

Fiscal Year 2027 Medicare Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System Proposed Rule (CMS-1849-P) Summary

On April 10, 2026, the Centers for Medicare & Medicaid Services (CMS) released its proposed 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 proposed rule was published in the *Federal Register* on April 14, 2026. **The public comment period will end on June 9.**

The payment rates and policies described in the FY 2027 IPPS proposed 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 had to meet a cost test, not a test of newness and substantial clinical improvement. There is also a proposal 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 proposed rule. These data files are generally available at: [FY 2027 IPPS Proposed Rule Home Page | CMS](#). Numbered tables included in the IPPS/LTCH rule are only available on the CMS website at the above hyperlink.

TABLE OF CONTENTS		
I.	IPPS Rate Updates and Impact of the Rule; Outliers	3
	A. Inpatient Hospital Operating Update	3
	B. Payment Impacts	3
	C. IPPS Standardized Amounts	6
	D. Outlier Payments and Threshold	7
II.	Medicare Severity (MS) Diagnosis-Related Groups (DRGs)	10
	A. Adoption of the MS-DRGs in FY 2008	10
	B. Changes to Specific MS-DRG Classifications	11
	C. Recalibration of the MS-DRG Relative Weights	38
	D. Add-On Payments for New Services and Technologies	40
III.	Changes to the Hospital Wage Index for Acute Care Hospitals	80
	A. Background	80
	B. Labor Market Area Delineations	80
	C. Worksheet S-3 Wage Data	80

	D.	Method for Computing the Unadjusted Wage Index	81
	E.	Occupational Mix Adjustment	81
	F.	Geographic Reclassifications	82
	G.	Wage Index Floors, Outmigration Adjustment and Other Wage Index Policies	85
	H.	Wage Index Tables	86
	I.	Labor-Related Share	86
IV.		Disproportionate Share (DSH) and Uncompensated Care Payments (UCP)	87
	A.	Background	87
	B.	Supplemental Payments: Indian Health Service (IHS), Tribal and Puerto Rico Hospitals	87
	C.	Uncompensated Care Payments	88
	D.	Payment Impacts	92
V.		Other Decisions and Changes to the IPPS for Operating System	93
	A.	Post-Acute Care Transfer Policy	93
	B.	Inpatient Hospital Update	94
	C.	Rural Referral Centers (RRCs)	95
	D.	Low-Volume Hospitals (LVH)	95
	E.	Medicare Dependent Small Rural Hospitals(MDH)	97
	F.	Indirect and Direct Graduate Medical Education	97
	G.	Nursing and Allied Health Education (NAH)	100
	H.	Payment Adjustment for Certain Immunotherapy Cases	103
	I.	Hospital Readmissions Reduction Program (HRRP)	104
	J.	Hospital Value-Based Purchasing Program (HVBP)	107
	K.	Hospital-Acquired Conditions (HAC) Reduction Program	111
	L.	Rural Community Hospital Demonstration Program	112
VI.		Changes to the IPPS for Capital-Related Costs	113
VII.		Changes for Hospitals Excluded from the IPPS	116
	A.	Rate-of-Increase	116
	B.	Critical Access Hospitals (CAHs)	116
VIII.		Long-Term Care Hospital Prospective Payment System (LTCH PPS)	117
	A.	Background	117
	B.	MS-LTC-DRGs and Relative Weights	119
	C.	Update and Other Changes to the LTCH PPS Payment Rates	124
	D.	Impact	130
IX.		Quality Data Reporting Requirements for Specific Providers	131
	A.	Overview	131
	B.	Crosscutting Quality Proposals and Requests for Request for Information (RFI)	131
	C.	Hospital Inpatient Quality Reporting Program (IQR)	138
	D.	PPS-Exempt Cancer Hospital Quality Reporting Program (PCH QRP)	151
	E.	Long-Term Care Hospital Quality Reporting Program (LTCH QRP)	156
	F.	Medicare Promoting Interoperability Program	160
X.		Other Provisions	174
	A.	Transforming Episode Accountability Model (TEAM)	174
	B.	Provider-Based Location Criteria	185
	C.	Expansion of the Comprehensive Joint Replacement (CJR) Model	185
	D.	Organ Acquisition and Reasonable Cost Payment Policies	209
XI.		Medicare Payment Advisory Commission (MedPAC) Recommendations	214
APPENDIX: IPPS Regulatory Impact Analysis Table			215

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

CMS estimates that the proposed rule will increase FY 2027 combined operating and capital payments to approximately 3,013 acute care hospitals paid under the IPPS by an estimated \$1.9 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 2.4 percent for hospitals that successfully report quality measures and are meaningful users of electronic health records (EHR). The 2.4 percent rate increase is the net result of a market basket update of 3.2 percent less 0.8 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 hospital 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	2.4	-0.8	1.6%
No EHR	75% of the MB	3.2	2.4	-2.4	0.0%
No IQR/EHR	100% of the MB	3.2	2.4	-3.2	-0.8%

B. Payment Impacts

CMS' impact table for IPPS operating costs shows FY 2027 payments increasing 1.2 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	-0.7 ²
Expiration of the MDH Program	-0.1 ³
FY 2027 Change to Uncompensated Care Payments	-0.2 ⁴

Contributing Factor	National Percentage Change
Wage Index Changes	-0.1 ⁵
Total	+1.2

¹ CMS indicates that this figure is 2.2 percent even though the update is 2.4 percent. The proposed rule indicates that it also includes the effect of the reduced update for hospitals not compliant with the IQR and EHR programs which must account for the 0.2 percentage point.

² CMS targets 5.1 percent of IPPS payments as outliers but estimates that it will pay 6.0 percent of IPPS payments as outliers in FY 2026 or 0.9 percentage points more than the target. As a result, CMS estimates total payments will decrease by 0.9 percentage points due to targeting 5.1 percent of total IPPS payments as outliers for FY 2027 and attribute 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.

⁴ These estimates can change substantially between the proposed and final rules because of a re-estimate of the factors affecting uncompensated care between the proposed and final rule in the National Health Expenditures Accounts.

⁵ CMS shows all wage index changes, including non-budget neutral changes in a single column that shows a -0.1 percentage point reduction in payments across all hospitals.

Table I Impact Analysis

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

Hospital Type	All Proposed Rule Changes
All Hospitals	1.2%
Urban	1.2%
Rural	0.8%
Major Teaching	1.5%

To the extent the impact on a given hospital category deviates from the national average of 1.2 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 proposing to continue NTAP payments for 41 technologies that remain eligible for add-on payments in FY 2027 and estimates Medicare will pay \$836 million in FY 2027 for these technologies.

Generally, CMS will discuss new NTAP applications under the traditional pathway—those requiring a substantial clinical improvement determination—in the proposed rule and not make a determination on substantial clinical improvement until the final rule.

For alternative pathway applications where the Food and Drug Administration (FDA) approval process is considered a proxy for substantial clinical improvement, CMS is proposing to approve 22 alternative pathway applications and estimates total expenditures of \$589 million.

Uncompensated Care. Medicare payments to be distributed for uncompensated care costs are estimated to decrease by \$253 million or by 3.3 percent. CMS estimates the change in uncompensated care payments between the proposed and final rule will change when it updates the National Health Expenditures Accounts in June at the same time it releases the Medicare Trustees Report.

Supplemental payments to Puerto Rico, Indian Health Service (IHS) and Tribal Hospitals are estimated to decrease another \$5.1 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) established the LVH program and provided authority to the Secretary to make an empirical determination of the payment for LVHs. Subsequent legislation changed the criteria to allow more hospitals to qualify. However, those qualifying criteria will expire on December 31, 2026, absent congressional intervention. CMS estimates that 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 proposing to add sepsis as an applicable condition beginning with the FY 2029 program year. In FY 2026, CMS adopted a policy to include Medicare Advantage (MA) beneficiaries into 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 indicates that it is unable to estimate the costs associated with adding sepsis as an applicable readmission condition beginning with FY 2029.

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 proposed 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.7.-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 2,455 hospitals. Table 1.G.8.-01 in the impact

section illustrates the proposed average net percentage payment adjustment by category of hospital (e.g., Large Urban, Other Urban, Rural) 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 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 proposes to continue 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. For the FY 2027 proposed rule, CMS is not yet able to finalize the estimated the FY 2027 costs of the demonstration and is not proposing a budget neutrality adjustment. CMS is proposing 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.

C. IPPS Standardized Amounts

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

	Update
Full Update	2.4%
No IQR	1.6%
No EHR	0.0%
No EHR/IQR	-0.8%

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, 0.99687 (a decrease of 0.13 percent).
- MS-DRG recalibration cap, 0.999753 (a decrease of 0.02 percent).
- Wage index, 1.000296 (an increase of 0.03 percent).
- Geographic reclassification, 0.972154 (a decrease of 2.78 percent).
- Transition for eliminating low-wage index policy 0.999782 or -0.02 percent.
- 5 percent cap on wage index reductions, 0.991972 or -0.80 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	2.4%
DRG Recalibration	-0.13%
DRG Recalibration Cap	-0.02%
Wage Index	0.03%
Geographic Reclassification	1.60%
25 th Percentile Transition Budget Neutrality	0.01%
5% Cap on Wage Index Reductions	-0.74%
Rural Community Hospital Demo	0.06%
Outlier	0.00%
Net Change*	3.19%

*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 +0.06 percent is from removing the FY 2026 adjustment.

The proposed increase in the capital rate is 4.0 percent from \$524.15 to \$545.22. The combined increase in the proposed operating standardized amount and the capital rate is 3.25 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%)	\$4,598.80	\$4,491.02	\$4,562.87	\$4,455.09
Non-Labor (34.0%)	\$2,369.07	\$2,313.54	\$2,350.56	\$2,295.04
WI<=1.0				
Labor (62%)	\$4,320.08	\$4,218.83	\$4,286.33	\$4,185.08
Non-Labor (38%)	\$2,647.79	\$2,585.73	\$2,627.10	\$2,565.05
National Capital Rate (All Hospitals)	\$545.22			

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 proposes adopting 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. CMS projects that the proposed outlier threshold for FY 2027 will result in outlier payments equal to 5.1 percent of operating DRG payments and 3.58 percent of capital payments. Accordingly, CMS is applying adjustments of 0.949 to the operating standardized amounts and 0.964231 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 December 2025 update to the FY 2025 Medicare Provider Analysis and Review File (MedPAR). The latest cost report data is the December 2025 update of the Provider-Specific File (PSF).

Charge Inflation. CMS proposes 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	\$623,467,062,919	6,868,125	\$90,776.90
FY 2025	\$677,169,023,175	6,951,572	\$97,412.36
Annual Rate of Increase			7.31%
Squared for 2 Years of Inflation			1.15154

CCRs. As it has done in the past, CMS is proposing to adjust the CCRs from the December 2025 update of the PSF by comparing the percentage change in the national average case weighted operating CCR and capital CCR from the December 2024 update of the PSF to the national average case weighted operating CCR and capital CCR from the December 2025 update of the PSF.

These data are shown in the table below.

	December 2024 PSF	December 2025 PSF	% Change	Factor
Operating	0.24059	0.235176	-2.25%	0.977497
Capital	0.01644	0.015639	-4.87%	0.951277

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 proposed rule, CMS is using the December 2025 extract of the Hospital Cost Report Information System (HCRIS) to determine the reconciliation amounts.

CMS determined 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 Medicare additional outlier funding). For FY 2027, CMS found that reconciliation would also be a small positive value.

As it found for FY 2026 using FY 2020 cost reports, CMS believes using the FY 2021 cost report data for FY 2027 reconciliation is producing an anomalous result. For this reason, CMS is proposing 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 less negative 0.04 percent or 5.14 percent). CMS will reevaluate this issue in the final rule with more updated data to determine whether the data used to determine outlier reconciliation remains anomalous.

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 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 proposed rule outlier threshold. CMS will also reconsider its capital reconciliation adjustment based on updated data available for the final rule.

FY 2025 Outlier Payments. CMS' current estimate, using available FY 2025 claims data, is that outlier payments for FY 2025 were approximately 4.86 percent of total MS-DRG payments or 0.24 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 proposed rule, CMS estimates that, using FY 2025 data, outlier payments will be 0.9 percentage points higher (6.0 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 account for changes in resource consumption. These adjustments are made to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. In FY 2008, CMS made significant changes to the prior 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 would be applied. For more information on these issues, CMS refers readers to the FY 2023 IPPS final rule (87 FR 48799 through 48800).

The offset adjustment to recoup expenditures associated with documentation and coding totaled 3.9 percent. However, CMS only returned 2.9588 of that 3.9 percent to the IPPS standardized amounts once the recoupment was completed. CMS argues that the statute does not authorize reinstating the remaining 0.9412 to the standardized amounts and rejected public comments in prior rules suggesting otherwise. The issue is now the subject of litigation in Federal Court.

B. Changes to Specific MS-DRG Classifications

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

a. Change Request Processes and Resources

Providers use the ICD-10 coding system to report diagnoses and procedures for Medicare hospital inpatient services under the MS-DRG system. MS-DRG change requests are accepted by CMS annually through the Medicare Application Request Information System™ (MEARIS) at [MEARIS™ | Home](#).¹ The deadline for submitting MS-DRG classification change requests to CMS for FY 2027 was October 20, 2025. Change requests may include requests to create, modify, or delete MS-DRGs, change ICD-10-CM diagnosis code(s) severity level designations, change ICD-10-PCS procedure code(s), Operating Room (OR) designations, or to review the complication or comorbidity (CC) Exclusions List or the surgical hierarchy. For FY 2028, the submission deadline is October 20, 2026.

CMS explains 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.

In the preamble, CMS provides detailed information related to the various aids CMS makes available so the public can better analyze and understand the impact of the proposals included in this proposed rule. For example, as in years past, CMS is providing a test version of the ICD-10 MS-DRG GROUPER Software (Version 44) which reflects the information found in Tables 6A-D that are available at: [FY 2027 IPPS Proposed Rule Home Page | CMS](#). As a result of new and modified code updates approved after the annual spring ICD-10 Coordination and Maintenance Committee meeting, any further changes to the MCE will be reflected in the finalized Definitions of Medicare Code Edits (MCE) Manual, made available in association with the annual IPPS/LTCH PPS final rule. Questions, comments, or recommendations regarding the MCE must be submitted to CMS at MSDRGClassificationChange@cms.hhs.gov so they may be reviewed and considered. 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](#).

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.

b. Overview of CMS' MS-DRG Analysis

In this section (II.C.1) of the preamble, CMS discusses its processes for making changes to MS-DRG classifications and proposes specific changes for FY 2027. Based on CMS' analysis of claims data and clinical appropriateness, CMS may either propose changes to the MS-DRG classification or propose maintaining the existing MS-DRG classification. CMS invites public comments on each proposed change. For this 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 describes what factors it 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 applies criteria to create subgroups, as described in the following table (reproduced below from the preamble):

Criteria Number	Three-Way Split 1_2_3 (MCC vs CC vs NonCC)	Two-Way Split 1_2_3 MCC vs (CC+NonCC)	Two-Way Split 1_2_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_2_3 split within the base MS-DRG	$R2 \geq 3.0$ for the two-way 1_2_3 split within the base MS-DRG

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

When analyzing requests to create a new MS-DRG, CMS 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 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 uses 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. When reviewing consumption of hospital resources, CMS noted that it is unclear to what degree the higher average costs for the analyzed cases are attributable to the severity of illness of the patient and other circumstances of the admission as opposed to the insertion of a short-term external heart

³ As noted in prior rulemaking (80 FR 49368)

assist device, and that there may have been other factors contributing to the higher costs. Additionally, to avoid unintended consequences, CMS believes that the diagnosis codes describing pulmonary embolism are most clinically aligned with the other diagnosis codes assigned to MDC 04 (where they are currently assigned). Finally, as requested, CMS explored alternative options for reassignment, however, for reasons explained in the preamble, the agency's review did not support any alternatives.

Based on the analyses performed, CMS is not proposing 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.

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.

Therefore, for FY 2027, CMS is proposing to maintain the current structure of MS-DRGs 163, 164, and 165. CMS indicates that it intends to continue to evaluate the clinical coherence and resource consumption costs that impact this subset of cases and their MS-DRG assignment.

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

In support of the new technology add-on payment application that was submitted for FY 2026 consideration, CMS received a request to create new ICD-10-PCS codes to differentiate cardiac procedures that involve the insertion of an implantable endocardial pacing system, such as the WiSE® CRT System, and a code proposal was displayed in association with the Spring

2025 ICD-10 Coordination and Maintenance Committee Update. As a result, effective October 1, 2025 (FY 2026), CMS implemented two ICD-10-PCS procedure codes (X2HN37B in combination with XHH80HB) to identify the insertion of the WiSE® CRT System 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 ICD-10-PCS procedure code X2HN37B that describes the insertion of the WiSE® CRT System from MS-DRGs 242, 243, and 244 to MS-DRGs 228 and 229 which the requestor said would more appropriately group the procedure with other leadless pacemaker cases.

CMS began its analyses by reviewing the procedure codes. CMS agrees 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. Therefore, to improve clinical coherence and to better account for the anticipated resources required, for FY 2027, CMS is proposing to reassign procedure code X2HN37B (Insertion of endocardiac pacing electrode into left ventricle, percutaneous approach, new technology group 11) from MS-DRG 264 to MS-DRGs 228 and 229. CMS is also proposing to delete the procedure code combination of X2HN37B and XHH80HB from the GROUPER logic of MS-DRGs 242, 243, and 244. CMS notes that under this proposal, procedure code X2HN37B would no longer need to be reported as part of a procedure code combination to satisfy the logic for assignment to MS-DRGs 228 and 229. When reported as a standalone procedure, ICD-10-PCS code XHH80HB will be assigned to proposed new MDC 05 MS-DRG 210 (Cardiac Pacemaker Revision or Device Replacement with MCC) and proposed new MS-DRG 211 (Cardiac Pacemaker Revision or Device Replacement without MCC), which are discussed below.

In CMS' review of claims for this request, the agency identified a low volume of cases for MS-DRGs 258 and 259 (Cardiac Pacemaker Device Replacement with MCC and without MCC, respectively), where procedure code XHH80HB is assigned when reported as a standalone procedure in Version 43.1. As a result, CMS further examined whether there were other MS-DRGs to which these cases could appropriately be reassigned, specifically identifying MS-DRGs 260, 261, and 262. Based on this further analysis and for reasons described more fully in the preamble of the proposed rule, for FY 2027, CMS proposes to delete MS-DRGs 258, 259, 260, 261, and 262 and to create two new MS-DRGs with a two-way severity level split for cases reporting procedure codes describing cardiac pacemaker revision or device replacement in MDC 05. These new MS-DRGs are proposed as new MS-DRG 210 (Cardiac Pacemaker Revision or Device Replacement with MCC) and as new MS-DRG 211 (Cardiac Pacemaker Revision or Device Replacement without MCC).⁴

⁴ For a list of procedure codes CMS is proposing to define in the logic for the proposed new MS-DRGs, see Table 6P.2a. Additionally, the discussion of the surgical hierarchy for the proposed modification is discussed in section II.C.14. of the proposed rule preamble and this summary.

Additionally, for FY 2027, CMS is proposing to delete base MS-DRG 264 and to 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. These new MS-DRGs are proposed as new MS-DRG 361 (Other Circulatory System O.R. Procedures with MCC) and as new MS-DRG 362 (Other Circulatory System O.R. Procedures without MCC). Under this proposal, CMS would reassign the 1,447 listed procedure codes in the GROUPER logic of MS-DRG 264 to new MS-DRGs 361 and 362.⁵

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

a. *Spinal Fusion and Pelvic Fixation Procedures*

As discussed in the FY 2026 IPPS proposed rule, CMS received a request to modify the GROUPER logic of several spinal fusion procedure MS-DRGs (specifically, MS-DRGs 426, 427, and 428; MS-DRGs 447 and 448; MS-DRGs 456, 457, and 458) by reassigning cases with an ICD-10-PCS code that describes “fusion of a sacroiliac (SI) joint using an internal fixation device with tulip connector or insertion of an internal fixation device with tulip connector into a pelvic bone” with another spinal fusion procedure code that currently maps [from] the lower severity level MS-DRG to the highest severity level (with MCC) MS-DRG. At that time, CMS indicated that due to the complexities and intricate logic inherent in these codes, the agency would need more time to consider this request.

For FY 2027, CMS received another request from the same 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 the previously listed MS-DRGs. CMS provides a detailed summary of the manufacturer’s request in the preamble and the ICD-10-PCS codes⁶ that may be reported to describe the iFuse Bedrock™ Granite Implant tulip connector device. CMS notes that because the ICD-10-PCS codes describing “Insertion” of internal fixation device with tulip connector are not assigned to one of the spinal fusion MS-DRGs as a standalone procedure, another ICD-10-PCS code describing a spinal fusion procedure would need to be reported on the same claim to group to one of the previously listed spinal fusion MS-DRGs.

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. CMS notes that reassignment of

⁵ For complete documentation of the GROUPER logic for MS-DRG 264, please refer to the ICD-10 MS-DRG Version 43.1 Definitions Manual which is available at: [MS-DRG Classifications and Software | CMS](#). The surgical hierarchy for the proposed modification is discussed in section II.C.14 of the preamble of the proposed rule and in this summary.

⁶ The ICD-10-PCS codes include XNH6058, XNH6358, XNH7058, XNH7358, XRGE058, XRGE358, XRGF058, XRGF358.

cases reporting the use of aprevo® technology was previously discussed in the FY 2024 and FY 2025 IPPS/LTCH PPS proposed and final rules. CMS lists 12 ICD-10-PCS codes that may be reported to describe lumbar fusion procedures that use the aprevo® device.⁷ CMS notes that for the Spring 2026 ICD-10-PCS code update, the manufacturer submitted a request to revise the descriptions for the procedure codes that describe use of the aprevo® device to specifically identify that the technology is designed from a virtual anatomic model.⁸ Because the deadline for public comments on the Spring 2026 procedure code update is April 17, the final code decisions on these proposals were not available to CMS for inclusion in Table 6B at the time the FY 2027 IPPS/LTCH proposed rule was published. If they are finalized, they will be specifically identified with a footnote in Table 6B in the final rule, and the public may provide feedback which will then be taken into consideration for the following fiscal year.

In response to these requests, CMS performed multiple analyses on the claims data from the September 2025 update of the FY 2025 MedPAR file to evaluate these requests. First, CMS analyzed claims data for MS-DRGs 028, 029, and 030 and for cases reporting a spinal fusion procedure with a custom-made anatomically designed interbody fusion device, cases reporting an SI joint fusion or spinal fusion procedure with insertion of an internal fixation device with tulip connector, and cases reporting an extensive fusion. Next, CMS analyzed claims data for MS-DRGs 402, 426, 427, 428, 447, 448, 450, 451, 456, 457, and 458 and for: 1) cases reporting a spinal fusion procedure with a custom-made anatomically designed interbody fusion device, 2) cases reporting an SI joint fusion or spinal fusion procedure with insertion of an internal fixation device with tulip connector, 3) cases reporting a fusion procedure with both technologies (that is, a single case reporting a procedure code describing a spinal fusion procedure with a custom-made anatomically designed interbody fusion device and another procedure code(s) describing an SI joint fusion or a spinal fusion procedure with insertion of an internal fixation device with tulip connector), 4) cases reporting an extensive fusion without either technology (that is, aprevo® or iFuse Bedrock™ Granite Implant System), 5) cases reporting an extensive fusion with a custom-made anatomically designed interbody fusion device, 6) cases reporting an extensive fusion with an SI joint fusion or spinal fusion procedure with insertion of an internal fixation device with tulip connector, and 7) cases reporting an extensive fusion with both technologies.

The results of these analyses are summarized in the preamble. For reasons described more fully in the preamble, CMS disagrees with the requested reassignment of cases reporting a spinal fusion procedure with the custom-made anatomically designed interbody fusion device from MS-DRG 402 to MS-DRG 450 because MS-DRG 450 is subdivided into two severity level subgroups and defined by single level spinal fusions (except cervical), meaning either the anterior column of the spine or the posterior column of the spine is fused in a single operative episode. Additionally, CMS disagrees with the requested reassignment of cases from the lower severity level to the higher severity level MS-DRG for cases reporting use of the aprevo® custom-made anatomically designed interbody fusion device, as well as for cases reporting use

⁷ The ICD-10-PCS codes include XRGA0R7, XRGA3R7, XRGA4R7, XRGB0R7, XRGB3R7, XRGB4R7, XRG0R7, XRG3R7, XRG4R7, XRGD0R7, XRGD3R7, XRGD4R7

⁸ The agenda and related meeting materials for these specific topics are available at: [ICD-10 Coordination and Maintenance Committee Procedure Code Materials | CMS](#)

of the iFuse Bedrock™ Granite Implant System. CMS highlights one significant finding, which is that extensive spinal fusion procedures, with or without the use of either or both technologies, increases resource utilization. To address the differences in resource utilization and additional treatment options for the patients whose spinal condition requires an extensive fusion procedure or a complex spinal fusion procedure that uses either the aprevo® custom-made anatomically designed interbody fusion device or the iFuse Bedrock™ Granite Implant System, CMS is proposing to establish a new base MS-DRG. Consistent with the agency’s process (as discussed in section II.C.1.b), CMS applied the established criteria to create subgroups in a base MS-DRG and determined that criteria were met for a three-way split.

In summary, for FY 2027, CMS is proposing 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). CMS is proposing to reassign cases reporting an extensive spinal fusion procedure from MS-DRGs 426, 427, 428, 456, 457 and 458 and to reassign cases reporting a spinal fusion procedure with use of the aprevo® 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. CMS is also proposing to revise the titles for MS-DRGs 426, 447, and 450 to remove the reference to “Custom-made Anatomically Designed Interbody Fusion Device” and to revise the titles for MS-DRGs 456, 457, and 458 to remove the reference to “Extensive Fusions”.⁹

b. Hip or Knee Procedures with Periprosthetic Joint Infection

In the FY 2026 IPPS proposed rule, CMS received a request to reassign cases reporting a hip or knee procedure with a principal diagnosis of periprosthetic joint infection (PJI) from the lower severity level “without CC/MCC” MS-DRG to the higher severity level “with CC” MS-DRG for: MS-DRGs 463, 464, and 465; MS-DRGs 466, 467, and 468; MS-DRGs 474, 475, and 476; MS-DRGs 480, 481, and 482; and MS-DRG 485, 486, and 487. For reasons more fully outlined in the preamble, based on CMS’ analysis of claims, CMS disagreed with the request and instead proposed to create new MS-DRGs 403 and 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC and without MCC, respectively). While several commenters expressed support for the proposal, one commenter stated they encountered inconsistencies when grouping cases using the Version 43 test GROUPER. In response, CMS provided details on how the GROUPER software program “clustering” may restrict MS-DRG assignment. In the end, in the FY 2026 IPPS final rule, as a result of CMS’ subsequent analysis, which involved removal of the restriction logic, and in addition to having an updated test Grouper that reflected potential changes, CMS did not finalize its proposal FY 2026, but stated that the agency would continue to consider these potential MS-DRG changes in future rulemaking. As discussed later in this section, CMS continues to believe it is appropriate to propose new MS-DRGs 403 and 404 to better differentiate and reflect the complexity of services, resource utilization, and severity of illness for patients diagnosed with a PJI. CMS describes the logic changes it made for the procedure code clusters within the MS-DRGs for its analysis. These changes are reflected in the test version of the ICD-10 MS-DRG GROUPER

⁹ Discussion of the surgical hierarchy for the proposed modification is discussed in section II.C.14 of the preamble of the proposed rule and this summary.

Software, Version 44, and the draft version of the ICD-10 MS-DRG Definitions Manual, Version 44 (available here: [MS-DRG Classifications and Software | CMS](#)).

Additionally in the FY 2026 IPPS proposed rule, CMS received and considered a separate request to modify the GROUPER logic of MS-DRGs 463, 464, and 465; MS-DRGs 466, 467, and 468; and MS-DRGs 492, 493, and 494 by reassigning cases with ICD-10-PCS code XW0V0P7 (Introduction of antibiotic-eluting bone void filler into bones, open approach, new technology group 7) that currently map to the lower severity level MS-DRG to the highest severity level (with MCC) MS-DRG. Due, in part, to the overlap in requests impacting the same MS-DRGs, CMS determined it needed more time to review and evaluate potential extensive modifications to the structure of these MS-DRGs in response to this request. For FY 2027, in addition to the previously listed MS-DRGs identified for CMS' consideration for FY 2026, the requestor added MDC 08 MS-DRGs 474, 475, and 476 and MS-DRGs 480, 481, and 482, that are also the subject of the request to reassign cases reporting a hip or knee procedure with a principal diagnosis of PJI from the lower severity level "without CC/MCC" MS-DRG to the higher severity level "with CC" MS-DRG, and further added MDC 08 MS-DRGs 477, 478, and 479. This same requestor submitted a request for the reassignment of cases reporting ICD-10-PCS code XW0V0P7 that currently map to 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 and MS-DRGs 628, 629, and 630 that is discussed separately in section II.C.5 of the preamble and this summary.

In response to this new request, CMS provides a historical overview of ICD-10-PCS code XW0V0P7 which was created in association with a new technology add-on payment application for CERAMENT® G, an implantable bone void filler combination device-drug product intended to treat bone infections.¹⁰ For the Spring 2026 ICD-10-PCS code update,¹¹ CMS notes that the manufacturer of CERAMENT® G submitted a request for a new code to describe another antibiotic-eluting bone void filler product, CERAMENT® V, as well as a revision to the existing code, ICD-10-PCS code XW0V0P7. Because the deadline for public comments on the Spring 2026 procedure code update is April 17, the final code decisions on these proposals were not available to CMS for inclusion in Table 6B at the time the FY 2027 IPPS proposed rule was published. If they are finalized, they will be specifically identified with a footnote in Table 6B in the final rule, and the public may provide feedback which will then be taken into consideration for the following fiscal year.

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, CMS continues its analysis of cases reporting a hip or knee procedure with a principal diagnosis of PJI, with removal of the restriction logic to address the request to reassign cases with ICD-10-

¹⁰ CMS refers readers to the September 8, 2020 ICD-10 Coordination and Maintenance Committee meeting materials found here: [ICD-10 Coordination and Maintenance Committee Procedure Code Materials | CMS](#). Additional discussion of CERAMENT® G can be found in section II.E.4 of the preamble of the FY 2026 IPPS proposed and final rules.

¹¹ [ICD-10 Coordination and Maintenance Committee Procedure Code Materials | CMS](#)

PCS code XW0V0P7. In the preamble, CMS presents a table showing the results of this analysis with removal of the restriction logic.

As a result of its analysis, CMS continues to believe the data support proposing a new base MS-DRG for the cases reporting a PJI with a hip or knee procedure to better differentiate and reflect the complexity of services, resource utilization, and severity of illness of these patients. CMS also proposes to remove diagnosis codes T84.53XA (Infection and inflammatory reaction due to internal right knee prosthesis, initial encounter) and T84.54XA (Infection and inflammatory reaction due to internal left knee prosthesis, initial encounter) from the logic for case assignment to MS-DRGs 485, 486, and 487 in association with the removal of the restriction logic so that cases reporting a PJI with a knee procedure from those MS-DRGs appropriately group to the proposed new base MS-DRG. CMS also proposes to redesignate procedure code XW0V0P7 from a “non-O.R. procedure” to a “non-O.R. procedure affecting the MS-DRG assignment” at the higher with MCC severity level for MS-DRGs 463, 474, 477, 480, and 492. With the proposed redesignation of code XW0V0P7 from non-O.R. to non-O.R. affecting the MS-DRG, these cases reporting ICD-10-PCS code XW0V0P7 would also be reassigned at the highest severity level in connection with a new base MS-DRG proposal and consistent with the proposal for assignment to MS-DRGs 463, 474, 477, 480, and 492 previously discussed. As such, the data support proposing a new base MS-DRG for cases reporting a principal diagnosis of PJI with a hip or knee procedure with or without procedure code XW0V0P7 with a two-way split. The following table illustrates CMS’ findings and reflects a simulation of the proposed 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) and MS-DRG 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection without MCC):

Proposed New MS-DRGs	Number of Cases	Average Length of Stay	Average Costs
With MCC	3,653	11.1	\$44,365
Without MCC	9,281	5.7	\$29,947

In connection with the proposed removal of the restriction logic, CMS notes that existing MS-DRGs 466, 467, and 468 and MS-DRGs 485, 486, and 487 would no longer meet criteria for a three-way split. The details of this analysis can be found in the preamble. As a result, CMS is proposing to delete MS-DRGs 466, 467, and 468 and create new base MS-DRG 499 (Revision of Hip or Knee Replacement). In conjunction with the creation of new base MS-DRG 499, CMS is proposing to remove 20 procedure codes (listed in a table in the preamble) from the logic list as individually listed codes. Additionally, CMS is proposing to delete MS-DRGs 485, 486, and 487 and create new base MS-DRG 400 (Knee Procedures with Principal Diagnosis of Infection).

To summarize, CMS proposes to:

- 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 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.
- 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 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 MS-DRG 463, 474, 477, 480, and 492 to reflect the proposed reassignment (see table below).
- Revise titles of MS-DRGs 463, 464, and 465 to replace the misleading term “and” with “or” (see table below). CMS explains that the logic for case assignment to these MS-DRGs is satisfied when either a procedure code describing a wound debridement or a skin graft (except hand) from the logic list is reported.

Current Description	Proposed Description
MS-DRG 463 Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders with MCC	MS-DRG 463 Wound Debridement or Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders with MCC or Insertion of Antibiotic-eluting Bone Void Filler
MS-DRG 474 Amputation for Musculoskeletal System and Connective Tissue Disorders with MCC	MS-DRG 474 Amputation for Musculoskeletal System and Connective Tissue Disorders with MCC or Insertion of Antibiotic-eluting Bone Void Filler
MS-DRG 477 Biopsies of Musculoskeletal System and Connective Tissue with MCC	MS-DRG 477 Biopsies of Musculoskeletal System and Connective Tissue with MCC or Insertion of Antibiotic-eluting Bone Void Filler
MS-DRG 480 Hip and Femur Procedures Except Major Joint with MCC	MS-DRG 480 Hip and Femur Procedures Except Major Joint with MCC or Insertion of Antibiotic-eluting Bone Void Filler
MS-DRG 492 Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC	MS-DRG 492 Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC or Insertion of Antibiotic-eluting Bone Void Filler
MS-DRGs 463, 464, and 465: Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders with MCC, without CC, and without CC/MCC (respectively)	MS-DRGs 463, 464, and 465: Wound Debridement or Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders with MCC, without CC, and without CC/MCC (respectively)

CMS notes that the surgical hierarchy is discussed in section II.C.14 of the preamble and that the proposed title changes are reflected in the test version of the ICD-10 MS-DRG GROUPER Software, Version 44, and the draft version of the ICD-10 MS-DRG Definitions Manual, Version 44, available here: [MS-DRG Classifications and Software | CMS](#)

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 of the proposed rule 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).

As noted previously, the ICD-10-PCS code XW0V0P7 was created in association with a new technology add-on payment application for CERAMENT® G, an implantable bone void filler combination device-drug product intended to treat bone infections.¹² For the Spring 2026 ICD-10-PCS code update,¹³ CMS notes that the manufacturer of CERAMENT® G submitted a request for a new code to describe another antibiotic-eluting bone void filler product, CERAMENT® V, as well as a revision to the existing code, ICD-10-PCS code XW0V0P7. Because the deadline for public comments on the Spring 2026 procedure code update is April 17, the final code decisions on these proposals were not available to CMS for inclusion in Table 6B at the time the FY 2027 IPPS proposed rule was published. If they are finalized, they will be specifically identified with a footnote in Table 6B in the final rule, and the public may provide feedback which will then be taken into consideration for the following fiscal year.

In the preamble, 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. As a result, CMS agrees with the requestor 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.

To better reflect the resource utilization and severity of illness of patients with diabetic osteomyelitis, for FY 2027, CMS is proposing 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 proposes to revise the title of MS-DRG 616 from "Amputation of Lower Limb for Endocrine, Nutritional and Metabolic Disorders with MCC" to "Amputation of Lower Limb for Endocrine, Nutritional and Metabolic Disorders with MCC or Insertion of Antibiotic-eluting Bone Void Filler" and to revise the title of MS-DRG 628 from "Other Endocrine, Nutritional and Metabolic O.R. Procedures with MCC" to "Other

¹² CMS refers readers to the September 8, 2020 ICD-10 Coordination and Maintenance Committee meeting materials found here: [ICD-10 Coordination and Maintenance Committee Procedure Code Materials | CMS](#)
Additional discussion of CERAMENT® G can be found in section II.E.4 of the preamble of the FY 2026 IPPS proposed and final rules.

¹³ [ICD-10 Coordination and Maintenance Committee Procedure Code Materials | CMS](#)

Endocrine, Nutritional and Metabolic O.R. Procedures with MCC or Insertion of Antibiotic-eluting Bone Void Filler” to reflect the reassignment of cases reporting procedure code XW0V0P7.

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. The code combinations are represented by two ICD-10-PCS procedure codes and include one ICD-10-PCS code for the resection of the prostate with one ICD-10-PCS code for the resection of bilateral seminal vesicles. The eight procedure code combinations are: 0VT00ZZ and 0VT30ZZ, 0VT00ZZ and 0VT34ZZ, 0VT04ZZ and 0VT30ZZ, 0VT04ZZ and 0VT34ZZ, 0VT07ZZ and 0VT30ZZ, 0VT07ZZ and 0VT34ZZ, 0VT08ZZ and 0VT30ZZ, and 0VT08ZZ and 0VT34ZZ.

For reasons described more fully in the preamble of the proposed rule, CMS has determined that specific assignment of these procedure codes in procedure code combinations in MS-DRGs 665, 666, and 667 is not required. Therefore, for FY 2027, CMS is proposing 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).

b. Islet Cell Transplantation

As discussed in section II.C.11.b.1 of the proposed rule and this summary, 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 describes the seven logic lists that comprise case assignment to MS-DRGs 673, 674, and 675 as displayed in the ICD-10 MS-DRG Version 43.1 Definitions Manual. The sixth and seventh logic lists are the components of the special logic in MS-DRGs 673, 674, and 675 for pancreatic islet cell transplantation. CMS notes that the seventh logic list entitled “and Non-Operating Room Procedures” is defined by the 11 ICD-10-PCS procedure codes¹⁴ describing the introduction of pancreatic islet cells. The 11 procedure codes are all designated as non-O.R.

¹⁴ As displayed in the proposed rule preamble, the 11 ICD-10-PCS procedure codes are 3E030U0, 3E030U1, 3E033U0, 3E033U1, 3E0J3U0, 3E0J3U1, 3E0J7U0, 3E0J7U1, 3E0J8U0, 3E0J8U1, XW033DA.

procedures affecting assignment to MS-DRGs 673, 674, and 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC, and without CC/MCC, respectively). As discussed in the FY 2005 IPPS final rule,¹⁵ the 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, performed to decrease or eliminate the need for insulin in patients with type 1 diabetes, in the absence of any other surgical procedure. 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.

CMS notes that the MS-DRGs are a classification system intended to group together diagnoses and procedures with similar clinical characteristics and utilization of resources, and that CMS generally seeks to identify sufficient sets of claims data with demonstrated clinical similarity in developing diagnosis related groups. After reviewing the indications for both whole organ pancreas transplant and pancreatic islet cell transplantation, and consideration of the intent of the MS-DRGs, CMS believes that for clinical coherence, 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. CMS acknowledges that islet cell transplants are not exactly the same as solid organ pancreas transplants, however, the agency believes the procedures are coherent given the similarity in clinical indication.

In the proposed rule, CMS describes its analysis of claims data from the September 2025 update of the FY 2025 MedPAR file to simulate reassignment of the 11 ICD-10-PCS procedure codes that describe the introduction of pancreatic islet cells from MS-DRGs 673, 674, and 675 to Pre-MDC MS-DRGs 008 (Simultaneous Pancreas and Kidney Transplant), MS-DRG 010 (Pancreas Transplant) and MS-DRG 019 (Simultaneous Pancreas and Kidney Transplant with Hemodialysis). CMS concludes that the simulation supports that the resulting MS-DRG assignments would be more clinically homogeneous, coherent and better reflect hospital resource use.

Therefore, for FY 2027, CMS is proposing 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 proposes to delete the sixth logic list entitled “or Principal Diagnosis” that is defined by ICD-10-CM diagnosis codes E10.21 (Type 1 diabetes mellitus with diabetic nephropathy), E10.22 (Type 1 diabetes mellitus with diabetic chronic kidney disease) and E10.29 (Type 1 diabetes mellitus with other diabetic kidney complication) and the seventh logic list entitled “and Non-Operating Room Procedures” from MS-DRGs 673, 674, and 675. Lastly, for consistency, CMS is proposing to change the title of MS-DRG 008 from “Simultaneous Pancreas and Kidney Transplant” to “Simultaneous Pancreas, Islet Cell and Kidney Transplant,” proposing to change the title of MS-DRG 010 from “Pancreas Transplant” to “Pancreas or Islet Cell Transplant” and proposing to change the title of MS-DRG 019 from “Simultaneous Pancreas and Kidney Transplant with Hemodialysis” to “Simultaneous Pancreas,

¹⁵ See the FY 2005 IPPS final rule (69 FR 48950 through 48953)

Islet Cell and Kidney Transplant with Hemodialysis” to better reflect the assigned procedures effective October 1, 2026, for FY 2027. Under this proposal, the current “principal or secondary diagnosis” logic in MS-DRGs 008, 010, and 019 would be maintained. Additionally, to maintain stability, CMS proposes to add logic to MS-DRG 010 to exclude cases also reporting kidney transplant procedures to ensure cases will continue to group accordingly to MS-DRGs 008 and 019.¹⁶

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.¹⁷

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. Based on its review and analysis, for FY 2027, CMS proposes to delete procedure codes 0VT00ZZ (Resection of prostate, open approach) and 0VT04ZZ (Resection of prostate, percutaneous endoscopic approach), which are assigned to MS-DRGs 707 and 708 as standalone procedures, because specific assignment of these procedure codes in procedure code combinations in MS-DRGs 707 and 708 is not required. Under this proposal, when the other parameters of the GROUPER logic are met, cases reporting procedure codes 0VT00ZZ and 0VT04ZZ 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, when the other parameters of the GROUPER logic are met, cases reporting procedure codes 0VT07ZZ (Resection of prostate, via natural or artificial opening) or 0VT08ZZ (Resection of prostate, via natural or artificial opening endoscopic) would group to MS-DRGs 713 and 714 (Transurethral Prostatectomy with CC/MCC and without CC/MCC), even when a procedure code describing the resection of the bilateral seminal vesicles is not also reported.

¹⁶ For a list of procedure codes CMS is proposing to define in the “Islet Cell Transplant Procedures” logic list in Pre-MDC MS-DRGs 008, 010, and 019, please see Table 6P.4a, Table 6P.4b, and Table 6P.4c associated with the FY 2027 IPPS proposed rule. The discussion of the surgical hierarchy for the proposed modification is discussed in section II.C.14 of the preamble of the proposed rule and this summary.

¹⁷ As listed in the FY 2027 IPPS proposed rule preamble, these eight procedure code combinations are 0VT00ZZ and 0VT30ZZ, 0VT00ZZ and 0VT34ZZ, 0VT04ZZ and 0VT30ZZ, 0VT04ZZ and 0VT34ZZ, 0VT07ZZ and 0VT30ZZ, 0VT07ZZ and 0VT34ZZ, 0VT08ZZ and 0VT30ZZ, 0VT08ZZ and 0VT34ZZ.

Additionally, during CMS' review of this issue and the examination of the MS-DRGs within MDC 12, the agency came to the conclusion that the titles of MS-DRGs 715 and 716 and MS-DRGs 717 and 718 no longer accurately reflect the assigned diagnoses. CMS is therefore proposing to change the title of MS-DRGs 715 and 716 from "Other Male Reproductive System O.R. Procedures for Malignancy with and without CC/MCC, respectively" to "Male Reproductive System and Other O.R. Procedures for Malignancy with and without CC/MCC, respectively" and to change the title of MS-DRGs 717 and 718 from "Other Male Reproductive System O.R. Procedures Except Malignancy with and without CC/MCC, respectively" to "Other Male Reproductive System O.R. Procedures with and without CC/MCC, respectively." CMS notes that the ICD-10 MS-DRG GROUPER Software, Version 44, has not yet been updated to reflect the proposed change to the titles.

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.

CMS reviewed the GROUPER logic for MS-DRGs 736, 737, 738, 739, 740, and 741 and identified 689 ICD-10-PCS procedure codes that describe uterine and adnexa procedures, 22 ICD-10-CM diagnosis codes that describe ovarian or adnexal malignancies, and 36 ICD-10-CM diagnosis codes that describe non-ovarian and non-adnexal malignancies. CMS identified five ICD-10-PCS procedure codes describing fluorescence guided procedures of the female reproductive system using pafolacianine for the ovarian indication, including 8E0U0EN, 8E0U3EN, 8E0U4EN, 8E0U7EN, and 8E0U8EN.

CMS then examined claims data from the September 2025 update of the FY 2025 MedPAR file for MS-DRGs 736, 737, 738, 739, 740, and 741 to identify cases reporting one of the five procedure codes. After reviewing its findings (described in the preamble of the proposed rule), CMS believes it is premature to consider a proposal for cases with an ICD-10-PCS code that describes fluorescence guided procedures of the female reproductive system using CYTALUX® (pafolacianine) for FY 2027 because of the wide variance in average costs and small number of cases across the MS-DRGs. CMS therefore declines to propose the requested reassignment for FY 2027.

However, during CMS' review of this issue, the agency noticed that the data analysis reflects 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. Specifically, CMS believes that their findings support restructuring the six MS-DRGs and creating a new MS-DRG for uterine and adnexa procedures for female reproductive system malignancies and eliminating the logic that differentiates cases by reporting principal diagnoses describing “ovarian or adnexal” and “non-ovarian or non-adnexal” malignancies.

Therefore, based on CMS’ analysis and for the reasons described in the FY 2027 IPPS proposed rule preamble, CMS is proposing the deletion of MS-DRGs 736, 737, 738, 739, 740, and 741, and the creation of a base MS-DRG for cases reporting uterine and adnexa procedures and a principal diagnosis describing a female reproductive system malignancy, split by a three-way severity level subgroup—specifically, 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 is proposing 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.¹⁸

9. MDC 25 (Human Immunodeficiency Virus Infections): Significant HIV Related Conditions

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. CMS also identified a subset of diagnoses that do not appear to describe a significant HIV related condition. Therefore, for FY 2027, CMS proposes to remove the term “SIGNIFICANT” under the header for MDC 25 and revise it to reflect, “AND PRINCIPAL DIAGNOSIS OF HIV RELATED CONDITION”.

CMS broadcasts 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,

¹⁸ For the lists of the 58 diagnosis codes and 689 procedure codes that CMS is proposing to define in the logic for the proposed new MS-DRGs, please refer to Table 6P.5a and Table 6P.5b associated with the FY 2027 IPPS proposed rule. For a discussion of the surgical hierarchy for the proposed modification, please refer to section II.C.14 of the preamble and this summary.

975, and 976 in consideration of any potential modifications that may be warranted. Any discussion regarding such modifications will be discussed in future rulemaking.

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. Therefore, for FY 2027, CMS is not making any proposals related to this issue.

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

a. Background

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, and each non-O.R. procedure is classified as either affecting or not affecting the MS-DRG assignment (with those that do not 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,¹⁹ 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.

¹⁹ Table 6B. – New Procedure Codes – FY 2027 is available on the CMS website: [FY 2027 IPPS Proposed Rule Home Page | CMS](#). CMS also refers readers to the ICD-10 MS-DRG Version 43.1 Definitions Manual at: [MS-DRG Classifications and Software | CMS](#) for detailed information regarding the designation of procedures as O.R. or non-O.R. (affecting the MS- DRG) in Appendix E--Operating Room Procedures and Procedure Code/MS-DRG Index.

As in years past, CMS discusses 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.

For this FY 2027 proposed rule, CMS received requests 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.

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, and in regard to procedure complexity, high cost, and is indicated for a rare patient population.

Upon review, CMS notes that the predecessor code for procedure code XW033DA is procedure code 3E033U1 (Introduction of nonautologous pancreatic islet cells into peripheral vein, percutaneous approach) which is 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 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 notes that these procedures do not typically require the resources of an operating room and are not surgical in nature. As such, CMS disagrees with designating procedure code XW033DA, which describes the intravenous portal vein administration of donislecel-jujn, as an O.R. procedure, and proposes to maintain the current designation of procedure code XW033DA as “non-O.R. affecting the MS-DRG” for FY 2027.

CMS believes that the underlying intent of this request is to change the MS-DRG assignment of procedure code XW033DA from MS-DRGs 673, 674, and 675 to MS-DRG 018, and notes that the category of cell and gene therapies continues to evolve. CMS continues to examine the complex issue of cell and gene therapy to appropriately reflect resource utilization while maintaining clinical coherence and stability in the relative weights under the IPPS MS-DRGs. CMS believes that this topic, relating to the administration of donislecel-jujn (Lantidra™), an allogeneic (donor) pancreatic islet cellular therapy, is appropriately aligned with and should be considered as part of that broader effort. Additionally, CMS refers readers to its discussion in section II.C.6.b regarding proposed modifications for cases currently mapping to MS-DRGs 673, 674, and 675.

(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.

CMS reviewed this issue and notes that the predecessor code for procedure code XW0V3WA is procedure code 3E0V3GC (Introduction of other therapeutic substance into bones, percutaneous approach) which is designated as a non-O.R. procedure. CMS examined claims data from the September 2025 update of the FY 2025 MedPAR file to determine the MS-DRGs reporting procedure code XW0V3WA and summarizes its findings in the preamble. Overall, the data indicate that the percutaneous introduction of AGN1 bone void filler into bones was not the underlying reason for, or main driver of, resource utilization for the small number of cases CMS was able to identify. CMS does not have claims data to further examine the impact of the percutaneous introduction of AGN1 bone void filler into bones when performed as a standalone procedure. In the absence of additional data, CMS believes that more time is needed to consider the clinical characteristics and resource utilization associated with this procedure before considering changing the designation of the procedure code to an O.R. procedure. Therefore,

CMS is proposing to maintain the designation of procedure code XW0V3WA as non-O.R. for FY 2027.

12. Proposed 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,²⁰ 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.²¹ 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.²² 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;²³ finalizing an increase in the severity levels for diagnosis codes related to homelessness;²⁴ and the finalization of nine guiding principles it believes are meaningful indicators of expected resource use by secondary diagnosis.²⁵ 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 2025,²⁶ 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 and refers readers to further proposed changes for FY 2027 as discussed in this section below.

²⁰ 72 FR 47152 through 47171

²¹ FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19235 through 19246) for a detailed discussion and proposals.

²² FY 2020 IPPS/LTCH PPS final rule (84 FR 42150 through 42152)

²³ FY 2022 IPPS/LTCH PPS final rule (86 FR 44940 through 44943)

²⁴ FY 2024 IPPS/LTCH PPS final rule (88 FR 58755 through 58759)

²⁵ FY 2025 IPPS/LTCH PPS final rule (89 FR 69076 through 69078)

²⁶ FY 2025 IPPS/LTCH PPS final rule (89 FR 69079 through 69084)

CMS has updated the Impact on Resource Use Files on the CMS website so that the public can review the mathematical data for the impact on resource use generated using claims from the FY 2019 through the FY 2025 MedPAR files: [MS-DRG Classifications and Software | CMS](#).

For new diagnosis codes approved for FY 2027, consistent with CMS' annual process for designating a severity level (MCC, CC, or NonCC) for new diagnosis codes, CMS first reviews the predecessor code designation, followed by review and consideration of other factors that may be relevant to the severity level designation, including the severity of illness, treatment difficulty, complexity of service and the resources utilized in the diagnosis or treatment of the condition. CMS notes that this process does not automatically result in the new diagnosis code having the same designation as the predecessor code.

c. Proposed Changes to Severity Levels

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

In prior rulemaking,²⁷ 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. As a continuation of CMS' examination of the SDOH Z codes, CMS reviewed the mathematical data on 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.²⁸

CMS summarizes its findings in the preamble and describes its typical process for establishing three different levels of CC severity using an iterative approach in which each diagnosis is evaluated to determine the extent to which its presence as a secondary diagnosis results in increased hospital resource use. CMS recalls how it addressed certain diagnoses, such as chronic illness diagnoses, in prior rulemaking,²⁹ specifically, the agency's position that such illnesses do not cause a significant increase in hospital resource use unless there is an acute exacerbation present or there is a significant deterioration in the underlying chronic condition. As a result, in revising the CC list at that time, CMS removed chronic diseases without a significant acute manifestation, stating that recognition of the impact of the chronic disease is accomplished by separately coding the acute manifestation.

Similarly, in CMS' further examination of the claims data and the current designation of the ICD-10-CM Z codes that describe homelessness, inadequate housing, and housing instability when reported as a secondary diagnosis, CMS now believes that change of designation from NonCC to CC should be based on the expected resource use associated with the treatment of an

²⁷ FY 2024 IPPS final rule (88 FR 58755 through 58759) and FY 2025 IPPS final rule (89 FR 69079 through 69084).

²⁸ 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.

²⁹ See the FY 2008 IPPS final rule (72 FR 47153).

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. Therefore, CMS is proposing 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.

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

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. Therefore, CMS proposes to maintain the severity level designation of ICD-10-CM diagnosis code R53.2 as an MCC for FY 2027.

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

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. Therefore, CMS proposes to maintain the severity level designations of ICD-10-CM diagnosis codes O63.0 and O63.9 for FY 2027.

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

For FY 2027, CMS is proposing additions to the diagnosis code MCC severity levels list (Table 6I.1) and additions and deletions to the diagnosis code CC severity levels list (Tables 6J.1&2). The tables with the proposed additions and deletions can be found on the CMS website at: [FY 2027 IPPS Proposed Rule Home Page | CMS](#)

e. Proposed CC Exclusions List for FY 2027

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.³⁰ 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;

³⁰ 52 FR 33143

- (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.

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).

CMS is proposing 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 preamble and this summary. Tables 6G.1, 6G.2, 6H.1, and 6H.2 showing proposed changes are available on the CMS website at: [FY 2027 IPPS Proposed Rule Home Page | CMS](#)

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

To identify new, revised, and deleted diagnosis and procedure codes for FY 2027, CMS has developed the following tables which are available at [FY 2027 IPPS Proposed Rule Home Page | CMS](#)

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

CMS notes that the code titles are adopted as part of the ICD-10 Coordination and Maintenance Committee meeting process and are therefore not subject to comment in the proposed or final rules. As part of this proposed rule, CMS is proposing 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 are set forth in Table 6A and the proposed O.R. status for the new procedure codes are set forth in Table 6B. Consistent with its established process, CMS reviews the predecessor code and MS-DRG assignment most closely associated with the new diagnosis or procedure code, and in the absence of claims data, CMS considers other factors that may be relevant to the MS-DRG assignment, including the severity of illness, treatment difficulty,

complexity of service and the resources utilized in the diagnosis and/or treatment of the condition.

14. Proposed 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.

Based on the proposed changes for FY 2027, CMS proposes to revise the surgical hierarchy for the Pre-MDC, MDC 05, MDC 08, MDC 10, MDC 11, MDC 12, and MDC 13. CMS notes that the rankings are subject to revision based on policies that are finalized for FY 2027. The proposed Version 44 surgical hierarchy rankings for newly proposed MS-DRGs for FY2027 are presented in the tables below. Complete tables of ranking revisions can be found in the preamble of the proposed rule.

Proposed Version 44 Surgical Hierarchy for Proposed New MS-DRGs			
MDC	Proposed New MS-DRG	Description	Proposed Rank
05	210-211	Cardiac Pacemaker Revision or Device Replacement	30
05	361-362	Other Circulatory System O.R. Procedures	34
08	523-525	Extensive or Complex Spinal Fusion Procedures Except Cervical	1
08	403-404	Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection	8
08	449	Revision of Hip or Knee Replacement	7
08	400-401	Knee Procedures with Principal Diagnosis of Infection	24
13	731-733	Uterine and Adnexa Procedures for Malignancy	1

For issues pertaining to the surgical hierarchy, as with other MS-DRG related requests, CMS encourages interested parties to submit 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.

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 September 9-10, 2025 meeting and the Fall 2025 ICD-10-PCS procedure code meeting. In lieu of its Spring 2026 meeting, the Committee solicited public comments (due April 17, 2026) and intends to review them to identify whether there is a consensus of support for any new diagnosis and procedure codes. The Committee will also determine those new procedure codes for which complete tabular and indexing changes can be made by June 2026 and will include those in the October 1, 2026 update to the ICD-10-CM diagnosis and ICD-10-PCS procedure code sets.

The Committee encourages public participation. CMS provides the following contact information for members to submit comments on the proposed procedure code topics: ICDProcedureCodeRequest@cms.hhs.gov. Members of the public may submit comments on the proposed diagnosis code topics to nchsicd10cm@cdc.gov.

Effective with discharges on and after April 1, 2026, CMS implemented 80 new ICD-10-PCS procedure codes including codes to describe the insertion of cardiac devices (i.e., leads) into the ventricular septum, codes to enable the differentiation between the endoscopic techniques utilized to drain hepatobiliary and pancreatic fluid collections, and codes to capture the utilization of adjunctive therapies such as microcurrent electrical neuromuscular stimulation (MENS) and frequency-specific microcurrent (FSM). These codes, including their O.R. status, MDC and MS-DRG assignment, are listed in a table in the proposed rule preamble. The 80 procedure codes are also reflected in Table 6B.- New Procedure Codes, which is available on the CMS website at: [FY 2027 IPPS Proposed Rule Home Page | CMS](#). CMS is soliciting public comments on the most appropriate MDC, MS-DRG, and operating room status assignments for these codes for FY 2027, as well as any other options for the GROUPER logic.

Additionally, CMS describes the mechanism and process it has developed for approving and updating diagnosis and procedure codes on April 1 and October 1 of each year.³¹ Beginning April 1, 2022, CMS adopted a new April 1 implementation date, in addition to the annual October 1 update.³² CMS is continuing to use several aspects of its existing established process to implement new codes through the April 1 code update, which includes presenting proposals for April 1 consideration at the September ICD-10 Coordination and Maintenance Committee meeting, requesting public comments, reviewing the public comments, finalizing codes, and announcing the new codes with their assignments consistent with the new GROUPER release information. CMS notes that there were code proposals presented and adopted for an April 1, 2026 implementation. CMS announced the new codes in November 2025 and provided the updated code files in December 2025. The NCHS provided the ICD-10-CM Official Guidelines

³¹ As required by section 503(a) of the Medicare Modernization Act (Pub. L. 108-173)

³² FY 2022 IPPS/LTCH PPS final rule (86 FR 44950 through 44956)

for Coding and Reporting in January 2026. By February 3, 2026, CMS made available the updated Version 43.1 ICD-10 MS-DRG GROUPER software and related materials on the CMS web page at: [MS-DRG Classifications and Software | CMS](#).

CMS notes that for FY 2026, there are 74,719 diagnosis codes and 79,193 procedure codes. At this time, there are 184 new diagnosis codes and 81 new procedure codes finalized for FY 2027 at the time of development of this proposed rule and 80 new procedure codes that were effective with discharges on or after April 1, 2026.

16. Replaced Devices Offered without Cost or with a Credit

a. Background

In the FY 2008 and FY 2012 final rules,^{33,34} 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.

b. Proposed Changes for FY 2027

As discussed in sections II.C.4 and C.5 of the proposed rule preamble and this summary, CMS is making several proposals related to adding and reassigning certain MS-DRGs under MDC 05 and MDC 08. CMS reprises these proposals in this section. CMS states that it generally maps new MS-DRGs onto the list when they are formed from procedures previously assigned to MS-DRGs that are already on the list. Further, CMS notes that several of the MS-DRGs are 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 is proposing that if the applicable proposed MS-DRG changes are finalized, the agency also would add proposed new MS-DRGs 210 and 211 and proposed new MS-DRG 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 is also proposing to continue to include the existing MS-DRGs currently subject to the policy. CMS provides a table displaying the affected MS-DRGs in the preamble of the proposed rule.

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).

³³ 72 FR 47246 through 47251

³⁴ 76 FR 51556 and 51557

In developing relative weights for FY 2027, CMS proposes to use:

FY 2025 MedPAR data: Bills received through December 31, 2025, 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 6,936,972 Medicare discharges regrouped using the FY 2027 proposed MS-DRG classifications.

FY 2024 Medicare Cost Reports: Medicare cost report data files from HCRIS, principally for FY 2024 cost reporting periods, using the December 31, 2025 update of the FY 2024 HCRIS. For FY 2027, CMS is not proposing any changes to its methodology and will calculate MS-DRG weights using national averages for the 19 CCRs. Accompanying the proposed 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 Proposed Rule Home Page | CMS](#). (Select file #4 under FY 2027 Proposed Rule Data files, “FY 2027 Proposed 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).

National Average CCRs. The FY 2027 proposed 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	0.377
Intensive Days	0.335	0.324
Drugs	0.177	0.180
Supplies & Equipment	0.297	0.301
Implantable Devices	0.255	0.256
Inhalation Therapy	0.148	0.141
Therapy Services	0.256	0.258
Anesthesia	0.071	0.074
Labor & Delivery	0.373	0.370
Operating Room	0.153	0.151
Cardiology	0.086	0.086
Cardiac Catheterization	0.098	0.070
Laboratory	0.098	0.095
Radiology	0.123	0.122
MRIs	0.065	0.065
CT Scans	0.032	0.032
Emergency Room	0.139	0.133
Blood and Blood Products	0.230	0.238
Other Services	0.327	0.323

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 proposes to continue its methodology for identifying clinical trial claims and expanded access use claims in MS-DRG 018 by excluding claims 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 (\$71,039) were 17 percent of the average costs of the cases assigned to MS-DRG 018 that are identified as non-clinical trial cases (\$412,218). Accordingly, CMS proposes a payment adjustor of 0.17 to the applicable clinical trial and expanded access use immunotherapy 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. The data underlying these adjustments will be updated for the FY 2027 final rule.

Proposed 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. CMS is proposing to continue this policy for FY 2027.

Other Issues. CMS proposes normalizing the relative weights by an adjustment factor of 1.944557 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 statute³⁵ 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.³⁶ The implementing regulations³⁷ 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

³⁵ Sections 1886(d)(K) and (L) of the Social Security Act

³⁶ Section 1886(d)(5)(K)(vi) of the Act

³⁷ 42 CFR 412.87

otherwise applicable to discharges involving the medical service or technology is determined to be inadequate,³⁸ 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.³⁹

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”.⁴⁰

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 used and links to files used for proposed threshold amount that were generally used for evaluating applications for FY 2027 and 2028 new technology add-on payments.

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.

³⁸ 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 capital-related costs (72 FR 47307 through 47308).

³⁹ 84 FR 42292 through 42297; regulations at §412.87(c) and (d), and 85 FR 58736

⁴⁰ 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).

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 reiterates⁴¹ 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 aspects⁴² are used by CMS in its evaluation of substantial clinical improvement:

- The totality of circumstances is considered when determining substantial clinical improvement.
- A determination of substantial clinical improvement which means: that the new service or technology offers a treatment option for a patient population unresponsive to, or ineligible for, currently available treatments; 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; a significant improvement⁴³ of clinical outcomes relative to services or technologies previously available; or 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 sources⁴⁴ 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.

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 and for certain microbial products that are designated by the FDA as a Qualified Infectious Disease Product (QIDP) and for a drug

⁴¹ Initially discussed in the FY 2003 IPPS final rule (67 FR 50015)

⁴² Established in the FY 2020 IPPS final rule and codified at §412.87(b)

⁴³ A substantial clinical improvement may 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.

⁴⁴ 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.

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. CMS notes that in the FY 2027 IPPS proposed rule, in section II.E.7, CMS is proposing to repeal these alternative pathways.

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.⁴⁵

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.⁴⁶

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).

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

⁴⁵ The governing regulatory eligibility criteria for a medical device that has received a Breakthrough Device designation is at § 412.87(c)

⁴⁶ The governing regulatory eligibility criteria for QDIPs and LPADs are at § 412.87(d).

new medical services or technologies are not subject to budget neutrality.⁴⁷ 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: (1) 65 percent of the costs of the new technology; or (2) 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: (1) 75 percent of the costs of the new technology; or (2) 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: (1) 75 percent of the costs of the new medical service or technology; or (2) 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: (1) 75 percent of the costs of the new medical service or technology; or (2) 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, does CMS then make 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, NDA, or BLA)⁴⁸ 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

⁴⁷ Section 503(d)(2) of Pub. L. 101-173 provides there will be no reduction or adjustments in aggregate payments under the IPPS due to add-on payments for new technologies.

⁴⁸ 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)

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 provide to 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 clearance⁴⁹ by May 1⁵⁰ 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)

As a resource to stakeholders to help assist with navigating the different CMS pathways for coverage, coding, and payment CMS uses the Pharmaceutical & Technology Ombudsman (PTO) (PharmTechOmbud@cms.hhs.gov). 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

For FY 2028, complete application information for requesting add-on payments, along with final deadlines for submitting a full application, will be posted as it becomes available at [New Medical Services and New Technologies | CMS](#). Once the application deadline has closed, CMS will post a list of the FY 2028 applications submitted, along with a brief description of each technology as provided by the applicant.⁵¹

⁴⁹ 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.

⁵⁰ 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.

⁵¹ This burden is subject to the PRA and approved under OMB control number 0938–1347 and has an expiration date of December 31, 2026.

At the time the proposed rule is published, CMS posts the application 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 continues to be withheld. Applications that are withdrawn prior to the publication of the 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.⁵² 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.⁵³ Applicant presentations as well as written comments received by the December 15, 2025 deadline were considered by CMS in the development of this proposed rule. Where applicable, CMS summarizes comments at the end of each discussion of the individual applications in this proposed rule. Comments that are unrelated to the “substantial clinical improvement” criterion are not summarized in this 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. Proposed FY 2027 Status of Technologies Receiving New Technology Add-On Payments for FY 2026

In this section of the proposed rule, CMS discusses the proposed 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 becomes 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

⁵² Section 1886(d)(5)(K)(viii) of the Act, as amended by section 503(b)(2) of Pub. L. 108-73.

⁵³ The recording of the virtual town hall is available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/newtech>.

additional fiscal year. In the FY 2025 IPPS final rule,⁵⁴ 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.

CMS is inviting public comments on its proposals to continue new technology add-on payments for FY 2027 for the technologies listed in Tables II.E.-01 (reproduced from the preamble below). CMS notes that these technologies are still considered "new" for purposes of new technology add-on payments because the 3-year anniversary date of the product's entry onto the U.S. market occurs on or after October 1, 2026.

CMS summarizes its rationale for continuing new technology add-on payments for CONTEPO™ (fosfomycin), which received FDA marketing authorization on October 22, 2025. CMS also discusses its rationale and determination of the newness period for ZEVTERA® which was subject to commercial delays, resulting in CMS considering the technology new for FY 2026. However, due to the increasing volume and complexity of circumstances in which applicants assert a delay in commercial availability, the agency believes that a delay that extends to after implementation of a new technology add-on payment should no longer be considered. For reasons described in more detail in the proposed rule preamble, **CMS is proposing 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.** Under this proposal, for a technology that is not yet available for sale when its new technology add-on payment becomes effective, CMS would consider the newness period to begin on September 30 preceding the start of the new technology add-on payment for the technology. As such, and consistent with this proposal, because the new technology add-on payment for ZEVTERA® became effective on October 1, 2024, CMS considers the beginning of the newness period for ZEVTERA® to commence on September 30, 2024.

Table II.E.-02 (reproduced from the preamble below) lists twelve technologies that were first approved for new technology add-on payments prior to FY 2025, including technologies determined to be substantially similar to such technologies, for which CMS proposes to discontinue making new technology add-on payments for FY 2027 because they are no longer "new".

CMS discusses its proposal to discontinue add-on payments for FY 2027 for the Ceribell Status Epilepticus Monitor in light of the fact that the manufacturer is seeking new technology add-on payments for a related product, the Ceribell Delirium Monitor System for FY 2027 which shares

⁵⁴ FY 2025 IPPS/LTCH PPS final rule (89 FR 69238 through 69242)

an ICD-10-PCS procedure code (XX20X89). To cases related to the Ceribell Delirium Monitor System and not the Ceribell Status Epilepticus Monitor, CMS is proposing to exclude cases that report the ICD-10-CM diagnosis codes that CMS believes would identify patients with status epilepticus in combination with the ICD-10-PCS procedure code XX20X89.⁵⁵

CMS notes 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 a 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 considers the beginning of the newness period for SAINT Neuromodulation System to commence on September 30, 2023. As a result, the technology would no longer be considered new for FY 2027.

CMS invites public comments on its proposals to both continue and discontinue new technology add-on payments for FY 2027 for the technologies listed in Tables II.E.-01 and II.E.-02.

⁵⁵ See Table 10.2 in the proposed rule preamble for a list of ICD-10-CM diagnosis codes that CMS believes would identify patients with status epilepticus, which CMS proposes to exclude from new technology add-on payment when reported in combination with ICD-10-PCS procedure code XX20X89.

TABLE II.E.-01: PROPOSED 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	Proposed Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
1	<i>Annalise Enterprise CTB Triage—OH</i>	10/10/2023	10/01/2024	10/10/2026	89 FR 69205 through 69208 90 FR 36665 through 36669	\$241.39	XXE0X1A
2	<i>AStar® System</i>	04/26/2024	10/01/2024	04/26/2027	89 FR 69208 through 69210 90 FR 36665 through 36669	\$97.50	XXE5X2A
3	<i>Edwards EVOQUE™ Tricuspid Valve Replacement System (“EVOQUE™ System”)</i>	02/01/2024	10/01/2024	02/01/2027	89 FR 69210 through 69213 90 FR 36665 through 36669	\$31,850.00	X2RJ3RA
4	<i>GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device)</i>	01/12/2024	10/01/2024	01/12/2027	89 FR 69213 through 69215 90 FR 36665 through 36669	\$47,238.75	X2VE3SA
5	<i>LimFlow™ System</i>	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	<i>Paradise™ Ultrasound Renal Denervation System</i>	11/7/2023	10/01/2024	11/07/2026	89 FR 69218 through 69221 90 FR 36665 through 36669	\$14,950.00	X051329
7	<i>PulseSelect™ Pulsed Field Ablation (PFA) Loop Catheter</i>	12/13/2023	10/01/2024	12/13/2026	89 FR 69221 through 69225 90 FR 36665 through 36669	\$6,337.50	02583ZF
8	<i>Symlicity Spyral™ Multi-Electrode Renal Denervation Catheter</i>	11/17/2023	10/01/2024	11/17/2026	89 FR 69225 through 69228 90 FR 36665 through 36669	\$10,400.00	X05133A
9	<i>TriClip™ G4</i>	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	Proposed Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
10	VADER® Pedicle System	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, XRH80FA, XRH83FA, XRH84FA, XRH80FA, XRH83FA, XRH84FA, 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 medocartil); 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 medocartil); 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

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Proposed Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
17	<i>AeroPace® System</i>	12/04/2024	10/01/2025	12/04/2027	90 FR 36773 through 36776	\$23,650.90	X2H13XB
18	<i>AGENT™ Paclitaxel-Coated Balloon Catheter</i>	02/29/2024	10/01/2025	02/29/2027	90 FR 36776 through 36779	\$4,013.75	XW0J3HA, XW0J3JA, XW0J3KA, XW0J3LA, XW0K3HA, XW0K3JA, XW0K3KA, XW0K3LA, XW0L3HA, XW0L3JA, XW0L3KA, XW0L3LA, XW0M3HA, XW0M3JA, XW0M3KA, or XW0M3LA
19	<i>alfapump® system</i>	12/20/2024	10/01/2025	12/20/2027	90 FR 36779 through 36781	\$21,450.00	0W1G3J6 in combination with 0JH80YZ
20	<i>aprevo®-C cervical interbody fusion device</i>	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	<i>CERAMENT® G (open fracture indication)</i>	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	<i>Emily's Care Nourish Test System (Model 1)</i>	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	<i>Esprit™ BTK Everolimus Eluting Resorbable Scaffold System</i>	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	<i>EUROPA™ Posterior Cervical Fusion System</i>	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	<i>iFuse TORQ TNT™ Implant System</i>	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	<i>Merit Wrapsody® Cell Impermeable Endoprosthesis (CIE)</i>	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	<i>Minima Stent System</i>	08/28/2024	10/01/2025	08/28/2027	90 FR 36806 through 36808	\$22,685.00	X27339B, X27439B, X27W39B, or X27X39B
28	<i>MY01 Continuous Compartmental Pressure Monitor</i>	04/29/2025	10/01/2025	04/29/2028	90 FR 36808 through 36810	\$2,112.50	XX2F3W9

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations	Proposed Maximum NTAP Amount for FY 2027	Coding Used to Identify Cases Eligible for NTAP
29	<i>PBC Separator with Selux AST System</i>	02/15/2024	10/01/2025	02/15/2027	90 FR 36810 through 36813	\$87.78	XXE5XY9
30	<i>restor3d TIDAL™ Fusion Cage</i>	03/24/2025	10/01/2025	03/24/2028	90 FR 36817 through 36819	\$18,196.75	XRGK0CA, XRGM0CA, XRGJ0CA, or XRGL0CA
31	<i>ShortCut™</i>	09/27/2024	10/01/2025	09/27/2027	90 FR 36819 through 36821	\$9,750.00	X28F3VA
32	<i>The WiSE CRT System</i>	04/11/2025	10/01/2025	04/11/2028	90 FR 36821 through 36823	\$41,145.00	X2HN37B in combination with XHH80HB
33	<i>TriVerity Test</i>	01/10/2025	10/01/2025	01/10/2028	90 FR 36823 through 36826	\$243.75	XXE5XBB
34	<i>VITEK® REVEAL™ AST System</i>	10/21/2024	10/01/2025	10/21/2027	90 FR 36826 through 36829	\$81.25	XXE5X4A
35	<i>EMBLAVEO™ (aztreonam-avibactam)</i>	02/07/2025	10/01/2025	02/07/2028	90 FR 36829 through 36831	\$9,000.68	XW033PB or XW043PB
36	<i>CONTEPO™ (fosfomycin)</i>	10/22/2025	01/01/2026	10/22/2028	90 FR 36831 through 36834	\$8,775.00	XW033WB or XW043WB
37	<i>AURLUMYN™ (iloprost injection)</i>	11/01/2024	10/01/2025	11/01/2027	90 FR 36680 through 36687	\$28,600.00	XW033QB or XW043QB
38	<i>BREYANZI® (lisocabtagene maraleucel)</i>	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	<i>GRAFAPEX™ (treosulfan)</i>	01/21/2025	10/01/2025	01/21/2028	90 FR 36707 through 36717	\$21,411.00	XW03388 or XW04388
40	<i>IMDELLTRA® (tarlatamab-dlle)</i>	05/16/2024	10/01/2025	05/16/2027	90 FR 36717 through 36727	\$7,117.50	XW033NA or XW043NA
41	<i>TECELRA® (afamitresgene autoleucel)</i>	08/01/2024	10/01/2025	08/01/2027	90 FR 36753 through 36761	\$472,550.00	XW03368 or XW04368

TABLE II.E.-02: PROPOSED 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
PROPOSED DISCONTINUATION OF TECHNOLOGIES FIRST APPROVED FOR NEW TECHNOLOGY ADD-ON PAYMENTS PRIOR TO FY 2025 THAT ARE NO LONGER CONSIDERED NEW FOR FY 2027 BECAUSE THE 3-YEAR ANNIVERSARY DATE WILL OCCUR PRIOR TO APRIL 1, 2027					
1	<i>CYTALUX® (pafolacianine) (lung indication)</i>	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	<i>EPKINLY™ (epcoritamab-bysp) and COLUMVI™ (glofitamab-gxbm)</i>	05/19/2023	10/01/2023	05/19/2026	88 FR 58818 through 58835 89 FR 69120 through 69126 90 FR 36665 through 36669
3	<i>Aveir™ AR Leadless Pacemaker</i>	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	<i>Aveir™ Dual-Chamber Leadless Pacemaker</i>	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	<i>Ceribell Status Epilepticus Monitor</i>	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	<i>DETOUR System</i>	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	<i>DefenCath® (taurolidine/heparin)</i>	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	<i>Phagenyx® System</i>	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	<i>REZZAYO™ (rezafungin for injection)</i>	07/19/2023	10/01/2023	07/19/2026	88 FR 58944 through 58946 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
PROPOSED DISCONTINUATION OF TECHNOLOGIES FIRST APPROVED FOR NEW TECHNOLOGY ADD-ON PAYMENTS PRIOR TO FY 2025 THAT ARE NO LONGER CONSIDERED NEW FOR FY 2027 BECAUSE THE 3-YEAR ANNIVERSARY DATE WILL OCCUR PRIOR TO APRIL 1, 2027					
10	<i>SAINT Neuromodulation System</i>	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	<i>TOPS™ System</i>	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	<i>XACDURO® (sulbactam/durlobactam)</i>	05/23/2023	10/01/2023	05/23/2026	88 FR 58946 through 58948 89 FR 69120 through 69126 90 FR 36665 through 36669
PROPOSED DISCONTINUATION OF TECHNOLOGY FIRST APPROVED FOR NEW TECHNOLOGY ADD-ON PAYMENTS IN FY 2026 THAT IS NO LONGER CONSIDERED NEW FOR FY 2027 BECAUSE THE 3-YEAR ANNIVERSARY DATE WILL OCCUR PRIOR TO OCTOBER 1, 2026					
1	<i>RECELL® Autologous Cell Harvesting Device</i>	06/07/2023	10/01/2025	06/07/2026	90 FR 36813 through 36817

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

CMS publicly posts applications for new technology add-on payment, beginning with FY 2024 applications.⁵⁶ CMS therefore provides succinct summary information in the proposed rule. The agency refers readers to <https://mearis.cms.gov/public/publications/ntap> for the publicly posted FY 2027 new technology add-on payment applications and supporting information (with the exception of certain cost and volume information, and information or materials identified by the applicant as confidential or copyrighted), 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 for the FY 2027 new technology add-on payment applications.

CMS received 15 applications for new technology add-on payments for FY 2027 under the new technology add-on payment traditional pathway. CMS reminds readers that to be eligible for FY 2027 new technology add-on payments, the technology must have received FDA marketing authorization by May 1 of the year prior to the beginning of the fiscal year for which the application is being considered. For technologies that are not already FDA market authorized for the indication that is the subject of the application, applicants must have a complete and active FDA market authorization request and submit proof of this with their CMS NTAP application. Of the 15 applications received under the traditional pathway, 3 applicants were not eligible for consideration for new technology add-on payment because they did not meet these requirements, and 4 applicants withdrew their applications prior to the issuance of this proposed rule. CMS addresses the remaining 8 applications in this proposed rule. HPA has provided a summary table of the 8 technologies and CMS' preliminary assessment.

Typically, in the annual proposed rule, CMS provides a summary of each traditional pathway application and describes any concerns the agency may have regarding whether the technology meets a specific new technology add-on payment criterion. For technologies that have already received FDA marketing authorization, CMS makes proposals to approve or disapprove each of these applications for new technology add-on payment. CMS does not make proposals to approve or disapprove the technology if the FDA has not yet made a determination as to whether the medical service or technology is safe and effective.

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

Technology	Preliminary Newness Date	Preliminary CMS Assessment and Application Link
<i>COBENFY</i> TM (<i>xanomeline and trospium chloride</i>)	October 9, 2024	Proposes disapproval: Unable to determine substantial clinical improvement MEARISTM Publication ntap NTP251006PD218
Command Center Electronic Glycemic Management System	August 4, 2017	Proposes disapproval: Concerns related to newness and substantial similarity. Unable to determine cost or substantial clinical improvement. MEARISTM Publication ntap NTP251005YD7PG
GAMIFANT [®] (emapalumab-lzsg)	June 27, 2025	Proposes disapproval: Unable to determine substantial clinical improvement.

⁵⁶ (87 FR 48986 through 48990).

Technology	Preliminary Newness Date	Preliminary CMS Assessment and Application Link
		MEARIS™ Publication ntap NTP250926GGG85
Orca-T	Pending FDA	CMS questions whether Orca-T meets the substantial clinical improvement criterion. MEARIS™ Publication ntap NTP251003TH4EH
RAPIBLYK™ (landiolol)	Commercial delay to July 21, 2025	Concerns related to newness and substantial similarity. Unable to determine substantial clinical improvement. MEARIS™ Publication ntap NTP251006EVR3D
WASKYRA™ (etuvetidigene autotemcel)	Commercial delay to March 31, 2026	Concerns related to newness and substantial similarity. Proposes disapproval: Unable to determine substantial clinical improvement. MEARIS™ Publication ntap NTP2510033XJPK
YARTEMLEA® (narsoplimab-wuug)	December 23, 2025	Proposes to approve. MEARIS™ Publication ntap NTP251006R7LMC
ZEVASKYN™ (prademagene zamikeracel)	Commercial delay to June 15, 2025	Proposes disapproval: Unable to determine substantial clinical improvement. MEARIS™ Publication ntap NTP251003GPVPO

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. CMS notes that the applicant submitted a FY 2026 new technology add-on payment application for this technology, which was not approved.⁵⁷ The application is available at [MEARIS™ | Publication | ntap | NTP251006PD218](#)

ICD-10 Coding: CMS does not express any concerns with the code (XW0DXVB) submitted for COBENFY™.

Newness: Regarding substantial similarity, CMS agrees that COBENFY™ uses a unique mechanism of action. CMS considers the beginning of the newness period to commence on October 9, 2024, the day on which COBENFY™ became commercially available.

Cost: Regarding the cost criterion, CMS agrees with the applicant that the technology meets the cost criterion.

Substantial Clinical Improvement: Regarding substantial clinical improvement, CMS received a public comment in response to the New Technology Town Hall meeting notice published in the *Federal Register* regarding the substantial clinical improvement criterion for COBENFY™, which the agency summarizes in this section. The applicant asserts that 1) the technology offers a treatment option for patients unresponsive to or ineligible for currently available treatments, 2) the technology offers the ability to diagnose a medical condition in a patient population where that condition is currently undetectable or earlier than allowed by currently available methods, and that use of the technology to make a diagnosis affects the management of the patient, and 3) the technology significantly improves clinical outcomes relative to services or technologies

⁵⁷ As discussed in the FY 2026 IPPS/LTCH PPS final rule (90 FR 36695 through 36702).

previously available. CMS expresses gratitude to the applicant for its comment, but continues to have concerns regarding whether COBENFY™ meets the substantial clinical improvement criterion. Despite the additional studies submitted by the applicant, CMS continues to question the applicant's assertions. CMS is therefore proposing to disapprove new technology add-on payments for COBENFY™ for FY 2027. CMS invites public comments on this proposal and whether COBENFY™ meets the substantial clinical improvement criterion.

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. The application is available at [MEARIS™ | Publication | ntap | NTP251005YD7PG](#)

ICD-10 Code: The applicant has requested an ICD-10 for this technology. The proposed rule does not address the applicant's ICD-10 application.

Newness: Based on the FDA 510(k) clearance letter and other information submitted by the applicant, CMS believes that the newness period for this technology commenced on August 4, 2017 or earlier. As this is more than 3 years ago, CMS does not consider the technology 'new' and is therefore proposing to disapprove Command Center for a new technology add-on payment for FY 2027. Additionally, CMS believes that Command Center is substantially similar to existing technologies because it uses the same or similar mechanism of action, maps to the same MS-DRG, and involves the treatment of the same or similar type of disease and patient population when compared to existing technologies, including its predicate device (K113853)

Cost: Based on the information received from the applicant, CMS is unable to determine whether the final inflated case weighted standardized charge per case exceeds the case weighted threshold amount; that is, whether Command Center meets the cost criterion for new technology add-on payment.

Substantial Clinical Improvement: The applicants asserts that: 1) the technology offers a treatment option for patients unresponsive to or ineligible for currently available treatments, 2) the technology offers the ability to diagnose a medical condition in a patient population where that condition is currently undetectable or earlier than allowed by currently available methods, and that use of the technology to make a diagnosis affects the management of the patient, and 3) that the technology significantly improves clinical outcomes relative to services or technologies previously available. Among other concerns, CMS notes that it appears that the applicant submitted studies using its predicate device (K113853) to support its assertions as to why Command Center represents a substantial clinical improvement but did not present any clinical

data comparing Command Center to its predicate device. After review of the information provided by the applicant, CMS is proposing to disapprove new technology add-on payments for Command Center for FY 2027 and invites public comment on this proposal and whether the technology meets criteria for a 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 (IFN γ) blocking antibody that targets and neutralizes IFN γ 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. The application is available at [MEARIS™ | Publication | ntap | NTP250926GGG85](#).

ICD-10 Coding: The applicants indicates that ICD-10-PCS codes XW033MA and XW043MA uniquely identify this technology. CMS identifies and seeks comment on the following relevant ICD-10-CM diagnosis codes (M06.10, M08.211-212, M08.221-222, M08.231-232, M08.241-242, M08.251-252, M08.261-262, M08.271-272, M08.28-29, M08.2A).

Newness: GAMIFANT® was approved by the FDA for market authorization on June 27, 2025. CMS agrees that GAMIFANT® has a new mechanism of action because it is the only FDA-approved treatment for HLH/MAS in known or suspected Still's disease. Therefore, CMS believes that GAMIFANT® is not substantially similar to existing technology and meets the newness criterion. CMS considers the beginning of the newness period to commence on June 27, 2025, the date on which GAMIFANT® received FDA market authorization.

Cost: CMS agrees with the applicant that the technology meets the cost criterion.

Substantial Clinical Improvement: The applicant asserts that the technology: 1) offers a treatment option for patients unresponsive to or ineligible for currently available treatments, and 2) significantly improves clinical outcomes relative to services or technologies previously available. CMS questions the first assertion because several second- and third-line therapies, including cyclosporine, etoposide, anakinra, and intravenous immunoglobulin, can also treat patients with an inadequate response or intolerance to glucocorticoids or with recurrent MAS. CMS raises concerns related to the submitted studies in support of the second assertion, and the lack of sufficient detail on the reported serious adverse events regarding the applicant's claim of a positive risk: benefit profile. CMS notes that the agency requests more detail on the visual analogue scale scoring system used in the clinical trials to assess the efficacy outcome data. Please refer to the preamble for more details about CMS' concerns. In summary, CMS is unable to determine whether GAMIFANT® represents a substantial clinical improvement over existing technologies, and is therefore proposing to disapprove new technology add-on payments for GAMIFANT® for FY 2027. CMS invites public comment on this proposal and whether the technology represents a substantial clinical improvement over existing technologies.

d. Orca-T

Orca Bio submitted an FY 2027 application for new technology add-on payments for Orca-T which is an allogeneic stem cell and T-cell immunotherapy derived from a human leukocyte antigen (HLA)-matched donor for the curative treatment of hematologic malignancies, including acute myeloid leukemia (AML), acute lymphoblastic leukemia (ALL), high-risk myelodysplastic syndrome (MDS), and mixed-phenotype acute leukemia (MPAL), in adults. The application is available at [MEARIS™ | Publication | ntap | NTP251003TH4EH](#)

ICD-10 Code: The applicant indicates that ICD-10-PCS codes XW033BA and XW043BA uniquely identify intravenous administration of Orca-T.

Newness: CMS notes that Orca-T is pending FDA marketing authorization, and that the FDA decision is anticipated by May 1, 2026. CMS believes that Orca-T is not substantially similar to existing technologies and meets the newness criterion. In particular, CMS notes that Orca-T is not substantially similar to alloHSCT because it maps to a different MS-DRG than alloHSCTs, CMS invites public comments on whether Orca-T is substantially similar to existing technologies and whether Orca-T meets the newness criterion.

Cost: CMS agrees with the applicant that the technology meets the cost criterion, and invites public comment.

Substantial Clinical Improvement: CMS summarizes a public comment it received in response to the New Technology Town Hall meeting notice published in the *Federal Register* regarding the substantial clinical improvement criterion for Orca-T. The commenter provided suggestions on how CMS should assess substantial clinical improvement, for example, by using evidence supported by standardized episode definitions that are reproducible.

CMS notes that the applicant asserts that the technology: 1) offers a treatment option for patients unresponsive to or ineligible for currently available treatments, and 2) significantly improves clinical outcomes relative to services or technologies previously available. In response, CMS expresses several concerns related to these assertions. For example, CMS remains unclear if there is a group of patients who can be treated with Orca-T, but cannot receive existing treatments for hematologic malignancies such as alloHSCT, CAR T-cell therapies, and chemotherapies. Additionally, CMS remains unable to assess whether Orca-T significantly improves clinical outcomes relative to services or technologies previously available without evidence comparing outcomes for Orca-T to other therapies available for patients with hematologic malignancies, including CAR T-cell therapies. As a result, CMS questions whether Orca-T results in improved clinical outcomes relative to existing hematologic malignancy treatments. CMS invites public comments on whether Orca-T meets the substantial clinical improvement criterion.

e. 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). The application is available at [MEARIS™ | Publication | ntap | NTP251006EVR3D](#).

ICD-10 Code: CMS notes that an ICD-10 code request has been submitted.

Newness: After its New Drug Application (NDA) approval on November 22, 2024, RAPIBLYK™ was not immediately for sale and became commercially available on July 21, 2025. CMS expresses interest in receiving more information regarding the cause of the marketing delay. Additionally, CMS states that, as it appears that RAPIBLYK™ and esmolol may use the same or similar mechanism of action to achieve a therapeutic outcome, are assigned to the same MS-DRG, and treat the same or similar patient population and disease, that is, adult patients with SVT including AF and AFL, the agency believes that these technologies are substantially similar to each other. If CMS determines that RAPIBLYK™ is substantially similar to esmolol, the newness period for RAPIBLYK™ would begin on December 31, 1986, the date esmolol received FDA approval. Therefore, RAPIBLYK™ would not be considered new and would be ineligible for new technology add-on payments for FY 2027. CMS invites public comments on whether RAPIBLYK™ is substantially similar to existing technologies and whether RAPIBLYK™ meets the newness criterion.

Cost: CMS agrees with the applicant that the technology meets the cost criterion and invites public comment.

Substantial Clinical Improvement: The applicants asserts that the technology: 1) offers a treatment option for patients unresponsive to or ineligible for currently available treatments, and 2) significantly improves clinical outcomes relative to services or technologies previously available. CMS summarizes the public comments it received in response to the New Technology Town Hall meeting notice published in the *Federal Register* regarding the substantial clinical improvement criterion for RAPIBLYK™. The applicant submitted additional studies in support of the application and discussed studies that had already been submitted. Additional clinician commenters expressed support for RAPIBLYK™ stating that there is a population for whom RAPIBLYK™ is a more appropriate treatment option than other beta blockers. A few commenters asserted that RAPIBLYK™ can treat a different patient population compared to other heart rate control drugs, including other beta blockers, as it has demonstrated effective management of tachyarrhythmias, even in patients with impaired cardiac function or at risk of hemodynamic instability or hypotension.

In response, CMS thanks the commenters, but continues to have concerns related to substantial clinical improvement. Among other concerns discussed in more detail in the preamble, CMS notes that the agency did not receive evidence to identify a patient population that is unresponsive to, or ineligible for, currently available treatments, and that it did not receive sufficient evidence to compare RAPIBLYK™ to other available treatments, such as amiodarone.

CMS continues to question whether the provided evidence is sufficient to demonstrate that RAPIBLYK™ leads to improved outcomes, reduced hospital LOS, and reduced ICU LOS in critically ill patients and those with POAF. As CMS is unable to determine that RAPIBLYK™ represents a substantial clinical improvement over existing technologies, the agency is proposing to disapprove FY 2027 new technology add-on payments for RAPIBLYK™ for FY 2027. CMS invites public comment on this proposal and whether RAPIBLYK™ meets the substantial clinical improvement criterion.

f. 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. The application is available at [MEARIS™ | Publication | ntap | NTP2510033XJPK](#)

ICD-10 Code: CMS notes that an ICD-10 code request has been submitted.

Newness: The applicant indicated that the technology was not expected to be commercially available until March 31, 2026. CMS expresses interest in additional information regarding when the technology first became available for sale and the cause of any delay in the technology's commercial availability, such as additional details regarding the establishment of commercial infrastructure. Regarding substantial similarity, CMS disagrees with the applicant that WASKYRA™ treats a new disease or new patient population because there are several other therapies FDA-approved for WAS in patients that cannot receive a HCT, such as ALYGLO™ and ASCENIV™ which are indicated for treatment of primary humoral immunodeficiency in patients with WAS and corticosteroids indicated for eczema. CMS also notes that no claim is made that WASKYRA™ has a new mechanism of action compared to existing treatments for WAS or that it changes the MS-DRG assignment. Therefore, CMS is unclear whether WASKYRA™ is substantially similar to existing treatments and is inviting public comments on whether WASKYRA™ is substantially similar to existing technologies and whether WASKYRA™ meets the newness criterion.

Cost: CMS agrees with the applicant that the technology meets the cost criterion and invites public comment.

Substantial Clinical Improvement: Regarding this criterion, CMS did not receive any written comments in response to the New Technology Town Hall meeting notice for WASKYRA™. The applicant asserts that the technology: 1) offers a treatment option for patients unresponsive to or ineligible for currently available treatments, and 2) significantly improves clinical outcomes relative to services or technologies previously available. However, the applicant did not provide any published or unpublished studies assessing the technology, practice guidelines, or other information. In the absence of such evidence, CMS is unable to determine that WASKYRA™ represents a substantial clinical improvement over existing technologies. Therefore, CMS is

proposing to disapprove new technology add-on payments for WASKYRA™ for FY 2027. CMS invites public comments on its proposal and whether WASKYRA™ meets the substantial clinical improvement criterion.

g. 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. The application is available at [MEARIS™ | Publication | ntap | NTP251006R7LMC](#)

ICD-10 Code: CMS has no concerns related to the indicated ICD-10-PCS codes (XW03357 and 7XW04357).

Newness: YARTEMLEA® received FDA market authorization on December 23, 2025.

Regarding substantial similarity, CMS agrees that YARTEMLEA® has a new mechanism of action and treats a new type of disease or patient population compared to existing technology, because YARTEMLEA® is the only FDA-approved therapy indicated for the treatment of adult and pediatric patients 2 years of age and older with hematopoietic stem cell TA-TMA. CMS notes that patients diagnosed with TA-TMA, including those treated with YARTEMLEA®, map to MS-DRGs 545-547. CMS believes that YARTEMLEA® is not substantially similar to existing technology and meets the newness criterion. The newness period is considered to commence on December 23, 2025, the date on which YARTEMLEA® received FDA market authorization for this indication. CMS invites public comments on whether YARTEMLEA® is substantially similar to existing technologies and whether YARTEMLEA® meets the newness criterion.

Cost: CMS agrees with the applicant that the technology meets the cost criterion and invites public comment.

Substantial Clinical Improvement: Regarding this criterion, CMS did not receive any written comments in response to the New Technology Town Hall meeting notice for YARTEMLEA®. CMS notes 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 is proposing to approve YARTEMLEA® for new technology add-on payments for FY 2027. CMS invites comment on this proposal and on whether YARTEMLEA® meets the substantial clinical improvement criterion.

h. 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). The application is available at [MEARIS™ | Publication | ntap | NTP251003GPVPQ](#)

ICD-10 Code: CMS has no concerns with the indicated ICD-10-PCS codes listed (XHR0XGA, XHR1XGA, XHR2XGA, XHR3XGA, XHR4XGA, XHR5XGA, XHR6XGA, and XHR7XGA).

Newness: ZEVASKYN™ receive FDA marketing approval on April 28, 2025. The applicant reports a marketing delay until June 15, 2025. CMS expresses interest in additional information regarding the cause of the reported delay in the technology's commercial availability, including whether ZEVASKYN™ was available for purchase before June 15, 2025 (two months after it received BLA approval on April 28, 2025). Regarding substantial similarity, CMS agrees with the applicant that ZEVASKYN™ uses a new mechanism of action and maps to a new MS-DRG as compared to VYJUVEK® and FILSUVEZ®. However, CMS believes that ZEVASKYN™ treats the same or similar type of disease or the same or similar patient population when compared to existing technology because other therapies, such as VYJUVEK® and FILSUVEZ®, are available to treat wounds in adult and pediatric patients with dystrophic epidermolysis bullosa (DEB), of which RDEB is a subtype. Based on the available information, CMS believes that ZEVASKYN™ is not substantially similar to existing technology and meets the newness criterion. CMS invites comments on whether ZEVASKYN™ is substantially similar to existing technologies and whether ZEVASKYN™ meets the newness criterion.

Cost: CMS agrees with the applicant that the technology meets the cost criterion and invites public comment.

Substantial Clinical Improvement: Regarding substantial clinical improvement, the applicant asserts that the technology: 1) offers a treatment option for patients unresponsive to or ineligible for currently available treatments, and 2) significantly improves clinical outcomes relative to services or technologies previously available.

CMS received a public comment addressing this criterion in response to the New Technology Town Hall meeting notice for ZEVASKYN™ which it summarizes in the proposed rule preamble. The commenter provided responses to questions posed at the Town Hall meeting related to study end points, and comparison of the technology to other therapies and the size of treated wound areas. CMS expresses appreciation for the comments, but continues to have concerns regarding whether ZEVASKYN™ meets the substantial clinical improvement criterion. Specifically, CMS questions whether the evidence submitted describes improvements in clinical outcomes over existing therapies rather than identifying a distinct patient population unresponsive to, or ineligible for, current available treatments that ZEVASKYN™ can treat. CMS notes that both VYJUVEK® and FILSUVEZ® demonstrated statistically significant wound healing in their respective clinical trials and therefore questions whether ZEVASKYN™ significantly improves wound healing compared to these treatments. CMS discusses additional

assertions made by the applicant related to benefits and safety of the technology, however, CMS states the submitted data is insufficient to support the assertions.

In summary, CMS is unable to determine that ZEVASKYN™ represents a substantial clinical improvement over existing technologies, and is therefore proposing to disapprove new technology add-on payments for ZEVASKYN™ for FY 2027. CMS invites comment on this proposal and whether ZEVASKYN™ meets the substantial clinical improvement criterion.

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

Beginning with applications for FY 2021, a medical device or product designated under FDA's Breakthrough Devices Program or as a Qualified Infectious Disease Product (QIDP) may qualify for a new technology add-on payment under an alternative pathway. Beginning with FY 2022, a medical product approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) may also qualify. Under an alternative pathway, a technology will be considered not substantially similar to an existing technology for purposes of the new technology add-on payment under the IPPS and will 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. These technologies must still be within the 2-to-3-year newness period to be considered "new," and must also still meet the cost criterion.

As discussed in section II.E.7. of the proposed rule and this summary, CMS is proposing to repeal the alternative pathway for new technology add-on payment beginning with applications received for new technology add-on payments for FY 2028 and require all applicants for new technology add-on payments to demonstrate that they meet all eligibility requirements to receive add-on payments.

In this section of the proposed rule, CMS provides a discussion of the concerns or issues the agency identified with respect to applications submitted under the alternative pathway along with succinct summary information regarding the applicant's assertions as to how the medical service or technology meets the applicable new technology add-on payment criteria. Detailed application information and supporting documentation is posted on the CMS MEARIS website: <https://mearis.cms.gov/public/publications/ntap>. In addition, CMS is making available separate online tables listing ICD-10 codes that CMS proposes to use to identify the Breakthrough Device-designated indication, or would be appropriate to exclude for cases related to a different technology, for purposes of the new technology add-on payment, if approved (See Table 10 found here: <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2027-ipp-proposed-rule-home-page>).

CMS received 32 applications for new technology add-on payments for FY 2027 under the new technology add-on payment alternative pathway. Of these, 7 applications were not eligible for consideration for new technology add-on payment and 3 applications were withdrawn prior to the issuance of the proposed rule. The remaining 22 technologies received a Breakthrough Device designation from FDA. CMS notes the dates by which technologies must receive FDA

marketing authorization and the circumstances under which the agency may provide for conditional approval.⁵⁸

In this proposed rule, CMS makes a proposal to approve or disapprove each of these 22 applications for FY 2027 new technology add-on payments. As several technologies considered in this section are subscription-based, CMS notes that there are unique circumstances for determining a cost for such technologies, and that the agency will continue to consider the issues relating to calculation of the cost per unit of technologies sold on a subscription basis as CMS gains more experience in this area. CMS continues to welcome 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.

For this summary, we have developed the table below showing CMS’ preliminary assessment of the 22 technologies CMS considered for a new technology add-on payment for FY 2027 under the alternative pathway. A brief summary of each technology follows the table and includes a summary of any special considerations discussed by CMS in the proposed rule.

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

Technology		Newness Date	Preliminary CMS Assessment and Application Link
a	Bayesian Health Sepsis Flagging Device	Pending FDA	Proposing approval 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	Proposing approval 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	Proposing approval with a maximum new technology add-on payment of \$10,205.00 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006TVQL6
d	CERAMENT® V	Pending FDA	Proposing approval with a maximum new technology add-on payment of \$5,687.50 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006EFW54
e	Ceribell Delirium Monitor System	12/8/2025	Proposing approval with a maximum new technology add-on payment of \$2,171 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006WFMK2
f	CMORE® CT System (posterior cervico-thoracic system)	12/8/2025	Proposing approval with a maximum new technology add-on payment of \$60,905 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP2510034V5CK
g	GORE® VIABAHN® FORTEGRA Venous Stent	12/19/2025	Proposing approval with a maximum new technology add-on payment of \$7,186.40 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006MBT8G
h	Infuse™ Bone Graft	2/13/2026	Proposing approval with a maximum new technology add-on payment of \$4,396.60 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP250929NNT8

⁵⁸ In accordance with the regulations at § 412.87(f)(2), § 412.87(f)(3), and § 412.87(d). For a complete discussion of this policy, please refer to the FY 2021 IPPS final rule (85 FR 58737 through 58742).

Technology		Newness Date	Preliminary CMS Assessment and Application Link
i	InVision Precision Cardiac Amyloid	5/21/2025	Proposing approval with a maximum new technology add-on payment of \$162.50 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251002J7D89
j	MediBeacon® Transdermal GFR Measurement System (TGFR)	Pending FDA	Proposing approval with a maximum new technology add-on payment pending submission of cost information. https://mearis.cms.gov/public/publications/ntap/NTP251003G1JT8
k	Micro Medical Solutions MicroStent and the MicroStent XL Peripheral Vascular Stent System	Pending FDA	Proposing approval with a maximum new technology add-on payment of \$4,550 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251002M8X4J
l	Nelli™ Seizure Monitoring System	1/20/2026	Proposing approval with a maximum new technology add-on payment of \$975 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP2509294WQJJ
m	NEXUS® Aortic Arch Stent Graft System	Pending FDA	Proposing approval with a maximum new technology add-on payment of \$35,880 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006114Y0
n	OmniaSecure™ MRI SureScan™ Lead Model 3930M	1/7/2026	Proposing approval with a maximum new technology add-on payment of \$7,796.75 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP250930Q7TFH
o	PearlMatrix™ P-15 Peptide Enhanced Bone Graft	6/18/2025	Proposing approval with a maximum new technology add-on payment of \$3,380 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251001VFM4K
p	PMcardio® STEMI AI ECG Model	Pending FDA	Proposing approval with a maximum new technology add-on payment of \$113.75 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006JRE0P
q	SAPIEN M3 Transcatheter Mitral Valve Replacement System	12/22/2025	Proposing approval with a maximum new technology add-on payment of \$35,100 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251003XXUEG
r	SetPoint System®	8/21/2025	Proposing approval with a maximum new technology add-on payment of \$38,675 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251006Y987F
s	Spur® Peripheral Retrievable Stent System	5/29/2025	Proposing approval with a maximum new technology add-on payment of \$2,596.75 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251001G2LL6
t	Trilogy™ Transcatheter Aortic Valve Regurgitation System	3/17/2026	Proposing approval with a maximum new technology add-on payment of \$25,675 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP25100691E86
u	ViaOne™ Epicardial Access System	Pending verification of commercial availability	Proposing approval with a maximum new technology add-on payment of \$1,300 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251001MFBVW
v	VUNO Med-DeepCARS®	Pending FDA	Proposing approval with a maximum new technology add-on payment of \$236.66 for FY 2027. https://mearis.cms.gov/public/publications/ntap/NTP251004DL00M

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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion and is proposing 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 proposes that the maximum add-on payment for this technology would be \$61.84 for FY 2027, which may be revised in the final rule, based on additional information received prior to the final rule. CMS invites public comments on whether the Bayesian Health Sepsis Flagging Device meets the cost criterion and CMS' proposal to approve new technology add-on payments for FY 2027.

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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that BriefCase-Triage meets the cost criterion. CMS proposes 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 proposes a maximum add-on payment to be \$137.53 for FY 2027, which may be revised in the final rule, based on additional information received prior to the final rule then. CMS invites public comments on whether the BriefCase-Triage meets the cost criterion and CMS' proposal to approve new technology add-on payments for FY 2027.

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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the CARA System meets the cost criterion. CMS proposes to approve the technology for add-on payments for FY 2027, subject to receiving FDA marketing authorization for the indication corresponding to the Breakthrough Device designation by May 1, 2026. As a result of questions raised by CMS related to the cost of the technology and its

Breakthrough Device indication (which are summarized in the proposed rule preamble), CMS would be interested in additional information including a clarification of: the components and process for use of the CARA Atlas™ Navigator, accounting for the difference in cost between a surgical procedure and an interventional procedure, and; the different uses of the CARA System components related to the Breakthrough Device designated indication. Based on information currently available, CMS is proposing that the maximum new technology add-on payment for a case involving the use of the CARA System would be \$10,205.00 for FY 2027, which may be revised in the final rule, based on additional information received prior to the final rule. CMS invites public comments on whether the CARA System meets the cost criterion and CMS' proposal to approve new technology add-on payments for FY 2027.

d. CERAMENT® V

BONESUPPORT Inc. submitted a FY 2027 application for new technology add-on payments for CERAMENT® V which is a resorbable, vancomycin-eluting ceramic bone graft substitute intended for use as a bone void filler as an adjunct to systemic antibiotic therapy and surgical debridement as part of the surgical treatment of osteomyelitis. CERAMENT® V is indicated for use on vancomycin-sensitive microorganisms. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Newness Period: CMS notes that the technology is not expected to be commercially available until a few months after FDA marketing authorization because of the required time to implement the technical requirements to comply with FDA marketing authorization and to produce the first batches of CERAMENT® V for the United States. CMS is interested in additional information regarding the anticipated cause for any delay in the technology's market availability, as another bone graft substitute from the applicant that was first approved for new technology add-on payment for FY 2023 (87 FR 48961 through 48966) did not have a delay in market availability.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing to approve CERAMENT® V 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. The maximum add-on payment would be \$5,687.50 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether CERAMENT® V meets the cost criterion and the agency's proposal to approve 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.

e. 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 notes 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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

ICD-10 Coding: The applicant has submitted a request for ICD-10-CM codes to differentiate use of the Ceribell Delirium Monitor System from use of the Ceribell Status Epilepticus Monitor, which was approved for new technology add-on payments for FY 2024 through FY 2026⁵⁹ and for which CMS is proposing to discontinue making new technology add-on payments for FY 2027. For purposes of the new technology add-on payment for FY 2027, if approved, CMS proposes to exclude certain cases⁶⁰ reporting ICD-10-PCS procedure code XX20X89 for patients with status epilepticus which would identify use of the Ceribell Status Epilepticus Monitor. CMS seeks comment on this proposal.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing to approve the Ceribell Delirium Monitor System for new technology add-on payments for FY 2027, with a newness period of December 8, 2025 which corresponds to the date the technology received FDA marketing authorization. The maximum add-on payment would be \$2,171 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether Ceribell Delirium Monitor System meets the cost criterion and the agency's proposal to approve new technology add-on payments for FY 2027.

f. 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 notes 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 would only be eligible 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). CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

ICD-10 Coding: CMS invites public comments on the use of ICD-10-PCS procedure codes listed in Table 10.1⁶¹ to identify use of the technology for the Breakthrough Device-designated indication for purposes of a new technology add-on payment, if approved.

⁵⁹ (88 FR 58927 through 58930; 89 FR 70009; 90 FR 37260)

⁶⁰ For the list of ICD-10-CM diagnosis codes that CMS believes would identify patients with status epilepticus, which CMS proposes to exclude from new technology add-on payment when reported in combination with ICD-10-PCS procedure code XX20X89, readers are invited to review Table 10.2 associated with the proposed rule which can be accessed online at: [FY 2027 IPPS Proposed Rule Home Page | CMS](#)

⁶¹ Table 10.1 can be accessed online here: <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2027-ipp-pps-proposed-rule-home-page>

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing to approve the CMORE® CT System for add-on payments for FY 2027 for the FDA-cleared indication covered by the Breakthrough Device designation. The newness period would commence on December 8, 2025 which is the date the technology became commercially available. The maximum add-on payment would be \$60,905 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether the CMORE® CT System meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

g. 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 ilio caval confluence in patients with symptomatic vessel obstruction. CMS provides a table with summary information about this product in the proposed rule, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is therefore proposing 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 is proposing that the maximum new technology add-on payment would be \$7,186.40 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether the GORE® VIABAHN® Venous Stent meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

h. 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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

ICD-10 Coding: CMS notes that Infuse™ Bone Graft has been granted other FDA approvals beyond the scope of its Breakthrough Device designation, and therefore proposes a list of nine relevant ICD-10-PCS procedure codes (specifically: 0SG00AJ, 0SF03AJ, 0SG04AJ, 0SG10AJ, 0SG13AJ, 0SG14AJ, 0SG30AJ, 0SG33AJ, and 0SG34AJ) that CMS believes 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. CMS seeks comment on this proposal.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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. The maximum add-on payment would be \$4,396.60 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether Infuse™ Bone Graft meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing to approve InVision PCA 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 May 21, 2025, the date on which the technology received FDA marketing authorization. The maximum add-on payment is proposed to be \$162.50 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether InVision PCA meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

j. MediBeacon® Transdermal GFR Measurement System (TGFR)

MediBeacon submitted a FY 2027 application for new technology add-on payments for the MediBeacon® Transdermal GFR Measurement System (MediBeacon® TGFR) which provides an assessment of glomerular filtration rate (GFR) at the point of care and employs an intravenously administered fluorescent tracer agent which has been engineered to be excreted exclusively by the kidneys. Per the applicant, noninvasive transdermal fluorescence detection of the excretion rate of the agent is converted into a GFR reading. CMS notes that the applicant previously submitted⁶² an application for new technology add-on payments under the name Transdermal GFR Measurement System Utilizing Lumitrace. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

⁶² Previous submissions for this technology for included for FY 2025 (89 FR 36128 through FR 36130; 89 FR 69204) and FY 2024 (88 FR 26954 through 26955; 88 FR 58919)

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is therefore proposing to approve the MediBeacon® TGFR 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. However, CMS notes that the applicant has not provided an estimate for the cost of the MediBeacon® TGFR. CMS notes that it appears that the TGFR Monitor component is not eligible for new technology add-on payment because the agency only makes new technology add-on payments for operating costs.⁶³ CMS would be interested in additional information about the TGFR Reusable Sensor, which also appears to be a reusable, capital expenditure. CMS expects the applicant to submit cost information prior to the final rule, and CMS will provide an update regarding the add-on payment amount for the technology, if approved, in the final rule. CMS invites public comments on whether the MediBeacon® TGFR meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027, subject to the technology receiving FDA marketing authorization as a Breakthrough Device for the indication corresponding to the Breakthrough Device designation by May 1, 2026.

k. Micro Medical Solutions MicroStent and the MicroStent XL Peripheral Vascular Stent System

Micro Medical Solutions, Inc. submitted a FY 2027 application for new technology add-on payments for the Micro Medical Solutions MicroStent and the MicroStent XL Peripheral Vascular Stent System (MicroStent) which is a self-expanding nitinol stent system for permanent implantation to improve luminal diameter in the treatment of ischemia in the lower leg. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing to approve MicroStent 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. The maximum add-on payment is proposed to be \$4,550 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether MicroStent meets the cost criterion and the agency’s proposal to approve 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.

l. 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. CMS notes that the applicant

⁶³ See: 72 FR 47307 through 47308.

previously submitted an application add-on payments.⁶⁴ CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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 notes 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 is proposing 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. CMS invites public comments on whether the Nelli™ Seizure Monitoring System meets the cost criterion and the agency's proposal to approve new technology add-on payments for FY 2027.

m. 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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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 proposes the maximum add-on payment would be \$35,880 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether the NEXUS® Aortic Arch Stent Graft System meets the cost criterion and the agency's proposal to approve 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.

n. 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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

⁶⁴ See: FY 2026 (90 FR 18189 through 18191; 90 FR 36770), FY2024 (88 FR 26940 through 26942; 88 FR 58919), and FY 2023 (87 FR 28341 through 28342; 87 FR 48960).

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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 proposes that the maximum add-on payment would be \$7,796.75 for FY 2027, but notes that this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether the OmniaSecure™ defibrillation lead meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

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. CMS notes that the applicant previously submitted an application for new technology add-on payments for this technology for FY 2026.⁶⁵ CMS provides a table with summary information about this product in the preamble, along with a link to its MEARIS application.

ICD-10 Coding: It appears to CMS that only the use of the PearlMatrix™ P-15 Peptide Enhanced Bone Graft in conjunction with a TLIF device, and the FDA Breakthrough Device designation it received for that use, would be relevant for purposes of the new technology add-on payment application for FY 2027. Therefore, in order to assess the technology for the indication that corresponds to the technology’s Breakthrough Device designation, CMS believes 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. CMS invites public comments on the use of these ICD-10-PCS procedure codes to identify use of the technology for the Breakthrough Device-designated indication for purposes of the new technology add-on payment, if approved.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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 notes that the proposed add-on payment amount is based on the submitted operating costs and not capital costs. After applying the standard calculation, CMS proposes that the maximum add-on payment would be \$3,380 for FY 2027, and that this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether

⁶⁵ See: 90 FR 18193 through 18195; 90 FR 36770.

PearlMatrix™ P-15 Peptide Enhanced Bone Graft meets the cost criterion and the agency's proposal to approve new technology add-on payments for FY 2027.

p. PMcardio® STEMI AI ECG Model

Powerful Medical Inc. submitted a FY 2027 application for new technology add-on payments for the PMcardio® STEMI AI ECG Model (PMcardio® STEMI AI) which is a stand-alone software device intended to analyze resting 12-lead ECGs of patients presenting with symptoms suspicious for acute coronary syndromes in the hospital setting. Per the applicant, the technology identifies ECG patterns of STEMI/STEMI equivalents as an adjunctive decision support tool used by healthcare professionals. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing to approve PMcardio® STEMI AI 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 proposes that the maximum add-on payment would be \$113.75 for FY 2027, but notes that this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether PMcardio® STEMI AI meets the cost criterion and the agency's proposal to approve new technology add-on payments for FY 2027, subject to the technology receiving FDA marketing authorization by May 1, 2026

q. 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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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. CMS considers the newness period to commence on December 22, 2025, the date on which the SAPIEN M3 TMVR System received FDA marketing authorization. CMS proposes that the maximum add-on payment would be \$35,100 for FY 2027, but notes that this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether the SAPIEN M3 TMVR System meets the cost criterion and the agency's proposal to approve new technology add-on payments for FY 2027.

r. 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). CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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. CMS considers the newness period to commence on August 21, 2025 the date on which the SetPoint System® became commercially available. CMS proposes that the maximum add-on payment would be \$38,675 for FY 2027, but notes that this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether the SetPoint System® meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

s. 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. CMS notes that the applicant submitted an application for new technology add-on payments for this technology for FY 2026.⁶⁶ CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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. CMS considers the newness period to commence on May 29, 2025, the date on which the technology received FDA marketing authorization. CMS proposes the maximum add-on payment would be \$2,596.75 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether the Spur® Peripheral Retrievable Stent System meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

t. 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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

⁶⁶ See: 90 FR 18203 through 18205; 90 FR 36770

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing 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. CMS considers the newness period to commence on March 17, 2026, the date on which the technology received FDA marketing authorization. CMS proposes the maximum add-on payment would be \$25,675 for FY 2027, but this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether the Trilogy™ Transcatheter Aortic Valve Regurgitation System meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

u. 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. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Newness Period: Based on statements made by the applicant regarding delayed commercial availability of this product, CMS is interested 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).

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing to approve ViaOne™ for new technology add-on payments for FY 2027, for the FDA-approved indication covered by its Breakthrough Device designation. CMS proposes that the maximum add-on payment would be \$1,300 for FY 2027, but notes that this amount may be updated in the final rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether ViaOne™ meets the cost criterion and the agency’s proposal to approve new technology add-on payments for FY 2027.

v. VUNO Med-DeepCARS®

VUNO Med Inc. submitted a FY 2027 application for new technology add-on payments for VUNO Med-DeepCARS® (DeepCARS®) which is an artificial intelligence based technology that monitors and assesses the risk of impending cardiac arrest within a 24-hour period among inpatients in general hospital wards. CMS provides a table with summary information about this product in the proposed rule preamble, along with a link to its MEARIS application.

Cost Criterion: CMS agrees that the technology meets the cost criterion. CMS is proposing to approve DeepCARS® 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 proposes that the maximum add-on payment would be \$236.66 for FY 2027, but notes that this amount may be updated in the final

rule based on revised or additional information CMS receives prior to the final rule. CMS invites public comments on whether DeepCARS® meets the cost criterion and the agency's proposal to approve new technology add-on payments for FY 2027, subject to the technology receiving FDA marketing authorization by May 1, 2026.

7. Proposed Alternative Pathway Repeal

Through prior rulemaking, CMS established an alternative inpatient new technology add-on payment pathway for certain transformative new devices and certain antimicrobial products.⁶⁷ 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.⁶⁸ 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.

CMS notes that the intent of the Breakthrough Devices Program is to help patients have more timely access to designated medical devices by expediting their development, assessment, and review. CMS reviews the Breakthrough Device designation criteria which are defined in section 515B(b) of the FD&C Act (21 U.S.C. 360e-3(b)). Per FDA guidance, a sponsor should demonstrate a reasonable expectation that the device could provide for more effective treatment or diagnosis of the disease or condition identified in the proposed indications for use. CMS notes that, as discussed in FY 2020 IPPS and CY 2020 OPPS final rules,⁶⁹ CMS believed that establishing an alternative pathway for new technology add-on payments under the IPPS and device pass-through payments under the OPPS was supportive of the goals of the Breakthrough Devices Program. However, as the agency has gained experience, CMS has concerns with the limited evaluation process for alternative pathway applications for new technology add-on and OPPS device pass-through payments. Specifically, CMS 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 a substantial clinical improvement, that is, 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. Therefore, CMS is proposing to repeal the alternative pathway for the IPPS new technology add-on payment and the OPPS device passthrough applications, and require all applicants for IPPS new technology add-on

⁶⁷ FY 2020 and FY 2021 IPPS final rules (84 FR 42292 through 42297; 85 FR 58737 through 58739).

⁶⁸ See the CY 2020 OPPS/ASC final rule (84 FR 61295 through 61296).

⁶⁹ See FY 2020 IPPS final rule (84 FR 42292 through 42297) and CY 2020 OPPS final rule (84 FR 61295 through 61296).

payments and OPSS 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 believes this requirement will better align spending and value and ultimately support providers in delivering the best data-driven care possible.

This 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). Technologies that are currently under review for FY 2027 new technology add-on payments under the alternative pathway will remain eligible for consideration for add-on payment under the alternative pathway. Technologies that have previously been approved for add-on payments under the alternative pathway will remain eligible for add-on payment under the alternative pathway.

Additionally, consistent with the proposed removal of the alternative pathway for certain antimicrobial products currently at § 412.87(d), CMS would also 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 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, as reflected at § 412.87(f)(2). CMS proposes to amend §412.87 to reflect these proposals. For reasons stated in the preamble, CMS is also proposing technical corrections to the introductory text at §412.87(d) and §412.88(a)(2)(ii)(A).

Similarly, CMS is proposing that all applications received for OPSS device pass-through payment status on or after October 1, 2026, including all applications received through the remainder of the CY 2028 OPSS 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). OPSS 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 have been met. Existing device category codes established based on the approval, either preliminary or via a final determination made in an OPSS/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 2 years, but no more than 3 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 is proposing to revise paragraph §419.66(c)(2)(ii) to reflect this proposed policy, effective October 1, 2026.

CMS notes that even if a technology does not receive new technology add-on payments or obtain pass-through status, CMS continues to pay for new technologies through the regular payment mechanism established by the DRG payment methodology and through appropriate Ambulatory Payment Classifications (APC). CMS reminds the reader that whether a technology receives new technology add-on payments or OPPS device pass-through payments does not affect coverage of the technology or the ability for Medicare providers to provide such technology to patients where appropriate.

The agency solicits information on alternate methods that stakeholders believe 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.

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 proposed rule wage index values are based on data from FY 2023 submitted cost reports. CMS is not proposing any changes to the categories of included and excluded costs for FY 2027 relative to prior years. The proposed rule calculations of the FY 2027 wage index are based on wage data of 3,006 hospitals. The data file used to construct the proposed wage index includes FY 2022 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. 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.

General wage index policies are unchanged from prior years. CMS notes that it proposes to exclude 68 providers due to aberrant wage data that failed edits for accuracy. However, if data aberrancies for these providers are resolved timely, CMS will include data from these providers to set the final rule FY 2027 wage indexes.

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 proposed 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. For the FY 2027 wage index timetable go to: [FY 2027 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 proposed rule includes a detailed listing of these steps. CMS calculates an unadjusted national average hourly wage of \$58.87.

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 will be 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 (2,922 of 3,006) used to determine the FY 2027 proposed rule wage index. The FY 2027 national average hourly wage, adjusted for occupational mix, is \$58.82.

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. The CY 2025 survey is available on the CMS website at: [2025 Occupational Mix Survey Hospital Reporting Form CMS-10079 for the Wage Index Beginning FY 2028 | CMS](#). Hospitals are required to submit

their completed 2025 surveys to their Medicare Administrative Contractors (MACs) by June 30, 2026.

The preliminary, unaudited CY 2025 survey data will be posted on the CMS website in mid-July 2026. 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), 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 707 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2027. There are 242 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2025 that will continue for FY 2027. There are 263 hospitals approved for wage index reclassification in FY 2026 that may continue for FY 2027. CMS indicates that there will be 1,212 hospitals (37 percent of all hospitals) in MGCRB reclassification status for FY 2027 (with 331 of these hospitals reclassified back to their 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 is proposing 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.

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 the average 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 is proposing 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.

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 even 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 indicates 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 is proposing 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.

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).⁷⁰

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 MGRB 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).

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 proposed FY 2027 wage index for 535 urban hospitals requiring a budget neutrality adjustment factor of 0.985465 (-1.45 percent) applied to hospital wage indexes.

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 proposing to continue the imputed floor policies unchanged for FY 2027.

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 40 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 proposes 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.

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 -0.80 percent for FY 2027.

⁷⁰ 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.

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*⁷¹ held that the 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 proposed 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)⁷², the hospital would be eligible for the transitional policy. CMS proposes to apply a budget neutrality adjustment of -0.02 percent for the low wage index transitional policy.

H. Wage Index Tables

Proposed rule wage index tables 2, 3 and 4 can be found at: [FY 2027 IPPS Proposed Rule Home Page | CMS](#). Select #2 under FY 2027 Proposed Rule Tables.

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.

⁷¹ *Bridgeport Hosp. v. Becerra*, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024)

⁷² Over a 3-year period if its wage index were decreasing by more than 5 percent each year, this would mean a 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.

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 time period relative to uncompensated care costs for that same time 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 on the basis of 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. This payment was established 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).⁷³ 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

⁷³ 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.

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 is not proposing 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. Proposed 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) January 2026 Medicare DSH estimates, which were based on the December 2025 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 January 2026 Medicare estimate of DSH payments for FY 2027 is \$15.303 billion. **The proposed Factor 1 amount is seventy-five percent of this amount, or \$11.477 billion.** The proposed Factor 1 for 2027 is about \$936 million less than the final Factor 1 for FY 2026.

The Factor 1 estimate for FY 2027 began with a baseline of \$12.901 billion in Medicare DSH expenditures for FY 2023. The table below shows the factors applied to update this baseline to the current proposed 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	1.0620	13.701
2025	1.029	1.022	1.0090	0.9937	1.0546	14.449
2026	1.026	1.019	1.0075	0.9675	1.0188	14.721
2027	1.024	1.009	1.0050	1.0015	1.0395	15.303

- 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 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 case-mix figures 2027 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.⁷⁴

- 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 “other” column also includes a factor for the estimated changes in Medicaid enrollment through 2027.⁷⁵

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	0.8	0.0	2.4

2. Proposed 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.⁷⁶

CMS estimates that the uninsured rate for the baseline year of 2013 was 14 percent and for CYs 2026 and 2027 is 9.0 percent and 9.1 percent, respectively. As required, the Chief Actuary of CMS certified these estimates.

Using these estimates, CMS calculates the proposed 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: 9.0 percent.

⁷⁴ <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/technicalpanelreport2010-2011.pdf>

⁷⁵ CMS did not provide the annual estimated percent change in Medicaid enrollment used in its projections.

⁷⁶The 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>

- Percent of individuals without insurance for CY 2027: 9.1 percent.
- Percent of individuals without insurance for FY 2027 (0.25 times 0.090) + (0.75 times 0.091): 9.1 percent

Proposed Factor 2 = $1 - |((0.091 - 0.14) / 0.14)| = 1 - 0.3500 = 0.6500$ (65.00 percent)

CMS calculated Factor 2 for the FY 2027 proposed rule to be 0.6500 or 65.00 percent, and the uncompensated care amount for FY 2027 to be \$11.477 billion x 0.6500 = \$7.46 billion which is about \$253 million less than the FY 2026 UCP total of about \$7.713 billion; the percentage decrease is 3.2 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.

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

FY 2027 Proposed Change in UCP

(\$ in billions)

	FY 2026	FY 2027	Change	% Change
Factor 1	\$12.413	\$11.477	-\$0.936	-7.5%
Factor 2	0.6214	0.6500	0.0286	+4.6%
UCP*	\$7.713	\$7.460	-\$0.253	-3.2%

* The UCP totals do not include supplemental payments for IHS/Tribal hospital and Puerto Rico hospitals. In FY 2027, these payments are estimated to account for \$102.8 million.

3. Proposed 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 is using the December 2025 HCRIS extract to calculate Factor 3 for the proposed rule but intends to use the March 2026 update of HCRIS 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)).

CMS notes that the March HCRIS data extract will be available during the comment period for this proposed rule if providers want to verify that their amended and/or reopened data is reflected in the March HCRIS extract.

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 have 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.⁷⁷

D. Payment Impacts

The regulatory impact analysis presented in Appendix A of the proposed 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 2,318 hospitals that are projected to be eligible for DSH in FY 2027.

The proposed total amount of uncompensated care payments (\$7.46 billion) combined with supplement payments for IHS/Tribal hospitals and Puerto Rico hospitals (\$102.8 million) is \$7.563 billion. This is a 3.3 percent decrease (about \$258 million) from FY 2026 payments. Changes in FY 2027 payments are driven by a decrease in Factor 1 and a slight increase in Factor 2. As noted above, Factor 2 has changed significantly between proposed and final rule for the past several years and may change again this year based on a re-estimate of the uninsured population in the NHEA.

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 -3.3 percent indicates that hospitals within that category are projected to experience a smaller decrease in payment compared to the average for all hospitals, and a percentage change less than -3.3 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 proposed uncompensated care payments and supplemental payments combined.

Hospital Type	Dollar Difference FY 2026-FY 2027 (\$ in millions)	Percent Change (%)
All Hospitals	-258	-3.3
Urban	-221	-3.0
Large Urban	-72	-1.7
Other Urban	-149	-4.6
Rural	-37	-8.5
Beds: 0-99 (Urban)	-24	-7.7
Beds: 250+ (Urban)	-135	-2.5
Beds: 0-99 (Rural)	-20	-8.5
New England (Urban)	-5	-2.4
Middle Atlantic (Urban)	10	1.1
South Atlantic (Urban)	-56	-7.5

⁷⁷ Comments on the list of mergers can be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov. It notes that this inbox is not intended for Worksheet S-10 audit process related emails, which should be directed to the MACs.

Hospital Type	Dollar Difference FY 2026-FY 2027 (\$ in millions)	Percent Change (%)
East South Central (Urban)	-68	-3.6
West North Central (Urban)	-15	-3.2
West South Central (Urban)	-20	-1.1
Pacific (Urban)	-31	-4.6
Middle Atlantic (Rural)	0	-0.4
Pacific (Rural)	0	-3.7
Puerto Rico	-5	-5.6
Teaching with 100 or more residents	-51	-1.6
Teaching with fewer than 100 Residents	-122	-4.4
Non-Teaching	-85	-4.8
Voluntary	-167	-3.7
Proprietary	-60	-5.6
Government	-32	-1.4

Under this proposal, rural hospitals are projected to receive a larger decrease in uncompensated care payments of 8.5 percent compared to a decrease in UCP payments of 3.0 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 smaller than average decrease of 1.6 percent compared with projected decreases for nonteaching hospitals and teaching hospitals with fewer than 100 residents of 4.8 percent and 4.4 percent, respectively. Government ownership hospitals are expected to receive a smaller than average decrease of 1.4 percent, while proprietary and voluntary hospitals are expected to receive larger than average decreases.

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.⁷⁸ 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

⁷⁸ 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.

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 proposed 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 proposed changes CMS is making to the MS-DRGs, it proposes 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 is proposing to pay MS-DRGs 362, 400, 404 and 457 using the special payment methodology. CMS is also proposing to pay MS-DRGs 463 and 617 using the special payment methodology.

B. Inpatient Hospital Update

The proposed inpatient hospital update for FY 2027 is calculated by determining the rate of increase in the hospital market basket for IPSS 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 applicable percentage increase.
- 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 market basket update.

Using a 2023 base year, IHS Global Insight, Inc.’s (IGI) 4th quarter 2025 forecast (with historical data through the 3rd quarter of 2025) of the hospital market basket is 3.2 percent. IGI’s 4th quarter 2025 forecast of total factor productivity is 0.8 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	-0.8	-0.8	-0.8	-0.8
Applicable Percentage Increase	2.4	0.0	1.6	-0.8

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 proposes to use FY 2025 data to set the CMI criteria. 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 1.7783 (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)	1.48840
2. Middle Atlantic (PA, NJ, NY)	1.55880
3. East North Central (IL, IN, MI, OH, WI)	1.64790
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.68390
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.63300
6. East South Central (AL, KY, MS, TN)	1.56700
7. West South Central (AR, LA, OK, TX)	1.78160
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.79165
9. Pacific (AK, CA, HI, OR, WA)	1.73290

The median regional CMIs in the proposed rule reflect the December update of the FY 2025 MedPAR containing data from bills received through December 31, 2025. 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 1 st 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
2 nd quarter of 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.

CMS is proposing 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 proposes 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, 2028. If a hospital’s written request for LVH status for FY 2027 is received after December 1, 2026, CMS proposes 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 to its MAC for both the portions of FY 2027 by September 1, 2026.

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).

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

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 CY 2026 OPSS 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 proposes the same policy for medical residency programs. 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 this proposed policy would be October 1, 2026.⁷⁹

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. Rural hospitals can receive adjustments to their 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 indicates 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 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 reviews its FY 2025 proposals on this topic as well a request for comments on potential criteria for defining a new medical residency program that it did after completing the FY 2025

⁷⁹ 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”.

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.

Effective for programs started on or after 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 proposes 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 distinguishes 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 proposes 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.

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

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 as

long as 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.

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 follows in the proposed rule and is not repeated here.

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
390081	Delaware County Memorial Hospital	Drexel Hill, PA	37964	November 7, 2022	28.60	27.96
390180	Crozer-Chester Medical Center	Chester, PA	37964	June 21, 2025	101.32	100.89

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 July 9, 2026** to be eligible to receive slots from these closed hospitals.

CMS will only accept applications submitted via MEARIS™ ([MEARIS™ \(cms.gov\)](https://www.cms.gov/MEARIS)). 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 provides the proposed MA nursing and allied health education payments and reduction in MA DGME payments for 2025. CMS proposes using the 3rd quarter 2025 update of the 2023 HCRIS projected forward two years to estimate 2025 payments. For 2025, CMS proposes 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.

2. Prohibiting Unlawful Discrimination

Like the policy CMS adopted prohibiting use of unlawful discrimination in accreditation standards for medical residency programs and its proposal to prohibit unlawful discrimination in DGME programs, CMS is proposing that individual NAH education programs and NAH accrediting bodies must not discriminate, or promote or encourage discrimination, based on race, color, national origin, sex, age, disability, or religion or use these characteristics as proxies. These policies would be effective October 1, 2026.

3. 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 is proposing 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.

4. 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 indicates 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.

Proposals.

After considering the public comments on the proposal in the FY 2025 IPPS proposed 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 its original 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 is also proposing 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 the indirect cost allocation is done. The first proposal would effectively 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 purposes of 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.

The second proposal clarifies 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 is proposing to require providers with approved NAH education program 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)).

H. Payment Adjustment for Certain Immunotherapy Cases

In some cases, the 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. In response to a comment on the FY 2025 IPPS final rule, CMS applies this policy to other situations where the hospital does not have a cost for the immunotherapy product.

CMS is proposing to adopt these same policies for FY 2027. Using the FY 2025 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 (\$71,039) were 17 percent of the average costs of the cases assigned to MS-DRG 018 that are identified as non-clinical trial cases (\$412,218). Accordingly, CMS is proposing to adjust the payment for MS-DRG 018 by applying an adjustor of 0.17 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.⁸⁰ 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),⁸¹ with total penalties for all such penalized hospitals estimated to be 0.48 percent of total payments for such hospitals.⁸²

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).

⁸⁰ 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>.

⁸¹ 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.

⁸² See Table V.I.-06 of the proposed rule.

CMS is proposing to add the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization (Sepsis Readmission) measure to the measure set, with a phased approach that would use “early look” reports for FY 2028 before the measure begins to be used in the FY 2029 payment adjustment.

b. Proposed Adoption of Sepsis Readmission Measure

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 that have shown 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 proposes to adopt for the HRRP, beginning with an applicable period of July 1, 2025, to June 30, 2027, for the FY 2029 program year, 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 readmission 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 on 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.
- *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 would be 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.

Pre-Rulemaking. The proposed Sepsis Readmissions measure was reviewed by the Pre-Rulemaking Measure Review (PRMR)⁸³ Hospital Recommendation Group during January 2026. Consensus was not reached, with only 65 percent recommending adoption. Those members who did not recommend adoption expressed concerns about adopting the measure directly into the HRRP because of the payment consequences (as opposed to providing hospitals time to adapt before payment consequences are implemented), methodological concerns, and the need for greater consistency in sepsis definitions. The consensus-based entity endorsed the measure on February 6, 2026.

Taking into consideration the PRMR recommendations, CMS is proposing to adopt the measure directly into the HRRP, but with a phased approach that would use “early look” reports for FY 2028, which would provide sepsis readmission rates and estimated HRRP payment adjustments before the measure begins to be used in the FY 2029 payment adjustment.

CMS proposes to adopt the updated measure set into the HRRP but acknowledges the conditions specified and notes they are not specific to the addition of MA data into the measures. The agency states it will review the applicability of stratifying the measures by MA and FFS data and will review shortening the readmissions period as well as the criteria to include care provided in ambulatory settings.

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 proposes to provide hospitals an “early look” report of their Sepsis Readmission measure results and estimated payment adjustment for the FY 2028 program year (for which the

⁸³ Committee members vote “recommend” or “do not recommend” that the measure be added to the applicable CMS program. In 2025, CMS removed the “recommend with conditions” voting option. A minimum of 75 percent agreement must be reached for consensus.

applicable period is July 1, 2024, through June 30, 2026). Data used in the early look period would not be used for payment adjustment and would not be made publicly available. Public reporting and the payment adjustment would begin with the FY 2029 program year (for which the applicable period is July 1, 2025, through June 30, 2027).

CMS publicly reports readmission measures results annually for each applicable condition for each applicable hospital on the Compare tool⁸⁴ or successor website and on the Provider Data Catalog.⁸⁵

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.⁸⁶ If the proposal to include sepsis as an applicable condition is finalized, then excess readmissions for sepsis would be included in the calculation of aggregate payments for excess readmissions beginning with the FY 2029 payment year. 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 proposed 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 estimated Medicare savings increased by \$169,651,338. Table V.I.-06 of the rule compares the current measure set to the proposed measure set and assesses the impact (by hospital characteristics) on payment reductions resulting from the inclusion of the Sepsis Readmission measure.

CMS invites public comment on the proposal.

J. Hospital Value-Based Purchasing Program (HVBP)

1. Background

a. Program Overview⁸⁷

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.

⁸⁴ The compare tool is available at <https://www.medicare.gov/care-compare>.

⁸⁵ The Provider Data Catalog is available at <https://data.cms.gov/provider-data>.

⁸⁶ 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.

⁸⁷ 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 is proposing modifications to five condition-specific and procedure-specific mortality measures beginning with the FY 2032 program year. CMS also issues requests for information (RFIs) on two topics: (i) measuring emergency room access and timeliness in the Hospital Inpatient Quality Reporting Program (IQR) and HVBP; and (ii) the potential future use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the IQR.

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 December 2025 update of the FY 2025 MedPAR file.⁸⁸

c. Estimated Impact Analysis

The proposed 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 Total Performance Scores, which are the most recently available scores that hospitals were given an opportunity to review and correct. The analysis shows that for the 2,455 hospitals, there is an average net percent positive payment adjustment of 0.131 percent, and the number of hospitals with a positive percent change in base operating DRG (51.5 percent) is higher than those with a negative change (48.5 percent).

2. HVBP Measures

CMS proposes to adopt 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 proposal is contingent on finalization of the adoption of the measures, with the same proposed updates, in the IQR beginning with the FY 2028 payment determination. The proposed updates are discussed in section IX.B.2.

⁸⁸ The agency is publishing proxy value-based incentive payment adjustment factors in Table 16 of the rule associated with the proposed rule, calculated using the FY 2027 HVBP methodology and historical baseline and performance periods for the FY 2026 HVBP, and by using the December 2025 update to the FY 2025 MedPAR file. The proxy adjustment factors will not be used to adjust hospital payments. CMS intends to provide updated tables in the FY 2027 IPPS/LTCH PPS final rule (and on the CMS website in Fall 2026) that will reflect the March 2026 update to the FY 2025 MedPAR file and 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 ⁸⁹	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 <i>Staphylococcus Aureus</i> (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)	0166		
Communication with Nurses			
Communication with Doctors			
Responsiveness of Hospital Staff*		X	X*
Communication About Medicines			
Discharge Information			
Care Transition*			
Cleanliness and Quietness of Hospital Environment			
Overall Rating of Hospital	0228		
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 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 proposes 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.

⁸⁹ 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 proposed changes to the mortality measures beginning with the baseline and performance periods for the FY 2032 program year, which are proposed 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	Baseline 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; 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 proposed rule, CMS is proposing 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 dome) 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 IQR 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 dimensions for the FY 2029 program year are shown in Table V.J.9 of the rule.

K. Hospital-Acquired Conditions (HAC) Reduction Program

The HAC program 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 HAC program’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 HAC program, out of 2,891 hospitals, 721 hospitals will be included in the worst-performing quartile (and subject to the program’s penalty).⁹⁰

⁹⁰ See Table I.G.8-01 in the rule.

There are currently the following 6 measures in the HAC REDUCTION PROGRAM for FY 2027 and subsequent years: ⁹¹

- 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).

CMS is not making any proposals or updates for the HAC program.

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, CMS reports there are 27 hospitals participating in the demonstration.

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

⁹¹ 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. Proposed FY 2027 Budget Neutrality Adjustment

CMS proposes to continue 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 eleven new hospitals in 2025, and it is 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.

Therefore, CMS does not propose to apply a budget neutrality offset in the FY 2027 IPPS/LTCH PPS proposed rule for FY 2027. Instead, CMS proposes to 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 to formulate estimated demonstration costs for FY 2027 and FY 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. As it has done in the past, CMS would 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. Comments are welcomed on the proposal.

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 is proposing a national capital Federal rate of \$545.22 for FY 2027.

Update Factor:

For FY 2027, CMS will increase the national capital Federal rate by 3.1 percent based on the capital input price index (CIPI) of 2.8 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 not proposing to apply 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 proposing to make 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 proposing to make 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		2.8
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
<i>Total Update</i>		3.1

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 3.61 percent of total capital payments before accounting for outlier reconciliation and 3.58 percent after subtracting 0.03 percentage points for outlier reconciliation. Therefore, the FY 2027 outlier adjustment factor is 0.9642 (-3.58 percent), compared to 0.9616 (-3.84 percent) in FY 2026. The net change is (0.9642/0.9616) or 0.27 percent. Thus, the outlier adjustment increases the FY 2027 capital federal rate by 0.27 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 proposes to divide the capital Federal rate by 0.9989, which was the effect of the 5 percent cap and transitional adjustment in FY 2026.

CMS then proposes continuing 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 1.0156 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 0.9913 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 0.9986. The incremental adjustment for the 10 percent cap on reductions to the DRG relative weights is 0.9998. The total adjustment is 0.9983 (0.9986 x 0.9998) 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 1.0139 (1.0156 x 0.9983, or 1.39 percent). The wage index and transitional exception for low-wage index hospitals of 0.9913 (or -0.87 percent) is then applied.

Proposed Rule Calculation:

The proposed 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	Proposed FY 2027	Change	Percentage Change
Update Factor ¹	N/A	1.0310	1.0310	3.10
GAF/DRG Adjustment Factor ¹	N/A	1.0139	1.0139	1.39
WI Cap/Transitional Exception ²	0.9989	0.9913	0.9923	-0.77
Outlier Adjustment Factor ²	0.9616	0.9642	1.0027	0.27
Capital Federal Rate	\$524.15	\$545.22	1.0402	4.02

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 1.0139 or 1.39 percent.

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 0.9642/0.9616, or 1.0027 (or 0.27 percent). The net change to the wage index cap and transitional exception is 0.9913/0.9989 or 0.9923 (-0.77 percent).

Considering the update factor and the budget neutrality adjustments, CMS is proposing to adopt a national capital Federal rate for FY 2027 of \$545.22, a 4.02 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 2025 4th quarter forecast of the hospital market basket for FY 2027 with historical data through the 3rd quarter of 2025 and is 3.2 percent. CMS will update this estimate based on more recent information for the final rule.

B. Critical Access Hospitals (CAHs)

The Frontier Community Health Integration Project (FCHIP) Demonstration⁹² 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

⁹² The FCHIP Demonstration was authorized by section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275).

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 is not proposing 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 cases are paid an IPPS comparable amount. The criteria for exclusion from the site neutral payment remain the same for FY 2026:

- 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 proposes 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.⁹³ 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 Proposed Changes to LTCH PPS Rates for FY 2027*	
Standard Federal Rate, FY 2026	\$50,824.51
Proposed Rule Update Factors	
Update per Section 1886(m)(3)(C) of the Act (including MFP reduction)	+2.4%
Penalty for hospitals not reporting quality data (including MFP reduction)	-2.0%
Net update, LTCHs reporting quality data	+2.4% (1.024)
Net update LTCHs not reporting quality data	+0.4% (1.004)
Proposed Rule Adjustments	
Proposed area wage index budget neutrality adjustment	1.0025505
Proposed Standard Federal Rate, FY 2027	
LTCHs reporting quality data $\$50,824.51 \times 1.024 \times 1.0025505$	\$52,177.04
LTCHs not reporting quality data $(\$50,824.51 \times 1.004 \times 1.0025505)$	\$51,157.95
Proposed 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)	\$51,679
Impact of Proposed Policy Changes on LTCH Payments in FY 2027	
Total estimated impact	2.3% (~ \$55 million)
*More detail is available in Table IV, “Impact of Proposed 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.	

⁹³ 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.

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 proposes to continue to apply 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 would be incorporated into the MS-LTC-DRG system for FY 2027 since the two systems share an identical base. Proposed MS-DRG changes are described elsewhere in this summary and details can be found in section II.C. of the preamble of the proposed rule. Other proposed changes to the MS-DRGs that affect assignments under the proposed GROUPER Version 44 are discussed in section II.C of the proposed 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. Proposed Development of the FY 2027 MS-LTC-DRG Relative Weights Methodology

For FY 2027, as it did for FY 2026, CMS proposes to use its historical 11-step methodology for calculating the relative weights, as described in the FY 2021 IPPS/LTCH PPS final rule (85 FR 58898 through 58907), subject to a 10-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 (87 FR 49162).

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

a. Proposed Relative Weights Source Data

FY 2027 proposed relative weights are derived from the December 2025 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. If better data become available, CMS would use those data and the finalized 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 proposes to identify FY 2025 cases that meet the statutory patient criteria depending on date of admission as follows. First, it would use 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 paid the LTCH PPS standard Federal rate in FY 2025 (based on the claim payment amount). Second, it would also use 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 proposes to use 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 proposes to remove cases with a length of stay of 7 days or less from applicable LTCH cases.

c. Volume-related Adjustments

CMS proposes to continue to account for low-volume MS-LTC-DRG cases using its quintile methodology and to use it 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.

It finds that there are 245 such MS-LTC-DRGs in the claims, and the quintiles each contained at least 49 MS-LTC-DRGs ($245/5 = 49$). If in the final rule CMS determines the number of MS-LTC-DRGs with less than 25 applicable LTCH cases is not evenly divisible by 5, it would use its historical methodology of assigning 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 proposes to make adjustments to the resulting low-volume MS-LTC-DRGs to preserve monotonicity.

CMS then determines a proposed 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. (See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html> for these low-volume MS-LTC-DRGs.)

d. Remove Statistical Outliers

Consistent with its current methodology, CMS proposes to remove statistical outlier cases from the LTCH cases with a length of stay of at least 8 days. It also proposes to continue to define 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 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. CMS proposes to continue this policy for FY 2027.

f. Hospital-Specific Relative-Value Methodology (HSRV)

CMS proposes to continue 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. 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 proposes to continue for FY 2027 its approach of combining 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 proposed 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 (414 of these MS-LTC-DRGs are identified for the proposed rule), CMS proposes to continue to cross-walk that no-volume MS-LTC-DRG to another proposed MS-LTC-DRG based on clinical similarities in resource use intensity and relative costliness to assign an appropriate proposed 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 would be 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 386 no-volume MS-LTC-DRGs, for which CMS proposes to assign relative weights based on clinical similarity and relative costliness to one of the remaining 354 (768 – 414 = 354) MS-LTC-DRGs for which it calculated relative weights based on the trimmed applicable LTCH cases in the FY 2025 MedPAR file data. When necessary, adjustments are made to account for nonmonotonicity. (See [Acute Inpatient PPS | CMS](#) for these zero-volume MS-LTC-DRGs.) The preamble includes an example of this methodology for determining the proposed relative weights for the FY 2027 MS-LTC-DRGs with no applicable LTCH cases. 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 proposes to assign 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 proposes to continue using 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 would apply 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 proposes to normalize relative weights using its established methodology for FY 2027. 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 proposed MS-LTC-DRG relative weights for FY 2027, each recalibrated MS-LTC-DRG uncapped relative weight is multiplied by the proposed 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 proposed update of the MS-LTC-DRG classifications and relative weights before applying the 10-percent cap (or the uncapped relative weights), CMS proposes to continue to use its established two-step budget neutrality methodology.

First, it proposes to apply 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 proposed Version 44 of the GROUPER and the proposed 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 FY 2026 MS-LTC-DRG relative weights to calculate an average case-mix index. Finally, it computes the ratio of these average 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 proposed MS-LTC-DRG relative weights for FY 2027, each recalibrated MS-LTC-DRG uncapped relative weight is multiplied by the proposed normalization factor of 1.27379 in the first step of the budget neutrality methodology, which produces “normalized relative weights.”

Next, CMS proposes to continue to determine 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 proposed budget neutrality factor of 1.0037632, 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 proposes 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 proposes to continue using its 3-step methodology to determine the budget neutrality adjustment factor for its 10-percent cap on relative weight reductions. It would:

- Simulate estimated total FY 2027 LTCH PPS standard federal payment rate payments for applicable LTCH cases using the proposed capped relative weights for FY 2027 (determined in Step 10) and proposed GROUPER Version 44;
- Simulate estimated total FY 2027 LTCH PPS standard federal payment rate payments for applicable LTCH cases using the proposed uncapped relative weights for FY 2027 (determined in Step 9) and proposed GROUPER Version 44; and
- Calculate the ratio of the estimated total payments.

The proposed budget neutrality adjustment factor for the 10-percent cap is 0.997832. To determine the proposed FY 2027 MS-LTC-DRG relative weights, CMS would multiply each capped relative weight by the proposed budget neutrality factor to meet the proposed budget neutrality requirement.

Extensive discussion of the entire 11-step process to determine MS-LTC-DRG relative weights is provided in the proposed rule (pages 621 through 641 of the display copy).

C. Update and Other Changes to the LTCH PPS Payment Rates

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. Proposed 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 proposes to use the 2022-based LTCH market basket to update the LTCH PPS standard Federal payment rate for FY 2027.

The proposed update to the 2022-based LTCH market basket is 3.2 percent (based on IGI's fourth quarter 2025 forecast of the 2022-based LTCH market basket) less 0.8 percentage points for multifactor productivity (renamed by BLS to be the total factor productivity (TFP)), which results in an update factor of 1.024 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 would be 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 proposed 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	-0.8 PP	-0.8 PP
Quality Data Adjustment	0.0	-2.0 PP
Total	2.4%	0.4%

3. Area Wage Levels and Wage-Index

a. Proposed Labor Market Areas

CMS adopted the revised labor market area delineations announced in OMB Bulletin No. 23-01⁹⁴ (issued on July 21, 2023) effective for FY 2025 under the LTCH PPS. It proposes to continue their use for FY 2027.

The proposed FY 2027 LTCH PPS wage index values in Tables 12A and 12B listed in section VI. of the Addendum reflect the proposed revisions to the CBSA-based labor market area delineations previously described. CMS provides a supplemental data file that includes an updated county-to-CBSA crosswalk reflecting the proposed revisions to the CBSA-based labor market area delineations, which will be posted at <https://www.cms.gov/medicare/payment/prospective-payment-systems/long-term-care-hospital/other-files-download>.

b. Proposed Labor-related Share

CMS proposes a FY 2027 labor-related share of 73.0 percent based on IGI’s fourth quarter 2025 forecast of the 2022-based LTCH market basket. This is based on the sum of the labor-related portion of operating costs (69.1 percent) and capital costs (3.9 percent). 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. CMS will use more recent data for the final rule to determine the FY 2027 LTCH PPS labor-related share if the data are available before the publication of that final rule.

c. Proposed Wage Index for FY 2027 for the Standard Federal Rate

To determine the applicable area wage index values for the FY 2026 LTCH PPS standard federal payment rate, CMS proposes to use the same data it would use to compute the proposed FY 2027 acute care hospital inpatient wage index, which uses wage data for cost reporting periods beginning during FY 2022. The FY 2027 standard federal payment rate area wage index values would be calculated consistent with the “urban” and “rural” geographic classifications, not taking into account IPPS geographic reclassifications under sections 1886(d)(8) and 1886(d)(10) of the Act. CMS also proposes to continue to apportion 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.

⁹⁴ <https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf>.

To determine area wage index values for areas where there are no IPPS wage data, CMS proposes to use its existing methodology, whereby 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

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 the revised CBSAs. To ensure budget neutrality, it includes this policy in the determination of the area wage level budget neutrality factor.

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 proposed rule applies would not be subject to the cap (even when other LTCHs in the same geographic area are receiving a wage cap).

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. Proposed Budget Neutrality Adjustments for Changes to the LTCH PPS Standard Federal Payment Rate Area Wage Level Adjustment

CMS proposes to compute the wage index in a manner that is consistent with prior years; this includes ensuring that any changes to the area wage index values or 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 proposed area wage level budget neutrality factor. CMS determined a proposed FY 2027 LTCH PPS standard federal payment rate area wage level adjustment budget neutrality factor of 1.0025505.

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 proposes 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.⁹⁵ CMS is also proposing to no longer cap the COLA factors for Alaska and Hawaii at 25 percent. The proposed FY 2027 COLA factors are discussed in more detail in FY 2027 IPPS proposed rule.

COLA Adjustment Factors: LTCHs Located in Alaska and Hawaii

Area	FY 2022 through FY 2026	Proposed 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

CMS seeks comment on its proposed methodology and the use of the Overseas Cost-of-Living Allowance data published by the Department of Defense.

5. Proposed 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.

⁹⁵ [Overseas Cost-of-Living Allowance | COLA | Defense Travel Management Office](#)

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 proposes to use its established methodology for determining the LTCH total CCR ceiling based on IPPS total CCR data from the December 2025 update of the Provider Specific File (PSF). Thus, it proposes an LTCH total CCR ceiling of 1.354 under the LTCH PPS for FY 2027 for HCO cases under either payment rate and for the site neutral payment rate.

CMS also proposes to use 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 December 2025 update of the PSF. They would be 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. Proposed 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 exceed 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) Proposed Fixed-loss Amount for LTCH PPS Standard Federal Payment Rate Cases

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; it does not believe 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 a behavioral change would have on charging practices and outlier payment trends in FY 2027. Using a variety of assumptions, 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).

For FY 2027, CMS proposes 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.

c. Proposed 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 proposes a fixed-loss amount for site neutral payment rate cases of \$51,679.

CMS also proposes a budget neutrality factor of 0.949 for site neutral payment rate cases for FY 2027. Consistent with the policy adopted in FY 2019, CMS proposes that the HCO budget neutrality adjustment would not be 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

CMS proposes to continue its policy that 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 would equal 73.75 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. Impact

CMS projects that the overall impact of the proposed payment rates and factors for all LTCHs will result in an increase of 2.3 percent (or approximately \$55 million) in aggregate payments.

Based on the FY 2025 LTCH cases that were used for the analysis in this proposed rule, approximately 7 percent of those cases were classified as site neutral payment rate cases. Thus, approximately 93 percent of LTCH cases would 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 2.3 percent (or approximately \$55 million), which is solely due to the projected 2.4 percent annual update to the LTCH PPS standard federal payment rate.

CMS estimates that aggregate FY 2027 LTCH PPS payments will be approximately \$2.459 billion, as compared to estimated aggregate FY 2026 LTCH PPS payments of approximately \$2.404 billion.

Table IV “Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments For LTCH PPS Standard federal Payment Rate Cases for FY 2027” in the proposed 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 2026		
	Number of LTCHs	Estimated Percent Change in Payments per Discharge
All LTCH providers	318	2.3%
By Location:		
Rural	16	1.7%
Urban	302	2.3%
By Ownership Type:		

Summary of Impact of Changes to LTCH PPS Standard Federal Payment Rate Cases for FY 2026		
	Number of LTCHs	Estimated Percent Change in Payments per Discharge
Voluntary	52	1.9%
Proprietary	258	2.3%
Government	8	3.9%
By Region		
New England	9	2.0%
Middle Atlantic	20	3.4%
South Atlantic	60	2.1%
East North Central	46	1.8%
East South Central	32	1.5%
West North Central	22	2.4%
West South Central	81	1.8%
Mountain	25	2.8%
Pacific	23	3.1%
*More detail is available in Table IV “Impact of Proposed Payment Rate and Policy Changes to LTCH PPS Payments for LTCH PPS Standard Federal Payment Rate Cases for FY 2027” on page 1548 of the display copy.		

IX. Quality Data Reporting Requirements for Specific Providers

A. Overview

In this section, CMS seeks comment on and proposes changes (including crosscutting quality program changes) to the Hospital Inpatient Quality Reporting Program (IQR), 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).

CMS invites comments on proposals under this section.

B. Crosscutting Quality Proposals and Requests for Request for Information (RFI)

1. Proposed Adoption of Advance Care Planning Electronic Clinical Quality Measure (eCQM) in IQR, PCH QRP, and Medicare Promoting Interoperability Program

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.

Therefore, CMS is proposing to adopt the Advance Care Planning eCQM in the IQR, PCH QRP, and Medicare Promoting Interoperability Program.

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 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.
- *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.⁹⁶
- *Exclusions.* None.

Pre-Rulemaking. The Advance Care Planning eCQM was included on the 2025 Measures Under Consideration List (MUC List) and considered by the Pre-Rulemaking Measure Review (PRMR) Hospital Committee in its January 2026 meeting. The committee reached consensus to recommend adoption of the eCQM for all three programs for which the eCQM is being proposed (IQR, PCH QRP, and Medicare Promoting Interoperability Program).⁹⁷ The measure has not received endorsement by the consensus-based entity (CBE). CMS is proposing adoption of the measure for the IQR and PCH QRP under the exceptions under those programs to the requirements for CBE endorsement.⁹⁸

Data Sources, Submission, and Public Reporting. The proposed 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 would monitor implementation and measure performance and consider refinements if setting-specific issues are identified.⁹⁹

CMS proposes, for the IQR and Medicare Promoting Interoperability Program, 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 CY 2028 reporting period/FY 2030

⁹⁶ The measurement period is a 12-month period that would run from January 1 through December 31 of each applicable CY.

⁹⁷ The recommendations for inclusion were: (i) for the IQR, 90 percent; (ii) for the PCH QRP, 95 percent; and for the Medicare Promoting Interoperability Program, 76 percent.

⁹⁸ 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.

⁹⁹ CMS proposes under section IX.D.5 of the rule to introduce eCQM reporting and submission requirements under the PCH QRP.

payment determination. For the PCH QRP, CMS proposes to adopt the eCQM beginning with the CY 2028 reporting period/FY 2030 program year.

2. Proposed Adoption and Modifications to Five Mortality Measures in the IQR and HVBP

Background. The following five mortality measures were initially included in the IQR, but beginning with the FY 2014 program year, were adopted into the HVBP under the Clinical Outcomes domain and subsequently were removed from the IQR:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization (MORT-30-AMI) measure;¹⁰⁰
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (MORT-30-HF) measure;¹⁰¹
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT-30-PN) measure;¹⁰²
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT-30-COPD) measure;¹⁰³ and
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT-30-CABG) measure.¹⁰⁴

CMS proposes to adopt modified versions of these measures in the IQR beginning with the FY 2028 payment determination and then include the modified versions of these measures in the HVBP (and remove them from the IQR) beginning with the FY 2032 payment determination. As proposed, the modified mortality measures would be publicly reported in the IQR for at least one year before adoption into the HVBP, as required under section 1886(o)(2)(C)(i) of the Act.

Overview of Proposed Updates. CMS proposes the following two substantive modifications 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 proposed initial performance period in the IQR for each of the measures would be July 1, 2024, through June 30, 2026, for the FY 2028 payment determination, and the proposed final performance period in the IQR would be July 1, 2027, through June 30, 2029, for the FY 2031 payment determination. The proposed initial performance period for the measures in the HVBP would be July 1, 2028, through June 30, 2030, for the FY 2032 Program Year.

¹⁰⁰ 76 FR 26495 through 26511.

¹⁰¹ 76 FR 26495 through 26511.

¹⁰² Adopted at 76 FR 26495 through 26511; modified at 81 FR 56994 through 56996.

¹⁰³ 80 FR 49557 through 49558.

¹⁰⁴ 81 FR 56996 through 56998.

Each of the measures would continue to measure 30-day all-cause mortality. Each measure would 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.

Pre-Rulemaking. The five modified mortality measures were included on the 2025 MUC List and considered by the PRMR Hospital Committee in its January 2026 meeting. The committee reached consensus to recommend all five modified measures for adoption into the IQR. For the HVBP, the committee reached consensus to recommend for inclusion all but one measure – the MORT-30-CABG measure. The committee largely supported the addition of the MA beneficiaries to the measures’ cohorts, noting that including the population would increase transparency and enhance meaningful comparisons of care. They also generally agreed that shortening the reporting period would facilitate more actionable information. Some members, though, who did not vote to recommend inclusion of these measures in the HVBP, suggested understanding the impacts of including the MA population on hospital performance before inclusion in the program. Some members expressed concerns about whether small or rural hospitals would be able to meet volume thresholds with the proposed reduced reporting period. CMS believes the effects of the reduced reporting period would be offset by the increased cohort size from including MA beneficiaries, as proposed. For the MORT-30-CABG, one member raised concerns for the potential for unintended consequences for hospitals to refuse care for patients with complex co-morbidities.

The five current measures are endorsed by the CBE and CMS has resubmitted the modified measures for endorsement for the Spring 2026 cycle.

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 proposed modified measures would be calculated and publicly reported on an annual basis using a rolling 24 months of prior data for the measurement period. Measure results would be publicly reported on the Compare tool beginning in July 2027, or as soon as feasible, for the IQR.

Technical Updates. CMS provides notification of technical updates to the risk adjustment methodology for the five modified mortality measures being proposed, beginning with the FY 2028 payment determination, to the IQR 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.

3. Request for Comment: Measuring Emergency Care Access and Timeliness in the IQR 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 post-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).

Request for Comment on Potential Future Use in the IQR 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 IQR 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.

CMS invites comment on the potential use of the Emergency Care Access & Timeliness eCQM into the IQR and HVBP, and lists a number of specific areas for comment, some of which include the following:

- The key barriers and challenges faced by inpatient providers in supporting process changes that improve bed availability and reduce ED boarding.
- Best practices for providers with inpatient departments to engage with colleagues and other departments and other settings.
- Any elements of the eCQM that are not applicable to inpatient care, which would warrant removal or modification if proposed for inclusion in the IQR.
- Any concerns related to duplication of encounters with the recently adopted HOQRP measure.
- Whether CMS should include the measure in the HVBP.
- Any unintended consequences that could result from inclusion of the measure in the IQR or HVBP.
- Any other measure ideas that should be considered to assess how inpatient departments can address ED boarding and better measure patient outcomes, such as harm from delays to inpatient care.

4. Request for Comment: Potential Future Use of Adult Community-Onset Sepsis Standardized Mortality Ratio Measure in the IQR

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 IQR 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.

Request for Comment on Potential Future Use in IQR. CMS invites comment on the potential future use in the IQR of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure and lists specific areas for comment, some of which include the following:

- Feasibility for hospitals (especially those in rural areas) to implement and report on the measure using existing data and workflows, as well as any data, workflow, or resource challenges that would be anticipated.
- Whether EHRs receive reconciled claims codes from payers or billing systems and if they do from billing systems, whether they can be represented in FHIR APIs.
- Whether EHR data reflect claims-adjudicated codes and whether there are time lags or other considerations for using claims codes for the measure.
- Whether third-party vendors reconcile the claim codes and if so how they receive and submit data, the standards that are used, and the frequency and cadence of data flow.
- Any anticipated challenges related to (i) mapping EHR data to the specified Sepsis measure FHIR profiles and value sets, (ii) making the required EHR data available in FHIR, (iii) accessing and linking claims data needed for exclusions and risk adjustment, or (iv) working with vendors or the National Healthcare Safety Network (NHSN) to implement the measure specifications.
- The extent to which the measure allows for fair comparison across hospitals and any suggestions for adjustments or stratifications that would improve fairness.
- Whether the measure meaningfully reflects quality/value of care such that CMS should consider including it in the HVBP.
- Any potential unintended effects of using the measure for payment adjustment.

C. Hospital Inpatient Quality Reporting Program (IQR)

CMS proposes changes to the IQR, including:

- In addition to the 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), to adopt (i) The Excess Days in Acute Care After Hospitalization for Diabetes (Diabetes EDAC) measure; and the Hospital Harm—Postoperative Venous Thromboembolism eCQM;
- To remove, beginning with the 2028 reporting period/FY 2030 payment determination, (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 issues an RFI on modifications to the Birthing Friendly Hospital Designation to expand the designation criteria.

CMS estimates if the proposals are adopted there would be, 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.

CMS reviews that historically, an average of 100 hospitals that participate in the IQR 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.

CMS invites public comment on the proposed changes to the IQR under this section.

1. Background

The IQR¹⁰⁵ 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).¹⁰⁶ 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>.

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 Consensus-Based Entity (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. Proposed New Measures for the IQR Measure Set

For the IQR measure set, in addition to the 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 proposes to adopt:

- The Excess Days in Acute Care After Hospitalization for Diabetes (Diabetes EDAC) measure; and
- The Hospital Harm—Postoperative Venous Thromboembolism eCQM.

a. Proposed Adoption of Excess Days in Acute Care After Hospitalization for Diabetes Measure

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-

¹⁰⁵ The IQR regulations are under 42 CFR 412.140.

¹⁰⁶ Prior to FY 2015, hospitals that did not submit the required data in accordance with IQR requirements were subject to a 2.0 percentage point reduction to their annual APU for the applicable FY. Starting with FY 2015, hospitals in noncompliance with the IQR reporting requirements are instead subject to a one-fourth reduction to their annual APU. See Section 1886(b)(3)(B)(viii) of the Act.

related costs. There are no publicly reported measures in the IQR on post-discharge care utilization for patients hospitalized for diabetes.

Therefore, CMS proposes 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

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 measure¹⁰⁷ indicated there is meaningful variation in the distribution of measure scores.

Measures Calculation. The final Diabetes EDAC measure score would represent excess days in acute care per 100 discharges and be reported as a rate. The final risk adjusted Diabetes EDAC measure 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 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 IQR use a 3-year performance period, but CMS in section IX.C.5 of the rule is proposing to add MA beneficiaries to the measure cohorts and shorten the performance periods to 2 years. In alignment, CMS proposes a 2-year performance period for the Diabetes EDAC measure. The performance period for the FY 2029 payment determination would include data for index admissions occurring between July 1, 2025,

¹⁰⁷ Hospital-level performance rates are shown in Table IX.C.1 of the rule.

and June 30, 2027. The measure would be publicly reported through the Compare tool beginning in July 2028, or as soon as feasible.

Pre-Rulemaking. The Diabetes EDAC measure was included on the 2025 MUC List and considered by the PRMR Hospital Committee in its January 2026 meeting. Consensus¹⁰⁸ was not reached (68 percent of members recommended adoption and 32 percent did not). Those recommending the measure for inclusion noted its importance for patients with diabetes. Some members provided considerations such as shortening the accountability period to a 7-day post-discharge period and adding sociodemographic risk factors. Members not recommending adoption expressed concerns about hospitals not having control over outpatient access or follow-up care, the 30-day post-discharge period, whether the risk adjustment was sufficient, the need for additional testing, and whether CBE-endorsement should be sought. CMS notes that hospitals have control over discharge planning, including scheduling follow-up appointments, and the measure aims to incentivize hospitals to implement such procedures as standard practices. CMS also states that the 30-day accountability period is consistent with the timeframes for the existing 30-day readmission and EDAC measures in the IQR. The measure underwent the same analysis and measure specifications development needed for the endorsement process, and the measure will be submitted to the CBE for endorsement review for the Spring 2026 cycle.

b. Proposed Adoption of the Hospital Harm—Postoperative Venous Thromboembolism eCQM

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 eQMs in the current IQR 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 would reduce burden.

Therefore, CMS proposes 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. In section IX.C.4, the agency proposes to remove the VTE-1 and VTE-2 eQMs contingent upon adoption of this outcome measure. The eCQM is also being proposed for adoption in the Medicare Promoting Interoperability Program, as discussed in section IX.F.9.

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

¹⁰⁸ A 75 percent vote is needed for consensus.

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 inpatient 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 MUC list and reviewed by the PRMR Hospital Committee during its January 2026 meeting. Only 35 percent of members recommended adopting the measure into the IQR 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.

To address these concerns, CMS notes that it is 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 IQR. It also refers to details in section IX.C.3.b(3)(c) of the preamble for details on the measure testing, notes that it conducts ongoing monitoring and evaluation to identify unintended consequences, and states 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 IQR quality measures. Further, CMS responds 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 proposed 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 proposed measure may be a replacement for the PSI 12 measure in the future.

The agency acknowledges that the proposed measure 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 states 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.

4. Proposed Removals from the Measure Set

CMS proposes to remove the following 3 measures beginning with the 2028 reporting period/FY 2030 payment determination:

- Venous Thromboembolism Prophylaxis (VTE-1) eCQM;¹⁰⁹
- Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM;¹¹⁰ and
- Discharged on Antithrombotic Therapy (STK-02) eCQM.¹¹¹

a. Proposed Removal of Two Venous Thromboembolism eCQMs

The VTE-1 and VTE-2 eCQMs are optional measures for hospitals to self-select. CMS proposes to remove them from the IQR beginning with the 2028 reporting period/FY 2030 payment determination, under measure removal factor 5¹¹² – the availability of a measure that is more strongly associated with desired patient outcomes for the particular topic, contingent on the finalization of the policy proposal to adopt 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 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–

¹⁰⁹ Adopted in the FY 2014 IPPS/LTCH PPS final rule.

¹¹⁰ Adopted in the FY 2014 IPPS/LTCH PPS final rule.

¹¹¹ Adopted in the FY 2014 IPPS/LTCH PPS final rule.

¹¹² The IQR's measure removal factors are under 42 CFR 412.140(g)(2) and (3).

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 also proposes removal of the VTE-1 and VTE-2 eCQMs from the Medicare Promoting Interoperability Program beginning with the CY 2028 reporting period.

b. Proposed 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 proposes to remove the measure from the IQR 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 IQR 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 also proposes removal of the STK-02 eCQM from the Medicare Promoting Interoperability Program beginning with the CY 2028 reporting period.

5. Proposed Modifications to Current Measures in IQR Measure Set

CMS proposes 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 proposing 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 would 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; (iii) 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 would be calculated using FFS claims data and MA encounter data and would 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 IQR.

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 would begin with the FY 2028 payment determination.

6. Summary of Previously Finalized and Proposed IQR Measures

Table IX.C.5 of the rule shows the previously finalized and newly proposed IQR measures for each of the FY 2028 through FY 2031 payment determinations, if the policies as proposed are adopted. Information from that table (and Tables IX.C.8 and IX.C.10) is consolidated and included in the table below (with formatting and presentation changes).

Previously Finalized and Newly Proposed IQR 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				
<i>STK-2 Antithrombotic therapy for ischemic stroke (CBE #0435e)^</i> <i>STK-3 Anticoagulation therapy for Afib/flutter (CBE #0436e)</i> <i>STK-5 Antithrombotic therapy by end of hospital day 2 (CBE #0438e)</i> <i>VTE-1 VTE prophylaxis (CBE #0371)^</i> <i>VTE-2 ICU VTE prophylaxis (CBE #0372)^</i> 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) <i>Malnutrition Care Score MCS (CBE #3592e)*</i> 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) <i>HH-FI Hospital Harm-Falls with Injury (CBE#4120e)*</i> <i>HH-RF Hospital Harm-Postoperative Respiratory Failure (CBE#4130e)*</i> <i>HH-VTE Hospital Harm—Postoperative Venous Thromboembolism (CBE#5325e)***</i> <i>ACP Advance Care Planning***</i>	Report 4 calendar quarters of data for Safe Use of Opioids AND Cesarean Birth AND Severe Obstetric Complications AND HH-HYPO AND HH-HYPER AND 3 of the following eQMs: STK-2 STK-3 STK-5 VTE-1 VTE-2 HH-ORAE MCS HH-PI HH-AKI IP-ExRad HH-FI HH-RF	Report 4 calendar quarters of data for Safe Use of Opioids AND Cesarean Birth AND Severe Obstetric Complications AND HH-HYPO, HH-HYPER, and HH-ORAE AND 3 of the following eQMs: STK-2 STK-3 STK-5 VTE-1 VTE-2 HH-PI HH-AKI IP-ExRad HH-FI HH-RF	Report 4 calendar quarters of data for Safe Use of Opioids AND Cesarean Birth AND Severe Obstetric Complications AND HH-HYPO, HH-HYPER, HH-ORAE, HH-PI, and HH-AKI AND 3 of the following eQMs: STK-2 STK-3 STK-5 MCS* IP-ExRad HH-FI* HH-RF* HH-VTE*** ACP*** <i>Proposed for Removal: STK-2, VTE-1, VTE-2</i>	Report 4 calendar quarters of data for Safe Use of Opioids AND Cesarean Birth AND Severe Obstetric Complications AND HH-HYPO, HH-HYPER, HH-ORAE, HH-PI, and HH-AKI AND 3 of the following eQMs: STK-3 STK-5 MCS* IP-ExRad HH-FI* HH-RF* HH-VTE*** ACP*** <i>Proposed for Removal: STK-2, VTE-1, VTE-2</i>
National Healthcare Safety Network Measures				
Healthcare Personnel Influenza Vaccination (CBE #0431)	X	X	X	X

Previously Finalized and Newly Proposed IQR Measures by Payment Determination Year				
	2028	2029	2030	2031
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)^	Proposed for Adoption	X	X	Proposed for Removal
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (MORT-30-HF) (CBE #0229)^	Proposed for Adoption	X	X	Proposed for Removal
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT-30-PN) (CBE #0468)^	Proposed for Adoption	X	X	Proposed for Removal
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT-30-COPD) (CBE #1893)^	Proposed for Adoption	X	X	Proposed for Removal
Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT-30CABG) measures (CBE #2558)^	Proposed for Adoption	X	X	Proposed for Removal
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^		Proposed for Adoption	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				

Previously Finalized and Newly Proposed IQR Measures by Payment Determination Year				
	2028	2029	2030	2031
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-Based 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
<p>* Proposed modification in this proposed rule from self-selected to mandatory reporting beginning with the FY 2030 payment determination.</p> <p>** These eCQMs will be mandatory rather than among the list for self-selection beginning for the 2030 payment determination.</p> <p>*** Proposed for adoption in this proposed rule beginning with the FY 2030 payment determination as self-selected eCQMs.</p> <p>^ Proposed for removal in this proposed rule beginning with the FY 2030 payment determination.</p> <p>^^ Proposed for adoption in this proposed rule for the FY 2028 payment determination through the FY 2031 payment determination.</p> <p>^^^In this proposed rule, CMS proposes modifications to the AMI EDAC, HF EDAC, and PN EDAC measures beginning with the FY 2028 payment determination.</p> <p>^^^^ Proposed for adoption in this proposed rule beginning with FY 2029 payment determination.</p>				

7. Future Considerations

a. Request for Information (RFI): Birthing-Friendly Hospital Designation Modification to Expand Designation Criteria

CMS seeks input on potential modifications to the Birthing-Friendly Hospital Designation (the Designation), specifically on (i) the inclusion of the Cesarean 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 Cesarean Birth eCQM and Severe Obstetric Complications eCQM (both of which are mandatory under the IQR and Medicare Promoting Interoperability Program). The Cesarean 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 18 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.

CMS seeks 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. The agency asks for input on a list of specific topics, some of which include the following:

- Any special consideration for small, rural, or safety net hospitals with the potential scoring methodology.
- Measure score weighting.
- A tiered approach to awarding the Designation by identifying levels of quality/performance.
- Approaches for peer grouping, such as use of delivery volume for grouping, whether there should be a minimum number of births required in the peer grouping, and any other variables that would be appropriate for grouping.
- Public reporting of the Designation results, including the use of one to three icons to represent summarized hospital performance and whether the Designation is easily interpreted by patients.

8. Form, Manner, and Timing of Quality Data Submission¹¹³

CMS is proposing changes to the reporting and submission requirements for eQMs and structural measures.

a. Requirements for eQMs

Table IX.C.8 of the rule summarizes the current eQM reporting and submission policies for the 2026 reporting/FY 2028 payment determination and subsequent years. Information from this table is also reflected in the IHQRP measure set summary table under section IX.C.6 above.

Proposal for Mandatory Reporting of Malnutrition Care Score eQM. The Malnutrition Care Score eQM was finalized in the FY 2023 IPPS/LTCH PPS final rule for adoption in the IQR measure set as an eQM which a hospital could self-select beginning with the CY 2024 reporting period/FY 2026 payment determination. CMS proposes to shift the eQM 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.

Proposal for Mandatory Reporting of Hospital Harm eQMs. CMS describes hospital harms as a significant source of morbidity, mortality, and cost. There are currently seven eQMs in the measure set that address different types of and various aspects of preventable hospital harm. Five of those eQMs are mandatory and two are currently self-select.

The agency is proposing that beginning with the 2028 reporting period/FY 2030 payment determination, Hospital Harm eQMs that have not yet been finalized for mandatory reporting would become mandatory in the third year of reporting. This would mean that the two remaining self-select Hospital Harm eQMs (Hospital Harm—Falls with Injury eQM and the Hospital Harm—Postoperative Respiratory Failure) would begin mandatory reporting in the 2028 reporting period/FY 2030 payment determination. The proposed Hospital Harm— Postoperative VTE eQM, proposed for adoption in section IX.C.3 of the rule, would become mandatory to report beginning with the 2030 reporting period/FY 2032 payment determination, after being available for 2 years of self-selected reporting.

Under this proposal, any newly adopted Hospital Harm eQM in the IQR or Medicare Promoting Interoperability Program would become mandatory for reporting after 2 years of self-selected reporting in the respective program.

Summary of Proposed Changes to the eQM Reporting and Submission Requirements. If a hospital does not have patients that meet the denominator criteria for any of the eQMs included in the proposal, the hospital would submit a zero denominator declaration, which allows the hospital to meet the reporting requirements for that eQM.

¹¹³ 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>.

Table IX.C.10 of the rule summarizes the proposed eCQM reporting and submission requirements for the 2028 reporting period/FY 2030 payment determination and subsequent years. Information from this table is also reflected in the IHQRP measure set summary table under section IX.C.6 above.

b. Data Submission and Reporting Requirements for Structural Measures

CMS proposes 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 update a hospital answering “yes” would 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 of Proposals

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 cross-program proposal discussed in section IX.B.1 to adopt the Advance Care Planning eCQM, CMS is also proposing for the PCH QRP the adoption of the Malnutrition Care Score eCQM and removal of the COVID–19 Vaccination Coverage Among Healthcare Personnel (HCP COVID–19 Vaccine) measure. In addition, CMS proposes reporting and submission requirements for eCQMs in the PCH QRP.

If the proposals are adopted, 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 proposed removal of the HCP COVID-19 Vaccine measure, and (ii) an increase in the total information collection burden of 15 hours at a cost of \$826 beginning for the FY 2030 program year, attributable to the proposed adoption of the Advance Care Planning eCQM and Malnutrition Care Score eCQM.

CMS invites public comment on the proposed changes to the PCH QRP under this section.

2. Proposed Adoption of Malnutrition Care Score eCQM

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.

CMS is proposing adoption of the Malnutrition Care Score eCQM in the PCH QRP beginning with the 2028 reporting period/FY 2030 program year.

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 IQR and Medicare Promoting Interoperability Program.

Measure Calculation.¹¹⁴ 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.

Pre-Rulemaking. The eCQM was on the 2025 MUC and considered by the PRMR Hospital Committee in its January 2026 meeting. Ninety-five percent of members voted to recommend adoption of the measure in the PCH QRP.

The eCQM was recently reviewed by the Endorsement and Maintenance Initial Recognition and Management Committee as part of measure maintenance in the Spring 2024 review cycle. The committee voted to endorse with the condition for the measure steward to review implementation data to examine whether the measure is associated with improved nutritional status for when the measure is again under measure review in the Spring 2029 cycle.

¹¹⁴ Table IX.D.1 of the rule provides details on the numerator and denominator cohort for each component.

3. Proposed Removal of COVID-19 Vaccination Coverage Amongst 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.¹¹⁵ The measure requires PCHs to report the COVID-19 vaccination status of HCP through the National Healthcare Safety Network (NHSN).

CMS proposes, beginning for the 2026 reporting period/FY 2028 program year, to remove this measure under measure removal factor 2, which provides for removal of a measure that does not align with the current clinical guidelines or practice.¹¹⁶ 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.

If the proposal is finalized, PCHs would 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 measure data received by CMS would 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 proposed rule, CMS also proposes to remove the measure from the LTCH QRP.

4. Summary of Previously Finalized and Newly Proposed PCH QRP Measures for FY 2028 Program Year and Subsequent Years

CMS summarizes the PCH QRP’s previously finalized measure set, reflecting the newly proposed measure set changes, in table IX.D.3. 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

¹¹⁵ 86 FR 45428-45434.

¹¹⁶ 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
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
COVID-19 vaccination coverage among HCP <i>* Proposed for Removal Beginning for 2026 reporting period/FY 2028 program year</i>				
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
Intermediate Clinical Outcomes				
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 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 <i>* Proposed for Adoption Beginning with 2028 reporting period/FY 2030 PY</i>			X	X
Malnutrition Care Score (CBE #3592e) <i>* Proposed for Adoption Beginning with 2028 reporting period/FY 2030 PY</i>			X	X

5. Proposed Updates to Form, Manner, and Timing of Quality Data Submission

CMS proposes the establishment of eCQM data submission and reporting requirements for the Program, which would apply to the proposed Advance Care Planning eCQM and Malnutrition Care Score eCQM.

a. Maintenance of Technical Specifications

CMS proposes that PCHs 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.¹¹⁷ CMS proposes that, as with the IQR, the technical specifications for eCQMs for the PCH QRP be contained in the Annual Update for Hospital Quality Reporting Programs (Annual Update). Measures specifications for eCQMs would be updated on an annual basis through the Annual Update process.

b. Proposed 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 proposed Advance Care Planning and Malnutrition Care Score eCQMs, if finalized, would be the first eCQMs included in the PCH QRP. Therefore, CMS is proposing, 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.

Proposed eCQM Reporting and Data Submission Requirements. CMS proposes to codify 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 proposes that health IT would 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 proposes to align the PCH QRP with other quality reporting programs by (i) requiring PCHs submit eCQM data through the QRDA Category I file format and (ii) 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 also proposes 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 would submit a zero in the denominator for an eCQM if the PCH's health IT is certified to the eCQM but the PCH

¹¹⁷ <https://ecqi.healthit.gov>

does not have patients that meet the denominator criteria. In this case, a zero in the denominator would be a successful submission for the eCQM.

- *Submitting a case threshold exemption.* A PCH using certified health IT would 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 or discharges per 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 IQR and Medicare Promoting Interoperability Program is by the end of two months following the end of the calendar year reporting period. CMS proposes the same eCQM submission deadline for the PCH QRP. For example, for the 2028 reporting period/FY 2030 program year, PCHs would need to submit eCQM data by February 28, 2029.

c. Review and Corrections Period for eCQM Data Submitted

As under the IQR, CMS proposes for the PCH QRP 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 2014.¹¹⁸ LTCHs submit data to CMS on the LTCH Continuity Assessment Record (CARE) and Evaluation 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.¹¹⁹ 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>.¹²⁰

CMS proposes changes to the LTCH QRP, including proposals (i) that LTCHs no longer be required to submit the Patient/Resident COVID-19 Vaccine item on the LCDS for patients who have expired in the LTCH, (ii) to remove 4 SPADES, and (iii) to revise the reconsideration request policy and process. The agency also issues requests for information on future measure

¹¹⁸ The program is authorized under section 1886(m)(5) of the Act and the regulatory program requirements are under 42 CFR 412.560.

¹¹⁹ Post-acute care providers required to report SPADEs are long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies.

¹²⁰ 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).

concepts, revising the final data submission deadline period, and advancing digital quality measurement.

For the LTCH QRP, CMS proposes to remove two measures (HCP COVID-19 Vaccine) measure and COVID-19 Percent of Patients/Residents Who Are Up to Date measure) beginning with the FY 2028 LTCH QRP and revise the LTCH QRP data submission deadlines beginning with the FY 2029 LTCH QRP. The agency also issues an RFI on future measure concepts for the LTCH QRP.

If the proposals are adopted, CMS estimates a total annual information collection burden reduction across 318 LTCHs of 4,473 hours for annual savings of \$207,309 beginning for the FY 2028 LTCH QRP compared to the currently approved information collection burden estimates.

CMS invites public comment on the proposals to the LTCH QRP under this section.

2. General Considerations Used for Selection of Measures; Quality Measures Currently Adopted

The 18 quality measures currently adopted for the LTCH QRP are shown in Table IX.E.-01 of the rule. No new measures are being proposed, but two are proposed for removal. Information from that table is provided below, with additional information to reflect the proposed removals for the FY 2028 LTCH QRP.

Quality Measures Previously Finalized and Newly Proposed 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	<i>Proposed for Removal</i>
Discharge Function (DC Function) Measure	X	X

Measure Title	FY 2027	FY 2028
COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date	X	<i>Proposed for Removal</i>

3. Proposed 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.¹²¹ The measure requires LTCHs to report the COVID-19 vaccination status of HCP through the NHSN.

CMS proposes, 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.¹²² 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.

If the proposal is finalized, LTCHs would 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 measure data received by CMS would not be used for LTCH QRP compliance or public reporting. CMS proposes the measure data would 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 of the proposed rule, CMS also proposes to remove the measure from the PCH QRP.

4. Proposed 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.¹²³ 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 proposes, 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 proposal to remove the HCP COVID-19 vaccine measure, CMS points to the latest CDC

¹²¹ 86 FR 45438-45446.

¹²² 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.

¹²³ 88 FR 59243-59250.

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 also proposes to 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 would not be required to collect or submit the measure data beginning with patients discharged on or after October 1, 2026.

If the removal is finalized, CMS proposes the measure data would 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.

5. RFI: LTCH QRP Measure Concepts Under Consideration for Future Years

CMS is seeking input on the importance, relevance, appropriateness, and applicability of the quality measure concept of advanced care planning for future years in the LTCH QRP. CMS describes that advance care planning facilitates shared decision-making by documenting resident preferences and furthering care consistent with goals throughout care transitions. CMS states that it will prioritize evidence-based outcome measures that promote person-centered care practices.

6. Form, Manner, and Timing of Data Submission under the LTCH QRP¹²⁴

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 had included in the FY 2026 IPPS/LTCH PPS proposed rule an RFI on reducing the data submission deadline from 4.5 months to 45 days.

CMS proposes 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 proposed 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

¹²⁴ 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 proposed for LCDS data affecting the FY 2029 payment determination are shown in Table IX.E.-02 of the rule and for CDC NHSN LTCH QRP measures affecting such payment determination are shown in Table IX.E.-03 of the rule. Both tables are shown below. The agency proposes that similar calendar year data submission deadlines would apply for future years.

Table IX.E.-02: Proposed 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

Table IX.E.-03: Proposed 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 - HCP COVID-19 Vaccine*	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

*Proposed for removal in section IX.E.3 effective with the FY 2028 LTCH QRP

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.¹²⁵ 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.¹²⁶ In the following provisions of this section, the term hospital includes a critical access hospital unless otherwise noted.

CMS proposes the following changes to the Medicare PIP program:

¹²⁵ Section 1886(b)(3)(B)(ix) of the Act.

¹²⁶ Section 1814(l)(4) of the Act.

- To revise the definition of CEHRT based on ONC’s HTI-5 proposed rule;¹²⁷
- 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;
- 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.

Comments are welcomed on the proposals.

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 proposed rule (reproduced below with minor editorial changes) the potential impact on Medicare PIP participants of the proposed certification criteria removals and revisions.

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.
Direct Project, Edge Protocol, and XDR/XDM – (h)(2)	Remove	ED of HTI-5 final rule.	Specified in Base EHR definition.

¹²⁷ See the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity proposed rule ([90 FR 60970](#)) (HTI-5 proposed rule).

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
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)(6)	Remove	January 1, 2027.	Specified criterion for the Provide Patients Access and HIE Bi-Directional Exchange measures.
Application Access—All Data Request – (g)(7)	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. 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 proposed 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 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. Regarding 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, hospitals would still be obliged to ensure the privacy and security of patients’ electronic health information under HIPAA and other applicable laws.

b. Proposed 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, effective January 1, 2027, CMS proposes to remove references to the following certification criteria from the definition of CEHRT at 42 CFR 495.4 for the Medicare PIP: “family health history,” “patient health information capture,” “automated numerator recording,” and “automated measure calculation”.

The agency states that it need not rely on ONC to finalize its proposed revisions for CMS to finalize its proposed changes to the regulatory definition of CEHRT for the Medicare PIP. It believes the functionalities reflected in the criteria for “family health history” and “patient health information capture” is fully embedded in certified health IT and is 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.

3. Proposal to Remove ONC Direct Review and ONC-ACB Surveillance Attestations

CMS proposes to remove 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. If the proposal is finalized, eligible hospitals and CAHs would not have to

report on these attestations by the March 1, 2027, submission deadline, and there would be no effect on their FY 2028 payment determination or FY 2026 cost reimbursement, respectively.

The agency's rationale for the proposal is to reduce administrative burdens in the measure and attestation set when feasible and to focus on "high-value, outcome-oriented measures." Previously, CMS believed that the attestations would complement and strengthen ONC's ability to perform surveillance and direct review activities. The agency stated that surveillance and direct review activities provide greater assurance to health care providers that their CEHRT would perform in a manner that meets their expectations, but surveillance and direct review would be ineffective unless health care providers cooperated with these activities. While CMS believes the activities are important, it no longer believes requiring a hospital to attest "Yes" to the ONC Direct Review attestation is necessary to demonstrate the meaningful use of CEHRT. It believes hospitals understand the value of participating in the direct review process, and the agency no longer sees a need for these attestations. However, it encourages hospitals to continue participating in these oversight processes when ONC, or an ONC-ACB, requests assistance.

4. Proposal to Remove 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 CY 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. Proposal to Remove 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

CMS proposes to remove 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. It believes the proposal will streamline reporting and reduce the complexity of multiple measure reporting options for the HIE objective; it would also focus program performance on measures that assess the adoption of newer health information technologies and more comprehensive methods of information sharing. This is consistent with 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.

If the proposal is finalized, then beginning with the EHR reporting period in 2028, 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 proposes to maintain 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.

In support of the proposal, CMS states that a majority of eligible hospitals and CAHs have been able to successfully report 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 indicates that it will continue to evaluate future potential changes to the current HIE Bi-Directional Exchange and Enabling Exchange Under TEFCA measures to transition from attestation-based to performance-based measures to drive more improvement around ongoing gaps in health information exchange among hospitals.

5. Proposed 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. Proposal to Modify the Electronic Prior Authorization Measure Beginning with the EHR Reporting Period in 2027

CMS proposes changes to the measure description. It 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. In response to commenter confusion, CMS proposes to change the word “discharge” to “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 are proposed to the exclusion criteria.

CMS also considered revising the measure to also permit hospitals to attest to the measure by using CEHRT to conduct a check for whether an item or service requires prior authorization, regardless of whether the query results in a request and approval of the prior authorization. It also considered including prior authorization for drugs administered during the hospitalization in the measure. Comment is sought on both potential policies.

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)).

In this proposed rule, CMS states that the use of health IT certified to the certification criteria is required for the Electronic Prior Authorization measure.

The agency notes that the three certification criteria are based on the HL7 Da Vinci CRD, DTR, and PAS Implementation Guides (IGs), and they address different parts of the electronic prior authorization workflow: (i) coverage requirements discovery, (ii) documentation templates and rules, and (iii) prior authorization support. The preamble includes two examples whereby a hospital may successfully report on the measure. In the first example, a hospital could successfully report on the measure using CEHRT that only includes a Health IT Module certified to one of the criteria, such as the “provider prior authorization API—coverage requirements discovery” criterion. In the second example, CMS raises the scenario whereby an initial prior authorization query from a health care provider to a payer results in a response indicating the need for additional information before a determination as to whether prior authorization is approved or denied can be provided, based on the coverage requirements identified. Additional certified Health IT Modules supporting additional elements of the electronic prior authorization workflow would then be needed to submit the prior authorization request after collecting the necessary documentation for the hospital to successfully report on the measure.

d. Proposal to Make 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 proposed changes in Prior Authorization API standards requirements that would occur in 2027.

CMS proposes to make 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. If the proposal is finalized, a hospital attesting “No” will not earn any bonus points. However, attesting “No” for the EHR reporting period in 2027 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.

If the proposal to make the measure optional for the EHR reporting period in 2027 is finalized, exclusions would not be available.

e. Proposal to Require the Electronic Prior Authorization Measure Beginning with the EHR Reporting Period in 2028

If CMS finalizes its proposal to make the Electronic Prior Authorization Measure an optional measure for the EHR reporting period in 2027, it proposes to delay requiring hospitals to report on the measure until the EHR reporting period in 2028. The requirements applicable to hospitals for this measure under the proposed delay mirror those requirements when the measure was first adopted. If the proposed revisions to the measure description (described above) are finalized, then the hospital would have to 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, or else the hospital would have to claim an applicable exclusion. No changes were proposed to the text of either exclusion.

A “No” response to the measure for the EHR reporting period in 2028 and subsequent years means the hospital would not meet the measure requirements, which means it would 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.

f. Request for Information on Future Potential Performance-Based Measure of Electronic Prior Authorization

CMS seeks 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 is specifically sought on barriers and challenges small, rural, or otherwise under-resourced hospitals might face reporting a performance-based electronic prior authorization measure.

6. Proposal to Adopt a 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).¹²⁸

Noting that the healthcare system has not yet achieved broad adoption of UDI documentation, CMS believes that UDIs should be integrated into data sources throughout the healthcare system, including the supply chain, EHRs, medical device registries, and claims, to fully realize the benefits of the UDI system. It notes that 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. Other certification criteria also support the use of UDIs.

b. Proposal to Adopt Unique Device Identifiers for Implantable Devices Measure Beginning With the EHR Reporting Period in CY 2027

CMS believes the electronic capture and discrete storage of UDIs would advance the safety of health care; broader use of UDIs aligns with the meaningful use of CEHRT through the Medicare PIP. The agency proposes to adopt the following measure entitled “Unique Device Identifiers for Implantable Medical Devices measure” under the Public Health and Clinical Data Exchange objective.

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.

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.

¹²⁸ FDA’s Global Unique Device Identification Database is which is accessible from two public portals, AccessGUDID435 and OpenFDA.

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.

c. Request for Information on the Future Direction of the Proposed Unique Device Identifiers for Implantable Devices Measure and Additional Options for Utilizing UDI

If the proposed measure is finalized, CMS intends to propose additional modifications to the measure in future rulemaking to further promote the appropriate capture of UDIs within the EHR. It seeks public comments on performance measures and additional UDI options, some of which are described below.

Performance Measures. With respect to designing a feasible performance measure, CMS asks what design features would assess the meaningful use of UDI data; for example, how should the denominator be defined and are there specific data sources or definitions that would be appropriate and less burdensome for identifying the denominator population? Would some implantable devices pose specific UDI capture challenges for a performance-based measure? Which measure would ensure the data quality of the UDI captured during patient care delivery is valid and usable? What complications arise when multiple implantable devices are used for a patient during a care episode? What measures would show whether a practitioner in a hospital used the UDI to compare quality, track recalls, coordinate patient follow-up across health systems, etc.? Should there be a performance threshold and, if so, should thresholds be phased in over time?

Additional UDI Options. In what other care settings or CMS programs should the agency consider addressing appropriate UDI capture and exchange? What are the technical barriers that prevent other care settings from capturing UDIs at the point of care? Do workflows or technologies exist that could reduce burdens for better utilization of UDI data exchange while maintaining 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 rule (shown below with slight stylistic modifications) includes the scoring methodology beginning in 2027, reflecting previously adopted policies and policy proposals in this proposed rule.

TABLE IX.F.-02: PROPOSED PERFORMANCE-BASED SCORING METHODOLOGY FOR EHR REPORTING PERIODS 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 (<i>bonus</i>)	Optional
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required
Public Health and Clinical Data Exchange	Report the following 7 measures: <ul style="list-style-type: none"> • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Laboratory Reporting • Antimicrobial Use Surveillance • Antimicrobial Resistance Surveillance • Unique Device Identifier** 	25 points	Required
	Report one of the following measures: <ul style="list-style-type: none"> • Public Health Registry Reporting • Clinical Data Registry Reporting • Public Health Reporting with TEFCA 	5 points (<i>bonus</i>)	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 this proposed rule, CMS proposes to remove the ONC Direct Review and ONC-ACB Surveillance attestations for the EHR reporting period in 2026 and subsequent years.
 *In section IX.F.5.d of this proposed rule, CMS proposes that the Electronic Prior Authorization measure be an optional bonus measure for CY 2027 EHR reporting period.
 ** In section IX.F.6 of this proposed rule, CMS proposes to adopt the Unique Device Identifier measure beginning with the EHR reporting period in CY 2027.

Table IX.F.-03 of the rule (shown below with slight stylistic modifications) includes the scoring methodology beginning in 2028, reflecting previously adopted policies and policy proposals in this proposed rule.

TABLE IX.F.-03: PROPOSED PERFORMANCE-BASED SCORING METHODOLOGY FOR EHR REPORTING PERIODS IN 2027

Objective	Measures	Maximum Points	Required/Optional
Electronic Prescribing	e-Prescribing	10 points	Required
	Query of (PDMP)	10 points	Required
Health Information Exchange	HIE Bi-Directional Exchange	30 points	Required (eligible hospitals and CAHs must choose one of the two reporting options)
	-OR- Enabling Exchange under TEFCA	30 points	
	Electronic Prior Authorization**	Unscored	
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	Required
Public Health and Clinical Data Exchange	Report the following 7 measures: <ul style="list-style-type: none"> • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Laboratory Reporting • Antimicrobial Use Surveillance • Antimicrobial Resistance Surveillance • Unique Device Identifier*** 	25 points	Required
	Report one of the following measures: <ul style="list-style-type: none"> • 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 this proposed rule, CMS proposes to remove the ONC Direct Review and ONC/CB Surveillance attestations for the EHR reporting period in 2026 and subsequent years.
*In section IX.F.4 of this proposed rule, CMS proposes to remove 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 CY 2028 and subsequent years.
** In section IX.F.5 of this proposed rule, CMS proposes to make the Electronic Prior Authorization optional in the CY 2027 EHR reporting period and required, but unscored, starting EHR reporting period in CY 2028.
*** In section IX.F.6 of this proposed rule, CMS proposes to adopt the Unique Device Identifier measure beginning with the EHR reporting period in CY 2027.

[Table IX.F.-04](#) 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 does 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.

8. Overview of Objectives and Measures for the EHR Reporting Period in 2027

Table IX.F.-06 lists the objectives and measures for the Medicare PIP for the EHR reporting period in 2027 as revised to reflect the proposals made in the proposed rule as well as proposed changes that would 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, then the applicable year is noted in the measure column.

Table IX.F.-07. 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.¹²⁹

a. Proposals to Adopt and Remove eCQMs

Beginning with the 2028 reporting period, CMS proposes to adopt and remove the same eCQMs for the Medicare PIP as it does for the HIQRP.¹³⁰

- It proposes to 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.
- The following three eCQMs are proposed to be removed 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.

b. Proposal to Modify 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 does 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,

¹²⁹ See sections 1814(l)(3)(A) and 1886(n)(3)(A) of the Act for these requirements applied to CAHs and hospitals, respectively.

¹³⁰ See summary sections IX.B.1., IX.C.3., IX.C.4., and IX.C.8.c. for a detailed discussion of the proposals.

CMS proposes 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 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.

[Table IX.F.-08](#) of the proposed rule summarizes the proposed Medicare PIP eCQM reporting requirements, and [table IX.F.-09](#) summarizes the previously finalized and newly proposed 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 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 framework¹³¹ 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 2023.¹³² 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 proposed rule, CMS proposes the following modifications for TEAM:

¹³¹ Innovation Center Strategy Refresh: <https://www.cms.gov/priorities/innovation/strategic-direction-whitepaper>

¹³² <https://www.federalregister.gov/documents/2023/07/18/2023-15169/request-for-information-episode-based-payment-model>

- 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 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 this proposed rule CMS has 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 allow certain physician-owned hospitals (POHs) to voluntarily opt into TEAM.

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.¹³³

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 will begin with an anchor hospitalization or anchor procedure and would 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.

¹³³ Maryland hospitals under the Total Cost of Care (TCOC) model are excluded from participating in TEAM.

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.

2. TEAM Provisions of this Proposed Rule

a. *Episodes*

TEAM tests five episode categories, identified in Table X.A.-01 (reproduced 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.¹³⁴

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, or 473	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 proposed rule, there are proposals to change certain MS-DRGs that affect the spinal fusion episode category in TEAM. Specifically, three new MS-DRGs are being proposed to better classify beneficiary acuity and resource utilization for a subset of spinal fusion procedures. If these new MS-DRGs are finalized, **CMS proposes to make conforming changes in TEAM, proposing at §512.525(d)(4)(i) that starting on October 1, 2026, MS-DRGs 523, 524, and 525 would be added to the spinal fusion episode category that would initiate a spinal fusion anchor hospitalization. CMS also proposes at §512.505 to**

¹³⁴ HCPCS (Healthcare Common Procedure Coding System).

update the spinal fusion definition to include these three new MS-DRGs. CMS seeks comment on these proposals.

CMS is also proposing changes in the TEAM episode attribution methodology. In section X.C. of the preamble of this proposed rule, the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model is being proposed as an expanded phase II model test under Section 1115A(c) of the Act. Similar to TEAM, CJR-X would be a mandatory episode- based payment model for acute care hospitals with a focus on Lower Extremity Joint Replacement (LEJR) episodes. Both TEAM and CJR-X test LEJR episodes, however TEAM tests a 30-day post-discharge period episode length while CJR-X would test a 90-day post- discharge period episode length. Given the model similarities and our desire to assess differences in outcomes between these two episode durations, the CJR-X model is proposing to exclude 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 proposes 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. CMS seeks comment on this proposal.**

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)

FY 2025 IPPS/ LTCH PPS Finalized TEAM Quality Measures		
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 FY25 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 proposed rule, CMS proposes to establish measurement performance periods for these three quality measures. **For Hospital Harm—Falls with Injury, and Hospital Harm—Postoperative Respiratory Failure, the agency proposes alignment with the Hospital IQR Program's calendar year reporting requirements, utilizing a one-year measurement performance period. For ISCMR, CMS proposes 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 proposed rule. **CMS seeks comment on the proposed measurement performance period timeframes.**

CSM also proposes changes to the TEAM Composite Quality Score (CQS) baseline period methodology. In the FY25 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 proposed rule, CMS now proposes two changes to the CQS baseline methodology: (1) establishing a sliding historical CQS baseline methodology and (2) aligning CQS baseline periods with the CMS hospital reporting program timeframes for specific measures that are currently not aligned.

CMS proposes 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 also proposes 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. CMS considered – but did not propose – an alternative approach under which the transition from fixed CQS baselines to the sliding historical CQS baseline methodology would begin in TEAM PY2 rather than TEAM PY1.

CMS summarizes its proposed changes to the CQS baseline periods, that would begin with TEAM PY1, in Table X.A.-03 of the proposed rule, reproduced below.

TABLE X.A.-03: PROPOSED CQS BASELINE PERIODS

Quality Measure	PY1 CQS Baseline Period	PY2 CQS Baseline Period	PY3 CQS Baseline Period	PY4 CQS Baseline Period	PY5 CQS Baseline Period
Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) Measure with Claims and Electronic Health Record Data (CMIT ID #356)	July 1, 2024 through June 30, 2025	July 1, 2025 through June 30, 2026	July 1, 2025 through June 30, 2026	July 1, 2026 through June 30, 2027	July 1, 2027 through June 30, 2028
CMS Patient Safety and Adverse Events Composite (CMS PSI-90) (CMIT ID #135)	July 1, 2023 through June 30, 2025	N/A	N/A	N/A	N/A
Hospital-Level Total Hip and/or Total Knee Arthroplasty (THA/TKA) Patient-Reported Outcome-Based Performance Measure (PRO-PM) (CMIT ID #1618)	July 1, 2024 through June 30, 2025	July 1, 2024 through June 30, 2025	July 1, 2025 through June 30, 2026	July 1, 2026 through June 30, 2027	July 1, 2027 through June 30, 2028
Hospital Harm—Falls with Injury (CMIT ID #1518)	N/A	January 1, 2026 through December 31, 2026	January 1, 2027 through December 31, 2027	January 1, 2028 through December 31, 2028	January 1, 2029 through December 31, 2029
Hospital Harm—Postoperative Respiratory Failure (CMIT ID #1788)	N/A	January 1, 2026 through December 31, 2026	January 1, 2027 through December 31, 2027	January 1, 2028 through December 31, 2028	January 1, 2029 through December 31, 2029
Thirty-day Risk—Standardized Death Rate among Surgical Inpatients with Complications (ISCMR) (CMIT ID #134)	N/A	July 1, 2023 through June 30, 2025	July 1, 2024 through June 30, 2026	July 1, 2025 through June 30, 2027	July 1, 2026 through June 30, 2028
Information Transfer Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) (CMIT ID #1797)	N/A	N/A	January 1, 2027 through December 31, 2027	January 1, 2028 through December 31, 2028	January 1, 2029 through December 31, 2029

In addition to aligning the TEAM CQS with IQR and HAC reporting requirements, CMS asserts that implementing the proposed sliding historical CQS baseline approach beginning in TEAM PY1 ensures consistent CQS baseline methodology throughout the model's duration and avoids mid-model transitions that could create confusion or complicate performance tracking. CMS states that this proposed approach provides participants with clarity and predictability regarding how their quality performance will be assessed throughout all performance years. However, in contrast to providing “clarity and predictability” through a sliding baseline approach, CMS also discusses a concurrent baseline methodology which would require quality performance

benchmarks to be recalculated annually using contemporaneous data, which will introduce “uncertainty” for model participants.

CMS seeks comment on whether a concurrent CQS baseline methodology would be preferable to the proposed sliding historical CQS baseline methodology and, if so, whether implementation should begin in TEAM PY1 or TEAM PY2.

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. TEAM regions are defined as the nine U.S. census divisions and the MS-DRG/HCPCS episode type is based on the episode categories that will be tested in the model: CABG, LEJR,

Major Bowel Procedure, SHFFT, and Spinal Fusion. CMS recaps detail on how spending data will be trimmed for purposes of calculating target prices, how these prices will be risk adjusted, how prices will be normalized, and how target prices will be reconciled with actual episode spending.

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 using a three-step mapping and scaling approach. However, CMS has 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 proposes to apply APC and MS-DRG update factors in final target price calculations beginning in performance year 1, to ensure the final target price and reconciliation amounts align with payment rates and weights that are applied during each performance year.

CMS proposes 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. CMS proposes to define the APC update factor at §512.505 as the component applied to the prospective trend factor to ensure that the APC weights corresponding to the performance year are incorporated into the final target

price calculations. The APC update factor, as set forth in §512.540(b)(7), would be calculated at the MS-DRG/HCPCS episode type and region level as the ratio of the benchmark prices calculated with APC weights corresponding to the calendar year of the performance year (CY 2026 for performance year 1) to the preliminary benchmark prices calculated with the APC weights corresponding to the calendar year prior to the performance year (CY 2025 for performance year 1).

Similarly, to account for changes in MS-DRG mapping and weights between the first and second fiscal years in a TEAM performance year, **CMS proposes 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. Specifically, the agency proposes updating methodology at §512.540(b)(7) to add a MS-DRG update factor to the calculation of the prospective trend factor for episodes with anchor end dates in the fourth quarter of the performance year.** CMS proposes to define the MS-DRG update factor at §512.505 as the component applied to the prospective trend factor for episodes with anchor hospitalization or anchor procedure end dates in the fourth quarter of the performance year.

Interestingly, CMS notes that despite these proposed enhancements, there could still be MS-DRG definition changes that may result in preliminary benchmark prices and target price components not being available. Therefore, **CMS proposes 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.**

CMS seeks comment on its proposal at §512.505 to add definitions of the APC update factor, MS-DRG update factor, and updated prospective trend factor. The agency also seeks comment on its proposal at §512.540(b)(7) to add APC and MS-DRG update factors in the calculation of the prospective trend factor to account for changes in HCPCS-APC and MS-DRG mappings and weights during a TEAM performance year. CMS also seeks comment on its proposals for performance years in which diagnosis or procedure codes are mapped to different TEAM triggering MS-DRGs between the first and second fiscal years: 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, and 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 this proposed rule, to improve predictive accuracy, better represent all episodes used in benchmark price construction, and recenter the risk adjusted benchmark price to the average of

the total non-risk adjusted benchmark price, CMS proposes, 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 proposes 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.** CMS considered, but did not propose, calculating the normalization factor using an additional two years of data prior to the baseline period, similar to the trend factor construction.

CMS seeks comment on its proposal 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 proposed rule, CMS is soliciting additional public feedback on inclusion of ASC episodes in TEAM.

Towards that end, CMS is asking 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?

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.¹³⁵

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; and 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

¹³⁵ 42 CFR 411.351 and 411.254(b).

designated health services. Section 6001(a) of the Affordable Care Act effectively eliminated the exceptions for physician ownership or investment in hospitals.¹³⁶

CMMI is considering 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 notes that TEAM is a mandatory model, and allowing voluntary participation could have cost and evaluation implications. Therefore, CMS requests 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.

¹³⁶ 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.

- What episode categories, beyond the episode categories currently tested in TEAM, should CMS consider testing for POHs?

B. Provider-Based Location Criteria

The provider-based rules (42 CFR §413.65) establish criteria that an entity must meet to be considered “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 is proposing to limit the application of the referral-based test to outpatient departments only.

C. Expansion of the Comprehensive Joint Replacement (CJR) Model

1. Overview of Proposed 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 proposed rule is proposing to expand the model to all eligible acute care hospitals nationwide, under the auspices of Comprehensive Care for Joint Replacement – Expanded (CJR-X). If finalized, all eligible acute care hospitals would be required to participate in the CJR-X model beginning October 1, 2027.¹³⁷

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).

CMS also discusses the financial performance of the CJR model, relevant here due to the current proposal to extend it via CJR-X due to its original savings for the Medicare program. 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.¹³⁸ CMS states that given this performance, the agency is now proposing 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.

¹³⁷ Interestingly, CMS does not publish an end date for CJR-X in this notice of proposed rulemaking. [Table X.C.-01](#), which inventories the CJR-X quality measures for each performance year, ends at PY5, suggesting the model will end in 2032 after five years, but CMS does not explicitly state this in the rule. Further, in the preamble language around this table, CMS states that “while only 5 performance years are displayed in the table, we are proposing that the measure performance periods would continue at the same cadence each performance year,” which implies that CJR-X could run indefinitely.

¹³⁸ Comprehensive Care for Joint Replacement Model – Seventh Annual Report (<https://www.cms.gov/priorities/innovation/data-and-reports/2025/cjr-py7-annual-report>)

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

a. Scope of Proposed Model

CMS proposes 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. **CMS seeks comment on these proposals, as well as comments on alternative start dates.**

b. Proposed Participants

Consistent with the CJR Model, CMS proposes that hospitals would be the model participants in CJR-X. For the purposes of CJR-X, CMS proposes 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. Although the CJR Model was confined to certain geographic areas, **CMS proposes 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.¹³⁹ **CMS seeks comment on these proposals.**

CMS proposes at §512.610(b)(1) to exclude hospitals that are TEAM participants from CJR-X, and proposes at §512.610(b)(2) to exclude acute care hospitals in the State of Maryland because of Maryland’s unique rate-setting authority. CMS seeks comment on these proposals.

c. Proposed Beneficiary Population

CMS proposes 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);
- 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.

¹³⁹ 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.

CMS proposes that if a beneficiary ceases to meet the inclusion criteria at some point in the CJR-X episode, the episode would be cancelled. **CMS seeks comment on the proposed beneficiary inclusion criteria, and the proposal to cancel episodes if a beneficiary no longer meets that criteria at §512.620.**

CMS indicates that it is proposing CJR-X because it offers an opportunity to improve quality of care, and that existing Medicare provisions would be effective in protecting beneficiary freedom of choice and access to appropriate care under CJR-X. Thus, CMS asserts that beneficiaries would not be able to opt out of CJR-X when they receive care from a CJR-X participant. However, **CMS proposes 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. CMS proposes the required content of such notification at §512.622(a)(4). Proposed §512.622(a)(2) would require that CJR-X participants notify each beneficiary prior to discharge from the anchor hospitalization or anchor procedure. Lastly, CMS proposes 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. CMS seeks comment on these proposals, as well as comment on the agency’s consideration of *not* requiring beneficiary notifications under CJR-X.**

d. Proposed Episode

CMS proposes 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 seeks comment on the proposed episode definition.

CMS proposes 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 OPSS claims for HCPCS codes 27130 or 27447, would trigger LEJR episodes in CJR-X. This definition would include inpatient hip, knee, and ankle replacement procedures paid through the IPPS under select MS- DRGs and hospital outpatient hip and knee replacement procedures billed under select HCPCS codes through the OPSS, but would exclude ankle replacements performed in the outpatient setting. **CMS seeks comment on its proposal at §512.625(a) to identify LEJR episodes with MS-DRGs and HCPCS 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 seeks comment on the items and services the agency is proposing to include in CJR-X at §512.625(b).

CMS proposes 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.¹⁴⁰

CMS seeks comment on the proposed excluded services, the lists of excluded services, and the process for updating the lists of excluded services for CJR-X included in §512.625(c), (d), and (e).

The proposed episodes would cover the surgical procedure and a subsequent period that is marked by significant post-acute care (PAC) needs, potential complications of surgery, and short-term, intense management of chronic conditions that may be destabilized by a joint replacement. **CMS proposes 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**

¹⁴⁰ Complete lists of proposed excluded MS-DRGs for readmissions and proposed excluded HCPCS codes for Part B services furnished during episodes after beneficiary discharge from an anchor hospitalization would be posted on the CMS CJR-X webpage within the Innovation Center website at <https://innovation.cms.gov>.

of the episode is the date of the anchor procedure or the date of discharge from an anchor hospitalization. CMS seeks comment on this proposal.

Similar to the CJR Model, CMS proposes 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 proposes to codify these policies at §512.630(e), and seeks comment on this proposal.

e. Proposed 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 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.

CMS proposes two modifications to the measures relative to CJR. First, CMS proposes 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 specifically proposes 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 provides detail on the background, clinical underpinnings, rationale, and goals of each measure [here](#). CMS seeks comment on the inclusion of these measures in the CJR-X quality measure set.

At §512.635(f), CMS proposes to display quality measure results on the publicly available CMS website in a form and manner consistent with other publicly reported measures. CMS would share each CJR-X participant's quality metrics with the hospital prior to display on the CMS website. 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 summarizes the quality measures proposed for CJR-X, and their corresponding performance periods, in Table X.C.-01 of the proposed rule, reproduced here:

TABLE X.C.-01: SUMMARY OF PROPOSED QUALITY MEASURE PERFORMANCE PERIODS BY YEAR IN CJR-X

Quality Measure	CJR-X PY1	CJR-X PY2	CJR-X PY3	CJR-X PY4	CJR-X PY5
Hospital-Level RSCR Following Elective Primary THA and/or TKA (CMIT ID #350)	April 1, 2026-March 31, 2028	April 1, 2027-March 31, 2029	April 1, 2028-March 31, 2030	April 1, 2029-March 31, 2031	April 1, 2030-March 31, 2032
Hospital Visits within 7 days of HOPD Surgery (CMIT ID #344, OP-36)	January 1, 2027-December 31, 2027	January 1, 2028-December 31, 2028	January 1, 2029-December 31, 2029	January 1, 2030-December 31, 2030	January 1, 2031-December 31, 2031
HCAHPS Survey (CMIT ID #338)	January 1, 2027-December 31, 2027	January 1, 2028-December 31, 2028	January 1, 2029-December 31, 2029	January 1, 2030-December 31, 2030	January 1, 2031-December 31, 2031
OAS CAHPS Survey (CMIT ID #162)	January 1, 2027-December 31, 2027	January 1, 2028-December 31, 2028	January 1, 2029-December 31, 2029	January 1, 2030-December 31, 2030	January 1, 2031-December 31, 2031
Hospital-Level THA/TKA PRO-PM (CMIT ID #1618)	July 1, 2026-June 30, 2027	July 1, 2027-June 30, 2028	July 1, 2028-June 30, 2029	July 1, 2029-June 30, 2030	July 1, 2030-June 30, 2031

CMS seeks comment on its proposals at §512.635(e) on how quality measures in CJR-X would be displayed and the quality measure performance periods.

CMS proposes the means by which CJR-X participating hospitals would submit the required quality data. **CMS proposes 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 proposes 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. Because hospitals already submit these data through existing processes, CMS indicates that CJR-X participants would not need to submit additional data for CJR-X.

Composite Quality Score

Under CJR-X, CMS will set a target price for LEJR episodes, which would be subject to a discount factor that varies as a function of a participant's quality performance. CMS in this NPRM describes how the CJR-X Composite Quality Score will be calculated using the data submitted by participants described above.

CMS proposes a composite quality score methodology for linking quality and payment in CJR-X that is similar to, but not the same as, 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 proposes 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.-02](#) of the proposed rule). This proposal 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).

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 seeks comment on this decision.**

Calculating the Composite Quality Score

CMS proposes adopting a similar calculation of the CJR Model composite quality score but with modifications to account for outpatient quality measures. Specifically, CMS proposes placing each of the five proposed quality measures into one of three quality domains: complications, patient experience, and patient reported outcomes. CMS proposes 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 would score each CJR-X model participant on the five proposed 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 proposed point values displayed in Table X.C-04, reproduced below:

TABLE X.C-04: POINT VALUES FOR PROPOSED 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
≥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	5.40	5.40	1.10
<30th	0.00	0.00	0.00	0.00	0.00

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 proposes 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 would similarly at §512.605 define the “outpatient composite quality score” as the sum of outpatient quality measure points values, capped at 20 points.**

CMS proposes 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. The

inpatient and outpatient composite quality score would be weighted based on the proportion of inpatient to outpatient episodes.

CMS seeks comment on the proposed methodology to calculate the composite quality score and on its proposed definitions for the composite quality scores at §512.605.

f. Proposed Pricing and Payment Methodology

The initial foundation for the pricing and payment methodology for CJR-X is the set of policies from the CJR Extension.

Overview of Proposed CJR-X Pricing and Payment Methodology

Generally, at proposed §512.640, CMS proposes 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 would apply 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:

$$\text{Preliminary Target Price} = \text{Benchmark Price} * \text{Prospective Trend Factor} * \text{Prospective Normalization Factor} * \text{Risk Adjustment Multipliers} * \text{Discount Factor}$$

Target Prices

Baseline Period for Benchmarking

CMS proposes using three years of baseline episode spending to calculate benchmark prices, which would be further adjusted to create preliminary target prices. Specifically, **CMS proposes 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 also proposes 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 proposes to roll this 3-year baseline period forward every year.**

CMS proposes to adjust baseline episode spending to trend all episode spending to the most recent year of the baseline period. At §512.605(e) CMS proposes to define a “baseline year” as any of the three fiscal years during a given baseline period.

CMS proposes 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 would then 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. This method would be consistent

with how CMS calculated the baseline trend factor for CJR in the performance years that used the 3-year baseline period, as described in the 2015 CJR final rule (80 FR 73342). **CMS proposes to calculate these baseline trend factor adjustments at the MS-DRG/HCPCS episode type and region level.**

CMS seeks comment on these proposals.

Regional Target Prices

CMS proposes 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. This approach would be consistent with PYs 4 through 8 of the CJR Model and aligns with the approach implemented in TEAM (89 FR 69751). CMS seeks comment on this proposal.

Services that Extend Beyond an Episode

CMS proposes 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. CMS seeks comment on this proposal.

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 proposes 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. CMS seeks comment on its proposal at §512.640(a)(3) for applying target prices to an episode that begins in one performance year and ends in the subsequent performance year.**

High-Cost Outlier Cap for Benchmarking

In the 2015 CJR final rule (80 FR 73335), CMS finalized a policy to limit hospital responsibility for high episode payment cases by utilizing a high price payment ceiling at two standard deviations above the mean episode payment amount in calculating the target price and in comparing actual episode payments during the performance year to the target prices. **For CJR-X, CMS proposes 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 proposes 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. CMS seeks comment on this proposal.**

Trending Prices

CMS is proposing a hybrid approach for trending prices under the CJR-X model that combines both prospective and retrospective adjustments. Specifically, CMS would 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 would 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. This approach is broadly aligned with the TEAM model but excludes additional “trend years” in order to keep the data used for pricing consistent with what is shared with participants. CMS also considered, but is not proposing, the use of payment system update factors or wider retrospective adjustment caps ($\pm 5\%$ or $\pm 10\%$), citing concerns about complexity and reduced pricing stability.

CMS is seeking comment on several aspects of this proposal, including the use and definitions of the prospective and retrospective trend factors and the appropriateness of the ± 3 percent cap. Additionally, CMS is requesting input on alternative methodologies for calculating trend factors that could improve pricing accuracy and mitigate the “ratchet effect,” particularly in light of evidence that spending reductions in LEJR episodes have begun to stabilize. CMS is especially interested in approaches that ensure target prices remain appropriate whether spending is increasing, decreasing, or leveling off, without undermining quality or patient safety.

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, the agency now believes that a 3 percent discount would not be sustainable for an expanded model, and **proposes 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. CMS seeks comment on this proposal.**

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. In the CJR Model, CMS established a low-volume threshold as fewer than 20 LEJR episodes across the 3-year baseline years of 2012 through 2014. Low-volume hospitals received target prices based on 100 percent regional data, rather than a blended target price that incorporated their participant-specific data. Under TEAM, the corresponding low-volume threshold is 31 episodes in a given episode category.

For CJR-X, CMS proposes at §512.605 to define “low-volume hospital” as a hospital with fewer than 31 LEJR episodes performed during the applicable baseline period. The agency correspondingly proposes at §512.640(a)(4) that low-volume hospitals would be excluded from reconciliation for the performance year. CMS seeks comment on these proposals.

Preliminary Target Prices

CMS proposes to define “preliminary target price” as the target price provided to the CJR-X participant prior to the start of the performance year. CMS proposes 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. CMS seeks comment on these proposals.

Risk Adjustment and Normalization

CMS [recaps the risk-adjustment protocols](#) used in the original CJR model, BPCI Advanced, and TEAM. **For CJR-X, CMS proposes 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 proposes 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.

CMS seeks comment on its proposals at §512.645(a-d) for risk adjusting episodes and 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.”

[Proposed 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 proposals for conducting an annual reconciliation process in CJR-X. As was the case in the CJR Model, **for CJR-X, CMS proposes 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).** In this section of the proposed rule preamble, CMS provides detail on the proposed 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.-05 of the proposed rule, reproduced here:

TABLE X.C.-05: RELATIONSHIP OF COMPOSITE QUALITY SCORE ON RECONCILIATION PAYMENT ELIGIBILITY 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 (NPRM) (§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. **CMS seeks comment on all of its proposals related to the CJR-X reconciliation process.**

g. Proposed 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 is proposing 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 proposes 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.**

CMS seeks comment on its proposed appeals process for CJR-X.

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 proposes 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, CMS is proposing that CJR-X would *not* allow for concurrent participation with TEAM.¹⁴¹ 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, in section X.A.2.a.(3). of this proposed rule, CMS proposes 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.

Interestingly, CMS does not seek comment on this proposal.

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. If the CJR-X policies in this NPRM are finalized, CMS expects to make 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 proposes 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 proposes 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).

¹⁴¹ See X.C.2.b.(2)(i) of this proposed rule’s preamble.

- Hospital.
- Critical Access Hospital (CAH).
- Non-physician provider group practice (NPPGP)
- Therapy group practice (TGP)
- Medicare ACO

CMS seeks comment on its proposed definition of “CJR-X collaborator.”

Sharing Arrangements

Similar to the original CJR Model (42 CFR 510.500), CMS proposes 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 proposes that a sharing arrangement would be to share reconciliation payment amounts or repayment amounts. **The agency proposes 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 proposes specific definitions for “gainsharing payments” and “alignment payments.”

CMS proposes that a sharing arrangement must comply with the provisions of section X.C.2.i.(4)(b) of this proposed rule and all other applicable laws and regulations, including the applicable fraud and abuse laws and all applicable payment and coverage requirements. CMS proposes 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 proposes 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 proposes 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.

CMS seeks comment on the proposed “sharing arrangement” definition at §512.605, the sharing arrangement proposals at §512.670(a), and whether additional or different safeguards are needed to ensure program integrity, protect against abuse, and ensure that the goals of the model are met.¹⁴²

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 proposes 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

¹⁴² CMS proposes exquisitely detailed requirements for sharing arrangements beyond the scope of this summary. Interested readers can find these requirements under “(b) 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 proposes 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. As an alternative, CMS considered whether gainsharing payments could be based “substantially” on these two factors, rather than “solely,” but proposed “solely” at least in part for consistency with CJR and TEAM gainsharing methodologies. As with its proposals regarding Sharing Arrangements, CMS proposes 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.

CMS seeks comment on its proposals at §512.670(c) on the conditions and restrictions on gainsharing payments, alignment payments, and internal cost savings under the model, as well as on the proposed documentation requirements at §512.670(d).

Distribution Arrangements

Similar to the CJR Model (80 FR 73541), CMS proposes 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 proposes 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. As with Financial Arrangements and Gainsharing Arrangements, CMS makes detailed supporting operational proposals that can be found under “(b) Requirements” [here](#).

CMS seeks comment on the proposed requirements for distribution arrangements under CJR-X at §512.675(b).

Downstream Distribution Arrangements

CMS proposes that CJR-X allow for certain financial arrangements within an ACO between a PGP and its members. Specifically, **the agency proposes 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 proposes 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 proposes 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.¹⁴³

CMS seeks comment on the definitions proposed at §512.605 for “downstream collaboration agent,” “downstream distribution arrangement,” and “downstream distribution payment.” CMS also seeks comment on its proposed requirements for downstream distribution arrangements at §512.680.

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 proposes 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 proposed rule, by engaging the CJR-X beneficiary in better managing their own health.

CMS seeks comment on the proposed conditions for CJR-X beneficiary incentives, as outlined in §512.685.

As with TEAM, CMS makes exceptionally detailed proposals regarding requirements for beneficiary incentives in the form of technology provided to CRJ-X beneficiaries.¹⁴⁴

Given the clinical goals of CJR-X, CMS proposes that any beneficiary incentives must advance one of the following goals:

- Beneficiary adherence to drug regimens.

¹⁴³ 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](#).

¹⁴⁴ CMS proposes that 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 proposes 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 proposes that these items of technology that exceed \$75 in retail value 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 make such detailed technology-related proposals with respect to beneficiary incentives.

- 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.

CMS seeks comment on its proposals for beneficiary engagement incentives at §512.685.

j. Proposed 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 proposes to:

- 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,
- Waive the originating site requirements of section 1834(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”).

CMS seeks comment on these specific proposed waivers of Medicare program requirements, as well as on possible waivers under section 1115A of the Act of certain Medicare program rules beyond those specifically discussed that might be necessary to test this model. CMS is especially interested in comments explaining how such waivers could provide providers and suppliers with additional flexibilities that are not permitted under existing Medicare rules to increase quality of care and reduce unnecessary episode spending, but that could be appropriately used in the context of CJR-X where CJR-X participants bear full responsibility for total episode spending.

k. Data Sharing

Based on its experience with prior models such as BPCI Advanced and CJR, CMS proposes 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.

In this proposed rule, CMS indicates that it proposes to make CJR-X participants accountable for quality and cost outcomes for CJR-X beneficiaries during an anchor hospitalization or anchor procedure and during the 30-day post-discharge period. **CMS believes that it is necessary for the purposes of this model to offer CJR-X participants the ability to request and receive summary or raw beneficiary-identifiable claims data for a 3-year baseline period as well as on a monthly basis during the performance year to help CJR-X participants engage in care coordination and quality improvement activities for CJR-X beneficiaries in an episode.** CMS notes that, as was the case with the CJR Model, in this proposed rule, the agency proposes to disclose beneficiary-identifiable data to only the hospitals that are bearing risk for episodes and not with their collaborators.

CMS proposes 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 proposes 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 proposes that sharing this data with CJR-X participants would be contingent on said participants 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](#).

CMS seeks comments on its proposals regarding the authority to share beneficiary-identifiable data with CJR-X participants, the minimum data that would need to be provided, and the timing and period of baseline period data, and other proposals related to CJR-X data sharing.

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. **CMS proposes 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 CEHRT¹⁴⁵ criteria are met, as established at 42 CFR 414.1425(b)(2).**

Correspondingly, CMS proposes 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).

CMS proposes 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 a clinician engagement list in a form and manner and by a date specified by CMS on a quarterly basis every performance year. CMS proposes to use the clinician engagement list for assessing QP determinations and for APP reporting. CMS specifies the proposed required contents of the clinician engagement list. CMS also proposes the CJR-X participants would be required to attest that there were no individuals to report on either a financial arrangements list or a clinician engagement list.

CMS seeks comments on the proposal to require CJR-X participants to submit a financial arrangements list and clinician engagement list on a quarterly basis or attest that there are no individuals to report.

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.

¹⁴⁵ CEHRT: Certified Electronic Health Record Technology.

- Miscellaneous Provisions on Bankruptcy and Other Notifications.
- Reconsideration Review Process.

CMS seeks public comment on whether CJR-X should set forth model-specific provisions related to any of the provisions identified previously.

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.

3. Information Collection Requirements for the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model

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 Analysis

A-12. Proposed Effects of the Comprehensive Care for Joint Replacement Expanded (CJR-X) Model

General Impacts

The proposed 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 \$725 million in net Medicare savings, driven by reduced episode spending and repayment amounts exceeding incentive payments. 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	\$7,908	\$8,145	\$8,365	\$11,320	\$12,569
Baseline Episode Spending	\$7,971	\$8,209	\$8,431	\$11,393	\$12,645
Reconciliation Payment Amounts	\$239	\$246	\$253	\$329	\$362
Repayment Amounts	-\$305	-\$314	-\$323	-\$415	-\$456
Total Impact (Savings)	-\$128	-\$132	-\$136	-\$159	-\$170
Impact as % of Baseline	-1.6%	-1.6%	-1.6%	-1.4%	-1.3%

Note: Reconciliation payments and repayments are attributed to the performance year, not the year in which payments occur.

CMS solicits comments on its assessment of CJR-X's impacts on Medicare beneficiaries.

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 is proposing to reconcile IOPO and HCL costs for non-renal organs as is done for OPO and HCL kidney costs. The proposal 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 or payable by THs and other Organ Procurement Organization (OPOs). The proposal will be 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 an OPO 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 proposes to require the contractor to establish (and adjust if necessary) non-renal SACs. For both kidney and non-kidney organ acquisition services, the proposal authorizes the TH to pay for pre-transplantation services based on an interim rate.

CMS is proposing 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 its 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 relate 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 is also proposing 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 indicates that only the contractor, not the IOPO, can adjust the organ SAC.

The remainder of this section summarized comments on a request for information in the FY 2022 proposed rule but did not make any additional proposals.

2. Reasonable Cost Payment Policies

Section 413.1(a)(2)(v) makes OPOs expressly subject to Medicare's reasonable cost principles, including §413.9 regarding costs related to patient care. CMS is restating this requirement because OPOs have asserted in administrative appeals that reasonable cost principles and rules do not apply to them because they do not provide direct patient care.

OPOs 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 OPO is providing 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 OPOs claimed unallowable costs and has recommended that CMS update applicable Medicare requirements to clarify the allowability of certain overhead costs. 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 is proposing to codify in regulation the longstanding prudent buyer definition found in the Provider Reimbursement Manual (PRM-1) section 2103.

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 OPOs 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 OPOs and HCLs set forth that public education costs are expenses associated with organizing awareness programs designed to inform the "general public" of the need for organs and organ transplant services.

Some OPOs have asserted that their engagement in entertainment and sporting events are types of public education costs that serve to 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 provides 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.¹⁴⁶

CMS believes allowable OPO public education costs are for an OPO'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 indicates 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 OPOs.

To address this issue, CMS is proposing 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 specifies other nonallowable costs, including drugs sold to other than patients, fines and penalties, and expenses associated with operating a gift shop. CMS also proposes to specify that costs incurred by OPOs 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.

Activities for Employees and Non-employees of the Provider. In the 2022 IPSS 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 is proposing to specify that these costs are not allowable. The proposed rule indicates that there are many cost-effective methods for improving employee morale that do not require these types of entertainment expenses.

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

¹⁴⁶ These examples include sponsorship of professional sports teams, race car drivers at nationally viewed racing events, floats at nationally viewed parades, musical entertainment and performers at these events, full season tickets to professional basketball games, autographed items, tickets to racing events, entrance to hospitality suites, sponsorship of Indy Car teams and dirt track race cars, rides in an Indy Car, pit lane and garage tours and driver appearances at off-track events.

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 is proposing to codify the current manual language and add further specificity but is not changing any current policy. The proposed rule indicates that the costs incurred by OPOs for professional education where the attendee is clinical staff of the OPO are allowable costs. Costs incurred by OPOs for OPO-sponsored seminars where continuing education credits are given and where the attendee is not on the OPO staff are not allowable costs.

b. Travel

The proposed rule clarifies 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.¹⁴⁷

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 OPO-sponsored seminars is a benefit to the seminar attendees, rather than a direct cost necessary for patient care.

CMS proposes 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).

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 provides 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, such

¹⁴⁷ 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.

that the department receiving a portion of overhead costs receives a direct benefit from being serviced by that cost center.

CMS is clarifying 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 is proposing 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 OPOs. 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 of 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 describes 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 are provided in the proposed rule. CMS is also proposing 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.

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 is proposing to add these provisions of the Standing Order to the regulations. The remainder of this section details the processes and procedures that apply to the appeal process.

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 is proposing an applicable percentage increase for FY 2027 of 2.4 percent provided the hospital submits quality data and is a meaningful EHR user.

MedPAC further recommended redistributing disproportionate share hospital (DSH) and uncompensated care payments using the MedPAC-developed Medicare Safety-Net Index (MSNI) for hospitals. MedPAC recommends 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 a MSNI policy. CMS cannot implement MSNI under current law. The proposed rule describes 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 PROPOSED RULE IMPACT ANALYSIS

	Number of Hospitals ¹	Proposed FY 2027 Outlier Payments (1) ²	Proposed FY 2027 Hospital Rate Update (2) ³	MDH Expiration (3) ⁴	Proposed FY 2027 Uncompensated Care Payments (4) ⁵	Proposed FY 2027 Weights and DRG Changes with Application of Recalibration Budget Neutrality (5) ⁶	Proposed FY 2027 Wage Index (6) ⁷	All Proposed FY 2027 Changes (7) ⁸
All Hospitals	3,013	-0.7	2.2	-0.1	-0.2	0.0	-0.1	1.2
By Geographic Location:								
Urban hospitals	2,357	-0.7	2.2	-0.1	-0.2	0.0	-0.1	1.2
Rural hospitals	656	-0.3	2.3	-0.4	-0.5	-0.5	0.3	0.8
Bed Size (Urban):								
0-99 beds	639	-0.5	2.3	-1.4	-0.3	0.0	0.0	0.0
100-199 beds	673	-0.6	2.3	-0.1	-0.2	-0.3	-0.1	1.0
200-299 beds	401	-0.6	2.3	0.0	-0.3	-0.2	-0.3	1.0
300-499 beds	391	-0.7	2.3	0.0	-0.2	0.0	-0.1	1.3
500 or more beds	251	-0.8	2.2	0.0	-0.1	0.2	0.0	1.6
Bed Size (Rural):								
0-49 beds	316	-0.2	2.2	-0.9	-1.1	-0.7	0.2	-0.7
50-99 beds	175	-0.2	2.3	-1.2	-0.4	-0.6	-0.1	-0.3
100-149 beds	95	-0.2	2.3	0.0	-0.4	-0.6	0.1	1.1
150-199 beds	41	-0.3	2.3	0.0	-0.7	-0.4	0.1	1.1
200 or more beds	29	-0.5	2.3	0.0	-0.3	-0.1	1.1	2.5
Urban by Region:								
New England	102	-0.7	2.3	-0.1	-0.1	-0.1	1.9	3.3
Middle Atlantic	272	-0.7	2.3	-0.1	0.0	-0.1	-0.3	1.1
East North Central	364	-0.5	2.3	-0.2	-0.3	0.0	-0.9	0.4
West North Central	155	-0.6	2.3	0.0	-0.4	0.1	0.4	1.8
South Atlantic	393	-0.6	2.2	-0.1	-0.3	0.0	-0.2	1.1
East South Central	140	-0.8	2.2	0.0	-0.3	0.1	0.6	1.8
West South Central	357	-0.5	2.1	0.0	-0.2	0.1	-0.8	0.7
Mountain	177	-0.6	2.3	0.0	0.1	0.2	-1.0	1.0
Pacific	346	-1.1	2.3	0.0	-0.2	0.0	0.4	1.5
Rural by Region:								
New England	19	-0.6	2.3	-1.0	-0.3	-0.3	2.4	2.4
Middle Atlantic	47	-0.4	2.3	-0.1	-0.1	-0.6	0.0	1.2
East North Central	106	-0.3	2.3	-1.2	-0.4	-0.5	-0.3	-0.4
West North Central	72	-0.2	2.3	-0.3	-0.5	-0.4	-0.1	0.9
South Atlantic	109	-0.3	2.2	-0.5	-0.9	-0.6	0.8	0.7
East South Central	122	-0.2	2.2	-0.3	-0.7	-0.5	0.4	0.9
West South Central	117	-0.2	2.1	-0.1	-0.9	-0.5	-0.5	0.0

	Number of Hospitals ¹	Proposed FY 2027 Outlier Payments (1) ²	Proposed FY 2027 Hospital Rate Update (2) ³	MDH Expiration (3) ⁴	Proposed FY 2027 Uncompensated Care Payments (4) ⁵	Proposed FY 2027 Weights and DRG Changes with Application of Recalibration Budget Neutrality (5) ⁶	Proposed FY 2027 Wage Index (6) ⁷	All Proposed FY 2027 Changes (7) ⁸
Mountain	40	-0.2	2.3	0.0	-0.6	-0.2	0.0	1.5
Pacific	24	-0.2	2.4	0.0	0.0	-0.8	0.2	1.5
Puerto Rico								
Puerto Rico Hospitals	51	-0.3	1.5	0.0	-2.1	-0.2	-0.9	-2.0
By Payment Classification:								
Urban hospitals	1,528	-0.7	2.2	0.0	-0.2	-0.1	0.1	1.3
Rural areas	1,485	-0.7	2.2	-0.1	-0.2	0.1	-0.2	1.2
Teaching Status:								
Nonteaching	1,710	-0.6	2.3	-0.3	-0.3	-0.2	0.0	1.0
Fewer than 100 residents	997	-0.6	2.3	-0.1	-0.2	-0.1	-0.2	1.1
100 or more residents	306	-0.8	2.2	0.0	-0.1	0.2	0.0	1.5
Urban DSH:								
Non-DSH	355	-0.7	2.4	-0.1	0.0	0.2	-0.2	1.7
100 or more beds	837	-0.7	2.2	0.0	-0.2	-0.1	0.1	1.3
Less than 100 beds	336	-0.5	2.2	-0.1	-0.7	-0.5	0.0	0.4
Rural DSH:								
Non-DSH	114	-0.7	2.4	-1.2	0.0	0.1	0.0	0.6
SCH	222	-0.1	2.3	0.0	-0.3	-0.6	-0.1	1.2
RRC	920	-0.7	2.2	0.0	-0.2	0.1	-0.2	1.2
100 or more beds	41	-0.6	2.2	-0.1	-0.2	0.0	-0.1	1.3
Less than 100 beds	188	-0.3	2.2	-2.6	-0.9	-0.7	0.3	-2.2
Urban teaching and DSH:								
Both teaching and DSH	483	-0.7	2.2	0.0	-0.1	-0.1	0.1	1.4
Teaching and no DSH	62	-0.6	2.4	-0.2	0.0	-0.1	-0.1	1.4
No teaching and DSH	690	-0.7	2.2	0.0	-0.3	-0.2	0.0	1.0
No teaching and no DSH	293	-0.7	2.4	0.0	0.0	0.3	-0.2	1.9
Special Hospital Types:								
SCH	425	-0.2	2.3	0.0	-0.2	-0.3	0.2	1.9
MDH	160	-0.2	2.3	-8.6	-0.5	-0.5	0.1	-7.6
Type of Ownership:								
Voluntary	1,909	-0.7	2.3	-0.1	-0.2	0.0	0.0	1.2
Proprietary	693	-0.5	2.3	0.0	-0.3	0.0	-0.5	1.0
Government	409	-0.8	2.1	0.0	-0.2	0.1	0.1	1.3
Medicare Utilization as a Percent of Inpatient Days:								
0-25	1,666	-0.7	2.2	0.0	-0.2	0.0	-0.1	1.2

	Number of Hospitals ¹	Proposed FY 2027 Outlier Payments (1) ²	Proposed FY 2027 Hospital Rate Update (2) ³	MDH Expiration (3) ⁴	Proposed FY 2027 Uncompensated Care Payments (4) ⁵	Proposed FY 2027 Weights and DRG Changes with Application of Recalibration Budget Neutrality (5) ⁶	Proposed FY 2027 Wage Index (6) ⁷	All Proposed FY 2027 Changes (7) ⁸
25-50	1,272	-0.7	2.3	-0.2	-0.2	-0.1	0.0	1.3
50-65	42	-0.6	2.4	-0.1	-0.1	0.0	-0.4	1.2
Over 65	9	-0.3	2.4	-4.6	0.0	1.3	0.9	-0.4
Medicaid Utilization as a Percent of Inpatient Days:								
0-25	2,009	-0.6	2.3	-0.1	-0.2	0.0	0.0	1.3
25-50	886	-0.8	2.2	0.0	-0.2	0.1	-0.3	1.1
50-65	88	-0.7	1.8	0.0	-0.1	-0.4	0.0	0.7
Over 65	30	-1.0	2.0	0.0	0.2	-0.5	0.1	0.9
FY 2027 Reclassifications:								
All Reclassified Hospitals	1,195	-0.7	2.2	-0.1	-0.2	0.1	-0.1	1.3
Non-Reclassified Hospitals	1,818	-0.7	2.3	-0.1	-0.2	-0.1	-0.1	1.1
Urban Hospitals Reclassified	1,007	-0.7	2.2	-0.1	-0.2	0.1	-0.1	1.3
Urban Non-reclassified Hospitals	1,368	-0.7	2.2	0.0	-0.2	-0.1	-0.1	1.1
Rural Hospitals Reclassified Full Year	276	-0.3	2.3	-0.2	-0.5	-0.5	0.2	1.0
Rural Non-reclassified Hospitals Full Year	362	-0.3	2.3	-0.6	-0.6	-0.5	0.4	0.6
All hospitals that reclassified from urban to rural in accordance with section 1886(d)(8)(E) as implemented at 42 CFR 412.103	882	-0.7	2.2	-0.1	-0.2	0.1	-0.2	1.2
Other Reclassified Hospitals (Section 1886(d)(8)(B), also known as Lugar hospitals)	53	-0.3	2.3	-1.8	-0.6	-0.7	0.5	-0.5

¹Because 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.

²This 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.

³This column displays the payment impact of the hospital rate update, including the 2.4 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 0.8 percentage point for the productivity adjustment).

⁴This column displays the impact of the expiration of the MDH status on January 1, 2027, a non-budget neutral payment provision.