

Vizient Office of Public Policy and Government Relations

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2027 Rates; Requirements for Quality Programs; and Other Policy Changes

May 1, 2026

Background & Summary

On April 10, the Centers for Medicare & Medicaid Services (CMS) issued the [annual proposed rule](#) to update the Fiscal Year (FY) 2027 Medicare payment and policies for the hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS) (“Proposed Rule”) (Fact sheet available [here](#)). CMS proposes to increase 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 by 2.4 percent. Based on various policy changes and circumstances described in the Proposed Rule, CMS anticipates hospital payments will increase by \$1.9 billion in FY 2027.

In addition to payment updates, the Proposed Rule contains several proposals, including expansion of the Comprehensive Care for Joint Replacement CJR Expanded (CJR-X) Model, refinements to the Transforming Episode Accountability Model (TEAM) and changes to the Medicare Promoting Interoperability Program.

CMS also provides several requests for information seeking feedback on issues such as the adoption of measures into hospital quality programs and the Medicare Promoting Interoperability Program, and potential modifications to the types of providers participating in TEAM.

Comments are due **no later than 5PM on June 9, 2026**, and most policies go into effect on October 1, 2026. Vizient looks forward to working with our provider clients to help inform our letter to CMS.

Proposed IPPS Payment Rate Updates for FY 2027

After accounting for adjustments required by law, the Proposed Rule increases IPPS operating payment rates by 2.4 percent in FY 2027 for hospitals that successfully participate in the Hospital IQR Program and are meaningful EHR users. The Proposed Rule includes an initial market-basket update of 3.2 percentage points, reduced by a 0.8 percentage point productivity adjustment; these changes are reflected in Table 1.

Table 1. Proposed IPPS Payment Rate Updates for FY 2027*

Proposed Policy	Average Impact on Payments (Rate)
Estimated market-basket update*	3.2%
Productivity Adjustment*	-0.8%
Estimated payment rate update for FY 2027 (before applying budget neutrality factors)	2.4%

*The FY 2027 estimated market-basket update and proposed productivity adjustment are based on the 4th quarter 2025 IGI forecast, which was the most recent forecast available at the time of development of the Proposed Rule. CMS indicates it will use more recent data if available for the Final Rule.

In addition, CMS proposes four applicable percentage adjustments applied to the standardized amount, as demonstrated in Table 2. To determine the proposed applicable percentage increase,

CMS adjusted the proposed market-basket rate-of-increase by considering (1) whether a hospital submits quality data; and (2) whether a hospital is a meaningful EHR user. CMS also applies a 0.8 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 the below table (e.g., reductions under the pay for performance programs).

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

FY 2027	Hospital submitted quality data and is a Meaningful EHR User	Hospital submitted quality data and is not a Meaningful EHR User	Hospital did not submit quality data and is a Meaningful EHR User	Hospital did not submit quality data and is not a meaningful EHR user
Proposed market-basket rate-of-increase	3.2	3.2	3.2	3.2
Proposed adjustment for not submitting quality data	0	0	-0.8	-0.8
Proposed adjustment for not being a Meaningful EHR User	0	-2.4	0	-2.4
Proposed Productivity Adjustment	-0.8	-0.8	-0.8	-0.8
Proposed applicable percentage increase applied to standardized amount	2.4	0.0	1.6	-0.8*

* Section 1886(b)(3)(B)(xi) of the Social Security Act states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

Proposed Payment Adjustment for Medicare DSH for FY 2027

The Affordable Care Act (ACA) required changes, which began in 2014, regarding 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 (“empirically justified”). The other 75 percent flows into a separate pool that is reduced relative to 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 Office of the Actuary estimate of the total amount of estimated Medicare DSH payments;
- **Factor 2:** Change in the national uninsured rates based on population estimates; and
- **Factor 3:** Each hospital’s percentage of total uncompensated care among all DSH hospitals.

For FY 2027, CMS proposes to continue to use the three most recent years of audited data on uncompensated care costs from Worksheet S–10 of the FY 2021, FY 2022 and FY 2023 cost reports to calculate Factor 3 in the uncompensated care payment methodology for all eligible hospitals. For FY 2027, CMS proposes total uncompensated care-based payments will be \$7.46 billion which is a slight decrease from the FY 2026 uncompensated care-based payments of \$7.71 billion. CMS estimates the empirically justified Medicare DSH payments for FY 2027 to be approximately \$3.83 billion. CMS projects that certain rural hospitals will experience a larger change in uncompensated care payments compared to the decrease urban hospitals are projected to experience. For example, small rural hospitals are projected to have an 8.5 percent reduction in payments, while urban hospitals are projected to receive a 3.0 percent payment reduction.

Uncompensated care payments are redistributive, meaning a hospital's payment depends on its uncompensated care amount relative to the total uncompensated care provided by all hospitals projected to receive Medicare DSH payments. The calculated payment amount is not directly tied to a hospital's number of discharges.

To calculate Factor 1 and model the impact of this Proposed Rule, CMS describes the various data sources it utilized, including the Office of the Actuary's (OACT's) January 2026 Medicare DSH estimates (based on data from the December 2025 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2026 IPPS Final Rule Impact File. For FY 2027, CMS provides that Factor 1 would be approximately \$11.477 billion (\$15.303 billion minus \$3.826 billion) and notes OACT will use more recent data in the FY 2027 IPPS Final Rule if available. CMS also indicates that Factor 1 estimates for the IPPS proposed rules are generally consistent with economic assumptions and actuarial analysis used to develop the President's Budget estimates.

For Factor 2, CMS proposes to use the methodology applied since 2018. To calculate Factor 2, among other sources, CMS relies on OACT estimates that the uninsured rate will be 9.0 percent for calendar year (CY) 2026 and 9.1 percent for CY 2027. Using a weighted average approach to estimate the rate of uninsurance during a fiscal year, CMS finds Factor 2 would be 65 percent. The proposed FY 2027 uncompensated care amount, if equivalent to proposed Factor 1 multiplied by proposed Factor 2, equals approximately \$7.460 billion.

To calculate Factor 3, CMS proposes using the three most recent years of audited cost report data (i.e., FY 2021, 2022 and 2023 cost reports) consistent with the approach used in recent years. CMS further clarifies that for the Proposed Rule, the agency used reports from the December 2025 HCRIS extract but intends to use the March 2026 update of HCRIS to calculate the final Factor 3 for the FY 2027 IPPS Final Rule.

In addition, CMS provides a FY 2027 IPPS Proposed Rule Medicare DSH supplemental data file on the [Proposed Rule website](#). **CMS welcomes comments on the proposals to calculate each factor.**

[Proposed Changes to Medicare Severity Diagnosis-Related Group \(MS-DRG\) Classifications and Relative Weights for FY 2027¹](#)

Under the IPPS, the DRG classifications and relative weights are adjusted, at least annually, to account for changes in resource consumption. Relative weight adjustments aim to reflect changes in treatment patterns, technology and other factors that may alter the relative use of hospital resources. For the Proposed Rule, the MS-DRG analysis was based on ICD-10 claims data from the September 2025 update of the FY 2025 Medicare Provider Analysis and Review (MedPAR) file, which contains hospital bills received from October 1, 2024 through September 30, 2025.

In addition, the proposed 19 national average cost-to-charge ratios (CCRs) for FY 2027 are provided in the [Proposed Rule](#) (pg. 205-206). These CCRs are used in the methodology CMS uses to determine the proposed relative weights. Table 5, on the [Proposed Rule website](#), provides information on proposed MS-DRGs, relative weighting factors and geometric and arithmetic mean lengths of stay. Also, CMS proposes the Major Diagnostic Category (MDC) and MS-DRG

¹ The proposed MS-DRG assignments, MDC assignments, severity-level designations, and O.R. status for all new FY 2027 diagnosis and procedure codes listed in Tables 6A and 6B found on the [CMS website](#).

assignments for new diagnosis codes and procedure costs (Tables 6A and 6B), which are on the [Proposed Rule website](#). **CMS welcomes comments on these proposals.**

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

Under the IPPS Medicare Severity–Diagnosis Related Group (MS-DRG) system, CMS maintains a defined list of procedure codes that are classified as operating room (O.R.) procedures. O.R. procedures are identified through a physician panel review of the hospital resources each procedure typically requires. Procedures not expected to use the O.R. are classified as non-O.R., and both categories influence MS-DRG assignment. CMS previously announced a multi-year effort to reevaluate all ICD-10-PCS codes to determine which should be considered O.R. procedures, noting that ICD-10 data may reveal additional resource-use factors. In the Proposed Rule, CMS states that it still needs more time to develop the process and methodology for this comprehensive review. **CMS also welcomes information on any other factors in consideration of the agency’s refinement efforts to recognize and differentiate the consumption of resources under the ICD-10 MS-DRGs.**

Proposed Changes in MS-DRG Severity Levels

For FY 2027, CMS proposes reversing severity-level upgrades for ten Z codes that cover homelessness, inadequate housing and housing instability based on the latest data as part of the agency’s multi-year effort to reassess SDOH-related Z codes.² CMS previously upgraded these codes from non-complication or comorbidity (Non-CC) to complication or comorbidity (CC), but proposes to reclassify all Z codes related to homelessness, inadequate housing and housing instability from CC back to Non-CC.³ CMS explains that since CC/MCC designations are intended to capture clinical complexity, these Z codes should not be classified as CCs.⁴

In the Proposed Rule, CMS explains that its data shows patients receiving antimicrobial Procedure Code XW0V0P7 have significantly higher costs and longer hospital stays. Based on these findings, CMS proposes to update the MS-DRG Grouper software so that this procedure is no longer treated as a non-O.R. code with no impact on severity. Instead, when XW0V0P7 appears on a claim, the software would automatically assign the case to the higher-severity MS-DRG with Major Complication or Comorbidity (with MCC) for several MS-DRGs.⁵

Proposed Changes to the Surgical Hierarchies

Some inpatient stays involve multiple surgeries, and each surgery on its own could lead to a different MS-DRG based on the main diagnosis. A surgical hierarchy, which is an ordering of surgical classes from the most resource-intensive to least resource-intensive, is used to assign cases to a single MS-DRG. For FY 2027, CMS proposes revisions to the surgical hierarchy for several Major Diagnostic Categories (MDCs), specifically Pre-MDC, MDC 05, MDC 08, MDC 10,

² A full list of these Z codes can be found on pg. 152 of the [Proposed Rule](#)

³ CMS previously upgraded homelessness-related diagnosis codes (Z59.00–Z59.02) from NonCC to CC in the FY 2025 IPPS [Final Rule](#), and in the FY 2025 IPPS [Final Rule](#), CMS upgraded seven additional codes (Z59.10-12; Z59.19; Z59.811, 812, 819) related to inadequate housing and housing instability from NonCC to CC.

⁴ CMS adds that any added complexity from social factors should be captured through separate coding of acute medical exacerbations, consistent with the approach used for chronic conditions consistent with previous established policy in the FY 2008 IPPS Final Rule, <https://www.govinfo.gov/content/pkg/FR-2008-08-19/pdf/E8-17914.pdf>

⁵ The MS-DRG codes include (463, 474, 477, 480, and 492). MS-DRG 463 is wound debridement and skin graft except hand for musculoskeletal system and connective tissue disorders with a major complication of comorbidity (MCC). MS-DRG 474 is amputation for musculoskeletal system and connective tissue disorders with MCC. MS-DRG 477 is biopsies of musculoskeletal system and connective tissue with MCC. MS-DRG 480 is hip and femur procedures except major joint with MCC. MS-DRG 492 is lower extremity and humerus procedures except hip, foot and femur with MCC.

MDC 11, MDC 12 and MDC 13.^{6,7} CMS emphasizes that these placements may change again in the Final Rule depending on the finalized MS-DRG classifications for FY 2027. **CMS requests comments on the proposed changes to the surgical hierarchy no later than October 20, 2026, to be included in the FY 2028 IPPS Proposed Rule.**⁸

Relative Weight Calculation for MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies)

In the [FY 2021 IPPS Final Rule](#), CMS created MS-DRG 018 for cases that include procedures describing Chimeric Antigen Receptor (CAR) T-cell therapies. For FY 2027, CMS proposes to continue the previously finalized MS-DRG 018 policy, which adjusts payment when CAR-T immunotherapy products are provided at no cost or outside the usual purchase process. Consistent with the methodology adopted in FY 2024 and expanded in FY 2026, CMS proposes to again exclude from the MS-DRG 018 average cost calculation any claims with diagnosis code Z00.6 (clinical trial) without payer-only code ZC, claims with condition code 90 and claims with standardized drug charges below the median for clinical trial cases (estimated at \$25,323, to be updated for the Final Rule). These exclusions prevent atypically low-cost cases, such as clinical trial, expanded access or free-product cases, from distorting the DRG's relative weight. CMS also proposes to continue calculating the adjustment process used since FY 2024: separate average costs for excluded and non-excluded cases, creating an adjustor based on their ratio and applying that adjustor so the national standardized cost used for MS-DRG weights reflects appropriate resource use.

In addition, CMS proposes, consistent with FY 2026 policy, to apply an adjustor of 0.17⁹ to payment for clinical trial, expanded-access, and no-cost-product cases assigned to MS-DRG 018, reflecting that these cases are significantly less expensive than standard immunotherapy cases.¹⁰ CMS plans to update the adjustor with more recent data in the Final Rule.

Proposed Changes to MS-DRGs Subject to the Post-acute Care (PAC) Transfer Policy and MS-DRG Special Payments Policies

When CMS proposes MS-DRG changes that add, delete or reassign diagnosis or procedure codes, the agency typically evaluates the affected MS-DRGs to determine whether they should be subject to the post-acute care transfer policy. This policy provides that a transferring hospital is paid on a per diem rate up to and including the full DRG payment, potentially including a cost outlier payment. Alternatively, the final discharging hospital is paid on the full prospective payment rate, potentially

⁶ An MDC is the broad clinical category, usually based on a body system or type of condition—that every inpatient case is assigned to based on its principal diagnosis. Once a case is placed into an MDC, the MS-DRG GROUPER uses that MDC's surgical hierarchy to determine the correct MS-DRG when multiple surgical procedures are present. Each MDC has its own hierarchy that ranks surgical classes from the most to the least resource-intensive, ensuring that cases with multiple procedures are assigned to the MS-DRG reflecting the highest-intensity surgical class within that MDC.

⁷ These changes are illustrated in tables on pg. 170-174 of the [Proposed Rule](#). Pre-MDC (Pre-Major Diagnostic Category), MDC 05 (Diseases & Disorders of the Circulatory System), MDC 08 (Diseases & Disorders of the Musculoskeletal System & Connective Tissue), MDC 10 ((Endocrine, Nutritional & Metabolic Diseases & Disorders), MDC 11 (Diseases & Disorders of the Kidney & Urinary Tract), MDC 12 (Diseases & Disorders of the Male Reproductive System); MDC 13 (Diseases and Disorders of the Female Reproductive System).

⁸ Comments should be submitted via MEARIS™ at <https://mearis.cms.gov/public/home>, so that they can be considered for possible inclusion in the annual proposed rule.

⁹ In FY 2026 CMS finalized this adjustor at .16

¹⁰ CMS notes that using updated FY 2025 MedPAR data, clinical trial and other low-cost CAR T-cell therapy cases in MS-DRG 018 have average costs of \$71,039, which is only 17 percent of the \$412,218 average cost for non-clinical-trial cases. In practice, each such case is weighted as 17 percent of a standard CAR-T case to prevent these low-cost cases from distorting the DRG's payment weight.

including a cost outlier payment.¹¹ For FY 2027, CMS proposes changes to several MS-DRGs as outlined in the [Proposed Rule](#) (pg. 441-442) and evaluates these MS-DRGs to determine whether they should be subject to the PAC transfer policy. CMS proposes adding thirteen new MS-DRGs to the list of MS-DRGs that are subject to the PAC transfer policy.¹² A table listing the proposed new or revised MS-DRGs that were reviewed to be subject to the PAC transfer policy is available in the [Proposed Rule](#) (pg. 445-446).

Proposed Deletion of Certain MS-DRGs

For FY 2027, CMS proposes to delete and reassign several cardiac pacemaker and joint-revision MS-DRGs. Under MDC 05, CMS proposes deleting MS-DRGs 258 and 259 (Cardiac Pacemaker Device Replacement with and without MCC) and MS-DRGs 260, 261, and 262 (Cardiac Pacemaker Revision Except Device Replacement with MCC, with CC, and without CC/MCC). CMS proposes to replace the deleted MS-DRGs with two new MS-DRGs—210 and 211 (Cardiac Pacemaker Revision or Device Replacement with and without MCC). All procedures currently assigned to the deleted MS-DRGs would be reassigned to these new MS-DRGs. Under MDC 08, CMS proposes deleting MS-DRGs 466, 467 and 468 (Revision of Hip or Knee Replacement with MCC, with CC and without CC/MCC, respectively) and create new MS-DRG 449 (Revision of Hip or Knee Replacement). The procedures currently assigned to MS-DRGs 466, 467 and 468 would be assigned to proposed new MS-DRG 449.¹³

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

Current law requires the HHS Secretary to adjust the standardized amounts for area differences in hospital wages by a factor that reflects the relative hospital wage level in the geographic area of that hospital compared to the national average. The wage index reflects data from the Medicare Cost Report and the Hospital Wage Index Occupational Mix Survey. The wage index must be updated annually, and any updates or adjustments must be budget neutral, meaning the overall, aggregate payment to hospitals cannot change. CMS provides wage index tables (Tables 2, 3, 4A and 4B) on the [Proposed Rule website](#).

¹¹ According to the [Office of the Inspector General](#), “The intent of this transfer policy is to avoid providing an incentive for a hospital to transfer a beneficiary to a post-acute-care setting early (before the beneficiary’s acute condition is stabilized) to minimize its costs while still receiving the full MS-DRG payment. Using a graduated per diem rate, Medicare adjusts the payment to the hospital to approximate the reduced cost for a beneficiary who has been transferred to a post-acute-care setting.” ... “The post-acute-care transfer policy defines a transfer as having occurred when a beneficiary whose hospital stay was classified within specified MS-DRGs is discharged from an IPPS acute care hospital in one of the following situations:

- The beneficiary is admitted on the same day to a hospital or hospital unit that is not reimbursed under the IPPS.
- The beneficiary is admitted on the same day to a skilled nursing facility.
- The beneficiary receives home health services from a home health agency, the services are related to the condition or diagnosis for which the beneficiary received inpatient hospital services, and the services are provided within 3 days of the date that the hospital discharged the beneficiary.
- The beneficiary is admitted on the same day to a hospice.”

¹² The list includes: a) MS-DRG 210 (Cardiac Pacemaker Revision or Device Replacement with MCC); b) MS-DRG 211 (Cardiac Pacemaker Revision or Device Replacement without MCC); c) MS-DRG 361 (Other Circulatory System O.R. Procedures with MCC); d) MS-DRG 362 (Other Circulatory System O.R. Procedures without MCC); e) MS-DRG 400 (Knee Procedures with Principal Diagnosis of Infection); f) MS-DRG 403 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint with MCC or Insertion of Antibiotic-eluting Bone Void Filler); g) MS-DRG 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint without MCC); h) MS-DRG 456 (Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or Infection or Extensive Fusions with MCC with MCC); i) MS-DRG 457 (Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or Infection or Extensive Fusions with MCC with CC0); j) MS-DRG 458 (Spinal Fusion Except Cervical with Spinal Curvature, Malignancy, or Infection or Extensive Fusions with MCC without CC/MCC); k) MS-DRG 523 (Extensive or Complex Spinal Fusion Procedures Except Cervical with MCC); l) MS-DRG 524 (Extensive or Complex Spinal Fusion Procedures Except Cervical with CC); m) MS-DRG 525 (Extensive or Complex Spinal Fusion Procedures Except Cervical without CC/MCC).

¹³ A chart containing the full list of these procedures can be found on pg. 189 of the [Proposed Rule](#).

Worksheet S–3 Wage Data for the FY 2026 Wage Index

The proposed FY 2027 wage index is based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2023.¹⁴ The wage data for the proposed FY 2027 wage index was obtained from Worksheet S-3, for cost reporting periods between October 1, 2022, and October 1, 2023. CMS notes that in previous fiscal years, the agency reviewed and evaluated the audited wage data, and the impacts of the COVID–19 Public Health Emergency (PHE) on such data. For FY 2027, CMS did not identify any significant issues with the FY 2023 wage data in terms of audits of this data.

For the proposed FY 2027 wage index, CMS removed 7 hospitals that converted to critical access hospital (CAH) status and 2 hospitals that converted to rural emergency hospital (REH) status on or after January 24, 2026, the cut-off date for CAH and REH exclusion from the FY 2027 wage index.

Proposed Occupational Mix Adjustment to the FY 2027 Wage Index

CMS uses an occupational mix adjustment to control the effects of hospitals' choices to employ different combinations of staff to provide care services. For the FY 2027 wage index, CMS used Worksheet S-3 wage data of 3006 hospitals and occupational mix surveys of 2922 hospitals. CMS notes it had a "response" rate of 97 percent and will apply proxy data for hospitals that did not reply, new hospitals and hospitals that submitted erroneous or aberrant data, as done in prior years. For FY 2027, CMS proposes to calculate the occupational mix adjustment factor using the same methodology the agency has used since the FY 2012 wage index and to apply the occupational mix adjustment to 100 percent of the FY 2027 wage index.

Proposed Update to the IPPS Labor-Related Share for FY 2027

For FY 2027, CMS proposes to apply two different labor-related shares depending on whether a hospital's wage index is above or below 1.0. Specifically, CMS proposes that hospitals with a wage index below 1.0 use a 62 percent labor-related share, while hospitals with a wage index above 1.0 use a 66 percent labor-related share. The labor-related share determines the portion of the national IPPS base payment rate that is adjusted by the area wage index.¹⁵ However, when CMS updated the market-basket using 2023 data beginning in FY 2026, the labor-related share increased to 66 percent, implemented in a budget-neutral manner. However, because the law requires CMS to select the higher-paying labor share for each hospital, CMS cannot offset the additional spending that results when hospitals with wage indexes at or below 1.0 are paid using the lower 62 percent share while hospitals with wage indexes above 1.0 use the higher 66 percent share resulting in the current proposal to create two labor-related market shares. Tables 1A and 1B of the [Proposed Rule](#) (pg. 1451) includes the proposed standardized amounts reflecting the proposed applicable percentage increases for FY 2027.

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

¹⁴ The proposed FY 2027 wage index includes all of the following categories of data associated with costs paid under the IPPS (as well as outpatient costs): 1) Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty). 2) Home office costs and hours. 3) Certain contract labor costs and hours including direct patient care (which includes nursing), certain top management, pharmacy, laboratory, and nonteaching physician Part A services, and certain contract indirect patient care services. 5) Wage-related costs, including pension costs.

¹⁵ Section 1886(d)(3)(E) of the Social Security Act requires CMS to use a 62 percent labor share and to pay hospitals based on whichever labor-related share, 62 percent or HHS's estimate, results in a higher payment.

“Rural Floor” Policy

The “rural floor” policy provides that area wage indexes applied to any hospital that is in an urban area of a state cannot be lower than the area wage index for hospitals in rural areas in that state. In addition, CMS applies a national budget neutrality adjustment when implementing the rural floor policy. Based on the FY 2026 wage index, which was used in the Proposed Rule, CMS estimates that 535 hospitals will receive the rural floor adjustment in FY 2027.

“Imputed Floor” Policy

The “imputed floor” policy provides a wage index minimum for all-urban states. In the FY 2022 IPPS Final Rule, CMS adopted the American Rescue Plan Act (ARPA) requirements to implement the “imputed floor” policy.¹⁶ For FY 2027, CMS proposes to continue applying the FY 2022 “imputed floor” policy.

“State Frontier Floor” Policy

The ACA requires that the wage index for hospitals in low density states (known as the “Frontier Floor” Wage Index) cannot be below 1.0000. CMS indicates there are no proposed changes to the frontier floor policy for FY 2027. In the Proposed Rule, 40 hospitals in Montana, North Dakota, South Dakota and Wyoming would receive the Frontier Floor value of 1.0000 for their FY 2027 wage index. While Nevada meets the criteria of a Frontier State, all hospitals within the state currently receive a wage index value greater than 1.0000.

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

For FY 2027, CMS proposes extending its FY 2026 budget-neutral transitional payment policy for hospitals that previously benefited from the FY 2024 low wage index policy and are still experiencing large wage index declines due to the discontinuation of this policy.¹⁷ For FY 2027, CMS would compare each hospital’s proposed wage index to its FY 2024 wage index. If the hospital’s wage index drops by more than 14.2625%, CMS would boost its payment by treating its FY 2027 wage index as no lower than 85.7375% of its FY 2024 value. This transitional adjustment would be applied after the standard 5% wage index cap decreases.

Cap on Wage Index Decreases and Budget Neutrality Adjustment

In the FY 2023 IPPS Final Rule, CMS finalized a wage index cap policy and associated budget neutrality adjustment for FY 2023 and subsequent fiscal years.¹⁸ Under this policy, a 5 percent cap is applied to any decrease to a hospital’s wage index from the prior fiscal year, regardless of the circumstances causing the decline. A hospital’s wage index will not be less than 95 percent of its final wage index for the prior fiscal year. Newly opened hospitals do not receive the cap in their first year. For FY 2027, CMS proposes to continue the previously adopted wage index cap and associated budget neutrality adjustment.

¹⁶ From FYs 2005–2018, CMS utilized an imputed floor policy for hospitals in all-urban states, and it was considered as a factor in the national budget neutrality adjustment. Section 9831 of the American Rescue Plan Act (ARPA) requires that for discharges occurring on or after October 1, 2021, the area wage index applicable to any hospital in an all-urban state may not be less than the minimum area wage index for the fiscal year for hospitals in that state established using the methodology that was in effect for FY 2018. Unlike the imputed floor policy that was in effect from FYs 2005–2018, the ARPA provided that the imputed floor wage index shall not be applied in a budget neutral manner.

¹⁷ In the FY 2020 IPPS [Final Rule](#), CMS finalized a policy that provides certain low wage index hospitals with the opportunity to increase employee compensation without the usual lag for those increases to be reflected in the calculation of the wage index. CMS achieved this by temporarily increasing the wage index values for certain hospitals with low wage indexes and also providing an adjustment to the standardized amount for all hospitals so that the policy was budget neutral.

¹⁸ <https://www.govinfo.gov/content/pkg/FR-2022-08-10/pdf/2022-16472.pdf>

Proposed Payment Adjustment for Low-Volume Hospitals

Federal law provides a non budget-neutral additional payment adjustment based on total per-discharge payments for qualifying low-volume hospitals under the IPPS.¹⁹ Congress has repeatedly extended the temporary low-volume hospital criteria, most recently through FY 2026 and the first quarter of FY 2027, ending on December 31, 2026.^{20,21} In the Proposed Rule, CMS proposes updating the regulatory text to reflect Congress's current extension of the current low-volume criteria and payment methodology through FY 2026 and the first quarter of FY 2027. The agency notes that without additional action from Congress, the low-volume hospital criteria and payment adjustment will revert to the original, more restrictive rules and methodology on January 1, 2027.²²

Proposed Changes in the 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. Starting January 1, 2027, all hospitals that previously qualified for MDH status and received payments based on their hospital-specific rate will be paid at the federal rate, which may be lower. In the past, Congress extended these payments through legislation. If the MDH payments were to be extended through the end of FY 2027, CMS estimates that these hospitals would receive additional payments of approximately \$0.4 billion in FY 2027.

New Technology Add-On Payments (NTAPs)

Under the IPPS, a service or technology may be considered for a NTAP if: (1) the medical service or technology is new ("newness" criterion); (2) the medical service or technology is so costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate ("cost" criterion); and (3) the service or technology demonstrates a substantial clinical improvement over existing services or technologies ("substantial clinical improvement" criterion). NTAPs are not budget neutral. As noted in the Proposed Rule [CMS Fact Sheet](#), CMS estimates an increase of \$464 million in NTAP payments in FY 2027 and estimates total payments for the technologies that applied under the alternative pathway for an NTAP, if approved, would be approximately \$589 million for FY 2027.

A table in the [Proposed Rule](#) (pg. 1488) provides a list of 41 technologies for which CMS proposes to continue NTAPs for FY 2027. CMS also lists the proposed NTAP discontinuations for FY 2026, because the 3-year anniversary date will occur prior to April 1, 2027, in the [Proposed Rule](#) (pg. 238).

CMS received 47 applications (15 traditional and 32 alternative) for an NTAP for FY 2027. Of the 15 traditional pathway applications, seven applicants were not considered in the Proposed Rule because they were ineligible or because they withdrew their application. For the remaining eight

¹⁹ [Social Security Act §1886](#)

²⁰ (Pub. L. 119-75), <https://www.congress.gov/bill/119th-congress/house-bill/7148/text>

²¹ For FY 2019–FY 2026 and the first quarter of FY 2027 (Oct 1–Dec 31, 2026), a hospital qualifies as low-volume if it is more than 15 road miles from another IPPS hospital and has fewer than 3,800 total discharges. During this period, qualifying hospitals receive an additional payment based on a sliding scale: up to a 25% increase for 500 or fewer discharges, phasing down to 0% for more than 3,800 discharges. Discharges includes all patients, regardless of payer.

²² Under this policy that was in place from 2005-2010, a hospital must be more than 25 road miles from another IPPS hospital and have fewer than 200 total discharges to qualify. Although the statute allows hospitals with under 800 discharges to be considered, CMS's analysis found that only hospitals with under 200 discharges show meaningful incremental costs, so only those hospitals receive the 25% adjustment. Hospitals with 200–799 discharges receive no adjustment. Eligibility continues to be based on total discharges from the most recent cost report and the 25-mile distance requirement.

applications, CMS made a proposal to approve or disapprove of the application only if the technology had received FDA marketing authorization for an NTAP. Additional information regarding these applications is in the Proposed Rule (pg. 240-290). For most of these applications, CMS proposes to disapprove of NTAPs.

Certain FDA-designated Breakthrough Devices, certain Qualified Infectious Disease Products (QIDPs), or certain products approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD), may also qualify for the NTAP under an alternative pathway which is less burdensome. CMS received 32 applications for NTAPs for FY 2027 under the alternative payment pathway, however, seven were not eligible for consideration and three withdrew their applications. For the remaining 22 applications, all of the technologies received a Breakthrough Device designation from FDA and several were for subscription-based technologies. **CMS welcomes input 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.** Additional information regarding each application is in the [Proposed Rule](#) (pg. 293-335).

Proposed Alternative Pathway Repeal for New Technology Add-on Payment²³ and Outpatient Prospective Payment System (OPPS) Device Pass-through²⁴

In the Proposed Rule, CMS expresses concern regarding the limited evaluation process for alternative pathway applications for NTAPs (e.g., QIDPs, LPADs, FDA-designated Breakthrough Devices) and OPPS device pass-through payments. As a result, CMS proposes to repeal the alternative pathway for new technology add-on payment and OPPS device pass-through applications. In addition, CMS proposes to require all applicants for NTAPs and OPPS device pass-through payments to demonstrate that they meet the same eligibility requirements (i.e., newness, cost and substantial clinical improvement) to receive add-on payments and/or pass-through payments.

As a result, beginning with applications received for NTAPs for FY 2028 and subsequent fiscal years, all applicants would need to meet all three of the criteria (i.e., newness, cost and substantial clinical improvement) to receive the additional payment. CMS clarifies that technologies that are currently under review for FY 2027 NTAPs under the alternative pathway will remain eligible for consideration under the alternative pathway. CMS also indicates that beginning with the FY 2028 NTAP applications, to be eligible for consideration 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.

Similarly, CMS proposes ending the OPPS alternative pathway starting with applications submitted on or after October 1, 2026, including applications received through the remainder of the CY 2028 application cycle ending on March 1, 2027. CMS clarifies that OPPS device pass-through payment applications submitted as of September 30, 2026 for devices that are part of the FDA's Breakthrough Devices Program and received FDA marketing authorization for the indication covered by the Breakthrough Device designation would be evaluated and could be approved under

²³ CMS created an alternative NTAP pathway for certain high-priority technologies, specifically Food and Drug Administration (FDA) Breakthrough Devices, Qualified Infectious Disease Products (QIDPs), and drugs approved under the Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) in the FY 2020 IPPS [Final Rule](#) to enhance Medicare beneficiary access to these products.

²⁴ CMS established a parallel alternative pathway under the Outpatient Prospective Payment System (OPPS) for Breakthrough Devices in the FY 2020 [Final Rule](#).

the alternative pathway, provided that all other criteria have been met. CMS proposes this policy would be effective October 1, 2026.

CMS seeks comment on the proposal to require all applicants for NTAPs and OPDS device pass-through payments to demonstrate that they meet the same requirements for eligibility.

Proposed Limits on When Manufacturers Claim Delay in Commercial Availability

CMS proposes a new policy, beginning in FY 2027, that limits when manufacturers can claim a delay in commercial availability for purposes of determining the start of a technology's 2- to 3-year "newness" period for NTAP payments. Under this proposal, CMS would only recognize commercial delays that occur before NTAP payments begin and will not consider later commercial availability dates once the NTAP becomes effective. If a product is still not for sale when the NTAP starts, CMS will set the newness start date to September 30 immediately preceding the NTAP effective date.²⁵
CMS requests feedback on this proposal.

Proposed Revision to Provider-Based Location Criteria Regulations Applicable to Off-Campus Facilities or Organizations

In the Proposed Rule, CMS expresses concern that allowing off-campus inpatient facilities serving remote locations to be provider-based departments (PBDs) may give these providers unwarranted payment advantages for inpatient services delivered far distances from the main provider campus. Under the existing rules, both off-campus inpatient and outpatient facilities can qualify as PBDs if located within 35 miles of the main hospital or, if farther away, meets one of two location tests. The two tests, the zip-code test²⁶ or the referral-based test,²⁷ are used to demonstrate that the site serves the same patient population as the main hospital. In the Proposed Rule, CMS indicates that it now interprets the referral-based test as being originally intended for isolated outpatient sites and is inappropriate for off-campus inpatient facilities, particularly those located more than 35 miles from the main hospital, because CMS believes it can create unwarranted payment advantages.

As a result, CMS proposes revising the provider-based regulations so inpatient off-campus facilities that are more than 35 miles of the main hospital can no longer use the referral-based test to show they serve the same patient population as the main hospital.²⁸ Under the proposal, off-campus inpatient facilities would only be allowed to use the zip-code test, while off campus outpatient facilities can continue using either method to demonstrate they serve the same patient population as the main provider. **CMS seeks comment on this proposal.**

Education

Proposed Removal of Restrictions on Experienced Faculty and Staff for New Residency Programs

²⁵ CMS explains that this change is needed to prevent manufacturers from extending NTAP eligibility for business reasons, such as extending NTAP payments longer than 2-to-3-year newness period.

²⁶ Facilities submit 12 months of data showing 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.

²⁷ 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).

²⁸ § 413.65)Requirements for a determination that a facility or an organization has provider-based status), <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-E/section-413.65>

Under current rules, CMS adjusts a hospital's GME and IME FTE caps only when a new residency program is established, and a program must have a new director, new teaching staff and new residents to qualify. In the Proposed Rule, CMS explains that prohibiting new programs from hiring experienced faculty or program directors is unnecessarily restrictive and that prior training experience already provides adequate safeguards against hospitals shifting existing programs or duplicating cap slots. CMS proposes, beginning on or after October 1, 2026, that the prior employment of faculty or a program director of new residency programs will no longer be considered when determining whether a residency program qualifies as new.

Proposed Requirement for New Residents

CMS proposes that for a residency program to be considered new, at least 90 percent of the individual residents must not have prior experience training in another program in the same specialty. For example, if a hospital establishes a new residency program in internal medicine, then, under this proposal, at least 90 percent of the residents in that program must not have previous training experience in another internal medicine program. The proposed requirement includes exceptions for small residency programs, displaced residents and residents admitted through a binding third-party matching program. **CMS asks for feedback on this proposal.**

Quality Programs

Cross-Program Proposals for the Hospital Inpatient Quality Reporting (IQR), Value-Based Purchasing (VBP) and the Medicare Promoting Interoperability Programs

Proposed Measure Adoption and Modifications

For the Hospital IQR, PCHQR and Medicare Promoting Interoperability Programs, CMS proposes to adopt the Advance Care Planning electronic clinical quality measure (eCQM) beginning with the CY 2028 reporting period/FY 2030 payment determination for the IQR and Medicare Promoting Interoperability Programs.²⁹ If this proposal is finalized, CMS proposes to publicly report data on the CMS [Care Compare](#) and the [CMS Provider Data Catalog](#) websites after a 30-day preview period. **CMS invites comments on this proposal.**

For the IQR and VBP Programs, CMS proposes adopting substantive measure updates to five condition-specific and procedure-specific mortality measures,³⁰ in the Clinical Outcomes domain. For the IQR program, these changes would start with the July 1, 2024 - June 30, 2026 performance period (FY 2028 payment determination). For the VBP Program, these changes would begin with the July 1, 2028 - June 30, 2030 performance period (FY 2032 program year).³¹ The proposed updates include expanding the measure inclusion criteria to include Medicare Advantage (MA) patients, shortening the performance period from three years to two years and moving to use individual ICD-10 codes instead of hierarchical condition categories (HCC) to improve the

²⁹ This measure 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). <https://ecqi.healthit.gov/ecqm/hosp-inpt/2028/cms1317v1>

³⁰ These measures include: 1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization (MORT-30-AMI) measure; 2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (MORT-30-HF) measure; 3) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT-30-PN) measure; 4) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT-30-COPD) measure; and 5) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT-30-CABG) measure.

³¹ A chart on pg. 664-665 of the [Proposed Rule](#) summarizes the proposed new performance periods for the Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program, beginning with the FY 2028 payment determination.

measure's risk adjustment methodology. CMS proposes that these updates are contingent upon the agency first adopting the same proposed refined mortality measures in the Hospital IQR Program beginning with the FY 2028 payment determination.³² **CMS invites public comment on these proposals.**

CMS also issued a Request for Information (RFI) asking for feedback on the possible adoption of the Measuring Emergency Care Access and Timeliness eCQM in both the VBP and IQR programs. CMS previously adopted this measure in the Hospital Outpatient Quality Reporting (OQR) Program for CY 2026 and is considering how best to measure care access and timeliness in the VBP and IQR programs. **CMS asks for feedback on whether to adopt the Measuring Emergency Care Access and Timeliness eCQM in the VBP and IQR programs as was adopted in OQR or modify the measure for inpatient use. Also, CMS invites comment on the potential use of the Emergency Care Access & Timeliness eCQM into VBP and IQR Programs.**

Hospital Readmissions Reduction Program (HRRP) Updates and Changes

The HRRP requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions. As required under law, hospitals are compared by peer groups based on the number of their Medicare-Medicaid dual-eligible beneficiaries (dual-eligibles) when determining the extent of excess readmissions. CMS proposes adopting one new measure to the HRRP.

Specifically, CMS proposes adopting the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure^{33,34} (Sepsis Readmission measure) for the HRRP beginning with "early look" reports for FY 2028.³⁵ CMS proposes that the Sepsis Readmission measure would be used for payment adjustment beginning with the FY 2029 program year, for which the applicable period is from July 1, 2025, to June 30, 2027. The Sepsis Readmission measure will include both Medicare and MA beneficiaries consistent with finalization of policy in the FY 2026 IPPS [Final Rule](#) to integrate MA data into the HRRP measure set beginning with the FY 2027 program year. Table V.I.-06 in the [Proposed Rule](#) (pg. 570-571) lists the comparison of proposed sepsis readmission measure in hospital readmissions reduction program by hospital characteristic. **CMS invites comment on these proposals including financial impacts related to post-discharge coordination, transition planning, or other areas associated with the acute clinical management of sepsis that hospitals may incur if this proposal is finalized.**

³² As required by law, CMS must first adopt updates to IQR and then Section 1886(o)(2)(C)(i) of the Social Security Act, https://www.ssa.gov/OP_Home/ssact/title18/1886.htm

³³ The numerator of the measure is defined as Medicare or MA beneficiaries aged 65 years 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. Patients must have been enrolled in Medicare Fee-for-Service or Medicare Advantage during the index admission and for the 12 months prior to the date of admission, discharged alive from a non-federal short-term acute care hospital, and not transferred to another acute care facility. Only an unplanned inpatient admission to a short-term acute care hospital can qualify as a readmission. Planned readmissions, which are generally not a signal of quality of care, are not included in the numerator.

³⁴ The measure denominator includes all Medicare or MA beneficiaries aged 65 years and older, hospitalized at non-federal short-term acute care hospitals who are discharged alive following a principal hospital discharge diagnosis of sepsis (including post-procedural sepsis), and with a continuous 12-month Medicare enrollment period prior to the index hospitalization. This measure excludes index admissions for patients who meet additional exclusion criteria, including: (1) admissions during which patients leave the hospital against medical advice (AMA) (excluded because providers may not have the opportunity to deliver full care and prepare the patient for discharge); (2) admissions for patients without at least 30 days post-discharge enrollment in Medicare or MA (excluded because the 30-day readmission outcome cannot be assessed in this group); (3) admissions resulting in patients discharged to hospice (readmission may not be a meaningful outcome for these hospice patients and the discharging hospital is not the most appropriate party to hold accountable for the readmission from hospice for this measure); (4) sepsis admissions captured in the pneumonia readmission measure (to avoid overlap with the pneumonia readmission measure); and (5) sepsis admissions within 30 days of an eligible sepsis index admission (excluded because they are considered readmissions, not index admissions).

³⁵ The applicable period is from July 1, 2024, to June 30, 2026. Data used in this early look period would not be publicly reported or used for payment adjustment.

Hospital Value-Based Purchasing Program (VBP)

The ACA established the Hospital VBP Program under which value-based incentive payments are made to hospitals that meet performance standards during specific performance periods. There are four Hospital VBP domains: Safety; Clinical Outcomes; Efficiency and Cost Reduction; and Person and Community Engagement. For FY 2027, CMS estimates that the total amount available for value-based incentive payments is approximately \$1.9 billion, based on the December 2025 update of the MedPAR file.

See the discussion [above](#) for CMS's cross-program proposals, including those affecting the Hospital VBP Program.

Hospital-Acquired Condition Reduction Program (HACRP) Updates and Changes

The ACA established the HACRP to reduce the incidence of hospital acquired conditions (HACs) by requiring hospitals to report on a set of measures (CMS Patient Safety and Adverse Events Composite (PSI 90) and the Centers for Disease Control and Prevent National Healthcare Safety Network Healthcare Associated Infection (HAI) measures). CMS notes that it is not proposing to add or remove any measures or proposing any changes to reporting or submission requirements in the Proposed Rule for the HACRP.

Hospital IQR Program

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. To receive the full payment increase under the Hospital IQR Program, hospitals must report data on measures selected by the Secretary of the Department of Health and Human Services for each fiscal year.

Proposed New Measures for the Hospital Inpatient Quality Reporting Program Measure Set

CMS proposes adoption of a new Excess Days in Acute Care After Hospitalization for Diabetes measure³⁶ to the Hospital IQR Program measure set beginning with the July 1, 2025 - June 30, 2027 performance period (FY 2029 payment determination). CMS proposes use of both Medicare and MA data and use of a two-year performance window. CMS explains this measure was proposed because there are currently no publicly reported measures of post-discharge care utilization for patients hospitalized for diabetes in the Hospital IQR Program.

CMS also proposes adoption of a new Hospital Harm—Postoperative Venous Thromboembolism (VTE) eCQM measure³⁷ to the Hospital IQR Program measure set beginning with the CY 2028 reporting period/FY 2030 payment determination as an option for self-selection.³⁸ CMS proposes

³⁶ This is an 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. https://p4qm.org/prmr-measures/muc2025-053?utm_source=copilot.com

³⁷ This is an outcome measure that assesses the proportion of inpatient hospitalizations for patients age 18 and older who have at least one surgical procedure performed inside the operating room during the admission, and who suffer the harm of a postoperative VTE during hospitalization or within 30 days after the first surgical procedure, <https://p4qm.org/measures/5325e>

³⁸ For self-selection participating hospitals may select the Hospital Harm—Postoperative VTE measure as one of the three self-selected eCQMs to be reported in addition to three mandatory eCQMs. A full list of eCQMs available for self-selection can be found on pg 733-735 of the [Proposed Rule](#).

this measure become mandatory beginning with the CY 2030 reporting period/FY 2032 payment determination.

Proposed Removals in the Hospital IQR Program Measure Set

CMS proposes removing three measures from the Hospital Inpatient Quality Reporting Program beginning with the CY 2028 reporting period/FY 2030 payment determination: (1) Venous Thromboembolism Prophylaxis (VTE-1) eCQM; (2) Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM; and (3) Discharged on Antithrombotic Therapy eCQM.

Proposed Refinements to Current Measures in the Hospital IQR Program Measure Set

CMS proposes refinements to three measures that are currently in the Hospital IQR Program measure set: (1) Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction measure; (2) Excess Days in Acute Care after Hospitalization for Heart Failure measure; and (3) Excess Days in Acute Care after Hospitalization for Pneumonia measure, beginning with the July 1, 2024 - June 30, 2026 performance period (FY 2028 payment determination). For all three measures, CMS proposes expanding the measures' inclusion criteria to include MA patients and shortening the performance period from 3 years to 2 years, beginning with the FY 2028 payment determination.

Proposed Update to the Maternal Morbidity Structural Measure

CMS proposes updating hospital reporting requirements for the Maternal Morbidity Structural Measure. Specifically, if a hospital answers "yes" to the measure as currently specified, the hospital will also need to report the name of the perinatal quality improvement collaborative program.³⁹ If a hospital attests "yes" but fails to list the perinatal quality improvement collaborative they participate in, CMS will treat the measure as not fully reported, and the hospital will receive a payment penalty.

Cross Program Proposals for Mandatory Reporting of the Malnutrition Care Score eCQM^{40,41}

The Malnutrition Care Score eCQM was initially adopted in the FY 2023 IPPS [Final Rule](#) into the Hospital IQR Program measure set from which hospitals could self-select beginning with the CY 2024 reporting period/FY 2026 payment determination. Given the agency's focus on well-being and nutrition and consistent with CMS's transition to fully digital quality measurement, CMS now proposes mandatory reporting of this measure with the CY 2028 reporting period/FY 2030 payment determination. CMS clarifies that hospitals may continue to self-select the measure for CY 2026 and CY 2027 before mandatory reporting begins.

Cross Program Proposals for Mandatory Reporting of the Hospital Harm eCQMs in IQR and Medicare Promoting Interoperability Programs

CMS proposes expanding its stepwise approach of gradually increasing the number of Hospital Harm eCQMs hospitals are required to report for the Hospital Harm IQR Program. Specifically, CMS proposes that beginning with the CY 2028 reporting period/FY 2030 payment determination, Hospital Harm eCQMs that have not yet been finalized for mandatory reporting will become

³⁹ If a hospital selects "yes" in response to the measure, the hospital would also be prompted to report a response to the following: "Which Statewide and/or National Perinatal Quality Improvement Collaborative Program does the hospital participate in?"

⁴⁰ [Maternal Morbidity Structural efaidnbmnnnibpcajpcgclefindmkaj/Maternal Morbidity Structural](#)

⁴¹ CMS adopted the Maternal Morbidity Structural measure beginning with the FY 2023 payment determination.

mandatory in the third year of reporting. Under this proposal, the Hospital Harm—Falls with Injury⁴² and the Hospital Harm—Postoperative Respiratory Failure⁴³ eCQMs would begin mandatory reporting in the CY 2028 reporting period/FY 2030 payment determination. CMS also proposes that the Hospital Harm— Postoperative VTE eCQM, proposed for adoption in the IQR Program outlined [above](#), would become mandatory to report beginning with the CY 2030 reporting period/FY 2032 payment determination, after being available for 2 years of optional self-selected reporting.

Furthermore, CMS proposes that in subsequent years, newly adopted Hospital Harm eCQMs would become mandatory eCQMs for reporting after 2 years of self-selected reporting in both the Hospital IQR Program and the Medicare Promoting Interoperability Programs.⁴⁴ Proposed eCQM changes to the Medicare PI Program are summarized [below](#).

Requests for Information

CMS issued two Requests for Information (RFIs) asking for feedback on the potential future adoption of the Adult Community-Onset Sepsis Standardized Mortality Ratio Measure and on improving the Birthing-Friendly Hospital Designation.

Specifically, CMS asks for input on the potential use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the IQR Program to help measure progress on improving the care of patients with sepsis. This measure is currently being developed as a digital quality measure (dQM) to enable real-time, automated reporting through Centers for Disease Control's (CDC) [National Healthcare Safety Network's](#) (NHSNLink) application programming interface (API). The questions for this RFI are found in the [Proposed Rule](#) (pg. 691-692).

Also, CMS asks for feedback on potential modifications to the Birthing-Friendly Hospital Designation adopted in the FY 2023 IPPS [Final Rule](#). Specifically, CMS requests information on the inclusion of the Cesarean Birth and the Severe Obstetric Complications eCQMs in the criteria for awarding the Birthing-Friendly Hospital Designation and a modified scoring methodology developed for the expanded designation. Questions regarding this RFI can be found in the [Proposed Rule](#) (pg. 744-745).

Proposed Changes to the Medicare Promoting Interoperability Program⁴⁵

In 2011, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established to encourage eligible professionals, eligible hospitals and critical access hospitals (CAHs) to adopt, implement, upgrade and demonstrate meaningful use of certified EHR technology (CEHRT). In recent years, the Medicare and Medicaid EHR Incentive Programs have evolved and are now known as the Medicare Promoting Interoperability (PI) Program. Under the Medicare PI Program, downward payment adjustments are applied to eligible hospitals and CAHs that do not successfully demonstrate meaningful use of CEHRT for certain associated EHR reporting periods. CMS explains that several of the Proposed Rule's proposals align with those included in the Office

⁴² [Hospital Harm - Falls with Injury | eCQI Resource Center](#)

⁴³ [Hospital Harm - Postoperative Respiratory Failure | eCQI Resource Center](#)

⁴⁴ A chart on pg. 753 of the [Proposed Rule](#) summarizes the proposed policies on reporting eCQMs for the CY 2028 reporting period/payment determination and subsequent years.

⁴⁵ Table IX.F.-06 on pg. 839- 851 of the [Proposed Rule](#) lists objectives and measures for the Medicare Promoting Interoperability Program for the EHR reporting period in CY 2027 and reflects the proposals in this proposed rule as well as proposed changes that would go into effect for the EHR reporting period beginning with CY 2027 and subsequent years.

of the National Coordinator for Health Information Technology (ONC) Health Data, Technology, and Interoperability: ONC Deregulatory Actions to Unleash Prosperity (HTI-5) [Proposed Rule](#).^{46,47}

Proposed Updates to the Definition of Certified Electronic Health Record Technology in the Medicare Promoting Interoperability Program⁴⁸

CMS proposes updating the definition of Certified Electronic Health Record Technology (CEHRT) for the Medicare PI Program to align with certain proposals in ONC's HTI-5 Proposed Rule, including removal of several ONC certification criteria. Therefore, CMS proposes deleting references to four specific criteria, "family health history", "patient health information capture", "automated numerator recording" and "automated measure calculation", from the CEHRT definition, effective January 1, 2027. If finalized, hospitals and CAHs would no longer be required to use EHR technology certified to these functions to meet CEHRT requirements. The revised CEHRT definition would reflect the updated ONC certification framework while maintaining the requirement to use EHR technology certified to the applicable Base EHR definition and other criteria needed to be a meaningful EHR user. In addition, CMS explains that while its proposal is consistent with ONC's HTI-5 framework, the agency will not rely on ONC's timeline and will independently finalize the CEHRT definition updates for the Medicare PI Program.

Proposal to Remove ONC Direct Review and ONC-Authorized Certification Body (ONC-ACB) Surveillance Attestations

CMS proposes removing the required ONC Direct Review attestation⁴⁹ and the optional ONC-ACB Surveillance attestation⁵⁰ from the Medicare PI Program. These changes would be effective with the data submission period beginning January 1, 2027. If this proposal is finalized, eligible hospitals and CAHs will not have to report on these attestations by the March 1, 2027 submission deadline and this update would not have an effect on hospitals' FY 2028 payment determination or FY 2026 cost reimbursement.

⁴⁶ Table IX.F.-01 on pg. 793 of the [Proposed Rule](#) the potential impact on Medicare Promoting Interoperability Program participants of the proposed certification criteria removals and revisions in the HTI-5 Proposed Rule.

⁴⁷ The HTI-5 proposed rule would change which ONC certification criteria count toward the CEHRT definition used in the Medicare Promoting Interoperability Program by removing or revising several requirements. ONC proposes eliminating multiple criteria within the Base EHR definition—such as implantable device lists and certain transport protocol functions—which would mean hospitals and CAHs would no longer need CEHRT that includes those capabilities. ONC also proposes removing four criteria explicitly referenced in the CEHRT definition, including family health history and automated measure calculation. Additional criteria that support specific Promoting Interoperability measures, such as those tied to providing patients electronic access to their health information, would be revised or removed, narrowing the required functionality for reporting. Some public health-related criteria would be removed or updated, shifting toward more flexible, functional requirements rather than specific standards.

⁴⁸ CMS notes that the certification criteria proposed for removal—such as family health history, patient information capture, and automated measure-calculation functions—are already standard features in certified health IT, so eliminating them will not reduce functionality. Developers are expected to continue supporting these capabilities, and they will still need to enable numerator and denominator reporting for Promoting Interoperability measures. CMS believes removing these requirements will reduce developer burden without affecting hospitals' ability to meet program reporting needs.

⁴⁹ Eligible hospitals and critical access hospitals (CAHs) must affirm cooperation with ONC Direct Review of their CEHRT by: (1) acknowledging the requirement to cooperate in good faith with ONC direct review of their health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and (2) if requested, cooperate in good faith with ONC direct review of their health information technology certified under the ONC Health IT Certification Program. The ONC Direct Review attestation is currently a required element of the Medicare Promoting Interoperability Program; submitting a "Yes" response, or claiming an applicable exclusion are the only means to fulfill the requirements of the attestation. The submission of a "No" response results in the eligible hospital or CAH failing to meet the attestation. If so, the eligible hospital or CAH would consequently fail to meet minimum program requirements and not be considered a meaningful EHR user for the EHR reporting period, subjecting it to a downward payment adjustment.

⁵⁰ Eligible hospitals and CAHs may also attest that they engaged in supporting providers with the performance of CEHRT activities by attesting that they: (1) acknowledge the option to cooperate in good faith with ONC-ACB surveillance of their health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received; and (2) if requested, cooperated in good faith with ONC-ACB surveillance of their health information technology certified under the ONC Health IT Certification Program. The ONC-ACB Surveillance attestation is optional: a "Yes" response on the attestation, a "No" response on the attestation, or non-response are all acceptable answers with respect to whether an eligible hospital or CAH is considered a meaningful EHR user for the EHR reporting period.

Proposal to Remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information Measures

In the Proposed Rule, CMS proposes removing the Support Electronic Referral Loops by Sending Health Information and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measures beginning with the EHR reporting period in CY 2028. The agency explains that this proposal streamlines reporting and reduces the complexity of multiple measure reporting options for the Health Information Exchange (HIE) objective. If this proposal is finalized, eligible hospitals and CAHs would fulfill requirements in the HIE objective by attesting “Yes” to either the HIE Bi-Directional Exchange measure⁵¹ or the Enabling Exchange Under TEFCA measure.⁵²

Proposed Updates to the Electronic Prior Authorization Measure

CMS introduces several refinements to the Electronic Prior Authorization (PA) measure, including updates to the measure’s language, how the measure will rely on ONC-certified PA capabilities, delaying adoption of the measure for one year and making adoption of the measure mandatory in CY 2028. **CMS requests feedback on how this measure could transition into a performance-based requirement in future years and seeks comments on potential expansions to the Electronic PA measure described below.**

Proposal to Make the Electronic PA Measure a Bonus Measure for the EHR Reporting Period in CY 2027

For CY 2027, CMS proposes delaying mandatory reporting of the Electronic PA measure to CY 2028 and making a bonus measure worth 10 bonus points. If this proposal is finalized, hospitals that attest “Yes” in CY 2027 would earn 10 bonus points, while hospitals attesting “No” would not be penalized and would still be considered meaningful EHR users. Further, exclusions would not be available for the Electronic PA measure for the EHR reporting period in CY 2027, as exclusions are unnecessary for optional measures.

Requests for Comment on Additional Expansion of the Electronic Prior Authorization Measure

CMS is exploring two potential expansions of the Electronic PA measure and is seeking public comment, but it is not yet proposing policy changes. CMS is considering allowing hospitals to satisfy the Electronic PA measure simply by using CEHRT to check whether PA is required, even if they do not submit a request. **CMS seeks comment on whether this added flexibility would help hospitals, particularly those beginning with the “coverage requirements discovery” functionality. CMS is also considering whether to include PA for drugs administered during the hospitalization in the measure and requests comment on whether this would be helpful.**

Proposal to Adopt Unique Device Identifiers for Implantable Devices Measure Beginning with the EHR Reporting Period in CY 2027⁵³

⁵¹ [Health Information Exchange \(HIE\) Bi-Directional Exchange](#)

⁵² [Enabling Exchange Under the Trusted Exchange Framework and Common Agreement™ \(TEFCA™\)](#)

⁵³ For this measure, eligible hospitals and CAHs would be required to attest “Yes” or “No” to meet measure requirements or claim an applicable exclusion. Not providing a “yes” or “no” attestation would result in failure to meet minimum program requirements, and the eligible hospital or CAH would be subject to a downward payment adjustment. No points will be assigned to this measure; rather, it would be one of seven measures required to satisfy the Public Health and Clinical Data Exchange objective. CMS proposes to allow both “Yes” and “No” responses to fulfill measure initially, to allow eligible hospitals and CAHs to become familiar with the concept of UDI, but highlights that the agency intends to propose modifying the measure in future rulemaking.

CMS proposes a Unique Device Identifiers for Implantable Devices Measure beginning with the CY 2027 EHR Reporting Period, requiring hospitals and CAHs to use CEHRT to electronically capture and store the full Unique Device Identifier (UDI) for each implantable medical device used in patient care. CMS proposes one exclusion for this measure and asks for comments on any additional exclusions that should be considered.⁵⁴ **If this proposal is finalized, CMS plans to consider future updates to the UDIs for Implantable Devices Measure and is requesting comment on how to design a performance-based measure that reflects meaningful use of UDI data, and how to address appropriate future UDI capture and exchange.**

Clinical Quality Measurement for Eligible Hospitals and CAHs Participating in the Medicare Promoting Interoperability Program

Proposals to Adopt and Remove eCQMs and Modify the eCQM Reporting and Submission Requirements to Align with the Hospital IQR Program

CMS proposes to align the Medicare Promoting Interoperability Program with the Hospital IQR Program as mentioned [above](#), by adopting similar eCQM updates beginning with the CY 2028 reporting period. Specifically, CMS would add two new eCQMs, the Hospital Harm: Postoperative Venous Thromboembolism and Advance Care Planning measures to the Medicare PI Program. CMS also proposes to remove three existing eCQMs: (1) Discharged on Antithrombotic Therapy; (2) Venous Thromboembolism Prophylaxis eCQM; and (3) Intensive Care Unit Venous Thromboembolism Prophylaxis. Further, to align with proposals in the Hospital IQR Program, CMS proposes requiring the Hospital Harm – Falls with Injury and Hospital Harm – Postoperative Respiratory Failure eCQMs to be self-selected for reporting in CY 2028 and CY 2029, becoming mandatory beginning in CY 2030. CMS also proposes to require mandatory reporting of the Malnutrition Care Score eCQM beginning with the CY 2028 reporting period.⁵⁵

Proposed Expansion of the Comprehensive Joint Replacement (CJR) Model

In conjunction with the release of the FY 2027 IPPS Proposed Rule, the Centers for Medicare and Medicaid Innovation (CMMI) announced the proposed expansion of the [CJR Model](#) known as the [Comprehensive Care for Joint Replacement Expanded \(CJR-X\) Model](#) ([Fact Sheet](#)), a mandatory episode of care model. If finalized, all eligible hospitals, except hospitals in Maryland, those participating in the Transforming Episode Accountability Model (TEAM) and other hospital types listed [below](#) would be required to participate in the CJR-X model beginning October 1, 2027. CMS notes that this model uses two-sided risk where participants could receive a reconciliation payment amount from CMS or pay CMS a repayment amount based on their spending and quality performance. CMS projects CJR-X would generate \$128 million in Medicare savings for performance year (PY) 1; \$132 million in savings in PY 2; and \$136 million in PY 3. In PYs 4 and 5, projected savings increase to \$159 million and \$170 million, respectively.⁵⁶

Overview of Proposed Expansion of the Comprehensive Care for Joint Replacement (CJR) Model

The CJR Model was a mandatory alternative payment model tested by CMMI from April 1, 2016 - December 31, 2024 in eligible hospitals within selected Metropolitan Statistical Areas (MSAs). The

⁵⁴ The exclusion is: a hospital or CAH may claim an exclusion if it implanted *five or fewer* medical devices subject to UDI requirements during the calendar year of the EHR reporting period.

⁵⁵ Table IX.F.-8 on pg. 856-857 of the [Proposed Rule](#) summarizes the proposed policies to modify reporting and submission requirements for eCQMs beginning with the CY 2028 reporting period.

⁵⁶ Table K-CL-01 in the [Proposed Rule](#) (pg. 1526) shows the projected financial impacts of CJR-X over a 5-year period, with estimated savings to Medicare in each performance year.

CJR Model aimed to improve quality and support more efficient care for beneficiaries undergoing lower extremity joint (hip and knee) replacements (LEJR).⁵⁷ Based on data indicating that CJR reduced spending without compromising quality, CMMI determined the CJR model meets the requirements for expansion.⁵⁸

Model Performance Period

CMS proposes that CJR-X would begin on October 1, 2027, with PYs aligned to the fiscal year (FY) cycle. Because the IPPS also follows an FY schedule, CMS anticipates that future CJR-X policy updates would be issued through the IPPS rulemaking. Under this proposal, the first CJR-X PY would run from October 1, 2027 through September 30, 2028, with subsequent PYs following the same annual FY timeline. CMS considered a later start date to allow additional time for CJR-X participants to prepare for the model, however, the agency ultimately decided to limit the amount of time between the final CJR Model PY and the model test as CJR-X. **CMS requests comment on the proposals to define “performance year” as aligning with FYs, beginning the model on October 1, 2027 and comments on alternative model start dates.**

Proposed Participants

CMS proposes that acute care hospitals be the CJR-X participants and the only entities able to initiate an episode. Specifically, CMS proposes defining a CJR-X participant as an acute care hospital located in any of the 50 United States (minus Maryland), the District of Columbia or a U.S. territory that initiates LEJR episodes and is paid under both the IPPS and OPSS.

Proposed Episodes

CMS proposes that CJR-X would include inpatient hip, knee and ankle replacements paid under the IPPS through specific MS-DRGs and outpatient hip and knee replacements billed under select Healthcare Common Procedure Coding System (HCPCS) codes through the OPSS. CMS proposes excluding outpatient ankle replacements from CJR-X. For hospital transfers, if the initial hospitalization is assigned to an included MS-DRG, a transfer would not trigger a new episode. If the first hospitalization is for a non-included MS-DRG, and the beneficiary is transferred and discharged under an included MS-DRG at the second hospital, the second hospitalization would initiate the episode. CMS notes that outpatient ankle replacements are currently being tested in TEAM and may be added to CJR-X in the future through notice-and-comment rulemaking.

CMS proposes to identify episodes using MS-DRG codes assigned to the anchor hospitalization or the HCPCS codes for qualifying outpatient procedures. Under the proposal, LEJR episodes would be triggered by MS-DRGs 469, 470, 521 and 522 for inpatient stays, and HCPCS codes 27130 and

⁵⁷ The CJR Model was initially designed to end on December 31, 2020, but was extended to 2024 with modifications to the methodology. It 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 PY. All providers and suppliers furnishing LEJR episodes of care to patients throughout the year were paid under existing Medicare payment systems. The target price included a discount that served as Medicare's portion of reduced expenditures from the LEJR episode, and initially incorporated a blend of historical, hospital-specific spending and regional spending for LEJR episodes, with the regional component of the blend increasing over time and eventually being 100 percent regional for PYs 4 through 8. Following the end of a CJR Model PY, actual total spending for a hospital's episodes was compared to the target price for those episodes. Depending on the participant hospital's quality and episode spending performance, the hospital could receive an additional payment from Medicare if spending was less than the target price or be required to repay Medicare for a portion of the episode spending that exceeded the target price.

⁵⁸ CMS notes that the seventh annual evaluation report found that the CJR Model had produced \$112.7 million in net savings to Medicare across CJR Model PYs 6 and 7.

27447 for outpatient procedures.⁵⁹ CMS acknowledges that final MS-DRG assignments may change after discharge, in which case participants would rely on CMS-shared data to confirm attribution.

CMS seeks comment on this proposal.

Also, CMS proposes to define episodes as including all Medicare Part A and Part B items and services,⁶⁰ with some exceptions, beginning with an admission to an acute care hospital stay or date of the procedure (“the anchor hospitalization”) or an outpatient procedure at a hospital outpatient department (HOPD) (“anchor procedure”), and ending 90 days following hospital discharge or anchor procedure.⁶¹ Day 1 is defined as the date of the outpatient procedure or the discharge date for inpatient cases. **CMS requests comment on the definition of episodes.**

CMS proposes that items and services for episodes would include the following items and services under Medicare Part A and Part B (subject to certain exclusions). **CMS seeks comment on the items and services potentially included in CJR-X:**

- 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
- Hospice services
- Part B professional claims dated in the 3 days prior to an anchor hospitalization if a claim for the surgical procedure is not detected as part of the hospitalization because the procedure was performed by the participant on an outpatient basis, but the patient was subsequently admitted as an inpatient.

CMS proposes exclusion from episodes certain Part A and B items and services that are clinically unrelated to a LEJR procedure, applying these exclusions both to the baseline period used for target price setting and to performance year episodes. Specifically, CMS proposes to exclude for specific categories of diagnoses, such as oncology, trauma medical admissions, organ transplant and ventricular shunts determined by MS–DRGs, and certain excluded Major Diagnostic Categories (MDCs).⁶² Additional information regarding exclusions is available in the [Proposed Rule](#) (pg. 931-934). **CMS also seeks comment on the proposed excluded services and the process for updating the list of excluded services for CJR-X.**

⁵⁹ MS-DRGs 469 (Major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)); 470 (Major joint replacement or reattachment of lower extremity without MCC); 521 (Hip replacement with principal diagnosis of hip fracture with MCC); 522 (Hip replacement with principal diagnosis of hip fracture without MCC); HCPCSs 27447 (Total knee arthroplasty); 27130 (Total hip arthroplasty)

⁶⁰ Items and services as described in 512.625(c).

⁶¹ In the case that an anchor hospitalization for the same episode type occurs within 3 days of an anchor procedure (for example, an outpatient procedure is later converted to an inpatient admission), the anchor procedure episode is canceled, and the episode start date for the anchor hospitalization is the same as the outpatient procedure.

⁶² MDCs are formed by dividing all possible principal diagnoses (from ICD-10-CM) into 25 mutually exclusive diagnosis areas. The diagnoses in each MDC correspond to a single organ system or etiology and in general are associated with a particular medical specialty. CMS proposes to exclude: MDC 02 (Diseases and Disorders of the Eye); MDC 14 (Pregnancy, Childbirth, and Puerperium); MDC 15 (Newborns); and MDC 25 (Human Immunodeficiency Virus).

CMS also proposes circumstances in which an episode may be cancelled (e.g., beneficiary no longer meets criteria for inclusion, beneficiary death during the anchor hospitalization or anchor procedure or if the beneficiary is in a TEAM episode and has a LEJR procedure at a CJR-X participant during the 90-day post-discharge period after a TEAM anchor hospitalization or anchor procedure). In addition, CMS proposes that when an episode is cancelled, Medicare would continue to pay for services furnished before and after the cancellation, but no episode spending calculation would occur and no reconciliation against the target price would be performed.

Proposed Beneficiary Population

CMS proposes that the CJR-X model would include care for beneficiaries who, at the time of their admission for an anchor procedure or anchor hospitalization, meet the following criteria: 1) Is enrolled in Medicare Part A and Part B; 2) Has Medicare as their primary payer; 3) Is not eligible for Medicare on the basis of end-stage renal disease; 4) Is not enrolled in any managed care plan (for example, MA, Health Care Prepayment Plans, cost-based health maintenance organizations); and 5) Is not covered under a United Mine Workers of America health plan. The agency acknowledges that a CJR-X episode may begin for a beneficiary who later stops meeting the inclusion criteria and, in these situations, CMS proposes to cancel the episode. **The agency asks for feedback on both the beneficiary inclusion criteria and the proposal to cancel episodes when a beneficiary no longer meets those criteria.**

As a beneficiary safeguard, CMS proposes requiring each CJR-X participant to provide written notification to CJR-X beneficiaries explaining any potential impact on the beneficiary's care, describing care options, how beneficiaries can access their records and claims data and identifying CJR-X collaborators with whom the participant has a sharing arrangement. Participants may satisfy the collaborator-list requirement by providing a publicly available web address where beneficiaries can access the full participant list. The beneficiary notice must be provided no later than the first time the beneficiary receives an item or service from the collaborator during an episode or as soon as reasonably possible if the beneficiary's condition prevents immediate notification. **CMS invites comment on the proposed requirements for notification to CJR-X beneficiaries and on the considerations to not require CJR-X beneficiary notifications.**

Proposed Quality Measures and Scoring

The proposed CJR-X quality measures build on the three measures used in the original CJR Model,⁶³ along with two new measures to account for the high percentage of hospital outpatient LEJR procedures. Table X.A.-05 of the [Proposed Rule](#) (pg. 955-956) includes a summary of proposed quality measure performance periods by year in CJR-X. **CMS seeks comment on the following measures proposed starting in PY 1 of CJR-X:**

- Hospital-level Risk-Standardized Complication Rate (RSCR) following elective primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (CMIT ID #350)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) (CMIT ID #338)
- Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome (PRO)-Based Performance Measure (PRO-PM) (CMIT ID #1618)
- Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems Survey (OAS CAHPS) (CMIT ID #162) **(NEW)**

⁶³ The inpatient quality measures carried over from the CJR model include: 1) Hospital-level RSCR for elective THA/TKA; 2) HCAHPS (inpatient patient experience survey); and 3) THA/TKA PRO-PM (patient-reported outcome performance measure that was voluntary in CJR) <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-H/part-510/subpart-E/section-510.400>

- Hospital Visits Within 7 days of Hospital Outpatient Department (HOPD) Surgery (CMIT ID #344, OP-36) **(NEW)**

CMS proposes to display CJR-X quality measure results on the publicly available CMS website, but CMS would share each CJR-X participant's quality metrics with the hospital prior to being publicly displayed. CMS anticipates publicly reporting PY 1 results in calendar year 2029 and continuing annual reporting with roughly a one-year lag. CMS proposes to collect quality measure data through the existing mechanisms of the Hospital IQR and HAC Reduction Program.

Composite Quality Score (CQS)

CMS proposes to establish a CQS for CJR-X that combines a hospital's performance across all inpatient and outpatient CJR-X quality measures into one overall score. This score would be used in the CJR-X payment methodology to determine the hospital's discount factor and, ultimately, its reconciliation target price. CMS proposes to evaluate CJR-X participants' quality performance by comparing each hospital's results on the required measures to the national distribution of hospitals reporting those same measures, using only hospitals that meet minimum case or survey counts. At reconciliation, each hospital's measure result would be converted into a national performance percentile and this percentile-based scoring approach would apply to all five proposed CJR-X quality measures. Table X.C-03 in the [Proposed Rule](#) (pg. 961) displays the proposed quality measures and associated quality domain weights.

CMS is proposing that each CJR-X participant be scored on all five required quality measures by converting its performance percentile, based on the national distribution of hospitals reporting the same measure, into a set number of quality points using the point values outlined in Table X.C-04 in [Proposed Rule](#) (pg. 962). Once a hospital's result is placed into a national percentile, CMS would translate that percentile into a standardized point score for the CQS.

CMS proposes to award quality points using small, incremental increases across performance deciles so that hospitals demonstrating meaningfully higher quality receive proportionally more points, with each measure's point spread reflecting its weight in the CQS. After assigning points for each measure, CMS would sum the inpatient measure points,⁶⁴ capped at 20 points, to create an inpatient composite score and sum the outpatient measure points,⁶⁵ also capped at 20 points, to create an outpatient composite score.

Model Participant Exclusions

CMS proposes excluding hospitals that are currently TEAM participants from CJR-X until the TEAM model concludes in 2030 or the hospital no longer meets the TEAM participant definition. At that point, any hospital meeting the CJR-X participant criteria would transition into CJR-X.

Also, CMS proposes excluding acute care hospitals in Maryland, citing the state's unique rate-setting authority and the fact that CJR-X's regional pricing methodology would not accurately reflect episode spending for Maryland hospitals. CMS indicates it may revisit this exclusion through future rulemaking to allow Maryland hospitals to participate in CJR-X while also participating in AHEAD.

Further, Indian Health Service (IHS) and Tribal hospitals are excluded from CJR-X participation as they are paid under the IPPS but not the OPSS. Similarly, CMS proposes that hospitals participating

⁶⁴ Defined as the sum of inpatient quality measure point values capped at 20 points

⁶⁵ Defined as the sum of outpatient quality measure points values, capped at 20 points.

in the Rural Community Hospital Demonstration, Critical Access Hospitals and Rural Emergency Hospitals would be excluded from CJR-X because they are not paid under IPPS.

Pricing and Payment Methodology

CMS details the CJR-X pricing and payment methodology in the Proposed Rule and specifically address the following topics with several additional questions posed for stakeholder feedback, some of which are noted in Table 3 below.

Table 3. CJR-X Pricing and Payment Proposals

Topic	Additional Information
<p>Target Prices (Proposed Rule pg. 969-987)</p>	<p>CMS seeks comment on using three years of baseline episode spending to calculate benchmark prices. For PY 1, baseline spending would be drawn from episodes with anchor hospitalization or procedure dates on or after October 1, 2023, and discharge or procedure dates through September 30, 2026. For PY 2 and future years, CMS would continue using a rolling three-year baseline. CMS also proposes adjusting baseline episode spending to be expressed in the dollars of the most recent baseline year. A “baseline year” would be any of the three fiscal years in the baseline period. To make spending comparable, CMS would calculate how much spending changed from baseline years 1 and 2 to year 3, then apply those adjustment factors so earlier-year spending is converted into “year 3 dollars.” Because more recent spending better predicts future costs, CMS proposes weighting the three baseline years at 17% for year 1, 33% for year 2, and 50% for year 3, ensuring that the most current spending patterns have the greatest influence on benchmark prices under CJR-X.</p> <p>CMS seeks comment on calculating target prices at the region/episode category level, among other topics related to target prices (e.g., services that extend beyond an episode, episodes that span PYs; high-cost outlier cap; discount factor, low volume hospitals, trending prices, preliminary target prices)</p>
<p>Risk Adjustment and Normalization (Proposed Rule pg. 987-994)</p>	<p>CMS seeks comment on proposals for risk adjusting episodes.⁶⁶</p>
<p>Incorporating the Composite Quality Score (CQS) into the Reconciliation Amount (Proposed Rule pg. 1000-1003)</p>	<p>CMS asks for comment on the proposal include a 2.0% discount factor in CJR-X preliminary target prices. CMS would adjust this discount factor at reconciliation based on each participant’s Composite Quality Score, placing hospitals into four categories, Excellent, Good, Acceptable, and Below Acceptable, which determines both eligibility for reconciliation payments and the size of any discount factor reduction.⁶⁷</p>
<p>Participant Responsibility for Increased Post-Episode</p>	<p>CMS seeks comment on the proposal to make CJR-X participants responsible for making repayments to Medicare based on high spending in the 30 days after the end of the episode. Also, CMS seeks feedback on the proposed methodology to calculate the threshold for high post-episode spend.</p>

⁶⁶ This could include using baseline data to calculate risk adjustment multipliers, participants would be provided with these risk adjustment multipliers prior to the start of the performance year, risk adjustment multipliers would be calculated at the MS-DRG level, resulting in a separate set of risk adjustment multipliers for each MS-DRG episode type; incorporating a prospective normalization factor into preliminary target prices, which would be subject to a limited adjustment at reconciliation.

⁶⁷ To receive a reconciliation payment when actual episode spending is below the reconciliation target price, a participant must achieve a minimum Composite Quality Score of at least 6.1. Participants scoring 6.0 or below (“Below Acceptable”) would not qualify for a discount factor reduction or a reconciliation payment, though they would still owe repayments if spending exceeds the target price. Participants scoring 6.1 to 12.0 (“Acceptable”) would be eligible for reconciliation payments but would retain the full 2.0% discount factor. Participants scoring 12.1 to 17.0 (“Good”) would qualify for a reduced 1.0% discount factor, increasing their reconciliation payment or reducing repayment liability. Participants scoring 17.1 or higher (“Excellent”) would receive a 0.0% discount factor, maximizing their potential reconciliation payment or minimizing repayment responsibility. CMS believes this structure encourages hospitals to achieve meaningful quality performance while preventing inappropriate reductions in care.

Payments (Proposed Rule pg. 1005-1006)	
Reconciliation Payments and Repayment (Proposed Rule pg. 1007-1007)	CMS seeks comment on the proposal to make reconciliation payments to, and collect repayment amounts from, CJR-X participants as a one-time, lump sum payment.

CMS proposes to allow beneficiaries to participate in both CJR-X and total cost-of-care or shared-savings models (such as the Medicare Shared Savings Program), with each model retaining its own savings or losses and without adjusting for overlap, in order to simplify participation and avoid the confusing recoupment mechanisms used in earlier models like CJR and BPCI. Under this approach, CJR-X episode spending would count toward an ACO’s total expenditures, but CJR-X reconciliation payments or repayments would not, and ACO savings or losses would not affect CJR-X episode spending.

Financial Arrangements

CMS proposes giving CJR-X participants flexibility to share reconciliation payments or repayment amounts with outside providers and to offer beneficiary incentives that support recovery. CMS also outlines how hospitals can enter financial arrangements with providers, suppliers, and certain organizations involved in CJR-X activities so they can share in financial results. Under the proposal, these partners would be called “CJR-X collaborators.”

CMS proposes a list of providers and suppliers that are Medicare-enrolled and eligible to participate in Medicare or entities that are participating in a Medicare ACO initiative that may be CJR-X collaborators in the [Proposed Rule](#) (pg. 1015-106). **CMS seeks comment on the proposed definition of CJR-X collaborators and any additional Medicare-enrolled providers or suppliers, such as Rural Emergency hospitals, Rural Health Clinics, and Federally Qualified Health Centers, that should be included in this definition.**

Sharing Arrangements

Similar to the CJR Model, CMS proposes that certain financial arrangements between a CJR-X participant and a CJR-X collaborator be termed as “sharing arrangements.” CMS proposes where a payment from a CJR-X participant to a CJR-X collaborator is made pursuant to a sharing arrangement, CMS proposes to define that payment as a “gainsharing payment”. Where a payment from a CJR-X collaborator to a CJR-X participant is made pursuant to a sharing arrangement, CMS proposes to define that payment as an “alignment payment”.

In the Proposed Rule, CMS provides additional requirements regarding sharing arrangements, including compliance with applicable laws and regulations, written agreement documentation, and written, non–volume-based criteria for selecting collaborators that prioritizes quality and contributions to model performance.

CMS proposes several safeguards for sharing arrangements (e.g., must be voluntary, in writing, signed before care is furnished and focused on future performance rather than past results, require collaborators—and their employees, contractors and subcontractors—to comply with all applicable CJR-X requirements, including beneficiary notifications, record access, Medicare enrollment rules and all relevant laws and regulations). CMS also proposes that each CJR-X participant’s governing body oversee all sharing arrangements, gainsharing and alignment payments and use of beneficiary incentives, with written agreements made available to CMS upon request. **CMS seeks comment on the proposed definitions, requirements, and whether additional safeguards are needed.**

In the [Proposed Rule](#), CMS proposes specific requirements for the written agreement and documentation requirements. Also, CMS proposes several conditions and limitations for gainsharing payments and alignment payments as program integrity protections for the payments to and from CJR-X collaborators. More information on these conditions and limitations is available in the [Proposed Rule](#) (pg. 1021-1029). Additional information regarding distribution arrangements is available in the [Proposed Rule](#) (pg. 1030-1034) and details on downstream distribution arrangements (pg. 1035-1038).

Beneficiary Incentives

In the Proposed Rule, CMS indicates that CJR-X participants may provide in-kind patient engagement incentives to beneficiaries in an episode, such as technology, subject to certain conditions. CMS provides that these incentives should directly relate to the beneficiary's medical care and advance clinical goals (e.g., medication adherence or reducing readmissions). CMS proposes requirements for the provision of technology items, including a maximum value of \$1,000 per episode and enhanced safeguards for items exceeding \$75 in value. CMS also proposes documentation requirements when incentives are provided (e.g., date the incentive was provided, retrieval attempts on the item or service, and the beneficiary's identity). **CMS seeks feedback on these requirements and whether further safeguards are needed for program integrity.**

Data Sharing

CMS proposes to make certain beneficiary-identifiable Medicare claims data and regional aggregate data available to participants in CJR-X for Medicare FFS beneficiaries who may initiate an episode and be attributed to them in the model. CMS also expects CJR-X participants to supplement this data with information from their own systems, such as electronic health records or health information exchanges.

CMS proposes to hold CJR-X participants accountable for quality and cost outcomes for beneficiaries during the anchor hospitalization or procedure and the post-discharge period and believes participants must be able to request and receive beneficiary-identifiable claims data to help CJR-X participants engage in care coordination and quality improvement activities for CJR-X beneficiaries in an episode. Participants would have access to a summary or raw claims data for a three-year baseline period and monthly during the performance year, but only for beneficiaries who initiated an episode at their hospital and only for items and services included in the episode definition.⁶⁸

CMS proposes to share beneficiary-identifiable data only with CJR-X participant hospitals that bear financial risk for episodes, and not with their collaborators. CMS also proposes that if a CJR-X participant entered into a data-sharing agreement wishes to receive beneficiary-identifiable claims data, they must submit a formal request for data on an annual basis in a manner, form, and by a date specified by CMS.⁶⁹

Proposed Waivers of Medicare Program Requirements

⁶⁸ Summary data would aggregate and categorize claims to give participants a broad view of episode spending and utilization, while raw data would provide unrefined, episode-level claims fields that allow more detailed analysis, such as identifying diagnosis codes associated with a readmission.

⁶⁹ More information regarding the CJR-X Data Sharing Agreement and attestations is available in the [Proposed Rule](#) (pg. 1075-1086).

CMS seeks comment on proposed waivers of certain Medicare program requirements to provide flexibilities to hospitals participating in CJR-X, as well as other providers and suppliers that furnish services to beneficiaries in episodes. Certain waivers are highlighted below.

Waiver of Direct Supervision Requirement for Certain Post-Discharge Home Visits

CMS proposes to waive the “incident to” requirement⁷⁰ allowing hospitals to furnish and bill for limited post-discharge home visits for CJR-X beneficiaries who do not qualify for Medicare home health services.⁷¹ CMS proposes to allow up to nine post-discharge home visits to be billed using a CJR-X–specific HCPCS G-code that would be created prior to the start of the model.⁷² CMS also proposes to waive the global surgery billing requirements to allow the surgeon or other practitioners to furnish and bill for the post-discharge home visits during surgical global periods.⁷³

Waivers of Certain Telehealth Requirements

Similar to the telehealth waivers provided in the original CJR model and during the COVID-19 public health emergency, CMS proposes that any Medicare-approved telehealth service, as long as it is not excluded from the CJR-X episode definition, may be furnished to a CJR-X beneficiary in their home, unless the service’s billing code requires the patient to be in a different setting (e.g., hospital follow-up codes cannot be used at home because the beneficiary is not an inpatient).⁷⁴

CMS also proposes to create a specific set of four new HCPCS G-codes to describe the evaluation and management (E/M) services furnished to CJR-X beneficiaries in their homes via telehealth. If the proposed CJR-X is finalized, CMS would specify the precise G-code created for CJR-X and share them with CJR-X participants prior to the first performance year. Table X.C.-06 in the [Proposed Rule](#) (pg. 1055) provides the proposed CJR-X telehealth waiver G-code crosswalk. CMS proposes to develop payment rates for these new telehealth G-codes for E/M services in the patient’s home that are similar to the payment rates for the office/outpatient E/M services, since the codes will describe the work involved in furnishing similar services. Additional information regarding telehealth waivers is included in the [Proposed Rule](#) (pg. 1055-1060).

Waiver of the 3-Day Skilled Nursing Facility (SNF) Rule

CMS proposes waiving Medicare’s three-day SNF rule for CJR-X beneficiaries, allowing hospitals to discharge patients to a SNF or swing bed in fewer than three days if all other coverage criteria are

⁷⁰ § 410.26(b)(5), [eCFR :: 42 CFR 410.26 -- Services and supplies incident to a physician's professional services: Conditions](#).

⁷¹ The waiver would not apply to any CJR-X beneficiary who qualifies, or would qualify, for Medicare home health services at the time the visit is furnished. CMS plans to monitor utilization closely to detect overuse or reductions in medically necessary care and may reassess the waiver’s necessity in the future.

⁷² The G-code would describe a home visit for patient assessment performed by clinical staff for an individual who is not considered homebound. It would cover activities such as assessing clinical status, evaluating safety and fall risk, reviewing functional status and ambulation, performing medication reconciliation and management, checking compliance with orders or the care plan, assessing activities of daily living, and ensuring the beneficiary is connected to community or other needed services.

⁷³ Under existing rules, the 90-day global surgical payment includes post-operative care furnished by the surgeon that is not separately billable by the surgeon or another practitioner unless care is formally transferred. However, the post-discharge home visits contemplated under CJR-X involve broader episode-level assessments, such as nursing evaluations of chronic conditions affected by surgery, that do not duplicate traditional post-operative follow-up.

⁷⁴ CMS notes that because the broader Medicare telehealth waivers recently extended are temporary and subject to Congressional approval, a CJR-X-specific telehealth waiver ensures continued access to home-based telehealth services within the model even if national flexibilities expire. <https://telehealth.hhs.gov/providers/telehealth-policy/telehealth-policy-updates#:~:text=Non%2Dbehavioral/mental%20telehealth%20services%20in%20Medicare%20can%20be%20delivered,the%20use%20of%20video%20technology>.

met. Hospitals can use the waiver only when sending beneficiaries to SNFs with at least a three-star overall rating, though swing-bed providers would be exempt from the star-rating requirement.⁷⁵

Alternative Payment Model Considerations

CMS aims to align the design of CJR-X with the Advanced Alternative Payment Model (APM) criteria in the Quality Payment Program (QPP) and enable CMS to have the necessary information on eligible clinicians to make the requisite Qualifying APM Participant (QP) determinations. CMS proposes that the CJR-X participant would be considered the APM entity but that the CJR-X participant's affiliated practitioners may be assessed for QP determinations depending on whether the CEHRT criteria are met. CMS also proposes to adopt two different APM options for CJR-X—an Advanced APM (AAPM option) where CJR-X participants would attest to meeting the CEHRT requirement and where the CJR-X participant's eligible clinicians may be assessed for QP determinations. The second option is a non-AAPM option where CJR-X participants would not meet CEHRT requirements and where the CJR-X participant's merit-based incentive payment (MIPS) eligible clinicians may be assessed for reporting and scoring through the APM Performance Pathway (APP).

CMS further details proposals regarding the financial arrangements list and clinical engagement list, including submission requirements are included in the [Proposed Rule](#) (pg. 1089-1093).

Termination of CJR-X

In the event CMS terminates CJR-X, the agency will provide written notice to CJR-X participants specifying the grounds for termination and the effective date of such termination.

Proposed Changes to the Transforming Episode Accountability Model (TEAM)

As finalized in prior rulemaking, TEAM is a 5-year mandatory alternative payment model tested by CMMI that began on January 1, 2026, and will end on December 31, 2030. However, several policies that were initially proposed were not finalized and other policies needed further consideration, as noted below.

Spinal Diffusion Modifications

CMS proposes adding MS-DRGs 523, 524 and 525 to the TEAM spinal fusion episode beginning October 1, 2026. CMS also proposes to update the spinal fusion definition to include these three MS-DRGs. CMS considered, but rejected, not updating the MS-DRGs, noting that doing so would reduce episode volume and limit model scale.

Performance Timeline for Certain Quality Measures

CMS proposes to set the measurement performance periods for three TEAM quality measures to align with the Hospital IQR Program's calendar year reporting requirements.⁷⁶ CMS proposes a one-year measurement performance period for the Hospital Harm—Falls with Injury and Hospital Harm—Postoperative Respiratory Failure measures and a two-year rolling measurement performance period for the Thirty-Day Risk-Standardized Death Rate among Surgical Inpatients with Complications (ISCMR) measure.⁷⁷

⁷⁵ Additional information on this waiver can be found in the [Proposed Rule](#) (pg. 1060-1067).

⁷⁶ CMS notes that TEAM aims to align with existing reporting requirements so as not to introduce additional burden to participants.

⁷⁷ Table X.A-02 [Proposed Rule](#) (pg. 868) displays the proposed measurement performance periods for these quality measures in TEAM.

Calculation of TEAM Composite Quality Score (CQS) Baselines

CMS proposes the following to calculate TEAM Composite Quality Score (CQS) baselines:

- Establishing 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. This is effective beginning with TEAM Performance Year 1 (PY 1).⁷⁸
- Shifting the CQS baseline periods for several TEAM quality measures from a calendar-year (January–December) timeframe to a July–June timeframe.^{79,80} **CMS considered delaying the shift to a sliding historical CQS baseline until TEAM Performance Year 2 (PY 2) instead of starting in PY 1 and requests comment on whether starting the new sliding baseline in PY 2, rather than PY 1, would be preferable.**

Updating TEAM Target Price Calculations

CMS proposes applying new APC and MS-DRG update factors to final TEAM target price calculations beginning in PY 1 to ensure that target prices reflect the coding and weight changes that occur during each performance year.

Requests for Information

CMS is exploring adding Ambulatory Surgical Centers (ASCs) to TEAM beginning as early as CY 2028 (PY 3). **CMS seeks feedback on how ASCs could be incorporated into TEAM, including model structure, participant roles and financial accountability, episode and target price construction and quality measurement. Through this RFI, CMS intends to gather information on the parameters under which ASCs could be incorporated into TEAM, including the degree to which the addition of ASCs would necessitate a separate model test.**⁸¹ In addition, CMMI is considering creating a voluntary opt-in pathway that would allow physician-owned hospitals (POHs) located in core-based statistical areas (CBSAs) that are not selected for TEAM to participate in the model.⁸²

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

CMS is proposing to expand its existing reasonable-cost reimbursement framework for organ

⁷⁸ Under this proposed approach, CQS baselines would be calculated using a rolling window of historical performance data that updates annually, rather than remaining fixed throughout the model's tenure.

⁷⁹ This affects the Hybrid Hospital-Wide Readmission Measure with Claims and Electronic Health Record Data ([Hybrid HWR](#)), [PSI-90](#), Hospital-Level Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome-Based Performance ([THA/TKA PRO-PM](#)), and [ISCMR](#) measures.

⁸⁰ This proposal does not affect the Hospital Harm—Falls with Injury and Hospital Harm— Postoperative Respiratory Failure or the Information Transfer PRO-PM, which will continue to use calendar year CQS baseline periods as originally finalized, consistent with their respective hospital reporting program requirements.

⁸¹ Specific questions related to this RFI are on pg. 893-895 of the [Proposed Rule](#).

⁸² Specific questions related to this RFI are on pg. 898-899 of the [Proposed Rule](#).

procurement,^{83,84} which currently only applies to kidney acquisition services,⁸⁵ to cover all non-renal organ acquisition and transplantation services furnished by independent organ procurement organizations (IOPOs)⁸⁶ and independent histocompatibility laboratories (HCLs).⁸⁷ Specifically, CMS proposes that kidney acquisition services will continue to be reimbursed on a reasonable-cost basis and will add non-renal organ acquisition services furnished by IOPOs and HCLs for reimbursement under reasonable-cost principles for cost-reporting periods beginning on or after October 1, 2027.

To implement the expansion of the reasonable cost framework, CMS outlines several technical revisions. For example, the Proposed Rule would add Organ Procurement Organizations (OPOs) and transplant hospitals as entities that pay IOPOs and HCLs using contractor-established interim rates.

CMS also proposes clarifications to payment mechanics, including that transplant hospitals and OPOs would pay IOPOs and HCLs using established rates, with Medicare reimbursing reasonable costs under existing cost reimbursement principles. Existing requirements for IOPOs and HCLs (e.g., such as filing cost reports, permitting contractor review, providing budget information, returning overpayments and not billing individuals) would remain in place.

Further, CMS proposes extensive revisions to clarify and codify the authority of both the CMS reviewing official and the Administrator in the appeals process for IOPOs and HCLs. The proposal includes technical revisions across several sections, such as updating definitions of Administrator review, clarifying the amount-in-controversy threshold, specifying when contractor hearing decisions are final or reviewable and outlining how jurisdictional, discovery and dismissal rulings may be reviewed. Information on these proposals can be found in the [Proposed Rule](#) (pg. 1155-1167).

What's Next?

Comments on the Proposed Rule are due on June 9, 2026. CMS is anticipated to publish the final rule around August 1, 2026, with the changes being effective at the beginning of the next federal fiscal year (October 1, 2026). Vizient's Office of Public Policy and Government Relations looks forward to hearing continued client feedback on this Proposed Rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or comments regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to [Randi Gold](#), Director, Hospital Payment Policy and Regulatory Affairs in Vizient's Washington, D.C. office.

⁸³ Under section 1861(v)(1)(A), reasonable cost is the necessary cost actually incurred in the efficient delivery of needed health care services to Medicare beneficiaries. Section 413.1(a)(2)(v) identifies OPOs and HCLs as provider types to which part 413 of the regulations apply, making them expressly subject to Medicare's reasonable cost principles, including 42 CFR 413.9 regarding costs related to patient care. Currently, the Medicare program reimburses the reasonable costs related to patient care of allowable kidney acquisition services furnished by IOPOs and HCLs, provided that they have an agreement with the Secretary.

⁸⁴ CMS formalized reimbursement rules for independent OPOs (IOPOs) and histocompatibility laboratories (HCLs), noting that hospital-based entities were already reimbursed under reasonable-cost principles but that independent organizations lacked oversight, creating a risk of overpayment. Congress addressed this through the ESRD Program Amendment (Pub. L. 95-292), which required Medicare payments to OPOs and HCLs not to exceed their actual reasonable costs and directed CMS to use cost reporting and audit processes. CMS implemented these requirements by limiting reimbursement for IOPO and HCL kidney acquisition services to reasonable costs, establishing standard acquisition charges and testing rates, and reconciling costs through annual cost reports. While hospital-based OPOs already undergo reconciliation for all organs they procure, these reasonable-cost and reconciliation requirements apply specifically to IOPOs and independent HCLs.

⁸⁵ 42 CFR § 413.420, (Payment to independent organ procurement organizations and histocompatibility laboratories for kidney acquisition costs). <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413/subpart-L/section-413.420>

⁸⁶ Organ procurement organizations (OPOs) perform or coordinate the procurement, preservation, and transportation of organs from deceased donors, and maintain a system for locating prospective recipients for organ transplantation.

⁸⁷ Histocompatibility laboratories (HCLs) are specialized clinical laboratories that perform tissue typing and compatibility testing on potential organ donors and recipients.