelled),
- The beneficiary dies during the CJR-X episode,
- In the event of "extreme and uncontrollable circumstances" (EUC), or
- The CJR-X episode is triggered during the course of a TEAM episode.

CMS proposed to codify these policies at §512.630(e).

Selected comments/response: CMS states that "some" commenters supported the proposed CJR-X episode definition. **CMS is finalizing with modification its proposed "episode" definition at §512.605** as all Medicare Part A and B items and services described in §512.625(b) (and excluding the items and services described in §512.625(c)) that are furnished to a CJR-X beneficiary during the time period that begins on the date of the beneficiary's admission to an anchor hospitalization or the date of the anchor procedure, as described at §512.630(c),[123] and ends on the 90th day following the date of discharge from the anchor hospitalization or anchor procedure, as described at §512.630(d).

Several commenters supported identifying CJR-X episodes by the proposed codes: MS-DRGs 469, 470, 521, and 522 and CPT codes 27447 and 27130. **CMS is finalizing without modification its proposal at §512.625(a) to identify LEJR episodes with MS-DRGs and HCPCS codes**.

[122] Complete lists of excluded MS–DRGs for readmissions and excluded HCPCS codes for Part B services furnished during episodes after beneficiary discharge from an anchor hospitalization would be posted on the CJR-X webpage within the Innovation Center website at https://innovation.cms.gov.
[123] The proposed rule referenced §512.625(a).

CMS is finalizing without modification the proposal at §512.630(c) that **an episode is initiated by a beneficiary's admission to a CJR-X participant for an anchor hospitalization that is paid under a MS-DRG specified in §512.625(a) or an anchor procedure billed under a HCPCS code specified in §512.625(a) and that the episode start date would be the day of the anchor procedure for outpatient procedures and the date of admission for an inpatient hospitalization. CMS also finalizes §512.630(c)(2) with modification to state if an anchor hospitalization is initiated on the same day as or within three days of an outpatient procedure for the same episode type at the same CJR-X participant, the episode start date will be that of the outpatient procedure rather than the admission date, and an anchor procedure will not be initiated.**

Some commenters urged CMS to provide additional clarity on which services would be included in a CJR-X episode. Commenters recommended that CMS include only services clinically related to the LEJR procedure.[124] Interestingly, one commenter recommended *expanding* the episode to include pre-operative therapy as related to surgical preparation and recovery planning furnished in the weeks before the anchor surgery. **CMS is finalizing without modification the proposal at §512.625(b) to include in a CJR-X episode all items and services paid under Medicare Part A and Part B, subject to the exclusions at §512.625(c). CMS is also finalizing with modification the proposal at §512.625(c) to exclude from CJR-X episodes certain Part A and B items and services that are clinically unrelated to an LEJR procedure or essential to appropriate care of certain beneficiaries. Specifically, CMS is updating §512.625(c)(1)(i)(B) to say, "Trauma unrelated to the CJR-X episode" rather than the proposed "Trauma medical."**

CMS proposed that episodes would cover the surgical procedure and a subsequent period that is marked by significant post-acute care needs, potential complications of surgery, and short-term, intense management of chronic conditions that may be destabilized by a joint replacement, which the agency proposed to define as 90 days under CJR-X. CMS indicates that "many" commenters recommended that CMS shorten the proposed CJR-X episode from 90 days to 30 days. However, **CMS nevertheless finalizes without modification the proposal at §512.630(d) to utilize a 90-day post-discharge episode length**. Lastly, **CMS is finalizing with modification the proposal at §512.630(e) to cancel episodes and not perform an episode spending calculation for reconciliation against the target price if the beneficiary no longer meets the criteria for inclusion at §512.620; the beneficiary dies during the episode; the CJR-X participant is subject to the EUC policy, *including due to a cyberattack*; or 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**.

e. Quality Measures and Scoring

The CJR Model relied on data already reported to the Hospital Inpatient Quality Reporting (IQR) Program (section 1886(b)(3)(B)(viii) of the Act) to assess quality without additional reporting burden for CJR participants. Measures used in the CJR Model included a joint replacement-specific measure and a general patient experience survey of the hospital stay. Specifically, the

[124] In response, CMS pointed readers to the CJR-X exclusion list maintained at https://www.cms.gov/priorities/innovation/innovation-models/cjr-x.

CJR Model utilized the Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measures. In addition to the two HIQR measures, the CJR Model offered participants an opportunity to receive additional points towards their quality score for voluntarily submitting THA/TKA patient-reported outcomes (PROs) and limited risk variable data following eligible elective primary THA/TKA procedures.

For CJR-X, CMS proposed two modifications to the measures relative to CJR. First, CMS proposed to weight the THA/TKA PRO more heavily, and second, CJR-X would adopt two additional measures to account for the high percentage of hospital outpatient LEJR procedures (CMIT #162, and CMIT #1618).

Thus, CMS proposed to use in CJR-X the following measures:

- Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CMIT ID #350)
- Hospital Visits Within 7 days of Hospital Outpatient Department (HOPD) Surgery (CMIT ID #344, OP-36)
- Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) (CMIT ID #338)
- Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS) (CMIT ID #162)
- Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome (PRO)-Based Performance Measure (CMIT ID #1618)

CMS proposed at §512.635(f) to display quality measure results on the publicly available CMS website in a form and manner consistent with other publicly reported measures. The timeframe for when CJR-X participants would receive data on CMS' proposed measures aligns with the Care Compare schedule that can be found here: https://data.cms.gov/provider-data/topics/hospitals/measures-and-current-data-collection-periods.

CMS also proposed the means by which CJR-X participating hospitals would submit the required quality data. CMS proposed that data submission for the Hospital-Level RSCR Following Elective Primary THA and/or TKA (CMIT ID #350), the HCAHPS survey (CMIT ID #338), and the Hospital-Level THA/TKA PRO-PM (CMIT #1618) would be accomplished through existing Hospital Inpatient Quality Reporting Program processes. CMS similarly proposed that data submission for the Hospital Visits within 7 days of HOPD Surgery (CMIT ID #344, OP-36) and the OAS CAHPS (CMIT ID #162) survey be accomplished through the existing Hospital Outpatient Quality Reporting Program.

Selected comments/response: Commenters generally supported CMS's proposed direction for CJR-X quality measurement, including consistency with CJR and alignment with TEAM and existing CMS quality programs. Some commenters recommended that CMS better align CJR-X quality performance measurement with TEAM and other Medicare quality reporting programs, such as IQR, OQR, ASCQR, and HVBP. CMS responded that coordinating quality measures

between CJR-X and TEAM LEJR episodes is preferable, whenever possible. However, CMS notes that by necessity, TEAM uses measures that are able to be reasonably applied to all five of its episode categories, not just LEJR episodes. Some commenters supported quality measures focused on LEJR and associated outcomes, while others supported a broader set of measures. While it does not appear that any commenters strongly opposed the proposed CJR-X measure set, several commenters asserted that it placed too much emphasis on measures that are not yet fully established or reliable. CMS recognized that some of the proposed measures are still voluntary or in the first year of reporting and the agency is still gathering data on provider performance. CMS committed to continuing to evaluate the reliability of the measures to ensure they remain appropriate for inclusion in CJR-X when the model begins in CY 2028.

CMS also received extensive comments on each of the proposed quality measures, some in support of a given measure, and others expressing various policy or operational concerns. However, none of the concerns moved CMS to change its proposed measure set, and **CMS is finalizing without modification its proposals at:**

- **§512.635(a)(1) to include the hospital-level RSCR following elective inpatient primary THA and/or TKA (CMIT ID #350) in the CJR-X quality measure set,**
- **§512.635(a)(2) to include the Hospital Visits within 7 days of HOPD Surgery (CMIT ID #344, OP-36) measure in the CJR-X quality measure set,**
- **§512.635(a)(3) to include the HCAHPS (CMIT ID #338) survey in the CJR-X quality measure set,**
- **§512.635(a)(4) to include the OAS CAHPS (CMIT #162, OP-46) survey in the CJR-X quality measure set, and**
- **§512.635(a)(5) to include the Hospital-Level THA/TKA PRO-PM (CMIT ID #1618) in the CJR-X quality measure set**.

CMS summarizes the quality measures proposed for CJR-X, and their corresponding performance periods (reflecting the later finalized start date of CJR-X), in Table X.C.-02 of the final rule, reproduced in slightly modified form here:

TABLE X.C.-02: SUMMARY OF QUALITY MEASURE PERFORMANCE PERIODS BY YEAR IN CJR-X

Quality Measure	CJR-X PY1 (1/1/28-12/31/28)	CJR-X PY2 (1/1/29-12/31/29)	CJR-X PY3 (1/1/30-12/31/30)	CJR-X PY4 (1/1/31-12/31/31)	CJR-X PY5 (1/1/32-12/31/32)
Hospital-Level RSCR Following Elective Primary THA and/or TKA (CMIT ID #350)	April 1, 2027-March 31, 2029	April 1, 2028-March 31, 2030	April 1, 2029-March 31, 2031	April 1, 2030-March 31, 2032	April 1, 2031-March 31, 2033
Hospital Visits within 7 days of HOPD Surgery (CMIT ID #344, OP-36)	January 1, 2028-December 31, 2028	January 1, 2029-December 31, 2029	January 1, 2030-December 31, 2030	January 1, 2031-December 31, 2031	January 1, 2032-December 31, 2032
HCAHPS Survey (CMIT ID #338)	January 1, 2028-	January 1, 2029-	January 1, 2030-December	January 1, 2031-December	January 1, 2032-December

	December 31, 2028	December 31, 2029	31, 2030	31, 2031	31, 2032
OAS CAHPS Survey (CMIT ID #162)	January 1, 2028-December 31, 2028	January 1, 2029-December 31, 2029	January 1, 2030-December 31, 2030	January 1, 2031-December 31, 2031	January 1, 2032-December 31, 2032
Hospital-Level THA/TKA PRO-PM (CMIT ID #1618)	July 1, 2027-June 30, 2028	July 1, 2028-June 30, 2029	July 1, 2029-June 30, 2030	July 1, 2030-June 30, 2031	July 1, 2031-June 30, 2032

CMS is finalizing without modification the proposal at §512.635(e) on how quality measures in CJR-X would be displayed. The agency is also finalizing (with modification) the quality measure performance periods used to assess quality performance. **Lastly, CMS is also finalizing without modification the proposal to collect quality measure data from existing CMS quality reporting programs.**

Composite Quality Score

Under CJR-X, CMS will set a target price for LEJR episodes, which will be subject to a discount factor that varies as a function of a participant's quality performance. CMS in this final rule describes how the CJR-X Composite Quality Score will be calculated using the data submitted by participants described above.

In the proposed rule, CMS proposed a composite quality score methodology for linking quality and payment in CJR-X that is similar to the methodology that was finalized for the CJR Model (80 FR 73363-73381), with a major difference being the inclusion of outpatient quality measures in CJR-X and thus the assessment of these measures in the composite quality score. The CJR-X participant's overall quality performance under the CJR-X would be considered in the pay-for-performance approach, rather than performance on each quality measure individually determining the financial opportunity under CJR-X.

Determining Quality Measure Performance

CMS believes that assessing measure performance by comparing CJR-X participants against a national distribution for the proposed CJR-X measures would be the most appropriate way to incorporate quality performance into CJR-X. Thus, at the time of reconciliation for a performance year, CMS proposed at §512.635(c) to assign each CJR-X participant's measure point estimate from the measure performance period to a performance percentile based on the national distribution of measure results for hospitals that are eligible for payment under the IPPS reporting the measure, that meets the minimum patient case or survey count (shown in Table X.C.-03 of the final rule). This approach applies to the Hospital-Level RSCR Following Elective Primary THA and/or TKA (CMIT ID #350); the Hospital Visits within 7 days of HOPD Surgery (CMIT ID #344, OP-36); the HCAHPS Survey (CMIT ID #338); the OAS CAHPS Survey (CMIT #162); and the Hospital-Level THA/TKA PRO-PM (CMIT #1618).

Some commenters expressed concerns about the minimum case counts, arguing that they may not align with the model's low-volume threshold, creating uncertainty for hospitals with enough

episodes to participate but too few cases for stable quality scores, or that the minimum case counts were too low to produce reliable quality performance scores. Other commenters raised technical questions about the data sources for quality measure performance determinations, and how certain measure point estimates will be derived. CMS provided clarifications where warranted, and committed to providing additional information in the future to help CJR-X participants understand the calculation of measure point estimates and the construction of the composite quality score. **CMS is finalizing without modification the proposal at §§512.635(c) and (d) to determine quality measure performance based on assigning the CJR-X participant's measure point estimate to a measure performance percentile based on the national distribution of measure results from hospitals eligible for payment under the IPPS**.

Quality Improvement

CMS indicates that the agency considered, but did not propose, including a policy that provides CJR-X participants quality improvement points when there is improvement of 2 deciles or more in comparison to the national distribution of measure results from the prior year. CMS reaffirms in the final rule that it will not include a policy for quality improvement in CJR-X at this time, but signals that the agency may revisit this concept in future rulemaking.

Calculating the Composite Quality Score

CMS proposed adopting a similar calculation of the CJR Model composite quality score but with modifications to account for outpatient quality measures. Specifically, CMS proposed placing each of the five proposed quality measures into one of three quality domains: complications, patient experience, and patient reported outcomes. CMS proposed for inpatient measures and outpatient measures to weight the complications domain at 50 percent, the patient experience domain at 40 percent, and the patient reported outcomes domain at 10 percent.

Under this approach, CMS scores each CJR-X model participant on the five quality measures based on the CJR-X participant's performance percentile as compared to the national distribution of hospitals that are eligible for payment under the IPPS measure performance, assigning points according to the point values displayed in Table X.C-05, reproduced below:

TABLE X.C-05: POINT VALUES FOR CJR-X QUALITY MEASURES

Performance Percentile	Hospital-Level RSCR Following Elective Primary THA and/or TKA (CMIT ID #350)	Hospital Visits within 7 days of HOPD Surgery (CMIT ID #344, OP-36)	HCAHPS Survey (CMIT ID #338)	OAS CAHPS Survey (CMIT ID #162)	Hospital-Level THA/TKA PRO-PM (CMIT ID #1618)
≥90th	10.00	10.00	8.00	8.00	2.00
≥80th and <90th	9.25	9.25	7.40	7.40	1.85

Performance Percentile	Hospital-Level RSCR Following Elective Primary THA and/or TKA (CMIT ID #350)	Hospital Visits within 7 days of HOPD Surgery (CMIT ID #344, OP-36)	HCAHPS Survey (CMIT ID #338)	OAS CAHPS Survey (CMIT ID #162)	Hospital-Level THA/TKA PRO-PM (CMIT ID #1618)
≥70th and <80th	8.50	8.50	6.80	6.80	1.70
≥60th and <70th	7.75	7.75	6.20	6.20	1.55
≥50th and <60th	7.00	7.00	5.60	5.60	1.40
≥40th and <50th	6.25	6.25	5.00	5.00	1.25
≥30th and <40th	5.50	5.50	4.40*	4.40*	1.10
<30th	0.00	0.00	0.00	0.00	0.00

* Erroneously listed as "5.40" in the proposed rule.

After determining the point value for each measure, CMS would sum the performance points for the inpatient measures to construct the inpatient measure composite quality score and sum the outpatient measures to construct the outpatient measure composite quality score.

CMS proposed at §512.605 to define the "inpatient measure composite quality score" as the sum of inpatient quality measure point values capped at 20 points. CMS proposed to similarly define at §512.605 the "outpatient composite quality score" as the sum of outpatient quality measure points values, capped at 20 points. CMS proposed to assign each CJR-X participant an "overall composite quality score," defined at §512.605 as the sum of the weighted average of the inpatient measure composite quality score and the outpatient measure composite quality score, capped at 20 points.

Selected comments/response: CMS indicates that "a few" commenters supported the weighting of the complications, patient experience, and patient reported outcomes measures, but that "many" commenters thought that the patient experience measures were too heavily weighted. Some commenters indicated the patient experience measures weighting introduces risk that is largely outside hospitals' clinical control. CMS disagreed, asserting that reducing patient experience weighting would place too much emphasis on clinical events alone and would not fully capture whether the episode was coordinated, understandable, and patient-centered. By contrast, some commenters stated that CMS's increased emphasis on patient-reported outcome measures is significant because giving these measures greater weight than in prior models transforms patient engagement and longitudinal follow-up into a direct financial performance variable. Other commenters suggested placing more weight on the PRO-PM in the CQS. Other commenters asked for clarifications of certain calculations and methodologies.

CMS is finalizing without modification the proposals at §512.605 for the definitions of "composite quality score," "inpatient measure composite quality score," "outpatient measure composite quality score," and "overall composite quality score." The agency is

also finalizing without modification its proposals at §512.635(b)(1) and (2) to calculate the composite quality score.

f. Pricing and Payment Methodology[125]

The initial foundation for the pricing and payment methodology for CJR-X is the set of policies from the CJR Extension.

Overview of CJR-X Pricing and Payment Methodology

Generally, CMS proposed to use three years of baseline data, trended forward to the performance year, to calculate target prices at the level of MS-DRG/HCPCS episode type and region. Under this approach, CMS applies a prospective trend factor and a discount factor to benchmark prices (as well as a prospective normalization factor) to calculate preliminary target prices. CMS in this overview describes the simplified equation for the construction of preliminary target prices as:

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

CMS notes that many of the payment and pricing policies that were proposed for CJR-X represent minor deviations from the policies that were tested in the original CJR Model and the CJR Extension.

Selected comments/response: CMS indicates that many commenters expressed concern that the proposed CJR-X pricing and payment methodology could create a "ratchet effect" in which prior savings and efficiency gains are incorporated into future benchmarks, resulting in progressively lower target prices over time. Commenters stated that continued downward pressure on target prices could penalize high-performing or historically efficient hospitals, create a "race to the bottom," reduce financial predictability, and make it difficult for hospitals to sustain investments in care redesign, care coordination staff, data infrastructure, post-acute care relationships, physician alignment strategies, and quality improvement programs. Commenters recommended that CMS adopt safeguards to mitigate the ratchet effect, including target price floors, limits on annual target price reductions, pricing protections for historically efficient hospitals, longer target price stability periods, glide paths, inflation-based updates, recognition of prior efficiency gains, additional stakeholder engagement, or ongoing monitoring of whether LEJR episode spending has reached a clinically sustainable level. CMS acknowledged commenters' concerns about the "ratchet effect," but the agency only committed to continuing to monitor CJR-X implementation, including target price sustainability, quality of care, beneficiary access, and potential unintended consequences. CMS stated that it may consider additional technical assistance, operational guidance, or future model modifications through notice and comment rulemaking if monitoring or evaluation identifies price ratcheting, unrealistic target prices, access barriers, or other concerning trends that warrant changes to the model.

[125] Note to reader: The material on CJR-X pricing and payment is extensive, and dense. For purposes of brevity, this summary only provides the topline proposals that CMS made in the April IPPS/LTCH proposed rule for FY 2027. For additional details behind these proposals, we refer the reader to HPA's summary of the proposed rule.

Target Prices

Baseline Period for Benchmarking

CMS proposed at §512.605 to define "baseline period" as the 3-year historical period used to construct the preliminary target price and reconciliation target price for a given performance year. CMS proposed to define "baseline episode spending" as total episode spending by all providers and suppliers associated with a given MS-DRG/HCPCS episode type for all hospitals in a given region during the baseline period. CMS proposed to roll this 3-year baseline period forward every year. CMS proposed to adjust baseline episode spending to trend all episode spending to the most recent year of the baseline period. CMS proposed at §512.605(e) to define a "baseline year" as any of the three fiscal years during a given baseline period.

CMS proposed to calculate the adjustment factors for baseline years 1 and 2 by dividing average episode spending for baseline year 3 episodes by average episode spending for episodes from baseline years 1 and 2, respectively. CMS then would apply the applicable adjustment factors to the episode spending of each episode in baseline years 1 and 2. This adjustment would bring all baseline episode spending forward to the most recent baseline year, so that baseline year 1 and 2 spending would be expressed in baseline year 3 dollars. CMS proposed to calculate these baseline trend factor adjustments at the MS-DRG/HCPCS episode type and region level.

Selected comments/response: As noted above, commenters were particularly concerned about the "ratchet effect" posed by the combination of these proposals. Commenters recommended that CMS modify the baseline methodology to reduce the effect of annual rebasing on future target prices. Commenters suggested alternatives such as using a longer baseline period, rebasing less frequently, maintaining target prices for multiple performance years, weighting baseline years equally, applying inflation or other update factors instead of annually rebasing to more recent spending, limiting the frequency or magnitude of target price reductions, or adopting safeguards to prevent target prices from falling below sustainable levels.

CMS recognizes the potential detrimental effects of the "ratchet effect" on CJR-X target prices, but asserts that the policies it has proposed, along with ongoing monitoring of CJR-X, balances target price accuracy, predictability, and mitigation of the ratchet effect. **CMS thus finalizes without modification the proposals at §512.605 to define "baseline episode spending," "baseline period," and "baseline year" and the proposals at §512.640(b)(2) and (3) to use 3 years of baseline episode spending, rolled forward for each performance year, with more recent baseline years weighted more heavily, to calculate CJR-X target prices.**

Regional Target Prices

CMS proposed at §512.640(b)(1) to provide target prices to CJR-X participants for each proposed MS-DRG/HCPCS episode type and region based on 100 percent regional data for all CJR-X participants prior to each PY.

Selected comments/response: CMS indicates that one commenter supported its regional target price proposal. Many commenters raised concerns about the proposed use of 100 percent regional data to calculate target prices. Some commenters stated that regional target prices could create volatility or unrealistic benchmarks if a region includes hospitals with substantially different cost structures, patient populations, or care delivery environments. Despite commenters' concerns, **CMS finalizes without modification the proposal at §512.640(b)(1) to provide regional target prices to all CJR-X participants for each performance year**.

Services that Extend Beyond an Episode

CMS proposed at §512.655 that, to the extent that a Medicare payment for included episode services spans a period of care that extends beyond the episode, these payments would be prorated so that only the portion attributable to care during the episode is attributed to the episode payment when calculating actual Medicare payment for the episode.

Selected comments/response: **CMS received no comments on its proposed methodology for prorating services that extend beyond the episode and is therefore finalizing without modification the proposal at §512.655 for prorating services that extend beyond the episode**.

Episodes that Begin in One Performance Year and End in the Subsequent Performance Year

CMS notes that some episodes will begin during one performance year and end during the following performance year. The agency proposed that all episodes would receive the target price associated with the date of discharge from the anchor hospitalization or the anchor procedure, as applicable, regardless of the episode end date.

Selected comments/response: **CMS received no comments on its proposal to apply target prices to episodes that begin in one performance year and end in the subsequent performance year and is therefore finalizing its proposal at §512.640(a)(3) without modification**.

High-Cost Outlier Cap for Benchmarking

For CJR-X, CMS proposed to cap both baseline episode spending and performance year episode spending at the 99th percentile of spending at the MS-DRG/HCPCS episode type, region and baseline year, referred to as the "high-cost outlier cap" and defined at proposed §512.605. CMS proposed to determine the 99th percentile of spending at the MS-DRG/HCPCS episode type, region, and baseline year during the applicable period, and then set spending amounts that exceed the high-cost outlier cap to the amount of the high-cost outlier cap.

Selected comments/response: CMS reports that commenters were generally supportive of a high-cost outlier cap as a matter of principle, but suggested alternatives, such as setting the cap at the 90th or 95th percentile. CMS was unpersuaded by these suggestions. **The agency is finalizing without modification the proposals at §512.605 to define "high-cost outlier cap" and at §512.640(b)(4) for calculating and applying the high-cost outlier cap**.

Trending Prices

CMS proposed a hybrid approach for trending prices under the CJR-X model that combines both prospective and retrospective adjustments. Specifically, CMS will apply a prospective trend factor (§512.640(b)(7)) to preliminary target prices to estimate expected changes in spending between the baseline and performance periods, thereby promoting pricing stability. At reconciliation, CMS will apply a retrospective trend factor (§512.645(f)) based on actual performance-year spending, capped at ±3 percent of the prospective adjustment, to improve accuracy while maintaining predictability.

Additionally, CMS requested input on alternative methodologies for calculating trend factors that could improve pricing accuracy and mitigate the "ratchet effect" (discussed above), particularly in light of evidence that spending reductions in LEJR episodes have begun to stabilize. CMS was especially interested in approaches that ensure target prices remain appropriate whether spending is increasing, decreasing, or leveling off, without undermining quality or patient safety.

Selected comments/response: CMS reports that some commenters supported CMS' proposed prospective trend factor and capped retrospective trend factor. Some commenters recommended that CMS adopt alternative trend approaches or additional monitoring related to the proposed trend methodology. Commenters recommended approaches such as regional trend factors, administrative or ACPT-like trend concepts, efficient-price benchmarks, or other methods intended to improve the accuracy and sustainability of the prospective and retrospective trend adjustments. Again, CMS was unmoved to change its proposed policies, and **the agency is finalizing without modification the proposal at §512.605 to define "prospective trend factor" and "retrospective trend factor." CMS is also finalizing without modification the proposal at §512.640(b)(7) to apply a prospective trend factor to preliminary target prices and at §512.645(f) to apply a retrospective trend factor with a +/-3 percent cap to reconciliation target prices**.

Discount Factor

In both the CJR Model and BPCI Advanced, CMS applied a 3 percent discount to benchmark prices when calculating preliminary target prices for LEJR episodes. However, based on evidence and participant feedback from the final performance years of the CJR Extension, in the IPPS/LTCH PPS proposed rule for 2027, CMS posited that a 3 percent discount would not be sustainable for an expanded model, and proposed at §512.640(b)(8) to apply a 2 percent discount factor to the benchmark price to serve as Medicare's portion of reduced expenditures from the episode.

Selected comments/response: Some commenters supported CMS' proposal to apply a 2 percent discount factor to target prices, rather than a 3 percent factor. However, many commenters opposed the proposed 2 percent discount factor or recommended that CMS reduce or eliminate the discount factor. Commenters stated that the 2 percent discount could be arbitrary, too aggressive, or difficult to achieve, particularly in a mandatory national model without a defined end date. Commenters expressed concern that the discount factor, when combined with annual

rebasing, regional benchmarking, trend methodology, and prior efficiency gains, could further reduce opportunities for hospitals to earn reconciliation payments and could contribute to long-term price ratcheting. CMS continues to put great weight on its ongoing monitoring of CJR-X to avoid any undue consequences of the model, and declined to make any changes to the proposed discount factor. **CMS finalizes without modification the proposals at §512.605 to define "discount factor" and at §512.640(b)(8) to apply a 2 percent discount factor to preliminary episode target prices**.

Special Considerations for Low-Volume Hospitals

In both the CJR Model and BPCI Advanced, CMS recognized that hospitals that perform a number of episodes below a certain volume threshold would have insufficient volume to receive a target price based on their own baseline data.

For CJR-X, CMS proposed at §512.605 to define "low-volume hospital" as a hospital with fewer than 31 LEJR episodes performed during the applicable baseline period (the same case threshold used in TEAM). The agency correspondingly proposed at §512.640(a)(4) that low-volume hospitals would be excluded from reconciliation for the performance year.

Selected comments/response: While a few commenters appear to have supported the proposal to exclude low-volume hospitals from reconciliation for a performance year, "many" commenters stated that the proposed low-volume threshold of fewer than 31 LEJR episodes during the applicable baseline period was too low to support reliable benchmarking or meaningful performance assessment. These commenters recommended increasing the threshold, or applying a different methodology. Again, however, CMS declined to change its proposal in light of public comments, and is **finalizing without modification the proposals at §512.605 to define "low-volume hospital" and at §512.640(a)(4) for setting and applying the low-volume threshold at reconciliation**.

Preliminary Target Prices

CMS proposed to define "preliminary target price" as the target price provided to the CJR-X participant prior to the start of the performance year. CMS proposed at §512.640(b)(9) that CMS would provide preliminary target prices to CJR-X participants, in a form and manner specified by CMS, prior to the start of each performance year.

Selected comments/response: CMS indicates that some commenters recommended that CMS provide preliminary target prices, target price methodologies, or related baseline data earlier or with more operational detail (*e.g.*, before the beginning of the performance year), noting that the proposed November dissemination would not be in advance of the proposed October 1 performance year start date. CMS notes that in this final rule, the agency is finalizing a January 1, 2028 start date for the first CJR-X performance year and aligning CJR-X performance years with the calendar year. Under that final policy, providing preliminary target prices by the end of November will give participants access to preliminary target prices before the start of each performance year. **Thus, CMS is finalizing without modification the proposals at**

§512.640(b)(9) to provide preliminary target prices to CJR-X participants prior to the start of each performance year.

Risk Adjustment and Normalization

In the proposed rule, CMS recapped the risk-adjustment protocols used in the original CJR model, BPCI Advanced, and TEAM. For CJR-X, CMS proposed at §512.645 to use the same risk adjustment methodology and variables, as defined at proposed §512.605, that are used in TEAM. Specifically, CMS proposed the following:

- To risk adjust target prices at the hospital level using a hospital bed size risk adjustment factor and a safety net risk adjustment factor.
- To risk adjust target prices at the beneficiary level using a 180-day lookback period to construct a "CJR-X HCC count risk adjustment factor," an "age bracket risk adjustment factor," a "beneficiary economic risk adjustment factor," and based on certain conditions or HCCs in the 180-day lookback period including—
  - Ankle procedure or reattachment, partial hip procedure, partial knee arthroplasty, total hip arthroplasty or hip resurfacing procedure, and total knee arthroplasty;
  - Disability as the original reason for Medicare enrollment;
  - Prior post-acute care use;
  - HCC 17: Cancer Metastatic to Lung, Liver, Brain, and Other Organs; Acute Myeloid Leukemia Except Promyelocytic;
  - HCC 36: Diabetes with Severe Acute Complications;
  - HCC 37: Diabetes with Chronic Complications;
  - HCC 48: Morbid Obesity;
  - HCC 125: Dementia, Severe;
  - HCC 126: Dementia, Moderate;
  - HCC 127: Dementia, Mild or Unspecified;
    HCC 151: Schizophrenia;
  - HCC 155: Major Depression, Moderate or Severe, without Psychosis;
  - HCC 199: Parkinson and Other Degenerative Disease of Basal Ganglia;
  - HCC 224: Acute on Chronic Heart Failure;
  - HCC 225: Acute Heart Failure (Excludes Acute on Chronic);
  - HCC 226: Heart Failure, Except End-Stage and Acute;
  - HCC 238: Specified Heart Arrhythmias;
  - HCC 253: Hemiplegia/Hemiparesis;
  - HCC 267: Deep Vein Thrombosis and Pulmonary Embolism
  - HCC 280: Chronic Obstructive Pulmonary Disease, Interstitial Lung Disorders, and Other Chronic Lung Disorders
  - HCC 326: Chronic Kidney Disease, Stage 5
  - HCC 327: Chronic Kidney Disease, Severe (Stage 4)
  - HCC 383: Chronic Ulcer of Skin, Except Pressure, Not Specified as Through to Bone or Muscle
  - HCC402: Hip Fracture/Dislocation

- To include a "prospective normalization factor" that would be subject to a limited adjustment at reconciliation based on the observed case mix, up to +/−5 percent to construct the "final normalization factor."

CMS considered, but did not propose, a more nuanced approach to the safety net hospital risk adjustment that segmented hospitals into three or more groups based on the share of FFS inpatient episodes provided to dual-eligible beneficiaries.

Selected comments/response: Commenters raised concerns about the proposed risk adjustment methodology, and suggested a number of technical changes. Beyond these, many commenters also recommended that CMS further refine beneficiary-level risk adjustment to account for social risk factors and circumstances that may affect post-acute care use, recovery, and episode spending. Commenters cited factors such as dual eligibility, disability, housing instability, food insecurity, transportation barriers, caregiver availability, home environment, access to outpatient or post-acute care, community resource availability, and beneficiary choice of post-acute care provider. Commenters expressed concern that hospitals treating beneficiaries with greater social needs or barriers to recovery could be disadvantaged if target prices do not adequately account for these factors. CMS acknowledges the potential impacts of social risk on episode spending, but asserts that the proposed beneficiary economic risk adjustment factor is intended to account for social risk in a standardized way by identifying beneficiaries who meet at least one of several criteria, including residence in an area with high community deprivation, eligibility for the Part D Low-Income Subsidy, or full Medicaid eligibility.

In a similar vein, CMS reports that "many commenters" recommended that the agency revise or broaden the proposed definition of "safety net hospital" for CJR-X. Commenters stated that defining safety net hospitals based on whether a hospital is in the top quartile in its region for the percentage of FFS LEJR inpatient episodes furnished to dually eligible beneficiaries would be too narrow, unstable, or inconsistent with other CMS approaches. Commenters recommended additional protections for safety net hospitals, near-safety-net hospitals, rural hospitals, sole community hospitals, Medicare-dependent, small rural hospitals, or other resource-constrained hospitals.

CMS acknowledged commenters' concerns on these issues, but declined to change its proposed policies in response to any of them. Therefore, **CMS is finalizing without modification the proposals at §512.605 for the definitions of "age bracket risk adjustment factor," "beneficiary economic risk adjustment factor," "CJR-X HCC count risk adjustment factor," "final normalization factor," "prospective normalization factor," and "safety net hospital." CMS also finalizes without modification the proposals at §512.645(a-d) for risk adjusting episodes**.

Process for Reconciliation

In the CJR Model, CMS performed an annual reconciliation calculation to compare CJR Model PY spending for a CJR participant to a reconciliation target price in order to determine if CMS owed the CJR participant a reconciliation payment, or if the CJR participant owed CMS a

repayment. This section outlines the agency's finalized policies for conducting an annual reconciliation process in CJR-X.

As was the case in the CJR Model, for CJR-X, CMS proposed to incorporate the participant's quality performance into the reconciliation calculation by adjusting the reconciliation target price for quality based on the CJR-X participant's Composite Quality Score (CQS). CMS provides detail on the reconciliation process, including annual reconciliation (§512.650), timing (§512.560(b)), the process of reconciliation for CJR-X participants who undergo a reorganization event (§512.605 and §512.610(b)), the process for updating preliminary target prices to create reconciliation target prices (§512.645(g)), and the process for applying the CQS to reconciliation target prices (§512.650(g)). CMS summarizes the latter process in Table X.C.-06 f the final rule, reproduced here:

TABLE X.C.-06: RELATIONSHIP OF COMPOSITE QUALITY SCORE ON RECONCILIATION PAYMENT ELIGIBILTY AND DISCOUNT FACTOR

Composite Quality Score (CQS)	Composite Quality Score Category	Eligible for Reconciliation Payment	Discount Factor
CQS <= 6.0	Below acceptable	No	2.0
CQS >= 6.1 and < 12.0	Acceptable	Yes	2.0
CQS >= 12.1 and <= 17.0	Good	Yes	1.0
CQS >= 17.1	Excellent	Yes	0.0

In this section, CMS also provides detail on the proposed calculation of the Raw Net Payment Reconciliation Amount (NPRA) (§512.650(c)(1) through (c)(5)), and its proposal for reconciliation payments and repayments (§512.650(d)).

In most instances, the reconciliation process for CJR-X draws heavily on the policies CMS implemented for the last three years of CJR.

Selected comments/response: None of the comments received were persuasive enough to move CMS to change any of its proposals regarding the CJR-X reconciliation process. As a result:

- **CMS is finalizing without modification the proposal at §512.650 to conduct one reconciliation for each performance year.**

- **CMS is finalizing without modification the proposal at §512.560(b) to perform reconciliation 6 months after the end of the performance year.**

- **CMS received no comments on its proposal at §512.650(b)(2) for conducting reconciliations for CJR-X participants that experience a reorganization event during a given performance year, and therefore finalizes this provision without modification.**

- **CMS is finalizing without modification its proposal at §512.645(g) to account for payment system changes during the construction of reconciliation target prices.**

- **CMS is finalizing without modification the proposal at §512.650(g) to link quality to payment by adjusting the discount factor for reconciliation target prices.**

- **CMS is finalizing without modification its proposal at §512.650(c)(1) through (c)(5) for calculating the raw NPRA.**

- **CMS is finalizing without modification the proposal at §512.650(c)(6)(i) and (ii) to apply 20 percent stop-loss and stop-gain limits to most CJR-X participants, and the proposal at §512.650(c)(6)(iii) to apply a 5 percent stop-loss limit to certain categories of CJR-X participants.**

- **CMS is finalizing without modification its proposal at §512.650(c)(7) to make CJR-X participants responsible for making repayments to Medicare based on high spending in the 30 days after the end of the episode and its proposed methodology to calculate the threshold for high post-episode spend.**

- **CMS is finalizing without modification its proposal at §512.650(d) to make reconciliation payments to, and collect repayment amounts from, CJR-X participants as a one-time, lump sum payment.**

g. Appeals Process

CMS asserts that it is necessary to have a process by which CJR-X participants may appeal the reconciliation report. Therefore, the agency proposed at §512.660(a) to permit CJR-X participants to submit a notice of calculation error regarding the calculations contained within the CJR-X reconciliation report if the CJR-X participant believes an error occurred in calculations due to data quality or other issues, or if the CJR-X participant believes an error occurred in calculations due to misapplication of methodology. Consistent with TEAM, CMS proposed at §512.660(b)(1) that if a CJR-X participant believes the CJR-X reconciliation report contains a calculation error, the CJR-X participant would be required to submit a timely error notice in writing documenting the suspected calculation error within 30 calendar days of issuance of the CJR-X performance report.

Selected comments/response: **CMS received no comments on the proposed appeals process for CJR-X at §512.660 and therefore the agency is finalizing this provision without modification.**

h. Concurrent Participation in Other CMS Models and Initiatives

CMS notes that historically, the overlap policies of CMS Innovation Center models, including the original CJR (80 FR 73274), were intended to avoid duplicative incentive payments or giving precedence to a single accountable entity. However, what resulted were confusing methodologies or misaligned incentives which were difficult to navigate. For CJR-X, CMS has developed an updated set of overlap policies informed by the agency's prior experience and stakeholder feedback.

Beneficiary Participation in Multiple CMS Models or Initiatives

CMS notes that a beneficiary could be in an episode in CJR-X by undergoing a procedure at an acute care hospital participating in CJR-X, and be attributed to a provider participating in a total cost of care or shared savings model or program. In such situations, each model or program incorporates a reconciliation process, where total included spending during the performance period or episode is calculated, as well as any potential savings achieved by the model or program. CMS proposed to allow any savings generated on an episode in CJR-X and any contribution to savings in the total cost of care model be retained by each respective participant. Under this approach the episode spending in CJR-X would be accounted for in the total cost of care model's total expenditures, but CJR-X's reconciliation payment amount or repayment amount would not be included in the total cost of care model's total expenditures. Likewise, the total cost of care model's savings payments or losses would not be included in the episode spending in CJR-X.

CMS states that this approach matches the procedure used in TEAM. However, CJR-X does not allow for concurrent participation with TEAM. CMS stresses that "TEAM supersedes the CJR-X model" and LEJR procedures at a hospital participating in TEAM that otherwise would trigger a CJR-X episode would instead initiate a TEAM episode. Conversely, CMS notes that if a beneficiary in a CJR-X episode has a procedure performed at a TEAM hospital that would initiate a TEAM episode during the CJR-X 90-day post-discharge period, then that procedure would not initiate a TEAM episode and the spending from that procedure would be included in the CJR-X episode.

Selected comments/response: CMS states that a few commenters supported the CJR-X overlap policy with other models, and with the approach to not allow overlap with TEAM. At the same time, many other commenters requested clearer and more aligned model overlap rules particularly between CJR-X and TEAM. Many commenters expressed concern about the cumulative impact of overlapping Medicare value-based care initiatives. Commenters stated that simultaneous mandatory models, including TEAM and CJR-X, could create significant operational and clinical confusion, require parallel clinical workflows, and create substantial operational, administrative, and financial burden for hospitals. In response, CMS indicated that the agency will continue to monitor operational experience for hospitals participating in CJR-X, TEAM, and other value-based care initiatives, and may consider this experience in future rulemaking.

After consideration of public comments, **CMS is finalizing without modification the policy at §512.630(e) that if a beneficiary in a TEAM episode has a LEJR procedure performed at a CJR-X hospital during TEAM's 30-day post-discharge period, then the LEJR procedure will not initiate a CJR-X LEJR episode and the spending from the LEJR procedure will be included in the TEAM episode**.

j. Financial Arrangements

CJR-X participants may wish to enter into financial arrangements with certain providers and suppliers that support CJR-X activities to share their reconciliation payment amount or repayment amount resulting from participation in CJR-X. CMS expects that all financial relationships established between CJR-X participants and providers or suppliers for purposes of CJR-X would be those permitted only under applicable law and regulations, including the applicable fraud and abuse laws and all applicable payment and coverage requirements. As discussed in section X.C.2.i.(9) of this final rule, **CMS has made a determination** that the anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 CFR 1001.952(ii)) is available to protect certain remuneration proposed in this section when arrangements with eligible providers and suppliers are in compliance with the requirements established in the final rule and the conditions of the safe harbor for CMS-sponsored model arrangements established at 42 CFR 1001.952(ii).

CJR-X Collaborators

CMS proposed to define "CJR-X collaborator" as a provider or supplier or participant in Medicare ACO initiatives who is making contributions to the CJR-X participant's performance in the model. At §512.605 CMS proposed to specifically define "CJR-X collaborator" as any of the following types of providers or suppliers or ACOs participating in Medicare:

- SNF
- HHA
- LTCH
- IRF
- Physician
- Nonphysician practitioner
- Therapist in a private practice
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Provider or supplier of outpatient therapy services
- Physician Group Practice (PGP)
- Hospital
- Critical Access Hospital (CAH)
- Non-physician provider group practice (NPPGP)
- Therapy group practice (TGP)
- Medicare ACO

Selected comments/response: Multiple commenters supported CMS' proposed definition of a CJR-X collaborator as a provider or supplier, or a participant in a Medicare ACO initiative, that contributes to a CJR-X participant's performance under the model. Commenters also supported the inclusion of physician group practices (PGPs) as CJR-X collaborators. Some commenters recommended including Rural Emergency Hospitals, federally qualified health centers, and rural health clinics as CJR-X collaborators. CMS indicates that it may consider expanding the list of entities who can be CJR-X collaborators in future rulemaking, but at present, **the agency is finalizing the definition of a CJR-X collaborator as proposed. The CJR-X Model will only allow providers or suppliers certified as Medicare providers or suppliers as defined in 42 CFR §512.605, to be a CJR-X collaborator**.

Sharing Arrangements

Similar to the original CJR Model (42 CFR 510.500), CMS proposed that certain financial arrangements between a CJR-X participant and a CJR-X collaborator be termed "sharing arrangements." For purposes of the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 CFR 1001.952(ii)), CMS proposed that a sharing arrangement would be to share reconciliation payment amounts or repayment amounts. The agency proposed to define "sharing arrangement" as a financial arrangement between a CJR-X participant and a CJR-X collaborator for the sole purpose of making gainsharing payments or alignment payments under CJR-X. CMS also proposed specific definitions for "gainsharing payments" and "alignment payments."

CMS proposed that a sharing arrangement must comply with the provisions of section X.C.2.i.(4)(b) of this final rule and all other applicable laws and regulations, including the applicable fraud and abuse laws and all applicable payment and coverage requirements. CMS proposed that the CJR-X participant and CJR-X collaborator must document this agreement in writing and, per monitoring and compliance guidelines (§512.670(b)), the written agreement must be made available to CMS upon request. CMS also proposed that the CJR-X participant must develop, maintain, and use a set of written policies for selecting individuals and entities to be CJR-X collaborators. Lastly, CMS proposed that if a CJR-X participant enters a sharing arrangement, its compliance program must include oversight of sharing arrangements and compliance with the applicable requirements of the model.

Selected comments/response: CMS indicates that most commenters supported its proposed sharing arrangements framework, although some commenters criticized CMS' proposed gainsharing and financial arrangement policies as insufficiently flexible, specific, or comprehensive to support effective collaboration among hospitals participating in the CJR-X Model and other providers and/or suppliers serving Original Medicare beneficiaries. Other commenters thought that the proposed gainsharing mechanisms would not be strong enough to meaningfully influence independent physician referral patterns, post-acute care decisions, or care standardization across the full 90-day episode. Various commenters made suggestions for changing the proposed gainsharing framework, however, CMS responded that "we are not modifying the gainsharing framework as requested." After considering the public comments received, **CMS is finalizing its proposal at §512.605 on the "sharing arrangement" definition and the proposal at §512.670(a) on general sharing arrangement policies without modification**.[126]

Gainsharing Payment and Alignment Payment Conditions and Limitations

CMS asserts that gainsharing payment eligibility for collaborators should be conditioned on two requirements: (1) quality of care criteria; and (2) the provision of CJR-X activities. CMS proposed that the quality of care criteria will be included in the sharing arrangement and mutually agreed upon by the CJR-X participant and CJR-X collaborator. With respect to the

[126] CMS finalizes extremely detailed requirements regarding CJR-X sharing arrangements. This level of detail is beyond the scope of this HPA summary, but interested readers can review the requirements here.

second requirement, to be eligible to receive a gainsharing payment, or to be required to make an alignment payment, a collaborator other than a PGP, NPPGP, or TGP must have directly furnished a billable item or service to a beneficiary during the same performance year for which the participant earned a reconciliation payment amount or repayment amount. CMS contends that these requirements will ensure that there is a relationship between eligibility for a gainsharing payment and the direct care for CJR-X beneficiaries during an episode for CJR-X collaborators.

CMS proposed that the amount of any gainsharing payments must be determined in accordance with a methodology that is solely based on quality of care and the provision of CJR-X activities; that they be distributed on an annual basis, not more than once per calendar year; that they not be a loan, advance payment, or payment for referrals or other business; and that they be clearly identified as a gainsharing payment at the time they are paid.

Selected comments/response: CMS states that multiple commenters recommended that CMS create additional, more consistent opportunities for gainsharing and incentive alignment among clinicians and providers involved in CJR-X episodes. Several commenters focused on orthopedic surgeons, noting that because surgeons have substantial influence over these clinical and operational factors, they should be able to share in the savings generated by participants in the CJR-X Model.

After considering the public comments, CMS finalizes its proposal at §512.670(c) on the conditions and restrictions on gainsharing payments, alignment payments, and internal cost savings under the model without modification.

As with its proposals regarding Sharing Arrangements, CMS finalizes myriad detailed requirements for gainsharing and alignment payments and limitations, and corresponding documentation requirements, which are generally consistent with the policies in effect for the final three years of CJR.

Distribution Arrangements

Similar to the CJR Model (80 FR 73541), CMS proposed that certain financial arrangements between CJR-X collaborators and other individuals or entities called "collaboration agents" be termed "distribution arrangements." For purposes of the Federal anti-kickback statute safe harbor for CMS-sponsored model arrangements (42 CFR 1001.952(ii)), CMS proposed that a "distribution arrangement" would be defined as a financial arrangement between a CJR-X collaborator that is a PGP, NPPGP or TGP and a collaboration agent for the sole purpose of sharing a gainsharing payment received by the PGP, NPPGP or TGP.

Selected comments/response: Some commenters recommended that CMS require, rather than merely permit, distribution arrangements between CJR-X participant hospitals and the surgeons and other physicians who perform procedures that trigger CJR-X episodes. The commenters stated that mandatory physician distribution arrangements should be a standard feature of CJR-X because surgeons and other procedural physicians play a central role in episode performance, care coordination, and cost and quality outcomes. CMS declined to act on this suggestion, but

said the agency may consider it in future rulemaking. After consideration of comments received, **CMS is finalizing without modification its proposal at §512.605 on the definitions for "collaboration agent," "distribution arrangements," and "distribution payment." CMS also finalizes, without modification, its proposals at §512.675(a) regarding distribution arrangements policies**.

As with Financial Arrangements and Gainsharing Arrangements, CMS lays out detailed supporting operational requirements that can be found under "(b) Requirements" here.

Downstream Distribution Arrangements

CMS proposed that CJR-X allow for certain financial arrangements within an ACO between a PGP and its members. Specifically, the agency proposed that certain financial arrangements between a collaboration agent that is both a PGP, NPPGP, or TGP and an ACO participant and another individual termed ''downstream collaboration agent'' be termed a ''downstream distribution arrangement.'' CMS proposed to define a "downstream distribution arrangement" as a financial arrangement between a collaboration agent that is both a PGP, NPPGP, or TGP and an ACO participant and a downstream collaboration agent for the sole purpose of sharing a distribution payment received by the PGP, NPPGP, or TGP. The agency proposed to define a "downstream collaboration agent" as an individual who is not a CJR-X collaborator or a collaboration agent and who is a PGP member, a NPPGP member, or a TGP member that has entered into a downstream distribution arrangement with the same PGP, NPPGP, or TGP in which he or she is an owner or employee, and where the PGP, NPPGP, or TGP is a collaboration agent.[127]

Selected comments/response: **CMS received no comments on its proposed requirements for downstream distribution arrangements at §512.680, and is thus finalizing this provision without modifications**.

Beneficiary Incentives

CJR-X participants may choose to provide in-kind patient engagement incentives to CJR-X beneficiaries in an episode, which may include, but would not be limited to, items of technology, subject to conditions consistent with 42 CFR 510.515.

CMS proposed that any beneficiary incentive must be provided directly by the CJR-X participant or by an agent of the CJR-X participant under their direction and control to the CJR-X beneficiary during an episode. Additionally, the item or service provided must be reasonably connected to the CJR-X beneficiary's medical care, and be a preventive care item or service or an item or service that advances a clinical goal, as described in section X.C.2.i.(7)(b) of the final rule, by engaging the CJR-X beneficiary in better managing their own health.

[127] As with Gainsharing Arrangements, Distribution Arrangements, and Financial Arrangements, CMS's subordinate technical proposals related to Downstream Distribution Payments are found at "(b) Requirements" here.

As with TEAM, CMS makes exceptionally detailed proposals regarding requirements for beneficiary incentives in the form of technology provided to CRJ-X beneficiaries.[128]

Given the clinical goals of CJR-X, CMS proposed that any beneficiary incentives must advance one of the following goals:

- Beneficiary adherence to drug regimens.
- Beneficiary adherence to a care plan.
- Reduction of readmissions and complications resulting from treatment during the episode.
- Management of chronic diseases and conditions that may be affected by treatment for the CJR-X clinical condition.

Selected comments/response: Commenters were generally supportive of CMS's proposed beneficiary engagement incentive policies. **CMS is finalizing its proposal at §512.685 on the requirements for CJR-X beneficiary incentives without modifications. CMS also finalizes its proposal at §512.685 for beneficiary engagement incentives that involve technology in CJR-X, without modifications. CMS received no comments on its proposals regarding clinical goals when offering beneficiary engagement incentives at §512.685, and is finalizing this provision without modification. Similarly, CMS received no comments on its proposed documentation requirements for beneficiary engagement incentives under CJR-X at §512.685(d), and the agency is finalizing these requirements without modification**.

j. Waivers of Medicare Program Requirements

CMS believes it is necessary and appropriate to provide flexibilities to hospitals participating in CJR-X, as well as other providers and suppliers that furnish services to beneficiaries in episodes. CMS contends that the agency's previous and current efforts in testing episode-based payment models have led it to believe that models where entities bear financial responsibility for total Medicare spending for episodes of care hold the potential to incentivize the most substantial improvements in episode quality and efficiency. Given these circumstances, waivers of certain program rules for providers and suppliers furnishing services to CJR-X beneficiaries (for example, waiving the requirement of a 3-day inpatient hospital stay as a condition for a Medicare-covered skilled nursing facility stay) may be appropriate to offer more flexibility than under existing Medicare rules for such providers and suppliers, so that they may provide appropriate, efficient care for beneficiaries.

CMS proposed to:

[128] Items or services involving technology provided to a beneficiary may not exceed $1,000 in retail value for any CJR-X beneficiary in any episode (per episode), and that items or services involving technology provided to a CJR-X beneficiary must be the minimum necessary to advance a clinical goal as discussed in this section for a CJR-X beneficiary in an episode. CMS imposes additional enhanced requirements for items of technology exceeding $75 in retail value as an additional safeguard against misuse of these items as beneficiary engagement incentives. Specifically, CMS requires that these items of technology remain the property of the CJR-X participant and be retrieved from the CJR-X beneficiary at the end of the episode. The CJR-X participant must document all retrieval attempts, including the ultimate date of retrieval. CMS does not explain why the agency feels the need to impose such detailed technology-related requirements with respect to beneficiary incentives.

- Allow CJR-X participants to provide up to nine post-discharge home visits to CJR-X beneficiaries via a waiver of "incident to" requirements;
- Waive the geographic site requirements of section 1834(m)(4)(C)(i)(I) through (III) of the Act that limit telehealth payment to services furnished within specific types of geographic areas, and waive the originating site requirements of section1834(m)(4)(C)(ii)(I) through (X) of the Act that specify the particular sites at which the eligible telehealth individual must be located at the time the service is furnished via a telecommunications system; and
- Waive the requirement for a 3-day hospital inpatient stay as a precondition for Medicare coverage of a subsequent skilled nursing facility stay (the "3-day SNF rule").

Selected comments/response: Some commenters requested broader waiver flexibility to support care delivery during CJR-X episodes. The commenters stated that CMS should provide robust waiver pathways for circumstances such as post-acute care capacity limits, SNF closures, severe weather, public health events, payer behavior, or beneficiary preference. Other commenters recommended that CMS waive certain inpatient rehabilitation facility (IRF) requirements for CJR-X beneficiaries. The commenters referenced the IRF 60 percent rule, the three-hour rule, and the preponderance requirement for therapy. Some commenters requested that CMS waive or clarify waiver of the homebound requirement for home health services under CJR-X. In general, commenters suggested greater flexibilities in discussing waivers of otherwise applicable Medicare program requirements under CJR-X. CMS declined to act on any of these suggestions, largely on the basis that none of these waivers of policy were discussed in the proposed rule.[129] The agency did, however, say that it may consider such additional waivers in future rulemaking. However, after consideration of public comments, **at this time CMS is not finalizing any additional waivers under section 1115A of the Act beyond those specifically discussed in this final rule**; the agency is finalizing each of these three waivers without modification.

k. Data Sharing

Based on its experience with prior models such as BPCI Advanced and CJR, in the IPPS/LTCH PPS proposed rule for 2027, CMS proposed to make certain beneficiary-identifiable claims data and regional aggregate data available to participants in CJR-X regarding Medicare FFS beneficiaries who may initiate an episode and be attributed to them in the model. For example, CMS believes that CJR-X participants may need access to certain Medicare beneficiary-identifiable data for the purposes of evaluating their performance, conducting quality assessment and improvement activities, conducting population-based activities relating to improving health or reducing health care costs, or conducting other health care operations listed in the first or second paragraph of the definition of "health care operations" under the HIPAA Privacy Rule, 45 CFR 164.501. CMS notes that, as was the case with the CJR Model, the agency proposed to disclose beneficiary-identifiable data to only the hospitals that are bearing risk for episodes and not with their collaborators.

[129] This seemed to be an odd response on the part of CMS, given that in the proposed rule, CMS "welcomed comments on additional waivers that should be considered under section 1115A of the Act beyond those specifically discussed in this final rule. [The agency was] especially interested in comments explaining how such waivers would increase quality of care and reduce unnecessary episode spending in the context of CJR-X."

CMS proposed that CJR-X participants must formally request data on an annual basis in a manner and form and by a date specified by CMS, indicating if they want summary beneficiary-identifiable data, raw beneficiary-identifiable data, or both. CMS proposed to make beneficiary-identifiable claims data for episodes in CJR-X available through two formats, summary and raw, both for the baseline period and on an ongoing monthly basis during their participation in the model as is done for BPCI Advanced and CJR (80 FR 73308). CMS proposed that sharing this data with CJR-X participants would be contingent on said participants annually entering into a data sharing agreement with CMS. CMS describes the period of baseline data (three years) and performance period data (as frequently as a running monthly basis) that would be provided to CJR-X participants, the formats in which these data would be provided, how it would be provided to requesters, and the contents of the proposed CJR-X data sharing agreement.

Selected comments/response: **CMS is finalizing without modification its proposal at §512.665(b)(6)(ii) and (d)(1)(ii) to make beneficiary-identifiable data and regional aggregate data available as frequently as a monthly basis and for up to 6 months after a performance year**. **CMS is also finalizing without modification the proposals at §512.665(e)(2), that the CJR-X participant agree to comply with all applicable laws and the terms of the CJR-X data sharing agreement and at §512.665(e)(1) that the CJR-X participant would need to submit the signed CJR-X data sharing agreement at least annually. CMS is also finalizing without modification its proposal at §512.605 for the definition of "CJR-X data sharing agreement."**

CMS received no comments on its proposals related to the content and requirements of the data sharing agreement, and therefore is **finalizing without modification the proposal at §512.665(e)(1)(ii) that CMS would impose certain requirements in the CJR-X data sharing agreement related to privacy, security, data retention, breach notification, and data destruction. CMS finalizes without modification its proposal at §512.665(e)(1)(iv) that if the CJR-X participant improperly misuses or discloses the beneficiary-identifiable data, the CJR-X participant would no longer be eligible to retrieve beneficiary-identifiable data and may be subject to additional sanctions and penalties available under law. Lastly, CMS is also finalizing without modification the proposal at §512.665(e)(iv) that if CMS determines that one or more grounds for remedial action has taken place then CMS may discontinue the provision of data sharing and reports to the CJR-X participant**.

l. Alternative Payment Model Options

CMS seeks to align the design of CJR-X with the Advanced APM (Alternative Payment Model) criteria in the Quality Payment Program and enable CMS to have the necessary information on eligible clinicians to make the requisite Qualifying APM Participant (QP) determinations. Eligible clinicians, as defined at 42 CFR 414.1305, may be eligible to receive benefits for participating in an Advanced APM, including burden reduction and financial incentives. In the proposed rule, CMS proposed that the CJR-X participant would be considered the APM entity, as defined at 42 CFR 414.1305, and that the CJR-X participant's affiliated practitioners, as

defined at 42 CFR 414.1305, may be assessed for QP determinations depending on whether the CEHRT[130] criteria are met, as established at 42 CFR 414.1425(b)(2).

Correspondingly, CMS proposed to adopt two different APM options for CJR-X: (i) an "AAPM option" which would be defined as an option in which CJR-X participants would attest to meeting the CEHRT requirement and in which the CJR-X participant's eligible clinicians may be assessed for QP determinations (to the extent CJR-X is determined to be an Advanced APM), and (ii) a "non-AAPM option" which would be defined as an option in which CJR-X participants would not meet CEHRT and in which the CJR-X participant's MIPS-eligible clinicians may be assessed for reporting and scoring through the APM Performance Pathway (APP) (to the extent the CJR-X is determined to be a MIPS APM).

Lastly, CMS proposed that, in order to capture physicians and nonphysician practitioners who are not listed on the CJR-X participant's financial arrangements list for QP determinations or APP reporting, CJR-X participants must also submit to CMS an extremely detailed clinician engagement list in a form and manner and by a date specified by CMS on a quarterly basis every performance year.

Selected comments/response: Comments on these proposals were generally supportive. Some commenters asked for operational clarifications (*e.g.*, how CMS would determine QP status for eligible clinicians participating concurrently in other Advanced APMs). **CMS is thus finalizing without modification the CJR-X Advanced APM options and the associated requirements at §512.615. CMS also finalizes without modification the definitions for "AAPM option" and "non-AAPM option" at §512.605**. Interestingly, given the level of detail that CMS proposed to require that CJR-X participants submit on the proposed clinician engagement list, commenters did not push back on the proposed requirements, and **CMS is finalizing without modification the proposals at §512.615(b) for CJR-X participants to submit a financial arrangements list and at §512.615(c) for CJR-X participants to submit a clinician engagement list.**

m. Standard Provisions

CMS states that CJR-X meets the criteria for application of the Standard Provisions for Mandatory Innovation Center Models (42 CFR part 512, subpart A). Unless otherwise specified, all CJR-X participants and CJR-X beneficiaries would be subject to the provisions at §§512.100 through 512.190, which address the following areas:

- Beneficiary Protections.
- Cooperation in Model Evaluation and Monitoring.
- Audits and Record Retention.
- Rights in Data and Intellectual Property.
- Monitoring and Compliance.
- Remedial Action.
- Innovation Center Model Termination by CMS.
- Limitations on Review.

[130] CEHRT: Certified Electronic Health Record Technology.

● Miscellaneous Provisions on Bankruptcy and Other Notifications.
● Reconsideration Review Process.

Selected comments/response: Some commenters recommended that CMS adopt and enforce robust beneficiary protections to preserve beneficiary choice, prevent patient steering, and maintain access to clinically appropriate post-acute care. Commenters stated that financial accountability for episode spending could create incentives for participating hospitals to steer beneficiaries toward lower-cost settings or narrow referrals without sufficient attention to individual clinical needs. CMS responded indicating that the standard provisions for mandatory Innovation Center models at §§512.100 through 512.190 are appropriate safeguards.

Should a CJR-X participant be terminated from the CJR-X Model, in alignment with the CJR Model, the participant hospital would remain liable for all repayments generated from episodes of care that ended prior to termination. With respect to the standard model provisions proposed, in addition to the remedial actions at §512.160(b), **CMS is finalizing at §512.610(c) that the agency may terminate a CJR-X participant from CJR-X if the CJR-X participant satisfies the grounds for remedial action at §512.160(a), the CJR-X participant may appeal the termination, in accordance with §512.610(c)(2), and terminated participants would remain liable for all negative NPRA generated from episodes of care that ended prior to termination**.

n. Termination of CJR-X

The general provisions relating to termination of the model by CMS in §512.165 would apply to CJR-X. Consistent with termination provisions of other Innovation Center models, in the event CMS terminates CJR-X, the agency would provide written notice to CJR-X participants specifying the grounds for termination and the effective date of such termination or ending. As provided by section 1115A(d)(2) of the Act, termination of the model under section 1115A(b)(3)(B) of the Act would not be subject to administrative or judicial review. CMS received no comments on its proposed CJR-X model termination policy.

3. Information Collection Requirements

Section 1115A of the Act authorizes the CMS Innovation Center to test innovative payment and service delivery models that preserve or enhance the quality of care furnished to Medicare, Medicaid, and Children's Health Insurance Program beneficiaries while reducing program expenditures. As stated in section 1115A(d)(3) of the Act, Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models under section 1115A of the Act. As a result, the information collection requirements contained in this proposed rule for CJR-X need not be reviewed by the Office of Management and Budget.

4. Impact

The CJR-X model expands a mandatory episode-based payment approach nationwide to promote value-based care for lower extremity joint replacement (LEJR) episodes. By holding hospitals financially accountable for both the cost and quality of care across an entire episode, the model is

expected to encourage care coordination, efficiency, and system-wide redesign among providers. Participants may earn performance-based payments for reducing costs while meeting quality standards, supported by access to claims data for better care planning. Beyond Medicare, the model may generate positive spillover effects in the broader healthcare market, as non-Medicare payers and providers adopt similar episode-based payment structures and improvements in care delivery.

Impacts on the Medicare Program. CJR-X is projected to reduce Medicare spending through incentives for hospitals to keep episode costs below target prices while maintaining quality. The model includes two-sided financial risk, meaning participants may either receive bonus payments or repay Medicare depending on performance. Safeguards such as stop-gain/stop-loss limits and outlier caps are designed to limit excessive financial risk. Over five years, the model is estimated to produce approximately $736 million in net Medicare savings, driven by reduced episode spending and repayment amounts exceeding incentive payments. CMS notes that these projections represent a portion of the potential savings to Medicare that CJR-X may produce since the model does not have an end date. Table K-CL.-01, reproduced below, provides CMS's assessment of the inputs to this aggregate five-year savings estimate. CMS expects savings to grow over time, though they moderate slightly in later years due to expanded participation and inclusion of safety-net hospitals.

Impacts on Medicare Beneficiaries. Medicare beneficiaries receiving joint replacements may benefit from improved care coordination, better transitions across care settings, and enhanced quality of services. The model emphasizes patient-centered care and includes quality measures focused on complications, patient experience, and outcomes to ensure high standards are maintained. Beneficiaries retain full freedom of choice in selecting providers and cannot be restricted to specific networks, although hospitals may recommend certain providers. Safeguards are included to prevent delays in care and to monitor for inappropriate patient selection or avoidance of complex cases. Overall, the model aims to improve patient outcomes while maintaining access and protecting beneficiary rights.

Table K-CL-01: Projected Financial Impacts of CJR-X (in Millions)

Performance Year	Year 1	Year 2	Year 3	Year 4	Year 5
CJR-X Episode Spending	$7,964	$8,202	$8,419	$12,320	$12,654
Baseline Episode Spending	$8,026	$8,266	$8,486	$12,394	$12,731
Reconciliation Payment Amounts	$241	$248	$254	$355	$365
Repayment Amounts	-$307	-$317	-$325	-$447	-$459
Total Impact (Savings)	-$129	-$133	-$137	-$166	-$171
Impact as % of Baseline	-1.6%	-1.6%	-1.6%	-1.3%	-1.3%

Note: Reconciliation payments and repayments are attributed to the performance year, not the year in which payments occur.

D. Organ Acquisition and Reasonable Cost Payment Policies

1. Reconciliation of Organ Acquisition Costs for Non-Renal Organs for Independent Organ Procurement Organization (IOPOs) and Histocompatibility Laboratories (HCLs)

Currently, Medicare pays for organ acquisition costs provided by IOPOs and HCLs based on reasonable costs. IOPOs and HCLs are paid by transplant hospitals (THs) and not directly by Medicare. The TH's costs are reported on the Medicare cost report and reconciled based on reasonable cost principles but only for kidney acquisition costs, not for other non-renal organs. IOPOs determine their charges for non-renal organ acquisition costs and those amounts are billed to and paid by THs. THs subsequently include those charges in their organ acquisition costs without the ability for determining reasonableness.

CMS proposed to reconcile IOPO and HCL costs for non-renal organs as is done for Hospital Organ Procurement Organization (HOPOs) for all organs and HCL kidney costs. The policy will require that IOPO and HCL non-renal organ acquisition costs be reviewed and analyzed by the Medicare contractor to ensure those costs are reasonable, necessary, related to patient care, and reconciled to payments made by THs. CMS proposed the policy to become effective October 1, 2027 to allow CMS time to update the IOPO and HCL cost reporting form and IOPOs and HCLs time to prepare to implement the changes from the new policy.

The proposal would also allow a HOPO to be a payor of an IOPO and HCL based on a kidney standard acquisition charge (SAC) for an IOPO and contractor-established rates for an HCL using reasonable cost principles. CMS further proposed to require the contractor to establish (and adjust if necessary) non-renal SACs. For both kidney and non-kidney organ acquisition services, the proposal authorized the TH to pay for pre-transplantation services based on an interim rate.

CMS proposed to specify that interim rates are contractor established rates, based on costs associated with procuring an organ for transplantation, incurred by an IOPO or HCL during its previous fiscal year. If there is not adequate cost data to determine the initial interim rate, the contractor would determine it according to the IOPO's or HCL's estimate of projected costs for the fiscal year.

Under the proposal, the contractor would establish, adjust (if necessary), and publish the non-renal organ interim rates for IOPOs and HCLs. Further proposals would allow reconciliation of these interim rates with actual costs after the close of the cost reporting period by the TH effective for cost reporting periods beginning on or after October 1, 2027. An overpayment or underpayment would result in a lump sum adjustment made directly between the contractor and the IOPO or HCL.

Subsequent proposals related to how initial and subsequent SACs for non-renal organs are developed and are modeled after existing regulations for kidneys. The contractor develops the IOPO's initial organ-specific SAC based on the IOPO's budget information. For subsequent years, the organ-specific SAC would use organ acquisition costs incurred in the prior cost reporting period and divide those costs by the number of usable deceased donor organs procured during that cost reporting period.

CMS also proposed to provide a listing of allowable organ acquisition costs that were omitted for establishing IOPO organ-specific SACs when CMS undertook rulemaking on this subject for the FY 2022 IPPS rule. The proposal indicated that only the contractor, not the IOPO, can adjust the organ SAC.

The remainder of this section in the proposed rule summarized comments on a request for information in the FY 2022 proposed rule but did not make any additional proposals.

Comments/Responses:

Legal Authority: There were detailed comments challenging CMS' authority to reconcile IOPOs and HCLs payment for non-renal organs on a reasonable cost basis. These commenters indicated that CMS' authority under the statute only allows them to subject renal organ acquisition costs to reasonable cost payment. Commenters indicated that when CMS expanded Medicare coverage to non-renal organ acquisition costs, it adopted payment policies through notice-and-comment rulemaking without applying reasonable cost reimbursement and reconciliation for non-renal organs.[131]

CMS disagreed stating that when it extended Medicare coverage to heart transplants and other solid organs, it did so without creating a separate, distinct payment standard for non-renal organs. HOPOs and hospital-based HCLs have always had their non-renal organ acquisition costs reimbursed and reconciled by Medicare on a reasonable cost basis. CMS' proposal would subject IOPOs and independent HCLs that perform identical organ procurement functions to the same process. The basis of CMS' argument appears to focus on the statute's use of the word "organ" rather than "kidney" as justification for its statutory authority to expand reconciliation of reasonable cost payment to non-renal organs provided by IOPOs and HCLs even though at the time the 1978 law being reference was enacted, Medicare only paid for renal organs.

Reliance Interests: Many commenters stated that OPOs have structured their operations around the existing payment policy for non-renal organs for decades and CMS should provide a more detailed justification when changing policy in the face of reliance interests absent a change in law. CMS responded that its proposal is grounded in the Agency's longstanding statutory authority to ensure that Medicare payments accurately reflect actual, reasonable costs. The response further implies that CMS did an RFI on this topic in a 2023 OPPS proposed rule (87 FR 44772 and 44773) previewing its concern about this topic.

Regulatory Burden: Multiple commenters emphasized that OPOs are currently navigating an unprecedented convergence of regulatory changes, including ongoing recertification cycles, expanded survey and enforcement protocols, new performance measures, and broader federal modernization initiatives. Many commenters urged CMS to delay implementation longer than one year. CMS responded that it will delay the policy until October 1, 2028 rather than October

[131] This argument would appear to suggest that if CMS does not have the authority to subject non-renal organs to reconciliation of their costs based on reasonable cost payment principles, it also does not have the authority to use reasonable costs to pay for them.

1, 2027. CMS plans to update the IOPO/HCL Medicare Cost Report to accommodate non-renal organ acquisition cost reconciliation.

SACs: Most commenters opposed CMS' proposal to require the Medicare contractor to establish and adjust, if necessary, IOPO non-renal SACs. Commenters argued that national average SACs would mask significant regional variation between OPOs and would fail to reflect the actual procurement costs in rural, geographically dispersed, or operationally complex service areas.

CMS responded that it did not propose national non-renal SACs. It proposed that the contractor would establish non-renal organ SACs for each IOPO, based on that IOPO's prior year actual costs and actual number of usable deceased donor organs. In the final rule, CMS is modifying its proposal to require the Medicare contractor to approve the non-renal SACs and testing rates at the beginning of the cost reporting period based on the IOPO's or HCL's prior year costs using reasonable cost principles. The Medicare contractor will publish the non-renal SACs (including adjusted SACs) and testing rates (including adjusted testing rates) so that the information is available to THs, OPOs and contractors.

Non-Medicare Payers: Several commenters stated most non-renal organs are transplanted into non-Medicare beneficiaries raising concerns about Medicare impermissibly shifting the cost burden to non-Medicare patients and payers. CMS responded that it would not consider this proposed method a violation of statute that prohibits cross-subsidization. The response goes through a detailed explanation of how Medicare's share of the IOPO or HCL's reasonable costs is based on non-renal organs transplanted into Medicare beneficiaries just as it is with kidneys. In determining Medicare's share of non-renal organ acquisition costs and non-renal HCL testing costs, CMS' final reconciliation policy will consider all usable non-renal organs to be Medicare usable organs except for those organs provided to military or VA hospitals, or to foreign countries. Further, CMS will ensure that the updated IOPO/HCL cost report will include explicit instructions for reporting tissue costs and tissue revenue, and for properly allocating tissue costs to prevent cost shifting.

Eliminating Operating Margins: Commenters asserted that CMS' proposed policy would eliminate operating margins and, when accounting for the 2 percent Medicare sequestration reduction, would result in zero or negative net reimbursement. CMS responded that it is authorized only to provide reasonable cost for organ acquisition before application of sequestration. While OPOs may only be reimbursed at reasonable cost for solid organs, many OPOs provide other services like tissue recovery, heart valve, bone, cornea and bone marrow that are not impacted by this proposal and can be provided with a margin of revenues over costs. Further, many IOPOs have foundations that assist IOPOs with costs.

Notice and Comment Rulemaking: Some commenters were concerned the proposed rule left many issues unaddressed and they had not been given a sufficient opportunity to provide comment consistent with rulemaking procedures. CMS disagreed and provided a detailed response as to how it has addressed specific issues raised by the commenters.

Financial Risk for TH: As THs pay IOPOs and HCLs, a commenter was concerned that THs face financial risk for later disallowances of costs by the MAC. CMS responded that THs will not

face retroactive payment adjustments or recoupments of IOPO costs after paying IOPOs in good faith. The financial risk will remain with the IOPO.

Recovering Costs from the VA: A commenter asserted that IOPOs cannot recover the full reasonable costs associated with organs transplanted at VA transplant centers. The commenter asked CMS whether IOPOs may bill VA transplant centers using a different SAC that captures final reasonable costs in full. IOPOs that provide non-renal organs to a hospital or another entity must bill the receiving entity the appropriate organ specific SAC. CMS' proposals do not affect this process. IOPOs may not use different SACs for different hospitals.

Final Action: CMS is finalizing its proposal to reconcile non-renal organ acquisition costs following the same procedures used for kidney reconciliation as follows:

- All policies are effective for cost reporting periods beginning on or after October 1, 2028 for IOPOs and HCLs.
- All usable non-renal organs are assumed to be Medicare usable organs except for those organs provided to military or VA hospitals, or to foreign countries.
- For each organ type, the IOPO must provide the Medicare contractor with its reasonable estimated SAC based upon its prior cost reporting period's costs and organ procurement volumes and its reasonable and documented estimate of its projected costs and organ procurement volumes for the subsequent cost reporting period, for contractor review to ensure reasonableness, and approval.
- Independent HCLs would provide the Medicare contractor with a reasonable estimate of its testing rates based on its prior year costs and a reasonable and documented estimate of its projected testing costs and volumes for the subsequent year, for contractor review to ensure reasonableness, and approval.
- IOPOs or HCLs may request that the contractor make an adjustment to interim payment rates or the contractor may initiate an adjustment but no more than quarterly.
- The IOPO or HCL must provide the Medicare contractor with an estimated adjusted SAC or testing rates, respectively, based on its actual cost data and its reasonable and documented estimate of costs through the end of its accounting period, to enable the Medicare contractor to review to ensure reasonableness, and approve the adjusted SAC or testing rate, respectively.
- If the determination of reasonable cost reveals an overpayment or underpayment resulting from the organ-specific interim reimbursement rates received or receivable by the IOPO or HCL from THs, an adjustment to the interim rate may be initiated by the contractor or requested by the IOPO or HCL. If a rate adjustment is made, then an IOPO or HCL may request that a lump sum adjustment be made directly between the contractor and the IOPO or HCL.
- The Medicare contractor will publish non-renal SACs and HCL testing rates used in billing THs for transparency.

2. Reasonable Cost Payment Policies

Section 413.1(a)(2)(v) makes all OPOs expressly subject to Medicare's reasonable cost principles, including §413.9 regarding costs related to patient care. CMS is restating this

requirement because IOPOs have asserted in administrative appeals that reasonable cost principles and rules do not apply to them because they do not provide direct patient care.

CMS' position is that IOPOs provide services directly related to patient care by procuring, perfusing, and transporting organs for transplantation into all organ recipients, including Medicare beneficiaries. While they may be paid indirectly by Medicare for these costs through a TH, the IOPO provides services related to patient care that clearly arise under the Medicare statute and regulations that apply reasonable cost principles.

The Office of Inspector General (OIG) found that certain IOPOs claimed unallowable costs and has recommended that CMS update applicable Medicare requirements to clarify the allowability of certain overhead costs.

Commenters generally supported CMS' reasonable cost proposals but asked for clarification on whether costs for preparing bids, including unsuccessful bids, and financing the legal, organizational and operational expenses required to expand into other donation service areas (DSAs) would be recognized as "related to patient care." They also asked CMS to clarify "related to patient care" as it applies to meals, education, and travel, to reflect how these items support an IOPO's core mission of procuring available organs for transplantation.

CMS responded that reasonable and necessary costs for expanding into other DSAs are generally considered allowable under Medicare cost reporting. These costs may include staffing costs, facility costs, transportation costs, outreach and education, and technology and equipment. Major capital expenditures that meet or exceed certain capitalization thresholds (for example, new facilities or major equipment) must be depreciated over the useful life of the asset rather than expensed in a single cost reporting period. Cost of preparing bids and unsuccessful bids to compete for DSA designation are business development costs which are generally unallowable under Medicare cost reimbursement. The response also states that services directly related to patient care are encompassed in a multitude of IOPO activities, including procuring, perfusing, and transporting organs for transplantation into all organ recipients, including Medicare beneficiaries. CMS believes this statement is sufficient and further guidance is unnecessary on the meaning of "related to patient care."

CMS restates longstanding principles of reasonable cost as described below:

Prudent Buyer. As a prudent buyer, the provider will seek to minimize its costs. The provider's actual costs will not exceed what a prudent and cost-conscious buyer would pay for a given item or service. CMS proposed to codify in regulation the longstanding prudent buyer definition found in the Provider Reimbursement Manual (PRM-1) section 2103.

Many IOPOs supported applying a general prudent-buyer standard to OPO overhead administrative expenses; however, most of these IOPOs also requested that CMS further clarify the standard. The commenters provided several specific issues upon which they requested CMS guidance. CMS' response emphasized that the prudent buyer standard is not a new requirement, but rather longstanding policy grounded in Medicare's reasonable cost statute and regulations,

which has been applied to all Medicare providers for decades including IOPOs. The response provided further guidance on many of the issues raised by the commenters.

Entertainment and OPOs Public Education and Outreach for Organ Donation Awareness. The PRM is explicit that costs for entertainment are not reasonable costs related to patient care. Medicare currently recognizes the costs incurred by IOPOs for public education regarding organ donation awareness as allowable costs if they are reasonable and necessary and related to patient care. The cost report instructions that apply to IOPOs and HCLs set forth that public education costs are expenses associated with organizing awareness programs designed to inform the public of the need for organs and organ transplant services.

Some IOPOs have asserted that their engagement in entertainment and sporting events are types of public education costs that reach large audiences to educate potential donors regarding the benefits of organ donation, and thus recruit candidates for organ donor registries. However, the proposed rule provided several examples of claimed costs that are far more than what a cost-conscious buyer should spend for providing targeted public education regarding organ donation within its donation service area.

CMS believes allowable IOPO public education costs are for an IOPO's community-based and locally focused efforts and effects, that include opportunities to register donors and track the number of registrations obtained during each effort. The proposed rule indicated that the Health Resources and Services Administration is authorized, on behalf of the Secretary of Health and Human Services, to develop a public awareness program that partners with existing national campaigns to inform the public about organ donation and these events need not be undertaken by IOPOs.

To address this issue, CMS proposed to modify the regulations to specifically indicate the following types of costs are non-allowable:

- Tickets, admission fees, or entry to sporting or other events, including national or professional sporting events.
- Sponsorship of sporting events, teams or athletes, including race car drivers or motor sports activities.
- Sponsorship of floats in national parades.
- Concert, theater, or performing arts events, professional musicians or other entertainers.
- Wine tours or alcoholic beverages.
- Retreats at spas or luxury resorts, spa services or treatments.
- Golf outings, ski trips, cruises and similar recreational excursions.

The proposal further specified other nonallowable costs, including drugs sold to other than patients, fines and penalties, and expenses associated with operating a gift shop. CMS also proposed to specify that costs incurred by IOPOs to engage in public education within its donation service area to increase awareness of organ donation and increase donor registration are allowable if they are reasonable and not of the type specified above.

Several commenters supported CMS's efforts to responsibly fund IOPOs' public education and outreach on organ donation awareness. Some of these commenters remarked that the disallowance of pure entertainment expenditures is consistent with longstanding Medicare cost principles and raises no operational concern for well-managed IOPOs. Many commenters opposed these proposals providing various legal and policy arguments that they believe support CMS continuing to allow these costs. For instance, many commenters argued that sporting venues can serve as legitimate platforms for public education, particularly those at venues that reach larger audiences. These commenters provided many examples of how they believe the kinds of activities that CMS is prohibiting are beneficial to the Medicare program.

CMS disagreed with the legal arguments noting that Medicare's reasonable cost statute explicitly indicates that "entertainment, including tickets to sporting and other entertainment events" are not costs related to patient care. The use of the term "including" signals the list is not all inclusive and CMS can define a broader category of unallowed costs. With respect to other comments, CMS seeks to provide a distinction between targeted community-based educational outreach activities and large-scale commercial sponsorships of sporting events, athletes, nationally televised parades and sports figures and personalities.

Entertainment and sponsorship costs do not become an allowable cost simply because they are associated with public education and community outreach on organ donation. Sponsorship arrangements are primarily for the purpose of promotional or sporting activities, rather than directly supporting the objectives of an IOPO's community-based public activities to educate individuals about organ donation and sign up organ donors and are not allowable costs under Medicare's reasonable cost principles. Purposeful public education initiatives and activities held at high-traffic or prominent venues may be allowable if the costs associated with delivering targeted public education is reasonable and does not involve sponsoring the team or venue. OPOs must maintain clear documentation demonstrating that costs claimed as public education are directly tied to organ donation awareness activities and donor registration.

Several commenters requested that CMS explicitly indicate types of costs that are allowable rather than just those that are unallowable and establish measurable requirements associated with outreach events that indicate effectiveness in recruiting donors. CMS responded that allowable costs would include IOPOs' participation and engagement in settings that can facilitate direct conversations with individuals regarding organ donation and provide opportunities to register donors and track the number of registrations obtained during each effort.

Examples would include setting up booths at local farmer's markets, health fairs, high school or local college events, partnering with community organizations, faith-based groups, schools and health care facilities, participating in local multicultural festivals, as well as providing education at driver's education programs and at local Department of Motor Vehicles and Department of Natural Resources so that individuals can register to become an organ donor while obtaining a driver's license or fishing license. The rule indicates that IOPO staff should be available to discuss, educate and answer questions directly about the organ donation process. The IOPO may provide modest token items and educational materials to individuals to support organ donation awareness.

One commenter indicated that focused DSA engagement fosters public trust, promotes consistent donor awareness, improves authorization rates, and reinforces equitable access to donation opportunities across diverse populations. Many commenters expressed concern that if CMS's proposal prohibited broad public education activities, such as social media campaigns, the effectiveness of outreach programs could be undermined, resulting in fewer donor registrations.

CMS' response acknowledges concerns about undermining an IOPO's public education programs resulting in fewer donor registrations. Based on commenter's feedback, CMS recognizes that certain broad reaching public education strategies, such as online campaigns, can serve as effective tools for increasing donor registration and awareness and constitute an allowable cost. Such activities may include, but are not limited to, community-based events, local school education programs, local driver's education programs, partnerships with driver's license bureaus, workplace outreach initiatives, faith-based outreach programs, radio and social media campaigns and billboards within the DSA. These types of public education activities must not be entertainment related or include sponsorship costs, or salaries paid to sponsor individuals such as public figures, celebrities, or athletes. These activities must be targeted to the IOPO's DSA community and designed to increase donor registration awareness within the IOPO's DSA. Such public education activities must be consistent with Medicare's reasonable cost principles and documented accordingly.

Several commenters indicated that HRSA alone does not provide sufficient public education, awareness, or donor engagement resources to support nationwide donor registration efforts. CMS agreed with this comment and the final rule describes permissible outreach activities that IOPOs can engage it that complement HRSA's efforts to increase organ donation.

Several commenters requested CMS confirm that the costs of donor family support and outreach activities remain allowable costs, while other commenters requested CMS allow costs of aftercare and bereavement services for families, such as donor family support and outreach, and donor recognition and remembrance events as allowable costs. CMS responded that while it recognizes the compassionate intent behind providing bereavement and aftercare services to donor families, these services are provided after the organ procurement process is complete. As such, they are not allowable organ acquisition costs under the Medicare program.

CMS is finalizing its proposed list of non-allowable activities provided above without modification. However, based on the public comments, CMS is modifying its proposal to allow the costs of certain broad reaching public education activities within an IOPO's DSA. Costs incurred by an IOPO to engage in public education within its DSA, including public education activities designed to reach a broad audience such as but not limited to, billboards, radio advertisements, and social media campaigns, to increase awareness of organ donation and increase donor registration within its DSA are allowable if they meet reasonable cost principles.

Activities for Employees and Non-employees of the Provider. In the 2022 IPPS rule, CMS had indicated that provider costs for events to improve employee morale (such as an annual employee picnic, holiday party, employee award ceremony or sponsorship of employee athletic programs) are allowable to the extent that they are reasonable. After further consideration, CMS proposed to specify that these costs are not allowable. The proposed rule indicated that there are

many cost-effective methods for improving employee morale that do not require these types of entertainment expenses.

Most commenters opposed CMS' proposal to disallow costs for employee morale and engagement activities. The commenters requested CMS retain its current standard of allowing de minimis or reasonable costs associated with employee engagement, morale, and retention when those costs are modest, mission-related, and consistent with prudent non-profit management.

CMS agreed with these comments indicating that any employee morale and engagement activities must be limited to employees of the provider. Consistent with its proposal, CMS continues to believe costs incurred by providers for entertainment or performers are not allowable costs in accordance with section 1861(v)(1)(8) of the Act. After considering the comments received, CMS is finalizing its proposal with modification at 42 CFR 413.5(c)(12) to specify that de minimis or modest costs incurred by providers for employees for purposes of improving employee morale are allowable costs, provided that such costs meet reasonable cost principles as outlined in §413.9(c).

Alcoholic Beverages. The PRM-1, chapter 21, section 2105.8 sets forth that costs incurred by providers for alcoholic beverages are not allowable. CMS proposed to codify these longstanding provisions into the regulations. All commenters agreed that costs incurred by providers to furnish alcoholic beverages are not allowable costs under Medicare. CMS is finalizing its proposal to modify §413.5(c)(13), to specify that costs incurred by providers to furnish alcoholic beverages are not allowable costs.

Professional Education and Travel. While Medicare has recognized costs incurred by OPOs for professional education and travel, the OIG has found that Medicare has paid for expenses of these types that have not met reasonable cost principles. The OIG recommended CMS update the applicable requirements to clarify what types of these costs are unallowable.

(a) Professional Education

CMS proposed to codify the current manual language and add further specificity but not change any current policy. The proposed rule indicated that the costs incurred by IOPOs for professional education where the attendee is clinical staff of the IOPO are allowable costs. Costs incurred by IOPOs for IOPO-sponsored seminars where continuing education credits are given and where the attendee is not on the IOPO staff are not allowable costs.

(b) Travel

The proposed rule clarified that overnight travel costs incurred by a provider on behalf of its staff for professional education courses are allowable when the event is located more than 50 miles away from the employee's workplace and requires more than 8 hours of attendance. Providers are expected to minimize travel-related costs to professional education activities by selecting economy or coach class accommodations. Unallowable costs, such as entertainment, travel and

vacation type of expenses, are not related to patient care and are not appropriate or allowable as professional educational expenses.[132]

Most commenters broadly requested that CMS expand allowable professional education costs to include meetings, seminars, and presentation where continuing education credits are given; and professional education provided to non-clinical staff. Commenters noted that limiting allowable costs to "W-2 employees" would exclude mission-critical contracted staff such as medical directors, recovery surgeons, and perfusionists, as well as non-clinical personnel in finance, IT, HR, and compliance who must maintain professional credentials to support IOPO operations. CMS agrees that costs associated with non-IOPO staff and contracted staff who directly support the donor hospitals and IOPO's operational role should be allowable.

Several commenters requested that CMS clarify that the 8 hour policy to pay for an overnight stay is general guideline rather than a requirement and that the policy allow for documented exceptions and includes costs for non-clinical staff as well as non-employees, such as contracted staff. CMS agrees and is clarifying that exceptions are permitted to the 8-hour policy but they must also be documented.

CMS further agrees with expanding the scope of allowable travel expenses to employees and contracted employees and personnel as it facilitates IOPOs' ability to accomplish their mission to maximize organ procurement. However, to align with Medicare's reasonable cost principles and to protect the Medicare trust fund, allowable costs must have a clear and demonstrable relationship to patient care.

The agency continues to believe that costs providers incur to host events, including executive and board meetings, educational or otherwise, at resorts or spas are not allowable under Medicare's reasonable cost principles. Regardless of educational content or intent, a venue that includes an entertainment or luxury component cannot be justified as a reasonable or necessary cost related to patient care.

After consideration of the comments received, CMS is finalizing its proposals with the following modifications:

- Costs incurred by IOPOs for professional education such as meetings, seminars, and presentations on organ donation to acquire useable organs from potential donors where continuing education credits are not given and where the attendee is clinical staff, non-clinical staff, or contracted staff including, but not limited to, IOPO staff, donor hospital staff, and physicians whose role is essential to the IOPO's objectives are allowable costs.
- Costs incurred by IOPOs for IOPO-sponsored seminars where continuing education credits are given and where the attendee is a member of the IOPO staff are allowable costs to the extent that they are patient care-related and meeting reasonable cost principles.

[132] CMS cites a seven-day cruise to Alaska for a Kansas City based provider claimed as an educational expense for continuing education courses on board as a non-allowable cost. The cost was allowed by the Provider Review Reimbursement Board in 1998 but overturned by the CMS Administrator.

- Costs incurred by IOPOs for IOPO-sponsored seminars where continuing education credits are given and where the attendee is not a member of the IOPO staff, are not allowable costs.
- Costs incurred by providers for employee travel are generally allowable to the extent that they are patient care related, reasonable, and necessary.
- Costs incurred by a provider to conduct, or send its employees, or staff, including contracted employees to, patient care related professional education refresher programs, seminars and workshops that increase the quality of patient care or operating efficiency of the provider, are generally allowable costs to the extent that they are patient care related and meet reasonable cost principles.
- Costs incurred by providers for entertainment and vacation travel expenses such as travel on cruises or to resorts or spas, or transportation to entertainment or sporting events, are not allowable costs regardless of whether they are or are not incurred in connection with professional educational seminars or continuing education.
- Costs incurred by providers related to the personal use of provider vehicles are not allowable costs.
- Costs incurred by IOPOs for public education within its donation service area in accordance with §413.5(c)(11) and professional education in accordance with §413.5(c)(14)(iii) are allowable overhead costs.
- Costs incurred by IOPOs for public education within their donation service area in accordance with §413.5(c)(11) and professional education in accordance with §413.5(c)(14)(iii) are allowable overhead costs.

Meals Provided to Employees and Non-Personnel. In the FY 2022 IPPS (86 FR 73416), CMS stated that meals were an allowable cost for OPO-sponsored seminars, provided the seminar related to patient care and met reasonable cost principles. However, upon further review, CMS believes the cost of meals at IOPO-sponsored seminars is a benefit to the seminar attendees, rather than a direct cost necessary for patient care. CMS proposed that costs incurred by providers for meals for their staff (including executives and management) and non-personnel (including attending physicians) are not allowable costs (including those provided to attendees at educational events).

Many commenters contended that meals are a legitimate operational necessity and should be considered allowable costs. Several commenters suggested CMS establish guidelines and limitations for allowable meal costs. CMS responded that it would be appropriate to consider the costs of meals or refreshments for employees as an allowable cost, including for contracted employees, at educational events pertaining to patient care, IOPO-sponsored seminars (with or without continuing education credits) when an overnight stay is required. For the costs of meals to be allowable, such costs must be reasonable and necessary and not substantially out of line with the amounts typically spent in accordance with 42 CFR 413.9.

After consideration of the comments received, CMS is finalizing its proposal with the following modifications:

- Costs incurred by providers for meals sold to visitors, meals for their employees and staff (including executives and management) and non-personnel (including attending physicians) are not allowable costs.
- Costs incurred by providers for de minimis refreshments provided to attendees at educational events, including attendees of IOPO-sponsored seminars (with or without continuing education credits) are allowable costs.
- Costs incurred by providers for meals for employees and contracted staff, whose role is essential to the provider's objectives, when an employee or contracted staff is required to travel away from their primary work location and an overnight stay is required, such as when completing trainings or education, provided such trainings are patient care related, are allowable costs.

3. Clarification and Codification of Cost Allocation Principles

On the Medicare cost report, a provider will have direct and indirect cost centers. Indirect costs will be allocated to direct cost centers based on various cost allocation statistics. The proposed rule provided a detailed description of the indirect cost allocation process (referred to as the "stepdown").

A provider's general service costs (that is, overhead costs) must be properly allocated to all centers which they serve, regardless of whether these centers produce revenue, to ensure costs for services to Medicare beneficiaries are correctly calculated. However, for a general services cost center to be allocated to an individual department, there must be a causal relationship, e.g., it receives a direct benefit from being serviced by that cost center.

CMS clarified proper allocation of indirect costs to various cost centers because it has found providers allocating overhead costs imprecisely resulting in overpayments where the hospital is paid based on reasonable costs. For instance, purchased services must bypass the step-down allocation process but are often included, resulting in higher reasonable cost payment for organ acquisition costs than is permissible. Any overhead costs are included in the price of the purchased service according to the proposed rule.

CMS proposed to add §413.24(d)(8) to specify that providers must not include a statistical cost which does not relate to the allocation of administrative overhead expenses when it causes an improper distribution of indirect costs. For example, when a hospital performs organ transplants, it may purchase organs (kidneys, hearts, livers) from outside sources such as IOPOs. These purchased organs carry a very high dollar value but have no causal relationship to administrative overhead compared to other hospital services. These purchased organs include all the OPO's overhead in the purchased price of the organ. For this reason, CMS indicates that these purchased services should not be receiving any allocated overhead.

The proposed rule described two methods for ensuring costs like purchased services do not receive any administrative overhead. One method is called the "Negative Adjustment Method." The Negative Adjustment Method subtracts costs associated with a direct service cost center that do not have a causal relationship to the indirect costs being allocated through the stepdown. The other method is called "Componentization" and requires costs in a cost center to be divided into

components. Those components served by the indirect cost center would receive an allocation through the stepdown while others would be bypassed.

Further detailed cost reporting instructions were provided in the proposed rule. CMS also proposed to codify in regulations that a provider that wishes to change its cost finding method must submit a request to its contractor, in writing, 90 days prior to the end of the cost reporting period to which the provider's request for a change applies. Approval of such a request will be binding on the provider.

Many commenters disagreed that CMS' proposal is codifying longstanding manual provisions into regulations; instead, the proposed policies are significant new policies that will substantially increase provider burden.

CMS disagreed and responded that its proposal is designed to prevent cost-shifting, and enforce Medicare's longstanding, fundamental cost-finding requirements that any statistical basis must reflect a causal and beneficial relationship between the cost center and the overhead being allocated. The Negative Adjustment Method is already described in existing MCR instructions (PRM-2, Chapter 40, Section 4020). The Componentizing Method is an optional alternative for providers that wish to more granularly allocate administrative and general. It is not mandated for all providers. CMS believes the administrative burden of accurate cost reporting is a reasonable and necessary cost of participating in the Medicare program.

Many commenters asserted that hospitals still incur their own A&G costs (contracting, legal, procurement, compliance, accounts payable, etc.) related to purchased services and therefore these costs should not be excluded from the indirect cost allocation base. Some commenters asked whether the proposed policy applies broadly beyond organs and CAR-T cell therapies to clinical services or supplies purchased from outside vendors. Examples of these services are purchased radiology services, purchased laboratory services, purchased therapy services, purchased dialysis services, anesthesia services, and medical education costs.

CMS responded that its proposal would not require all purchased service costs be removed from the accumulated cost statistic. Instead, CMS would only require the exclusion of contract services for organs, donor tissue, blood products, and CAR-T, that are acquired on behalf of a patient and passed directly to the payer without markup to be excluded from the indirect cost allocation.

Several THs commented that the allocation proposal would exclude organ acquisition costs from the accumulated cost statistic and result in underpayments. CMS responded that its proposal does not eliminate reimbursement for transplant program management, coordination, compliance, or infrastructure costs. The proposal addresses only the mechanism by which A&G overhead is allocated, not whether transplant-related administrative costs are allowable.

Some commenters indicated that CMS's proposal is a departure from the "averaging principle" articulated by CMS in Humana of Aurora v. Heckler, 753 F.2d 1580 (10th Cir. 1985) and St. James Hosp. v. Heckler, 760 F.2d 1460, 1472 (7th Cir. 1985). The "averaging principle" means that for every dollar over-allocated to Medicare, another dollar is under-allocated away from

Medicare. These commenters assert that CMS has never mandated that providers adjust their accumulated cost statistics for costs that receive no benefit or resources from A&G.

CMS disagrees indicating that the averaging principle permits reasonable approximations in cost allocation where the statistical basis bears a reasonable relationship to the costs being allocated. The 'averaging principle' does not override the requirement that a causal or beneficial relationship must exist to the overhead being distributed. Where a specific allocation methodology results in distortions, even if the distortion may "average out" across the system, CMS is not required to perpetuate that distortion.

After considering the public comments, CMS is finalizing its cost allocation policy as proposed.

4. CMS Administrator Review of CMS Reviewing Official Determination for IOPOs and HCLs

A Medicare contractor closes a Medicare cost report by providing a Notice of Program Reimbursement (NPR) to the provider. The NPR may be appealed. Under current rules, an IOPO or HCL that is dissatisfied with its NPR may request a hearing before a contractor hearing officer if the amount in controversy is $1,000 or more. Once the contractor hearing officer decision is issued, an IOPO or HCL is entitled to obtain review by a CMS reviewing official or the CMS reviewing official can review the contractor's decision without a request from the IOPO or HCL. The CMS reviewing official's decision is made on behalf of the CMS Administrator.

On May 2, 2023, the CMS Administrator issued Standing Order 2023-1, to allow IOPOs and HCLs to request that the Administrator review a CMS reviewing official decision and to confirm that the Administrator can review a CMS reviewing official decision on his or her own motion. CMS proposed to add these provisions of the Standing Order to the regulations. The remainder of this section in the proposed rule dealt with processes and procedures that apply to the appeal process.

The public comments raised complex legal issues regarding whether the Administrator can provide an additional level of review of an agency decision by a CMS reviewing official. Some commenters objected to codifying the standing order arguing that the existing Agency review process complies with the Appointments Clause in the U.S. Constitution, as confirmed by the Supreme Court precedent. CMS responded that its rule would make explicit and clearer that the CMS Administrator, a Senate-confirmed principal officer of the United States, will have discretionary authority to issue a final decision binding the U.S. Department of Health and Human Services for reimbursement appeals for IOPOs and HCLs.

The proposed rule set forth a detailed predictable procedure for that potential review by the principle officer (the Administrator). The principal officer would not be required to review every decision, only that the principal officer would not be prohibited from doing so. Proposing codification of the right of a party to request Administrator review of a CMS reviewing official decision would ensure that affected entities have a formal, legally recognized avenue for appeals.

A few commenters argued that an IOPO that prevails before the hearing officer remains exposed to reversal through two successive CMS-controlled stages. These commenters requested that

CMS adopt a single layer of Administrator-level oversight above the Hearing Officer and eliminate the reviewing official level of review. CMS responded the commenters' proposed remedy to eliminate the CMS reviewing official level would reduce procedural protections for IOPO and HCL reimbursement appeals. The CMS reviewing official level of review provides an intermediate review on contractor hearing officer decisions before they become final and allowing for the correction of errors at the agency level without burdening the Administrator with numerous appeals.

Commenters requested that the Administrator's own-motion review authority be constrained by defined timelines, recusal standards, limited to questions of law and issues identified on appeal, and ensure the parties have sufficient opportunity to prepare and submit supporting documentation relevant to an appeal. Other commenters requested that the Administrator's Notice declining a review include a brief explanation to better inform IOPOs' understanding of the reasonable cost principles.

CMS responded that overly prescriptive criteria would limit the Administrator's ability to address novel or unforeseen legal questions, prevent the correction of errors that fall outside of narrowly defined triggering criteria, and reduce the general flexibility necessary for sound administrative review. Consistent with other CMS administrative appeals contexts, the CMS Administrator's discretionary review is generally not intended to function as a full de novo proceeding but rather as a discretionary review of legal and policy questions although the Administrator may correct errors of fact. CMS notes that the discretionary nature of Administrator review means that a declination does not constitute a substantive ruling on the merits, therefore, there is no need to provide a substantive statement on why the Administrator has declined to review a matter. This policy would be consistent with the process for review of Provider Reimbursement Review Board matters.

A couple of commenters stated the proposal would add further delay to an already protracted appeals process. CMS responded that any delays currently experienced by IOPOs or HCLs are attributable to pre-existing systemic factors that predate this rulemaking and are not a result of CMS' proposed discretionary Administrator review structure. Further, this rulemaking codifies the existing framework already established in the Agency's Standing Order 2023-1.

A few commenters raised a concern about retroactivity and fundamental fairness because the policy was proposed to be effective for pending appeals. CMS responded that this proposal adds a potential avenue for Administrator review; it does not remove any existing right or remedy available to IOPOs or HCLs that undermine procedures for pending appeals.

One commenter praised the skills and experience of the current CMS reviewing official indicating that the CMS Administrator does not have the relevant subject expertise and experience with federal regulations concerning appeals, provider audit and reimbursement matters, Medicare cost report issues, and related subjects to make better decisions than the CMS reviewing official. While CMS appreciated the commenter's complimentary words about CMS' reviewing officials, the purpose of the CMS Administrator's review is to provide an opportunity for review by a principal officer of the United States

There was one comment requesting that CMS implement a nondiscretionary right of administrative appeal for disputes above a material financial threshold. CMS disagrees. This approach would transform the Administrator's review from a discretionary oversight mechanism into a mandatory appellate tier rather than allowing the Administrator to focus on cases of genuine legal and policy significance.

CMS is finalizing its proposals for Administrators discretionary review of IOPO and HCL appeals with several modifications to provide greater clarity with respect to the timelines and a variety of other issues.

E. Health Information Technology Standards

1. Background

In section II.J. of the 2026 CMS Interoperability Standards and Prior Authorization for Drugs Proposed Rule,[133] ONC proposed to adopt health information technology (IT) standards and implementation specifications in 45 CFR 170.215 for interoperability APIs and related activities on behalf of HHS. ONC proposed to adopt these standards on behalf of HHS in one location within the CFR for use within other HHS programs.

Additionally, ONC proposed adopting updated versions of certain standards that the Secretary previously adopted in the HTI-4 final rule.[134] The proposed updated versions (listed and discussed in section II.J.6. of the proposed rule) would be codified in 45 CFR 170.215. If finalized, the updated versions of the standards would be indicated for use by CMS subject to any other requirements that are finalized from the CMS Interoperability Standards and Prior Authorization for Drugs proposed rule.

Finally, ONC proposed adopting an additional standard in 45 CFR 170.215(k)(3) that supports the exchange of attachment information for prior authorization transactions. Summaries of the standards that ONC proposes to adopt and subsequently incorporate by reference are discussed in section X.E.9 of this final rule.

ONC is finalizing these proposals as part of the FY 2027 IPPS/LTCH PPS final rule.

2. Adoption of Standards and Implementation Specifications

ONC summarizes its statutory authorities to improve health care quality, safety, and efficiency through the promotion of health IT and exchange of electronic health information (EHI). In consultation with representatives of other relevant federal agencies, the ONC National Coordinator may adopt health IT standards, implementation specifications, and certification criteria, consistent with the schedule published by Health Information Technology Advisory

[133] "Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability Standards and Prior Authorization for Drugs for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) both Agencies and CHIP Managed Care Entities, and Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges" (91 FR 19890).
[134] See 90 FR 37162 and 37181.

Committee (HITAC). The HITAC advises and recommends to the National Coordinator standards, implementation specifications, and certification criteria relating to its implementation of a health IT infrastructure on two areas in particular: (1) a policy framework to advance an interoperable health IT infrastructure; and (2) priority target areas for standards, implementation specifications, and certification criteria.

ONC's Interoperability Standards Advisory (ISA) supports the identification, assessment, and public awareness of interoperability standards and implementation specifications that can be used by the health care industry to address specific interoperability needs. It is updated annually based on recommendations received from the public and subject matter experts. The ISA currently includes the implementation specifications finalized in section X.E.7 of this final rule.

3. Proposal To Adopt Standards for Use by HHS

ONC proposed to adopt standards in 45 CFR 170.215(j), (k), (m), and (n) to support the continued development of a nationwide health IT infrastructure and support ongoing federal alignment of standards for interoperability and health information exchange. ONC previously adopted versions of these standards in the HTI-4 final rule.[135] In addition, ONC proposed adopting an additional standard, specifically, the HL7 Da Vinci Clinical Data Exchange (CDex) Implementation Guide (IG) in 45 CFR 170.215(k)(3).

Final Action. ONC finalizes its proposals to adopt the standards described below. It updates the citations where standards are adopted in regulation based on a policy proposed as an alternative proposal[136] to replace previously adopted versions in 45 CFR 170.215 where applicable.

- HL7 FHIR® Da Vinci—Coverage Requirements Discovery IG [Implementation Guide], Version 2.2.1 - STU 2.2 (adopted in 45 CFR 170.215(j)(1)(i)). URL: https://hl7.org/fhir/us/davinci-crd/2.2.1/en.
- HL7 FHIR® Da Vinci—Documentation Templates and Rules Implementation Guide, Version 2.2.0 - STU 2.2 (adopted in 45 CFR 170.215(j)(2)(i)). URL: https://hl7.org/fhir/us/davinci-dtr/2.2.0/en.
- HL7 FHIR® Da Vinci Prior Authorization Support (PAS) FHIR Implementation Guide, Version 2.2.1 - STU 2.2 (adopted in 45 CFR 170.215(j)(3)(i)). URL: https://hl7.org/fhir/us/davinci-pas/2.2.1/en.
- HL7 FHIR® CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) [Implementation Guide], Version 2.2.0 - STU 2.2 (adopted in 45 CFR 170.215(k)(1)(i)) URL: https://hl7.org/fhir/us/carin-bb/STU2.2.
- HL7 FHIR® Da Vinci Payer Data Exchange (PDex) US Drug Formulary Implementation Guide, Version 2.1.0 - STU 2.1 (adopted in 45 CFR 170.215(m)(1)). URL: https://hl7.org/fhir/us/davinci-drug-formulary/STU2.1.
- HL7 FHIR® Da Vinci Payer PDex [Payer Data Exchange] Plan Net Implementation Guide, Version 1.2.0 - STU 1.2 (adopted in 45 CFR 170.215(n)(1)). URL: https://hl7.org/fhir/us/davinci-pdex-plan-net/STU1.2.

[135] See 90 FR 37130.
[136] See 90 FR 20003 through 20004.

- HL7 FHIR® Da Vinci Clinical Data Exchange (CDex) IG [Implementation Guide], Version 2.1.0 - STU 2.1 (adopted in 45 CFR 170.215(k)(3)(i)).URL: https://hl7.org/fhir/us/davinci-cdex/STU2.1.

ONC clarifies that it is adopting version 2.2.0 of the CARIN IG for Blue Button® in this final rule; the proposed rule incorrectly referred to proposed version of the IG as 2.1.2. It also notes that it did not propose to incorporate the CDex IG as part of any health IT certification criteria at 45 CFR 170.315 in the CMS Interoperability Standards and Prior Authorization for Drugs proposed rule, and it does not finalize any such requirements related to certification criteria in the policies finalized in this final rule.

Selected Comments/Responses. CMS reports that many commenters supported the proposals to adopt updated versions of implementation guides previously adopted in the HTI-4 final rule and specifically for the proposed adoption of version 2.2.1 of the CRD IG, version 2.2.0 of the DTR IG, and version 2.2.1 of the PAS IG for electronic prior authorization.

Support was also expressed for the adoption of the CDex IG as the standard for prior authorization attachments because the IG provides flexibility for different types of attachments, can support different scenarios, and complements the PAS IG. Some commenters expressed reservations about the CDex IG, worrying about the impact of widespread use of CDex on prior authorization workflows. They believe that the CDex IG can play an important role in supporting standardized transmission of clinical information outside of structured data elements, but they emphasize that payers should prioritize use of structured data through questionnaires transmitted under the DTR IG. ONC notes that HHS has not yet finalized any related proposals to require its use at this time.

Other comments noted that the PlanNet IG does not fully support real-world use cases today and that there are implementation gaps within the current version, including discrepancies between the IG's requirement for REST-based access and bulk consumption patterns for "provide directory data." Another commenter pointed to open implementation questions regarding version 2.2.0 of the CARIN IG for Blue Button®. ONC thanks commenters for these insights and says it and CMS will continue to monitor and "encourage efforts to improve these IGs."

Many commenters urged CMS and ONC to ensure standards are tested in real-world settings prior to any compliance dates set for conformance to the standards and recommended that HHS adopt approaches to testing that go beyond conformance testing to a certain version of a standard and advance approaches that test interoperability between real-world implementations using all permissible versions of a standard. While ONC says it agrees with this comment, it nonetheless believes it must adopt version 2.2.1 of the CRD IG, version 2.2.0 of the DTR IG, and version 2.2.1 of the PAS IG to ensure clarity about the ability to use these versions as well as benefit from the significant improvements made over the previously adopted versions.

4. Expiration Dates for Certain Versions of Adopted Standards

ONC proposed adding an expiration date of January 1, 2028, to corresponding versions of standards currently in 45 CFR 170.215(j), (k), (m), and (n) if its proposals to adopt newer

versions of adopted standards and specifications were finalized. After the expiration date, only non-expired versions of the relevant standards would be available for use.

ONC refers to the time before January 1, 2028, as a transition period that would allow health IT developers flexibility to complete development towards the existing standards and to iterate to newer standards. However, ONC is also concerned that this flexibility may lead to more heterogeneity where some deployed health IT uses one standard and other deployed health IT uses newer versions of those standards, thus complicating shared goals with CMS to facilitate a FHIR-based ecosystem for prior authorization, payer to payer exchange, and patient access to coverage information. Thus, ONC proposed an alternative approach where it would remove and replace currently adopted standards with the standards it has proposed upon the effective date of a final rule, without providing for a transition period during which multiple versions of each standard would be available for HHS use.

Final Action. ONC finalizes its alternative proposal to replace previously adopted versions of corresponding standards with the versions finalized in this rule upon the effective date of this final rule. ONC adopts the standards shown in the table below at the listed regulatory citations and removes the versions currently adopted in those citations:

Standard Versions Effective October 1, 2026	Regulatory Text Citation
HL7 FHIR® Da Vinci—Coverage Requirements Discovery IG [Implementation Guide], Version 2.2.1 - STU 2.2	45 CFR 170.215(j)(1)(i)
HL7 FHIR® Da Vinci—Documentation Templates and Rules Implementation Guide, Version 2.2.0 - STU 2.2	45 CFR 170.215(j)(2)(i)
HL7 FHIR® Da Vinci Prior Authorization Support (PAS) FHIR Implementation Guide, Version 2.2.1 - STU 2.2	45 CFR 170.215(j)(3)(i)
HL7 FHIR® CARIN Consumer Directed Payer Data Exchange (CARIN IG for Blue Button®) [Implementation Guide], Version 2.2.0 - STU 2.2	45 CFR 170.215(k)(1)(i)
HL7 FHIR® Da Vinci Payer Data Exchange (PDex) US Drug Formulary Implementation Guide, Version 2.1.0 - STU 2.1	45 CFR 170.215(m)(1)
HL7 FHIR® Da Vinci PDex [Payer Data Exchange] Plan Net Implementation Guide, Version 1.2.0 - STU 1.2	45 CFR 170.215(n)(1)

Selected Comments/Responses. ONC says most commenters supported the proposed expiration date of January 1, 2028, for previously adopted standards, which would mean implementers required to use a standard in an applicable section of 170.215 would need to use the proposed updated versions of the standards after that date. ONC responds that while transitions periods can be helpful, they are not appropriate in every scenario when moving between two versions of required standards.

ONC disagrees with commenters who believe the proposed expiration date of January 1, 2028, for previously adopted versions would support preparation for the January 1, 2027, compliance date for establishment of certain payer APIs. ONC believes having multiple standards in effect as of January 1, 2027, may present risks under certain circumstances, such as potential interoperability issues. Several commenters also raised concerns with multiple versions of the same standard during the transition period, which they assert could cause misalignment in capabilities and functionalities between exchange partners.

ONC acknowledges the preference many commenters expressed for an expiration date of January 1, 2028, for previously adopted versions of standards. However, it nonetheless remains convinced that the alternative proposal is the most effective way to address the interoperability and compatibility concerns raised by having multiple standards in effect during a transition period. It believes replacing these standards with the updated versions upon the effective date of this final rule will ensure that the entities using these standards will develop to a common baseline as they initially deploy systems to meet proposed and finalized requirements. By removing previously adopted versions that would soon become obsolete, ONC believes it is ensuring that regulated entities focus development efforts on versions of the standards that will effectively support interoperability.

ONC reiterates that CMS is not addressing in this final rule the compliance dates proposed in the 2026 CMS Interoperability Standards and Prior Authorization for Drugs proposed rule for payer APIs to conform to these standards. The updated versions of standards finalized in this final rule would only be required for payer APIs if CMS finalizes its proposals in a future 2026 CMS Interoperability Standards and Prior Authorization for Drugs final rule.

5. Incorporation by Reference

In accordance with regulations,[137] ONC summarizes in section X.E.9 of the final rule the material it incorporates by reference in the Code of Federal Regulations. ONC also lists several methods by which the materials may be accessed by interested parties, including online and in-person options. Links to the implementation guides for the standards finalized in this final rule are shown above in section X.E.3 of this summary.

6. Impact

ONC states that the changes between the currently adopted standard versions and these new standard versions are small in scope and would not require significant effort to adopt. ONC determines that the finalized updates would not require new adoption of technology by health IT users or adoption of new certification criteria by developers of certified health IT, as those requirements are associated with prior finalized CMS and ONC rulemaking. ONC estimates that developers of certified health IT would face little burden to adopt the updated standard versions given these factors, and it estimates that the effort on those developers to adopt these standard versions would be de minimis.

XI. Medicare Payment Advisory Commission (MedPAC) Recommendations

In its March 2026 Report to Congress, MedPAC recommended an update to the hospital inpatient rates by the amount specified in current law. CMS responded that consistent with the statute, it proposed an applicable percentage increase for FY 2027 of 2.4 percent provided the hospital submits quality data and is a meaningful EHR user. Based on later information, CMS is finalizing an update of 2.3 percent for FY 2027.

MedPAC further recommended redistributing disproportionate share hospital (DSH) and

[137] See 1 CFR 51.5(a) and (b)(2).

uncompensated care payments using the MedPAC-developed Medicare Safety-Net Index (MSNI) for hospitals. MedPAC recommended adding $1 billion to this MSNI pool of funds to help maintain the financial viability of Medicare safety-net hospitals and recommended transitional approaches for an MSNI policy. However, CMS cannot implement MSNI under current law. The proposed rule described CMS' authority under section 1886(r) of the Act, which requires that it to distribute DSH and uncompensated care payments according to a formula specified in statute.

TABLE I.—FY 2027 FINAL RULE IMPACT ANALYSIS

	Number of Hospitals[1]	FY 2027 Outlier Payments (1)[2]	FY 2027 Hospital Rate Update (2)[3]	MDH Expiration (3)[4]	FY 2027 Uncompensated Care Payments (4)[5]	FY 2027 Weights and DRG Changes with Application of Recalibration Budget Neutrality (5)[6]	FY 2027 Wage Index (6)[7]	All FY 2027 Changes (7))[8]
All Hospitals	3,005	-0.6	2.2	-0.1	0.2	0.0	0.0	1.7
By Geographic Location:								
Urban hospitals	2,357	-0.7	2.2	-0.1	0.3	0.0	0.0	1.8
Rural hospitals	648	-0.2	2.2	-0.5	-0.1	-0.4	0.0	1.1
Bed Size (Urban):								
0-99 beds	640	-0.5	2.2	-1.4	0.1	0.0	-0.2	0.2
100-199 beds	673	-0.6	2.2	-0.1	0.1	-0.2	0.0	1.5
200-299 beds	400	-0.5	2.2	0.0	0.2	-0.1	-0.1	1.6
300-499 beds	393	-0.6	2.2	0.0	0.2	0.0	-0.1	1.6
500 or more beds	249	-0.8	2.1	0.0	0.4	0.2	0.2	2.1
Bed Size (Rural):								
0-49 beds	309	-0.2	2.1	-0.9	0.0	-0.5	-0.1	0.3
50-99 beds	174	-0.2	2.2	-1.2	0.0	-0.5	0.1	0.5
100-149 beds	95	-0.2	2.2	0.0	-0.1	-0.4	-0.1	1.4
150-199 beds	41	-0.2	2.2	0.0	-0.3	-0.3	0.1	1.4
200 or more beds	29	-0.4	2.2	0.0	0.0	-0.2	0.2	1.9
Urban by Region:								
New England	102	-0.6	2.2	-0.1	0.1	-0.1	0.3	1.9
Middle Atlantic	272	-0.7	2.2	-0.1	0.3	-0.1	1.0	2.7
East North Central	364	-0.5	2.2	-0.2	0.0	0.0	0.6	2.2
West North Central	155	-0.5	2.2	0.0	-0.1	0.1	-0.9	0.7
South Atlantic	393	-0.6	2.1	-0.1	0.3	0.0	0.5	2.3
East South Central	139	-0.6	2.1	0.0	0.3	0.1	-1.0	0.9
West South Central	356	-0.5	2.0	0.0	0.8	0.1	-0.3	2.1
Mountain	177	-0.6	2.2	0.0	0.5	0.1	-0.8	1.4
Pacific	347	-1.0	2.2	0.0	0.1	0.0	-1.0	0.3
Rural by Region:								
New England	19	-0.5	2.3	-1.1	0.1	-0.3	1.0	1.6
Middle Atlantic	46	-0.3	2.2	-0.1	0.1	-0.4	-0.1	1.4
East North Central	104	-0.3	2.2	-1.2	-0.1	-0.3	0.8	1.2
West North Central	71	-0.2	2.2	-0.3	-0.2	-0.3	-0.5	0.7
South Atlantic	110	-0.2	2.1	-0.5	-0.3	-0.4	0.5	1.1
East South Central	119	-0.2	2.1	-0.3	0.1	-0.3	-0.9	0.6
West South Central	114	-0.2	2.1	-0.1	-0.2	-0.3	-0.4	0.9
Mountain	41	-0.1	2.3	0.0	0.2	-0.1	0.1	2.3
Pacific	24	-0.2	2.3	0.0	0.0	-0.6	-0.4	1.2
Puerto Rico								
Puerto Rico Hospitals	52	-0.3	1.4	0.0	0.2	-0.1	-1.8	-0.5
By Payment Classification:								
Urban hospitals	1,524	-0.7	2.2	0.0	0.3	-0.1	-0.3	1.5
Rural areas	1,481	-0.6	2.2	-0.1	0.2	0.0	0.2	1.8
Teaching Status:								
Nonteaching	1,696	-0.6	2.2	-0.3	0.1	-0.1	-0.1	1.2
Fewer than 100 residents	1,003	-0.6	2.2	-0.1	0.2	-0.1	-0.1	1.6
100 or more residents	306	-0.7	2.1	0.0	0.4	0.2	0.2	2.1
Urban DSH:								
Non-DSH	370	-0.6	2.3	-0.1	0.0	0.0	0.2	1.9
100 or more beds	827	-0.7	2.1	0.0	0.4	-0.1	-0.3	1.4
Less than 100 beds	327	-0.5	2.1	0.0	0.2	-0.3	-0.2	1.2
Rural DSH:								

	Number of Hospitals[1]	FY 2027 Outlier Payments (1)[2]	FY 2027 Hospital Rate Update (2)[3]	MDH Expiration (3)[4]	FY 2027 Uncompensated Care Payments (4)[5]	FY 2027 Weights and DRG Changes with Application of Recalibration Budget Neutrality (5)[6]	FY 2027 Wage Index (6)[7]	All FY 2027 Changes (7))[8]
Non-DSH	130	-0.5	2.3	-1.3	0.0	0.0	0.2	0.7
SCH	212	-0.1	2.2	0.0	0.0	-0.4	0.2	2.0
RRC	923	-0.6	2.1	0.0	0.2	0.1	0.2	1.9
100 or more beds	31	-0.6	2.1	-0.1	0.3	0.1	0.9	2.7
Less than 100 beds	185	-0.2	2.1	-2.4	0.0	-0.5	0.1	-1.1
Urban teaching and DSH:								
Both teaching and DSH	480	-0.6	2.1	0.0	0.5	-0.1	-0.2	1.7
Teaching and no DSH	68	-0.6	2.3	-0.3	0.0	-0.1	0.2	1.6
No teaching and DSH	674	-0.7	2.2	0.0	0.2	-0.2	-0.6	0.9
No teaching and no DSH	302	-0.6	2.3	0.0	0.0	0.2	0.2	2.1
Special Hospital Types:								
SCH	419	-0.2	2.3	0.0	0.0	-0.3	0.1	1.9
MDH	166	-0.2	2.2	-8.3	0.0	-0.4	0.1	-6.8
Type of Ownership:								
Voluntary	1,905	-0.6	2.2	-0.1	0.2	0.0	0.1	1.7
Proprietary	693	-0.4	2.2	0.0	0.1	0.0	-0.4	1.4
Government	405	-0.7	2.0	0.0	0.7	0.1	-0.1	2.0
Medicare Utilization as a Percent of Inpatient Days:								
0-25	1,664	-0.6	2.1	0.0	0.4	0.0	0.0	1.9
25-50	1,265	-0.7	2.2	-0.2	0.0	-0.1	0.1	1.5
50-65	41	-0.4	2.3	-0.1	0.0	0.0	0.6	2.3
Over 65	9	-0.2	2.3	-4.6	0.0	0.7	-0.2	-2.2
Medicaid Utilization as a Percent of Inpatient Days:								
0-25	2,037	-0.6	2.2	-0.1	0.1	0.0	0.1	1.7
25-50	860	-0.7	2.1	0.0	0.3	0.1	-0.1	1.8
50-65	84	-0.7	1.8	0.0	1.3	-0.2	-0.7	1.6
Over 65	24	-0.9	2.1	0.0	0.3	-0.2	-1.6	-0.4
FY 2027 Reclassifications:								
All Reclassified Hospitals	1,103	-0.6	2.2	-0.1	0.2	0.0	0.2	1.9
Non-Reclassified Hospitals	1,902	-0.6	2.1	-0.1	0.3	-0.1	-0.2	1.5
Urban Hospitals Reclassified	977	-0.7	2.2	-0.1	0.2	0.1	0.2	1.9
Urban Non-reclassified Hospitals	1,398	-0.7	2.2	0.0	0.3	-0.1	-0.3	1.4
Rural Hospitals Reclassified Full Year	272	-0.2	2.2	-0.2	-0.1	-0.4	-0.1	1.2
Rural Non-reclassified Hospitals Full Year	358	-0.3	2.2	-0.6	0.1	-0.4	0.3	1.2
All hospitals that reclassified from urban to rural in accordance with section 1886(d)(8)(E) as implemented at 42 CFR 412.103	885	-0.7	2.2	-0.1	0.2	0.1	0.2	1.9
Other Reclassified Hospitals (Section 1886(d)(8)(B), also known as Lugar hospitals)	52	-0.3	2.2	-1.6	0.1	-0.5	0.0	-0.1

[1] Because data necessary to classify some hospitals by category were missing, the total number of hospitals in each category may not equal the national total. Discharge data are from FY 2025, and hospital cost report data are from the latest available reporting periods.

[2] This column displays the effects of estimated outlier payments returning to their targeted levels in FY 2027 as compared to the estimated outlier payments for FY 2026.

[3]This column displays the payment impact of the hospital rate update, including the 2.3 percent update to the national standardized amount and the hospital-specific rate (the 3.2 percent IPPS market basket rate-of-increase reduced by the 0.9 percentage point for the productivity adjustment).

[4] This column displays the impact of the expiration of the MDH status on January 1, 2027, a non-budget neutral payment provision.
[5] This column displays the effects of the changes to estimated uncompensated care payments in FY 2027 as compared to FY 2026 as a percent change in estimated total payments. See also the table in section I.G.2 of this Appendix.
[6] This column displays the payment impact of Version 44 GROUPER, the changes to the relative weights and the recalibration of the MS-DRG weights based on FY 2025 MedPAR data, and the 10-percent cap where the relative weight for a MS-DRG will decrease by more than ten percent in a given fiscal year. This column displays the application of the recalibration budget neutrality factor and the 10-percent cap budget neutrality factor (which can be found in section II.A.4 of the Addendum of this final rule).
[7] This column displays the effects of the changes to the FY 2027 wage index. This includes: (1) the update to wage index data using FY 2023 cost report data, the application of the wage index budget neutrality factor and the update to the labor and nonlabor shares; (2) the effects of geographic reclassifications by the Medicare Geographic Classification Review Board (MGCRB), showing the payment impact of going from FY 2026 reclassifications to the reclassifications scheduled to be in effect for FY 2027; (3) the effects of the application of the rural floor; (4) the effects of urban to rural reclassifications under section 1886(d)(8) of the Act on the wage index; (5) the effects of the application of "LUGAR" status under section 1886(d)(10) of the Act on the wage index; and (6) the adjustments to the wage index driven by non-budget neutral policies. These non-budget neutral policies include: (a) the imputed floor for all-urban states; (b) the policy that requires hospitals located in frontier States have a wage index no less than 1.0; and (c) the policy which provides for an increase in a hospital's wage index if a threshold percentage of residents of the county where the hospital is located commute to work at hospitals in counties with higher wage indexes. The budget neutrality factors for the effects that are budget neutral can be found in section II.A.4 of the Addendum of this final rule. This column also displays the redistributive effects of the budget neutral transition for the discontinuation of the low wage index hospital policy from hospitals that do not benefit from the transition to hospitals that do benefit (primarily all the hospitals located in Puerto Rico) due to the associated budget neutrality factor. The budget neutrality factor for the transition can be found in section II.A.4 of the Addendum of this final rule.
[8]This column shows the estimated change in payments from FY 2026 to FY 2027.