VIZIENT OFFICE OF PUBLIC POLICY AND GOVERNMENT RELATIONS

FY 2027 Inpatient Prospective Payment System Final Rule Summary

MEDICARE PROGRAM; HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEMS FOR ACUTE CARE HOSPITALS (IPPS) AND THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM AND POLICY CHANGES AND FISCAL YEAR (FY) 2027 RATES; REQUIREMENTS FOR QUALITY PROGRAMS; OTHER POLICY CHANGES; AND ADOPTION OF UPDATED VERSIONS OF CERTAIN HEALTH INFORMATION TECHNOLOGY STANDARDS

August 11, 2026

BACKGROUND & SUMMARY

On July 31, the Centers for Medicare & Medicaid Services (CMS) issued the annual final rule to update the Fiscal Year (FY) 2027 Medicare payment and policies for the hospital inpatient prospective payment system (IPPS) (hereinafter, "Final Rule") (fact sheet available here). CMS finalized a 2.3 percent increase in the inpatient payment rate for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. Based on various policy changes and circumstances described in the Final Rule, CMS estimates that aggregate payments to acute care hospitals will increase by $2.9 billion in FY 2027 compared with FY 2026. CMS also finalized changes to certain IPPS new technology add-on payment (NTAP) and outpatient prospective payment system (OPPS) transitional pass-through payment pathways.

CMS finalized a range of policies, including measure changes in the Hospital IQR Program, Hospital Value-Based Purchasing Program (VBP), Hospital Readmissions Reduction Program (HRRP), and Medicare Promoting Interoperability (PI) Program. CMS also established the mandatory, nationwide Comprehensive Care for Joint Replacement Expanded (CJR-X) model and modified the existing Transforming Episode Accountability Model (TEAM), including expanding the eligible episodes to include spinal fusion.

With limited exceptions, most provisions are effective October 1, 2026. However, CJR-X begins January 1, 2028.

FINAL IPPS PAYMENT RATE UPDATES FOR FY 2027

After accounting for statutory adjustments, CMS finalized a 2.3 percent IPPS operating payment rate increase for hospitals that successfully submit IQR data and are meaningful EHR users. The update reflects a 3.2 percent market-basket increase, unchanged from the Proposed Rule, reduced by a 0.9 percentage point productivity adjustment, as shown in Table 1.

Table 1. Proposed and Final IPPS Payment Rate Updates for FY 2027

Policy	Proposed	Final
Market-basket update	3.2%	3.2%
Productivity adjustment	-0.8%	-0.9%
Payment rate update before budget-neutrality factors	2.4%	2.3%

In addition, CMS finalized four applicable percentage increases to the standardized amount, as shown in Table 2. To determine each final applicable percentage increase, CMS adjusted the market-basket rate of increase based on (1) whether a hospital submits quality data and (2) whether a hospital is a meaningful EHR user, and then applied the 0.9 percentage point reduction for the productivity adjustment. For the final payment calculation, hospitals may be

subject to other payment adjustments under the IPPS which are not reflected in Table 2 (e.g., reductions under certain quality programs).

Table 2. Final FY 2027 Applicable Percentage Increases for the IPPS

FY 2027	Quality data / Meaningful EHR user	Quality data / Not meaningful EHR user	No quality data / Meaningful EHR user	No quality data / Not meaningful EHR user
Market-basket rate-of-increase	3.2	3.2	3.2	3.2
Quality reporting adjustment	0.0	0.0	-0.8	-0.8
Meaningful EHR user adjustment	0.0	-2.4	0.0	-2.4
Productivity adjustment	-0.9	-0.9	-0.9	-0.9
Applicable percentage increase	2.3	-0.1	1.5	-0.9

MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSH) PAYMENT ADJUSTMENT FOR FY 2027

The ACA required changes, which began in 2014, to the way disproportionate share hospital (DSH) payments are made to hospitals. Under this payment formula, hospitals receive 25 percent of the Medicare DSH funds that they would have received under the prior formula (the empirically justified amount). The remaining 75 percent flows into a separate pool that is adjusted based on changes in the number of uninsured who received care and then distributed based on the proportion of total uncompensated care each Medicare DSH provides. This pool is distributed based on three factors:

- Factor 1: 75 percent of the total Medicare DSH payments estimated by the Office of the Actuary (OACT);
- Factor 2: Change in the national uninsured rates; and
- Factor 3: Proportion of total uncompensated care each Medicare DSH hospital provides.

As noted in the Final Rule, CMS estimated Medicare DSH expenditures for FY 2027 to be $15.767 billion.
For Factor 1, CMS estimates the empirically justified Medicare DSH payments for FY 2027 to be approximately $3.942 billion (25 percent of estimated Medicare DSH payments for FY 2027). Therefore, the final Factor 1 for FY 2027 is $11.825 billion (approximately 75 percent of estimated Medicare DSH payments for FY 2027).

For Factor 2, CMS considered OACT's projected uninsured rates for CY 2026 (9.2 percent) and CY 2027 (9.5 percent), resulting in a final Factor 2 of 67.14 percent. Based on this, the final FY 2027 uncompensated care payment amount is $7.939 billion.

For Factor 3, CMS continues to use the three most recent years (FYs 2021-2023) of audited cost report data, a scaling factor, and various trim-methodology policies.

In addition, CMS provides an FY 2027 IPPS Final Rule Medicare DSH supplemental data file on the Final Rule website.

HOSPITAL WAGE INDEX

The FY 2027 wage index is based on Worksheet S-3 wage data from cost reporting periods beginning in FY 2023. The final occupational mix-adjusted national average hourly wage is $58.83.

Labor-Related Share

The labor-related share is used to determine the proportion of the national IPPS base payment rate to which the area wage index is applied. CMS finalized a 66.0 percent labor-related share for hospitals with a wage index greater than 1.0000 and the statutory 62 percent labor-related share for hospitals with a wage index at or below 1.0000.

Discontinuation of the Low-Wage Index Hospital Policy and Budget Neutrality Adjustment

In the Final Rule, CMS reiterates that the low-wage index hospital policy remains discontinued following the D.C. Circuit's decision in *Bridgeport Hospital v. Becerra*.[1] For FY 2027, CMS finalized a narrow, budget-neutral transitional payment exception for hospitals that benefited under the FY 2024 low-wage policy and continue to experience a substantial decline.[2] CMS estimates 54 hospitals will receive transitional payments due to this policy.

LOW-VOLUME HOSPITAL ADJUSTMENT

Consistent with the law, CMS indicates that the temporary low-volume hospital criteria and payment methodology remain in effect for discharges from October 1 through December 31, 2026. During this period, a hospital qualifies if it is more than 15 road miles from another IPPS hospital and has fewer than 3,800 total discharges. The adjustment ranges from 25 percent for hospitals with 500 or fewer discharges to zero for hospitals approaching 3,800 discharges.

Unless Congress passes legislation to extend the temporary low-volume hospital criteria, beginning January 1, 2027, the criteria revert to an older standard. CMS estimates that the expiration of the temporary policy will reduce aggregate FY 2027 low-volume hospital payments by approximately $258 million and that approximately 589 hospitals will no longer qualify.

MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL (MDH) PROGRAM

Under current law, additional payments for Medicare-dependent, small rural hospitals (MDHs) and the temporary change in payments for low-volume hospitals will expire December 31, 2026. CMS finalized regulatory changes given the upcoming deadline. Absent congressional action, hospitals that previously qualified as MDHs will lose MDH status for discharges on or after January 1, 2027, and will be paid based on the IPPS federal rate.

NEW TECHNOLOGY ADD-ON PAYMENTS AND OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) DEVICE PASS-THROUGH

According to a CMS fact sheet, the agency estimates that additional payments for inpatient cases involving new medical technologies will increase by approximately $779 million in FY 2027, primarily driven by new approvals for new technology add-on payments. CMS also indicates that NTAPs will continue for 41 technologies and that CMS approved 19 new technologies for FY 2027, as described in the Final Rule (pg. 50422-50423).

Alternative Pathway Repeal

In prior rulemaking, CMS established an alternative inpatient new technology add-on payment (NTAP) pathway for certain transformative new devices and certain antimicrobial products that did not require applicants to satisfy the substantial clinical improvement criterion. CMS also established an alternative transitional pass-through payment pathway for devices that are part of FDA's Breakthrough Devices Program and have received FDA marketing authorization for the indication covered by the Breakthrough Device designation.

In the Final Rule, CMS finalized, with some modifications, the proposal to repeal the alternative NTAP pathways for FDA-designated Breakthrough Devices, Qualified Infectious Disease Products (QIDPs), and products approved under the Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD). Beginning with FY 2028 applications, technologies generally must meet all three standard NTAP criteria: newness, cost, and substantial clinical improvement. All applicants must receive FDA marketing authorization by May 1 before the fiscal year for which payment is requested. CMS also removed the conditional approval process for certain antimicrobial products.

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[1] Bridgeport Hospital v. Becerra, 108 F.4th 882 (D.C. Cir. 2024).

[2] If an eligible hospital's FY 2027 wage index is more than 14.2625 percent below its FY 2024 wage index, the hospital will receive an additional payment based on an FY 2027 wage index equal to 85.7375 percent of its FY 2024 wage index.

CMS finalized limited exceptions under which certain technologies remain eligible to apply for NTAP under the alternative pathway through FY 2029:

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

In the Final Rule, CMS clarifies that technologies previously approved for NTAP under the alternative pathway, including technologies approved for FY 2027 in the Final Rule, remain eligible for a continued add-on payment subject to the existing continuation requirements.

CMS also finalized, with modifications, the proposal that applications for device pass-through payment status on or after October 1, 2026[3], and applications received for subsequent calendar years will have to demonstrate that the technology met all the standard eligibility requirements. CMS also finalized a limited exception such that the following devices will remain eligible to apply for OPPS device passthrough payment under the alternative pathway through CY 2029: a new device that is part of FDA's Breakthrough Devices Program and has received Breakthrough Device designation as of September 30, 2026, and has received marketing authorization as a Breakthrough Device for the indication covered by the Breakthrough Device designation.

OUTLIER PAYMENTS

CMS finalized an FY 2027 fixed-loss outlier threshold of $49,346, compared with the proposed threshold of $51,704.

MS-DRG SEVERITY LEVELS

CMS finalized a policy reclassifying ten diagnosis codes related to homelessness, inadequate housing, and housing instability from complication or comorbidity (CC) to non-CC status.[4] CMS explains that CC and major complication or comorbidity designations are intended to reflect clinical complexity and resource use and that these social risk factors alone should not qualify a case for a higher severity level.

MS-DRG 018: CAR T-CELL AND OTHER IMMUNOTHERAPIES

CMS finalized the existing methodology for cases in MS-DRG 018 involving clinical trials, expanded access use, or products not purchased in the usual manner, including no-cost products. Based on updated data, CMS finalized an adjustor of 0.16 to payment for applicable clinical trial, expanded access and no-cost product cases, rather than the 0.17 adjustor included in the Proposed Rule.

PROVIDER-BASED LOCATION CRITERIA FOR OFF-CAMPUS FACILITIES

CMS finalized the proposal to restrict use of the referral-based "same patient population" test[5] to outpatient facilities and organizations. An off-campus inpatient facility or organization located more than 35 miles from the main provider may no longer use the test under which at least 75 percent of patients who required the type of care furnished by the

[3] These applications include all applications received through the remainder of the CY 2028 OPPS application cycle ending on March 1, 2027.
[4] The affected codes are Z59.00, Z59.01, Z59.02, Z59.10, Z59.11, Z59.12, Z59.19, Z59.811, Z59.812, and Z59.819.
[5] Facilities submit 12 months of data showing 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 (for example, at least 75 percent of the patients of a Rural Health Clinic (RHC) seeking provider-based status received inpatient hospital services from the hospital that is the main provider).

main provider received that care from the main provider. As finalized, off-campus inpatient locations can only use the zip-code overlap test while off-campus outpatient facilities can continue using either method to demonstrate they serve the same patient population as the main provider.

GRADUATE MEDICAL EDUCATION AND NURSING AND ALLIED HEALTH EDUCATION

REQUIREMENTS TO PROHIBIT UNLAWFUL DISCRIMINATION BY GRADUATE MEDICAL EDUCATION PROGRAMS AND NURSING AND ALLIED HEALTH EDUCATION PROGRAMS

Effective October 1, 2026, an approved medical residency training program must not discriminate, or promote or encourage discrimination, on the basis of race, color, national origin, sex, age, disability, or religion, including the use of those characteristics or intentional proxies for those characteristics as a selection criterion for employment, program participation, resource allocation, or similar activities, opportunities, or benefits. CMS finalized parallel requirements for approved nursing and allied health (NAH) education programs and accrediting bodies.

MODIFICATIONS TO CRITERIA FOR NEW RESIDENCY PROGRAMS

CMS finalized changes to the criteria for determining whether a residency program is new for purposes of building direct graduate medical education (GME) and indirect medical education caps. In addition to receiving initial accreditation by the appropriate accrediting body, at least 90 percent of the individual residents who enter the program during the five-year cap-building period must not have previous experience training in another program in the same specialty. This requirement includes exceptions for small residency programs, displaced residents, and residents admitted via a binding third-party matching program. In determining whether a program is genuinely new for cap-building purposes, CMS will no longer consider the previous employment of the program director or faculty.

QUALITY PROGRAMS

The Final Rule adopts several new and modified measures across the Hospital IQR, Hospital Value-Based Purchasing (VBP), Hospital Readmissions Reduction (HRRP), and Medicare Promoting Interoperability programs. CMS did not finalize measure changes for the Hospital-Acquired Condition Reduction Program.

CROSS-PROGRAM POLICIES FOR THE HOSPITAL IQR, HOSPITAL VALUE-BASED PURCHASING (VBP) AND MEDICARE PROMOTING INTEROPERABILITY PROGRAMS

Measure Adoption and Finalization

For the Hospital IQR and Medicare Promoting Interoperability programs, CMS finalized the adoption of the Advance Care Planning electronic clinical quality measure (eCQM).

Also, beginning with the FY 2028 payment determination, CMS finalized the proposal to adopt substantive measure updates to five condition-specific and procedure-specific mortality measures in the Hospital IQR Program. CMS finalized the same measure updates for the Hospital VBP Program beginning with the FY 2032 program year. The final updates include expanding the measure inclusion criteria to include Medicare Advantage (MA) patients, shortening the performance period from three years to two years. CMS also finalized a technical update to the risk adjustment methodology for the five modified mortality measures to use individual International Classification of Diseases (ICD–10) codes instead of hierarchical condition categories (HCC) to improve the measure's risk adjustment methodology.

HOSPITAL READMISSIONS REDUCTION PROGRAM

CMS finalized the adoption of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure with modifications beginning with two years of early look reports for the FY 2028 (applicable period of July 1, 2024 to June 30, 2026) and FY 2029 (applicable period of July 1, 2025 to June 30, 2027) program years, and use beginning with the FY 2030 program year (applicable period of July 1, 2026 to June 30, 2028). A table in the

Final Rule (pg. 49885) lists the finalized hospital 30-day, all-cause, risk-standardized unplanned readmission measures in the hospital readmissions reduction program.

HOSPITAL VALUE-BASED PURCHASING PROGRAM

CMS finalized modifications to five condition- and procedure-specific mortality measures beginning with the FY 2032 program year: acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, and coronary artery bypass graft surgery mortality. The modified measures add Medicare Advantage beneficiaries, shorten the performance period from three years to two years, and use individual ICD-10 codes rather than hierarchical condition categories in risk adjustment. CMS estimates that approximately $1.9 billion will be available for FY 2027 value-based incentive payments. No other VBP measure-set changes were finalized.

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

CMS finalized several changes to the Hospital IQR Program, as outlined in Table 3.

Table 3. Finalized Hospital IQR Program Changes

Topic	Finalized Change
New measures	Adopt the following three new measures: (1) Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes beginning with the FY 2029 payment determination; (2) Advance Care Planning eCQM beginning with the FY 2030 payment determination; and (3) Hospital Harm-Postoperative Venous Thromboembolism (VTE) eCQM beginning with the FY 2030 payment determination.
Modified mortality measures	Adopt changes to five mortality measures, as noted above.
Modified EDAC measures	Add MA data, shorten the performance period to two years, and use ICD-10 codes for AMI, heart failure, and pneumonia EDAC measures beginning with the FY 2028 payment determination.
Measure removals	Remove VTE-1, VTE-2, and Discharged on Antithrombotic Therapy (STK-02) beginning with the FY 2030 payment determination.
Data reporting and submission requirements for eCQMs	(1) Mandatory reporting for the Malnutrition Care Score eCQM beginning with the FY 2030 payment determination; (2) mandatory reporting for the Hospital Harm eCQMs after 2 years of self-selected reporting beginning with the FY 2030 payment determination with modifications; and (3) an update to the reporting of the Maternal Morbidity Structural measure beginning with the FY 2028 payment determination.
Mandatory Malnutrition Care Score	Require reporting beginning with the CY 2028 reporting period/FY 2030 payment determination.
Mandatory Hospital Harm eCQMs	Require Falls with Injury and Postoperative Respiratory Failure beginning CY 2028 reporting period; require Postoperative VTE beginning with CY 2030 reporting period. CMS also finalized a general policy under which newly adopted Hospital Harm eCQMs will become mandatory after two years of self-selected reporting. For public reporting, CMS modified the proposal so that a Hospital Harm eCQM will be displayed on the Provider Data Catalog during its first mandatory reporting year and on Care Compare and in the Overall Hospital Quality Star Rating beginning with the second mandatory reporting year.
Maternal Morbidity structural measure	Beginning with the FY 2028 payment determination, a hospital attesting "Yes" must identify the statewide or national perinatal quality improvement collaborative in which it participates.

MEDICARE PROMOTING INTEROPERABILITY PROGRAM

CMS finalized several changes to the Medicare Promoting Interoperability (PI) Program, as outlined in Table 4.

Table 4. Final Medicare Promoting Interoperability Program Changes

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

ORGAN ACQUISITION, REASONABLE COST AND COST ALLOCATION POLICIES

CMS finalized extending the reasonable-cost reconciliation framework for independent organ procurement organizations (IOPOs) and histocompatibility laboratories (HCLs) to include non-renal organ acquisition and testing services. To implement the expanded reasonable-cost framework, CMS finalized several technical revisions. The change is effective for cost reporting periods beginning on or after October 1, 2028. Among other changes, CMS finalized clarifications to payment mechanics (e.g., allowable costs, cost allocation) and revisions to clarify and codify the authority of both the CMS reviewing official and the Administrator in the appeals process for IOPOs and HCLs.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

As finalized in prior rulemaking, TEAM is a five-year mandatory alternative payment model that began January 1, 2026, and ends December 31, 2030. Although TEAM has begun, CMS finalized the following policies:

- Adding MS-DRGs 523, 524 and 525 to the spinal fusion episode category for anchor hospitalizations beginning October 1, 2026;
- Clarifying that CMS will not attribute an episode to a TEAM participant if the beneficiary is in a CJR–X episode and has a procedure performed at a TEAM participant that would initiate an episode during the CJR–X 90-day post-discharge period.
- Establishing concurrent measurement periods and Composite Quality Score baseline periods, as shown in a table the Final Rule (pg. 50096).
- Revising the pricing methodology to apply Ambulatory Payment Classification (APC) and MS-DRG update factors in final target price calculations; and
- Calculating the risk adjustment multiplier and normalization factor using the baseline period clinical episodes starting with performance year 2.

In response to a request for information regarding physician-owned hospitals (POHs) participating in TEAM, CMS indicated that the agency intends to propose a policy for POH participation in future rulemaking.

COMPREHENSIVE CARE FOR JOINT REPLACEMENT EXPANDED (CJR-X) MODEL

CMS finalized CJR-X as a mandatory, nationwide expansion of the prior Comprehensive Care for Joint Replacement Model. With limited exceptions, all acute care hospitals eligible for payment under both the IPPS and OPPS that initiate covered lower-extremity joint replacement episodes must participate. In the Final Rule, CMS delayed the model start from October 1, 2027, to January 1, 2028, and changed performance years from fiscal years to calendar years. The model does not have a specified end date. CMS estimates $725 million in Medicare savings over the first five performance years.

PARTICIPANTS

CMS finalized that CJR–X participation would be mandatory for all eligible acute care hospitals nationwide and that CJR–X participants will remain CJR–X participants unless they no longer meet the definition of CJR–X participant, CMS terminates CJR–X participant, or CMS terminates CJR-X. CMS expects to post a list of the CJR–X participants on the CJR–X website for the 2028 performance year/2030 payment year by the end of 2026. CMS anticipates quarterly updates to the list, to reflect hospital mergers, closures, and other changes that add or remove hospitals. Also, CMS finalized excluding TEAM participants and Maryland hospitals from CJR-X.

BENEFICIARY POPULATION

CMS finalized, with modification, the following beneficiary inclusion criteria: An individual is a CJR-X beneficiary if, based on a 180-day lookback period that ends on the day prior to an anchor procedure or anchor hospitalization, the individual:

1) Is enrolled in Medicare Parts A and B;
2) Has Medicare as their primary payer;
3) Is not eligible for Medicare on the basis of having end-stage renal disease;
4) Is not enrolled in any managed care plan (for example, Medicare Advantage, health care prepayment plans, or cost-based health maintenance organizations);
5) Is not covered under a United Mine Workers of America health care plan; and
6) Is in an episode.

CMS also finalized beneficiary notification requirements as proposed. However, CMS indicated that the agency will consider updates to this policy through future notice and comment rulemaking provided the changes would not fundamentally alter beneficiary protections.

EPISODES AND INCLUDED SERVICES

CMS finalized a definition of "episode" to generally mean all Medicare Part A and B items and services (subject to exclusions)[6] that are furnished to a CJR-X beneficiary during the time period that begins on the date of the beneficiary's admission to an anchor hospitalization or the date of the anchor procedure, and ends on the 90th day following the date of discharge from the anchor hospitalization or anchor procedure. CMS also finalized definitions of "anchor hospitalization" as the initial hospital stay upon admission for a lower extremity joint replacement (LEJR) for which the institutional claim is billed through the inpatient prospective payment system (IPPS), and "anchor procedure" as a Total Hip Arthroplasty (THA) or Total Knee Arthroplasty (TKA); procedure that is permitted and paid for by Medicare when performed in a hospital outpatient department (HOPD) and billed through the Hospital Outpatient Prospective Payment System (OPPS).

CMS also finalized the proposal to identify LEJR episodes with MS-DRGs and HCPCS codes.

[6] CMS indicates that the lists of exclusions will be maintained on the CJR-X website at https://www.cms.gov/priorities/innovation/innovation-models/cjr-x

In addition, CMS provides that an episode is initiated by a beneficiary's admission to a CJR-X participant for an anchor hospitalization that is paid under certain MS–DRGs or by an anchor procedure billed under certain HCPCS codes. The episode start date is the date of the anchor procedure for outpatient procedures and the admission date for inpatient hospitalizations. CMS also clarifies that if an anchor hospitalization is initiated on the same day as or within three days of an outpatient procedure for the same episode type at the same CJR-X participant, the episode start date will be that of the outpatient procedure rather than the admission date, and an anchor procedure will not be initiated.

QUALITY MEASURES AND SCORING

CMS finalized that the CJR-X quality measure set will include the following measures: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA and/or TKA; Hospital Visits Within 7 days of Hospital Outpatient Department Surgery; Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS); Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS); and Hospital-Level THA/TKA Patient-Reported Outcome-Based Performance Measure (PRO-PM). CMS converts measure performance into a Composite Quality Score (CQS) that determines the participant's quality category and adjusts the discount factor used in reconciliation. Tables in the Final Rule (pg. 50169) includes the measures and quality domain weights for the CQS and point value for CJR-X quality measures.

Target prices are calculated at the regional and episode-type level using three years of baseline spending, risk adjustment, trend and normalization factors, and a high-cost episode cap. Most participants are subject to 20 percent stop-loss and stop-gain limits, however, safety-net hospitals, rural hospitals, MDH and sole community hospitals are subject to a five percent stop-loss limit.

FINANCIAL ARRANGEMENTS AND WAIVERS

CMS finalized policies allowing participant hospitals to enter into financial arrangements and certain care redesign relationships with specified entities, subject to applicable requirements and safeguards. CMS also finalized certain Medicare program waivers including: (1) certain telehealth geographic, originating-site, and payment requirements for otherwise covered telehealth services included in the episode and furnished in the beneficiary's home, except the face-to-face encounter used for home health certification; (2) the SNF three-day inpatient-stay requirement for admission to a qualified SNF or swing-bed provider within 30 days after discharge from the anchor hospitalization or the date of the anchor procedure; and (3) the direct-supervision requirement for up to nine post-discharge home visits furnished under general supervision to beneficiaries who do not qualify for Medicare home health services.

WHAT'S NEXT?

Most provisions of the Final Rule are effective October 1, 2026, with some exceptions, including CJR-X which begins January 1, 2028.

Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this Final Rule. Please direct your feedback to Jenna Stern, Vice President, Regulatory Affairs and Public Policy, in Vizient's Washington, D.C. office.

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