Medicare IPPS Proposed Rule Payment Brief

Federal Fiscal Year 2027 | Version 1

Overview and Resources

On April 10, 2025, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2027 proposed rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and market basket, the following policies are being proposed in this rule:

- Utilizing FFY 2025 Medicare Provider and Review (MedPAR) and FFY 2024 Hospital Cost Reporting Information System (HCRIS) data for standard calculations;
- Updating cost-of-living adjustments (COLAs) for hospitals located in Alaska and Hawaii;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies, including hospital eligibility for DSH Uncompensated Care (UCC) payments in FFY 2027 being based on audited FFYs 2021–2023 S-10 data;
- Continuing the budget neutral transitional wage index value for providers who were eligible for the low wage index policy in FFY 2024;
- Changes to reclassification policies;
- Updates on policies regarding new residency programs;
- Updates to the Transforming Episode Accountability Model (TEAM);
- Implementation of the Comprehensive Care for Joint Replacement Expanded (CJR–X) Model;
- Updates to the Medicare Promoting Interoperability Program; and
- Updates to the Value-Based Purchasing (VBP) Program, Readmission Reduction Program (RRP), and Hospital Inpatient Quality Reporting (IQR) Program;

Proposed program changes would be effective for discharges on or after October 1, 2026, unless otherwise noted. CMS estimates the overall impact of this proposed rule update to be an increase of approximately $1.9 billion in aggregate payments for acute care hospitals in FFY 2027 over FFY 2026. This estimate includes increased operating (including outliers), uncompensated care, new technology, and capital payments and decreases due to the expiration of the low-volume and Medicare Dependent Hospital (MDH) programs as of December 31, 2026, and new technology add-on payment changes as of October 1, 2027.

A copy of the proposed rule and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2027-ipps-proposed-rule-home-page.

An online version of the proposed rule can be found at https://www.federalregister.gov/d/2026-07203.

Comments on this proposed rule are due to CMS by June 9, 2026 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "CMS-1849-P."

Page references and italicized text are from the April 14, 2026 *Federal Register* unless otherwise noted.

IPPS Payment Rates

Pages 19496–19498, 19548–19552, 19794–19821, and 19863

The table below lists the federal operating and capital rates proposed for FFY 2027 compared to the rates currently in effect for FFY 2026. These rates include all market basket increases and reductions as well as the application of proposed annual budget neutrality factors. These rates do not reflect any hospital-specific adjustments (e.g., penalty for non-compliance under the IQR Program and Electronic Health Record (EHR) Meaningful Use (MU) Program, quality penalties/payments, DSH, etc.).

	Final FFY 2026	Proposed FFY 2027	Percent Change
Federal Operating Rate	$6,752.61	$6,967.87	+3.19%
Federal Capital Rate	$524.15	$545.22	+4.02%

The following table provides details for the proposed annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2026.

Proposed FFY 2027 Update Factor Component	Operating Standardized Amount	Hospital Specific Rate	Capital Federal Rate
Market Basket/CIPI Update	+3.2%		+3.1%
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.8 percentage points (PPTs)		–
MS-DRG Reclassification and Recalibration Budget Neutrality (BN) Factor (before cap)	-0.13%		+1.56%
MS-DRG Weight Cap Policy BN	-0.02%		-0.02%
Wage Index/Geographic Adjustment Factor (GAF) BN Factor	+0.03%	-	-0.14%
Geographic Reclassification BN Factor*	+1.60%	-	
Wage Index Cap Policy BN*	-0.74%	-	-0.76%
Transition for the Discontinuation of the Low Wage Index Policy BN*	+0.01%	-	
Outlier Adjustment Factor*	0.00%		+0.27%
Rural Community Hospital Demonstration BN**	+0.04%	-	-
Net Rate Update	**+3.19%**	**+2.24%**	**+4.02%**

*Net change after removal of the FFY 2026 adjustment and application of the FFY 2027 adjustment.
** Change after the removal of the FFY 2026 adjustment, no adjustment was proposed for FFY 2027.

The proposed market basket and CIPI update percentages are based on IHS Global Inc.'s fourth quarter 2025 forecast with historical data through third quarter 2025.

Effects of the IQR and EHR MU Incentive Programs

Pages 19496–19498, 19794–19795, and 19815–19816

The IQR market basket penalty imposes a 25% reduction to the full market basket and the EHR MU penalty imposes a 75% reduction to the full market basket; hence the entirety of the full market basket update is at risk between these two penalty programs. This penalty affects providers paid using the operating standardized rate or a hospital-specific rate. The following table shows the various update scenarios for FFY 2027.

	Neither Penalty	Soley IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket Update (3.2% MB less 0.8 PPT productivity adjustment)	+2.4%			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.2%)	–	-0.8 PPT	–	-0.8 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.2%)	–	–	-2.4 PPTs	-2.4 PPTs
Net Rate Update	**+2.4%**	**+1.6%**	**+0.0%**	**-0.8%**

Outlier Payments

Pages 19802–19811 and 19818

For FFY 2027, CMS is proposing to incorporate total outlier reconciliation dollars from the FFY 2021 cost reports into the outlier model using a similar methodology to what has been used since FFY 2020, modified to reflect the additional cost reports identified due to the new criteria for cost report identification finalized for FFY 2025. Since these new criteria are not effective until the FFY 2025 cost reports, CMS would apply these criteria to FFY 2021 cost reports as if they had been in place at the time of cost report settlement and estimate outlier reconciliation dollars based on these cost reports and other supplemental data collected from Medicare Administrative Contractors (MACs).

An analysis done by CMS using this methodology determined operating outlier payments at 5.1% of total IPPS operating payments. However, due to this analysis resulting in reconciliation dollars being zero when the result is typically negative, CMS is proposing to hold data for incorporating reconciliation dollars constant and use the percentage of total operating outlier reconciliation dollars to total Federal operating payments from the FFY 2025 IPPS final rule. Using this data would result in outlier reconciliation dollars targeting an outlier threshold of 5.14%. Consistent with the approach used since FFY 2020, CMS proposes to continue to apply a 0.949 outlier offset factor to the operating standardized amount.

Using a similar methodology and after considering capital outlier reconciliation, the estimated capital outlier threshold is proposed to be 3.60% of total capital payments for FFY 2027. Consistent with the approach taken in FFY 2020, CMS proposes to apply a net 1.0027 outlier adjustment to the capital rate.

CMS is proposing an outlier fixed-loss cost threshold of $51,704 for FFY 2027, which includes a charge inflation factor calculated using the December 2024 MedPAR file for FFY 2024 charge data and the December 2025 MedPAR file for FFY 2025 charge data. This threshold is 28.0% higher than the FFY 2026 outlier threshold of $40,397. The outlier fixed-loss cost threshold would be $52,096 without applying the proposed methodology for incorporating an estimate of outlier reconciliation in the determination of the outlier threshold.

Rural Community Hospital (RCH) Demonstration Program

Page 19547–19548 and 19863

As of the publication of this rule, CMS has not been able to finalize the FFY 2027 estimated costs of the RCH demonstration due to timing issues with the addition of 11 new hospitals in 2025. Due to this, CMS is not proposing to apply a budget neutrality offset to the IPPS operating standardized rate stated in this proposed rule. However, CMS proposes to apply this offset for both FFY 2027 and FFY 2028 in the FFY 2028 IPPS proposed rule.

Stem Cell Acquisition Budget Neutrality Factor

Page 19796

CMS proposes to continue to not remove the Stem Cell Acquisition budget neutrality factor from the federal operating rate and to not apply a new factor for FFY 2027 as they do not believe that it would satisfy budget neutrality requirements. CMS intends to consider the use of cost report data regarding reasonable acquisition costs when it becomes available for future budget neutrality adjustments.

COLA

Pages 19813–19814

In order to account for differences in the cost of living due to location the IPPS provides COLAs for IPPS hospitals in Alaska and Hawaii. The COLA is applied by multiplying the capital rate, as well as the non-labor-related portion of the operating standardized amount, by the applicable COLA factor.

In FFY 2026, CMS analysis showed that updating the COLA factors using their existing methodology would have resulted in these factors decreasing. Although COLA factors are typically updated when the labor-related share is updated (every four years), due to this decrease CMS had chosen to maintain the factors that had been in place for FFYs 2022–2025. After considering comments received from FFY 2026 rulemaking, CMS is proposing to update COLA factors for FFY 2027 using Overseas Cost-of-Living Allowance Data published by the Department of Defense rather than using Consumer Price Index data, as has been done in previous rulemaking. Additionally, CMS is proposing to no longer cap the COLA factors at 1.25. CMS is soliciting feedback on any information regarding the resulting COLA factors and may consider alternative methodologies in the final rule.

Area	Final COLA Factors FFYs 2022–2026	Proposed COLA Factors FFY 2027
Alaska:		
City of Anchorage and 80-kilometer (50-mile) radius by foot	1.22	1.28
City of Fairbanks and 80-kilometer (50-mile) radius by foot	1.22	1.32
City of Juneau and 80-kilometer (50-mile) radius by foot	1.22	1.36
Rest of Alaska	1.24	1.44
Hawaii:		
City and County of Honolulu	1.25	1.20
County of Hawaii	1.22	1.32
County of Kauai	1.25	1.26
County of Maui and County of Kalawao	1.25	1.24

Wage Index and Geographic Adjustment Factor

Pages 19459–19479, 19799–19802, and 19818–19819

A complete list of the proposed wage indexes to be used for payments in FFY 2027 is available on the CMS website at https://www.cms.gov/files/zip/fy2027-ipps-nprm-tables-2-3-4a-4b.zip. CMS plans to publish the final wage index data public use files (PUFs) on April 30, 2026 at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index-files/fy-2027-wage-index-home-page. Only potential errors in the data made by CMS or a MAC can be corrected within these PUFs and the errors must be submitted by May 29, 2026.

Occupational Mix Adjustment

Pages 19468–19470

CMS proposes to use the calendar year (CY) 2022 Occupational Mix Survey for the calculation of the wage index for FFY 2027. The FFY 2027 occupational mix adjusted wage indexes based on this survey can be found in Table 2 on CMS's IPPS website. CMS is also proposing a FFY 2027 occupational mix adjusted national average hourly wage of $58.82.

Additionally, a new measurement of occupational mix is required for FFY 2028. This occupational mix would be based on a new CY 2025 survey and is available at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index-files/2025-occupational-mix-survey-hospital-reporting-form-cms-10079-wage-index-beginning-fy-2028. Hospitals are required to submit their completed survey to their MACs by June 30, 2026. The preliminary, unaudited survey data will be posted on the CMS website by mid-July 2026.

Redesignation and Reclassification Policies

Pages 19470–19474 and 19800

Current regulations allow a hospital that has been reclassified by the Medicare Geographic Classification Review Board (MGCRB) to withdraw their application any time before the MGCRB issues a decision, within 45 days of the date of filing for public inspection of the proposed rule, or within seven days of receiving a decision, whichever is later. A hospital may also terminate an existing approved reclassification, effective for the second and third year of the three-year reclassification period, provided the request for termination is received within 45 days of the date of filing for public inspection of the proposed rule, or within seven days of receiving a decision, whichever is later. These withdrawal and termination requests may be cancelled by submitting a request by the next application deadline for MGCRB application. A provider can also cancel an eligible withdrawal or termination in order to make the reclassification effective for any remaining years of the three-year reclassification period, referred to as a request for reinstatement. Applications for FFY 2028 reclassifications are due to the MGCRB by September 1, 2026. This is also the deadline for cancelling a previous wage index reclassification termination for FFY 2027. Applications and other information about MBGCRB reclassifications will be made available in mid-July 2026 at https://www.cms.gov/medicare/regulations-guidance/geographic-classification-review-board.

Based on comments received in previous rulemaking, CMS is proposing to include ferry routes when mapping shortest routes when determining mileage for the purposes of proximity. CMS would apply the same measurement method for miles traveled on land to those traveled by ferry over water. As such, maps submitted to the MGCRB from nationally recognized electronic mapping services showing the shortest route over roads from the front entrance of the hospital to county lines would need to include miles traveled by ferry as evidence of the shortest route.

CMS requires that hospitals seeking reclassification submit wage data for the area in which they are geographically located as well as the area to which they seek to be reclassified to demonstrate that the area they are seeking to be reclassified into has a higher pre-reclassification wage index than the area they are geographically located. CMS is

proposing a clarification that the most recent three-year average hourly wage data must be submitted to the MGCRB for these reclassification decisions to remove any ambiguity in this regulation.

Currently, it is possible that a hospital without three years of published hourly wage data may be denied a reclassification to their home CBSA since current regulations require that a hospital with a rural reclassification must demonstrate that its three-year average hourly wage is at least 82% of the average hourly wage of its own geographic labor market. CMS is proposing to waive this requirement for hospitals seeking to reclassify into the CBSA in which they are located.

Outmigration Adjustments

Pages 19475–19476

For FFY 2027, CMS proposes to continue updating out-migration adjustments based on a custom tabulation of the American Community Survey utilizing data from 2016–2020. This is consistent with methodology used for determining FFY 2012 out-migration adjustments. Proposed out-migration adjustments by county can be found in Table 4a released with this rule.

Permanent Cap on Wage Index Decreases

Pages 19476 and 19801

CMS applies a 5% cap on any decrease to a hospital's IPPS wage index, compared with the previous year's final wage index. The cap is applied regardless of the reason for the decrease, is implemented in a budget neutral manner, and excludes newly opened hospitals. This also means that if an IPPS provider's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the IPPS provider's capped wage index in the prior FFY and will be applied to the final wage index a hospital has on the last day of the prior FFY. For FFY 2027, CMS is proposing that this will be the wage index published in the FFY 2026 final rule, irrespective of the transitional payment exception wage index value.

If a hospital reclassifies as rural under 42 CFR §412.103 with an effective date after the end of the prior FFY day, this policy applies to the reclassified wage index instead. Additionally, a new IPPS is paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPPS hospital will not have a wage index in the prior FFY.

Addressing Wage Index Disparities between High and Low Wage Index Hospitals

Pages 19477–19478, 19801–19802, and 19818–19819

In the FFY 2025 interim final rule with comment period (IFC), CMS recalculated the IPPS hospital wage index to remove the low wage index policy and the associated budget neutrality for FFY 2025 and implemented a transitional exception payment to providers who were eligible for the low wage index policy in FFY 2024. For hospitals who were eligible for the low wage index policy in FFY 2024, this transition set their wage indexes to 95% of their FFY 2024 wage index, was implemented without a corresponding budget neutrality adjustment, and did not permanently set each eligible provider's FFY 2025 wage index to this value.

For FFY 2026 and subsequent years, CMS previously adopted the discontinuation of the low wage index hospital policy and associated budget neutrality. In order to mitigate the impact that ending this policy will have on hospitals, CMS adopted a transitional policy applicable to hospitals that benefited from the low wage index policy in FFY 2024. Similar to the FFY 2026 transition, for FFY 2027 CMS proposes that if a hospital's FFY 2027 wage index was reduced by more than 14.2625% from their FFY 2024 wage index, the FFY 2027 wage index would instead be set

to 85.7375% of its FFY 2024 wage index. This transition would be applied after the application of the 5% cap on FFY 2027 wage index values compared to those in FFY 2027. This transition is proposed to be budget neutral for both the federal operating and capital rates.

Labor-Related Share

Pages 19478–19479 and 19799

The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. For FFY 2027, CMS is proposing to maintain the current labor-related share of 66.0% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

DSH and UCC Payments

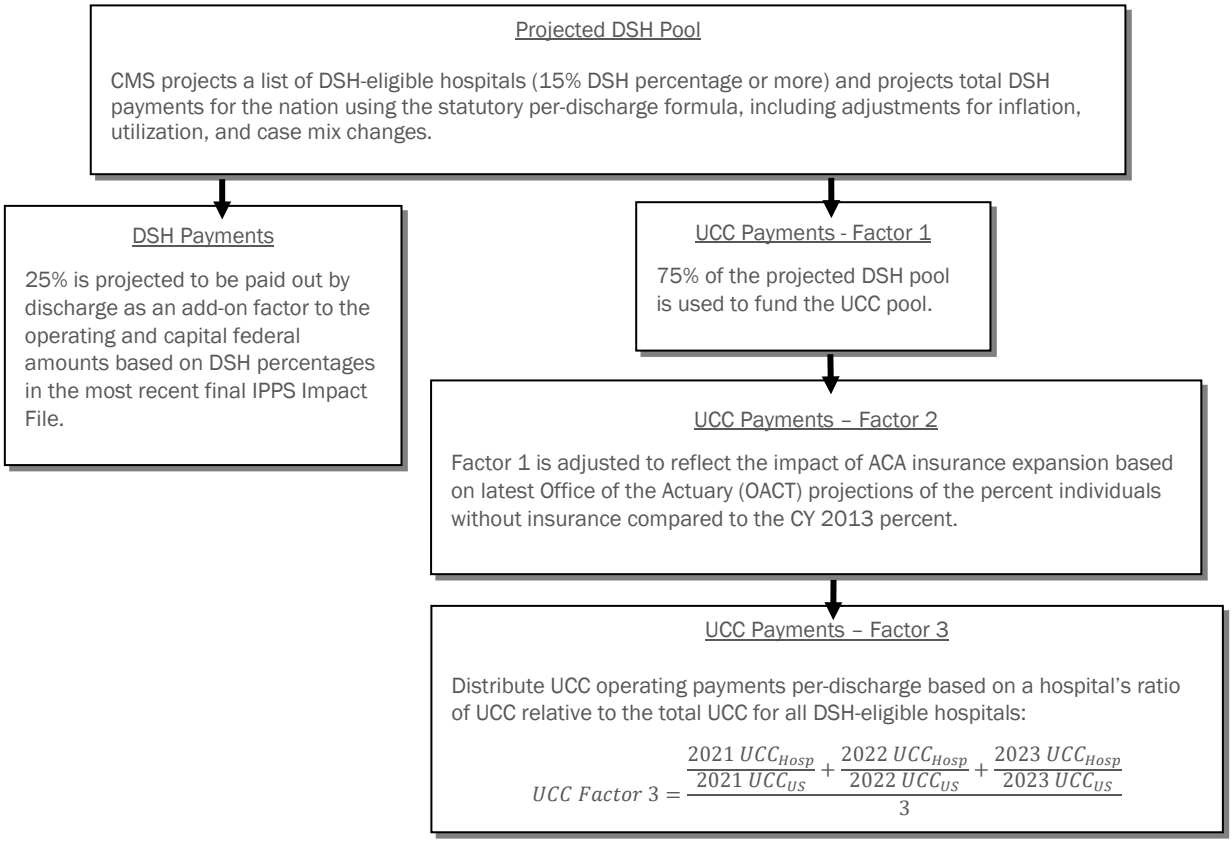
Pages 19479–19490

The ACA mandates the implementation of Medicare DSH calculations and payments to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds must continue to be paid to DSH-eligible hospitals using the statutory method. The remaining 75% of the funds, referred to as the UCC pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This UCC pool is distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

The following table details the proposed total DSH pool and each factor of the UCC pool.

	Final FFY 2026	Proposed FFY 2027	Percent Change
Projected Total DSH Pool	$16,550,000,000	$15,303,000,000	-7.53%
UCC Factor 1 – Base Funding (75% of Total DSH Pool)	$12,412,500,000	$11,477,250,000	-7.53%
UCC Factor 2 – Available Pool	$7,713,127,500 62.14% Factor 1 adjustment	$7,460,212,500 65.00% Factor 1 adjustment	-3.28%
UCC Factor 3 – Distribution	Audited FFYs 2020–2022 S-10 Line 30 Data (Trimmed)	Audited FFYs 2021–2023 S-10 Line 30 Data (Trimmed)	

The following schematic describes the DSH payment methodology mandated by the ACA:



Actual DSH eligibility is determined at cost report settlement. Unless a merger occurs, there will be no update to a hospital's UCC payment or UCC factors as published in the FFY 2027 IPPS proposed rule Impact File. CMS may recoup DSH and UCC payments if a hospital is determined to be ineligible for DSH at the time of settlement. Conversely, CMS will apply DSH and UCC payments if a hospital is determined to be eligible for DSH payments at cost report settlement, but not prior.

CMS uses the most recent three years of audited cost report data in the determination of Factor 3. Specifically, for FFY 2027 CMS will use FFYs 2021–2023 for this determination. Hospitals that do not have data for all three years will have their Factor 3 determined based on the average of the available data for the appropriate years. In the rare case when CMS uses a cost report that starts in one FFY and spans the entirety of the subsequent FFY, the same cost report will not be used to determine UCC costs for the earlier FFY. As an alternative for the earlier FFYs, the most recent prior cost report that spans some portion of that FFY will be used. To ensure that total UCC payments for all eligible hospitals are consistent with the total estimated UCC amount made available to hospitals, a scaling factor will be applied to the Factor 3 values for each of these hospitals. For each DSH-eligible hospital, this scaling factor is calculated as:

$$\frac{1}{Actual\ sum\ of\ all\ hospital\ Factor\ 3\ values}.$$

This quotient is then multiplied by the UCC payment determined for each DSH-eligible hospital to obtain a scaled UCC payment amount. This process ensures that the sum of the scaled UCC payments for all hospitals is consistent with the estimate of the total amount available to make UCC payments.

For new hospitals, CMS is proposing to continue the policy that if the hospital has a preliminary projection of being eligible for DSH it may receive interim DSH payments but would not receive interim UCC payments. Factor 3 values for new hospitals would use a denominator based solely on UCC costs from cost reports for the most recent year for which audits have been conducted. The resulting Factor 3 adjustment would then have a scaling factor applied to it to ensure that the total UCC pool is paid out. This also applies to newly merged hospitals with data based on the surviving hospital's CCN. If the hospital's cost reporting period is less than 12 months, the data from the newly merged hospital's cost report is annualized.

CMS proposes continuing to trim cost-to-charge ratios in the calculation of Factor 3. If a hospital's unaudited UCC costs for a FFY are greater than 50% of total operating costs for that FFY, then a ratio of UCC costs to the hospital's total operating costs for the other year is applied to the total operating costs of the aberrant year. Additionally, for hospitals that have not had their FFY 2021, FFY 2022, and/or FFY 2023 cost reports audited, CMS would continue the policy for an alternative trimming methodology using a threshold of three standard deviations from the mean ratio of insured patients' charity care costs to total uncompensated care costs, and a dollar threshold that is the median total uncompensated care cost reported on most recent audited cost reports for hospitals that were projected to be DSH-eligible, including IHS, Tribal, and Puerto Rico hospitals. Specifically, in cases where a hospital's insured patients' charity care costs are greater than $7 million and the ratio of the hospital's cost of insured patient charity care to total UCC costs is greater than 60%, CMS excludes the hospital from the prospective Factor 3 calculation. For hospitals subject to this alternate trim and determined to be DSH-eligible at cost report settlement, CMS will continue to apply its policy where those hospitals' UCC payments will be calculated after their MACs have reviewed the UCC information reported on worksheet S-10, subject to the previously mentioned scaling factor.

CMS is projecting that 2,318 hospitals may be eligible for DSH UCC payments in FFY 2027 based on audited FFYs 2021–2022 S-13 data. CMS provides a file that includes estimated DSH UCC eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH UCC payment methodology. The file is available at https://www.cms.gov/files/zip/fy2027-ipps-nprm-medicare-dsh-supplemental-data-file.zip.

Indirect and Direct GME Payments

Pages 19319 and 19504–19526

In order to ensure that accreditation for approved medical residency programs and nursing and allied health (NAH) education programs are in compliance with anti-discrimination laws, CMS is proposing that these programs, *"…must not discriminate, or promote or encourage discrimination, on the basis of race, color, national origin, sex, age, disability, or religion including the use of those characteristics or intentional proxies for those characteristics as a selection criterion for employment, program participation, resource allocation, or similar activities, opportunities, or benefits."*

In FFY 2025 rulemaking, CMS requested information on what constitutes a "new" program eligible to receive Medicare-funded CMS slots and what criteria would need to be established to determine program newness. A summary of comments received on this topic can be found on pages 19506–19507. Based on comments received, CMS is proposing that, effective for programs starting on or after October 1, 2026, previous employment of the facility or program director would not be considered in determining whether a residency program should be

considered new for cap-building purposes. Programs that started on an earlier date that are still within the five-year cap-building period as of October 1, 2026 would continue to be subject to the newness criteria currently in place.

CMS also proposes that for a residency program to be considered new, at least 90% of the individual resident trainees (not full-time equivalents [FTEs]) must not have previously trained in the same specialty as the new program. This requirement would be waived for small programs (16 or fewer resident/fellow positions), residents admitted via a binding resident matching program, and certain displaced residents. CMS and the MAC would determine whether a program has satisfied the 90% threshold by counting all residents who enter a program during the five-year cap building period. These proposed requirements would be in addition to the program receiving their initial accreditation.

CMS is not proposing any new policies that would affect the calculation of Direct GME or IME payments following a merger but does include clarification and examples on how these calculations are handled on pages 19510–19517.

In the proposed rule, CMS provided public notification of the closure of two teaching hospitals for the purposes of the established application process for the resident slots attributed to this hospital.

CCN	Provider Name	City/State	CBSA	Terminating Date	IME Cap (includes all adjustments)	Direct GME Cap (includes all adjustments)
390081	Delaware County Memorial Hospital	Drexel Hill, PA	37964	November 7, 2022	28.60	27.96
390180	Crozer-Chester Medical Center	Chester, PA	37961	June 21, 2025	101.32	100.89

CMS is proposing to clarify the nature of allowable indirect costs of approved educational activities and to refine the cost reporting procedures to ensure that hospitals appropriately allocate overhead costs to the NAH cost centers. CMS had proposed similar policy updates in the FFY 2026 IPPS proposed rule but did not finalize any of the policies due to comments received. Detail on both the past and current proposals can be found on pages 19521–19522.

Lastly, the IME adjustment factor will remain at 1.35 for FFY 2027.

Updates to the MS-DRGs

Pages 19321–19459, 19490–19495, and 19798–19799, 19819–19820

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. CMS is proposing to use ICD-10 claims data from the September 2025 update of the FFY 2025 MedPAR file (discharges from October 1, 2024 through September 30, 2025) and the December 2025 update of the FFY 2024 Medicare costs reports to determine FFY 2027 MS-DRGs and recalibration of relative weights.

CMS only accepts MS-DRG classification requests via the Medicare Electronic Application Request Information System™ (MEARIS™) and will not accept requests via email. MEARIS™ can be accessed at https://mearis.cms.gov/, which contains links and documentation related to this system. MS-DRG change requests, feedback, and other suggestions for FFY 2028 must be submitted by October 20, 2026.

Updates to MS-DRG relative weights are calculated to be budget neutral before the application of the 10% reduction cap. As such, CMS is proposing a budget neutrality factor of 0.998687 to the operating rate and 1.0156 to the capital rate.

CMS previously adopted a permanent 10% cap on reductions to a MS-DRG's relative weight in a given year compared to the weight in the prior year, implemented in a budget neutral manner. CMS proposes to continue this policy and apply a budget neutrality adjustment of 0.999753 to the operating rate and 0.9998 to the capital rate in FFY 2027. This cap policy would only apply to a given MS-DRG if it retains its MS-DRG number from the prior year and would not apply to the relative weight for any new or renumbered MS-DRGs for the year.

CMS is proposing 766 payable MS-DRGs for FFY 2027 (compared to 770 for FFY 2026), with 74.0% of MS-DRG weights changing by less than +/- 5%, 19.2% changing at least +/-5% but less than +/- 10%, and 5.0% changing +/- 10% or more. Of these MS-DRGs, 5.9% are affected by the relative weight cap on reductions and 1.8% are new MS-DRGs.

The five MS-DRGs with the greatest proposed year-to-year change in weight, taking into account the relative weight cap, are:

MS-DRG	MS-DRG Title	Final FFY 2026 Weight	Proposed FFY 2027 Weight	Percent Change
465	WOUND DEBRIDEMENT OR SKIN GRAFT EXCEPT HAND FOR MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS WITHOUT CC/MCC	1.8237	2.5108	37.68%
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS WITH MV >96 HOURS WITH SKIN GRAFT	21.3505	27.8628	30.50%
779	ABORTION WITHOUT D&C	0.8413	1.0665	26.77%
488	KNEE PROCEDURES WITHOUT PRINCIPAL DIAGNOSIS OF INFECTION WITH CC/MCC	1.7689	2.2072	24.78%
425	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES WITHOUT CC/MCC	1.5003	1.8502	23.32%

The full list of the proposed FFY 2027 MS-DRGs, MS-DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy2027-ipps-nprm-table-5.zip. For comparison purposes, the final FFY 2026 DRGs are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy2026-ipps-fr-table-5.zip

MS-DRG Changes

Pages 19322–19391 and 19490–19495

Based on the analysis of FFY 2025 MedPAR claims and requests from stakeholders, CMS is proposing changes to a number of MS-DRGs effective for FFY 2027. Specifically, CMS is proposing the following:

- *"Reassigning an ICD–10–PCS code describing the insertion of an endocardiac pacing electrode to MS–DRGs 228–229, deleting MS–DRGs 258, 259, 260, 261 and 262, and creating proposed new MS–DRGs 210 and 211 (Cardiac Pacemaker Revision or Device Replacement with MCC and without MCC, respectively).*

- *Reassigning the ICD–10–PCS codes describing extensive spinal fusions, fusions performed with a custom-made anatomically designed interbody fusion device and fusion of the sacroiliac joints using an internal fixation device with tulip connector from MS–DRGs 402, 426–428, 447–448, 450–451, and 456–458 to proposed new MS–DRGs 523, 524, and 525 (Extensive or Complex Spinal Fusion Procedures Except Cervical with MCC, with CC, and without CC/MCC, respectively).*
- *Redesignating an ICD–10–PCS code describing introduction of an antibioticeluting bone void filler from non-O.R. to non-O.R. affecting the MS–DRG assignment for MS–DRGs 463, 474, 477, 480, 492, 616, and 628.*
- *Deleting MS–DRGs 485–487, and creating proposed new MS–DRG 400 (Knee Procedures with Principal Diagnosis of Infection).*
- *Deleting MS–DRGs 466–468, and creating proposed new MS–DRG 449 (Revision of Hip or Knee Replacement).*
- *Creating proposed new MS–DRG 403 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC or Insertion of Antibiotic-eluting Bone Void Filler) and proposed new MS–DRG 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection without MCC).*
- *Deleting MS–DRGs 736, 737, 738, 739, 740 and 741 and creating proposed new MS–DRGs 731, 732, and 733 for uterine and adnexa procedures for female reproductive system malignancies.*
- *Deleting MS–DRG 264 (Other Circulatory System O.R. Procedures) and creating proposed new MS–DRGs 361 and 362 (Other Circulatory System O.R. Procedures with and without MCC, respectively).*
- *Adding ICD–10–PCS procedure codes describing the introduction of pancreatic islet cells to a new ''Islet Cell Transplant Procedures'' logic list in Pre-MDC MS–DRGs 008, 010, and 019."*

The tables on pages 19492–19493 and 19495 detail which of these proposed new or revised MS-DRGs would be subject to the post-acute care transfer policy and special payment policy, respectively, for FFY 2027.

New Technology

Pages 19396–19459

CMS states that numerous new medical services or technologies are eligible for add-on payments outside the PPS. Table II.E.-01 on pages 19404–19406 shows the 41 technologies approved for FFY 2026 that CMS proposes would continue to receive add-on payments for FFY 2027 since their three-year anniversary date will occur on or after October 1, 2026. Table II.E.-02 on page 19408 shows the 12 new technologies that were first approved for payments prior to FFY 2025 that CMS is proposing to discontinue making new technology add-on payments for FFY 2027 since their three-year anniversary date will occur before April 1, 2027. This table also includes one technology approved for new technology add-on payments in FFY 2026 that is proposed to no longer receive these payments for FFY 2027 because the three-year anniversary date will occur prior to October 1, 2026.

CMS is seeking comments on whether or not 15 new technologies should receive add-on payments under the traditional pathway and whether or not 22 new technologies should receive payment under the alternative pathway for FFY 2027. For FFY 2028 and subsequent years, CMS is proposing to repeal the alternative pathway for new technology add-on payments and Outpatient PPS (OPPS) pass-through applications. This would include applications for FDA-approved Breakthrough Devices and Qualified Infectious Disease Products (QIDPs), or drugs approved under FDA's limited population pathway for antibacterial and antifungal drugs (LPAD pathway). Under this proposal,

applicants would need to meet the three criteria evaluated under the traditional pathway in order to receive new technology add-on payments. Technologies under review for FFY 2027 for add-on payments under the alternative pathway would remain eligible for consideration in this pathway. Likewise, technologies already approved under the alternative pathway would remain eligible for add-on payments.

Chimeric Antigen Receptor (CAR) T-Cell Therapies

Pages 19392–19394, 19526–19527, and 19798

In the FFY 2021 final rule, CMS assigned cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to a new MS-DRG 018 [Chimeric Antigen Receptor (CAR) T-cell Immunotherapy]. As additional procedure codes for CAR-T cell therapies are created, CMS will use its established process to assign these procedure codes to the most appropriate MS-DRG.

As providers do not typically pay the cost of a drug for clinical trials, CMS proposes to continue the adjustment to the payment amount for clinical trial cases that group to MS-DRG 018. The proposed adjustment of 0.17 would be applied to the payment amount for clinical trial and expanded access use immunotherapy cases that group to MS-DRG 018, and other cases where the immunotherapy product is not purchased in the usual manner. To capture these payments within the relative weight methodology, in the FFY 2026 IPPS final rule CMS adopted to exclude claims with standardized drug charges below the median standardized drug charge of claims identified as clinical trials in MS-DRG 018 when calculating the average cost for MS-DRG 018. For FFY 2027, the median standardized charge is proposed to be $25,323. This policy is in effect for two years (FFY 2026 and 2027), until claims data reflects the addition of the code indicating that the immunotherapy product is not purchased in the usual manner.

Rural Referral Center (RRC) Status

Pages 19498–19499

Hospitals that meet a minimum case-mix and discharge criteria (as well as one of three optional criteria relating to specialty composition of medical staff, source of inpatients, or referral volume) may be classified as RRCs. This special status provides an exemption from the 12% rural cap on statutory DSH payments and exemption from the proximity criteria when applying for geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The proposed FFY 2027 minimum case-mix and discharge values by region are available on the pages listed above.

Low-Volume Hospital Adjustment

Pages 19319 and 19499–19503

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. The current payment adjustment formula for hospitals located more than 15 miles from another subsection (d) hospital, with between 500 and 3,800 total discharges is:

$$\text{Low Volume Hospital Payment Adjustment} = \frac{95}{330} - \frac{Total\ Discharges}{13{,}200}$$

Providers with less than 500 total discharges will receive a 25% payment increase. The Consolidated Appropriations Act (CAA) of 2026 extended the current criteria through December 31, 2026. On January 1, 2027, and subsequent years, the criteria for the low-volume hospital adjustment will return to more restrictive, statutory levels. To receive a low-volume adjustment under the statutory policy, subsection (d) hospitals will need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

For a hospital to acquire low-volume status for FFY 2027, consistent with historical practice, CMS is proposing that a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria for low volume hospital status. The MAC must receive a written request by September 1, 2026 for the adjustment to be applied to payments for its discharges beginning on or after October 1, 2026. For hospitals whose request is received after September 1, 2026, if accepted, the adjustment will be applied prospectively within 30 days of low-volume hospital determination.

A hospital that qualified for the low-volume hospital payment adjustment for FFY 2026 may continue to receive the adjustment for the period beginning January 1, 2027 without reapplying if it meets both the more restrictive discharge and mileage criteria applicable for this time frame.

Medicare-Dependent, Small Rural Hospital (MDH) Program

Pages 19319 and 19503–19504

The MDH program has been extended multiple times since its creation for FFY 2012, with the most recent extension being through December 31, 2026 as granted by the CAA of 2026. Beginning January 1, 2027, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based on the IPPS federal rate. Hospitals that will lose this status may apply for Sole Community Hospital status in advance of the expiration of the MDH program.

Transforming Episode Accountability Model (TEAM)

Pages 19656–19670

In the FFY 2025 IPPS final rule, CMS adopted a new five-year mandatory episode-based payment model with the goal of improving quality of care while reducing Medicare spending for beneficiaries undergoing certain high-expenditure, high-volume surgical procedures. The procedures included in this model are:

- Lower Extremity Joint Replacement;
- Surgical Hip/Femur Fracture Treatment;
- Spinal Fusion;
- Coronary Artery Bypass Graft; and
- Major Bowel Procedure.

This mandatory model began on January 1, 2026 and will last for five years. Hospitals required to participate were determined by CBSA, with CMS selecting 188 CBSAs using a stratified random sampling methodology from a list of

803 eligible CBSAs. These hospitals will continue to bill Medicare FFS but will have Medicare episode spend reconciled against hospital and beneficiary risk-adjusted target prices by episode type and region. These target prices will be based on regional Medicare episode spend with reconciliation payments/recoupments adjusted for quality performance. A 2.0% discount factor is applied for the Lower Extremity Joint Replacement, Surgical Hip/Femur Fracture Treatment, and Spinal Fusion episode categories; and a 1.5% discount factor is applied for the Coronary Artery Bypass Graft and Major Bowel Procedure episode categories.

A full discussion of TEAM, including details on how CBSAs were chosen, adopted episodes, quality measures and reporting, and other details can be found in the FFYs 2025 and 2026 IPPS rules.

Episodes

Pages 19656–19658

Inpatient episodes in TEAM rely on MS-DRG codes to identify when an anchor hospitalization is initiated. As such, any changes to MS-DRGs that are included in TEAM may affect episode volume and the number of beneficiaries included in the model. Should the proposed MS-DRGs updates that affect the spinal fusion category within IPPS be finalized, CMS is proposing to make conforming changes in TEAM.

For beneficiaries that are already in a CJR–X episode that have a procedure performed at a TEAM participant that would initiate a TEAM episode during the CJR–X 90-day post discharge period, CMS proposes to not attribute the episode to the TEAM participant.

Quality Measures

Pages 19658–19663

CMS is proposing to align measurement performance periods in TEAM for three quality measures that become effective in performance year two with the Hospital IQR Program. For the Hospital Harm-Falls with Injury and Hospital Harm-Postoperative Respiratory failure measures, CMS proposes to utilize a one calendar year measurement performance period. For the Thirty-day Risk-Standardized Death Rate among Surgical Impactions with Complications measure, CMS proposes to align with the Hospital IQR Program's two-year rolling measurement period. Table X.A.-02 on page 19659 shows the proposed quality measure performance periods for these measures.

Additionally, CMS is proposing two changes to the Composite Quality Score (CQS) within TEAM: establishing a sliding historical CQS baseline methodology; and aligning CQS baseline periods with the CMS hospital reporting program for specific measures that are currently not aligned. Table X.A.-03 on page 19660 shows the proposed TEAM performance year quality measure CQS baseline periods. CMS is also seeking feedback on alternative policies related to CQS baseline periods on pages 19659–19663.

Normalization Factor

Pages 19667–19668

Currently, the normalization factor is calculated at the MS-DRG/HCPCS and region level using the most recent baseline year only. CMS is concerned that this does not fully reflect all baseline episodes used to create benchmark prices and does not consistently re-center risk adjusted benchmark prices to the average of the total non-risk adjusted benchmark prices. Beginning in performance year two, CMS proposes to calculate the prospective normalization factor using all applicable episodes in the three-year baseline period. This is expected to improve predictive accuracy and smooth potential short-term fluctuations.

RFI—Ambulatory Surgical Center (ASC) Episodes

Page 19668

CMS is soliciting feedback on the inclusion of ASC episodes in TEAM, beginning in calendar year 2028 for performance year 3 the earliest, since procedures in ASCs would need to be incorporated into TEAM differently than those performed in the outpatient setting. Specifically, CMS is seeking comments on the questions on page 19668.

RFI—Hospital with Physician Ownership

Pages 19668–19670

CMS is considering allowing physician-owned hospitals that are located in CBSAs not selected for mandatory TEAM participation to voluntarily opt-in to the model. Specifically, CMS is seeking comments on the questions on pages 19669–19670.

Expansion of the CJR Model

Pages 19671–19729

The CJR Model was a mandatory alternative payment model tested by the Center for Medicare and Medicaid Innovation between April 1, 2016 and December 31, 2024 in all eligible acute care hospitals within selected Metropolitan Statistical Areas (MSAs). CMS is proposing to expand this model to all eligible acute care hospitals nationwide. The CJR–X Model aims to improve quality of care for lower extremity join replacements (LEJRs) by incentivizing hospitals, physicians, and post-acute care providers to work together to improve quality and coordination of care. If adopted, all eligible hospitals would be required to participate in the CJR–X Model beginning October 1, 2027.

Rather than aligning performance years (PYs) with CYs, the CJR–X model would use FFYs. Therefore, CMS is proposing that the first PY of the CJR–X Model would run from October 1, 2027 through September 30, 2028, and preceding PYs would follow the same structure. This would allow over a year for hospitals without experience with the original CJR Model to prepare for implementation.

CMS proposes to define a CJR–X participant as "*…an acute care hospital located in any of the 50 United States, District of Columbia, or U.S. Territory that initiates LEJR episodes and is paid under both the IPPS and OPPS, unless it meets an exception described in section X.C.2.b.(i.) of this proposed rule.*" Hospitals who are proposed to fall under this definition also include safety-net hospitals, hospitals located in rural areas or rural census tracts, Medicare-dependent hospitals and sole community hospitals. Hospitals participating in TEAM are excluded until TEAM ends on December 31, 2030. Hospitals located in Maryland are currently excluded but will be re-evaluated for inclusion in future rule making.

A full discussion of CJR–X, including proposed episodes, quality measures and reporting, appeals, and other details can be found on the pages listed above.

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

Pages 19670–19671

In order for a facility or organization associated with a hospital for have "provider-based" status it must satisfy specific criteria, which includes the location criterion demonstrating that it serves the "same patient population" as the main provider. This is done by *"…submitting records showing that, during the immediately preceding 12-month period, and for each subsequent 12-month period, that either: at least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider… or at least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider…."*

CMS is proposing to limit the application of the latter portion of this criterion to outpatient departments only.

Organ Acquisition Policies

Pages 19729–19751

CMS is proposing to hold Independent Organ Procurement Organizations (IOPOs) and Histocompatibility Laboratories (HCLs) to reasonable cost reimbursement for organ acquisition and transplantation services. The proposed policies are aligned with current regulations of reasonable cost reimbursement for kidney acquisition and transplantation services. Details on these policies, including proposals on reimbursement and reconciliation of acquisition costs, reasonable cost payment policies, and details on appeals can be found on the pages above.

Updates to the IQR Program and Electronic Reporting Under the Program

Pages 19564–19605

The tables on pages 19595–19596 outline the previously adopted and proposed Hospital IQR Program measure sets for FFYs 2028–2031 payment determination.

Proposed Modifications to Five Mortality Measures

Pages 19568–19574

Beginning with the FFY 2028 payment determination, CMS is proposing modifications to the following mortality measures in the Hospital IQR program:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization (MORT-30-AMI)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization (MORT-30-HF)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization (MORT-30-PN)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (MORT-30-COPD)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (MORT-30-CABG

Specifically, CMS is proposing to expand the measure inclusion criteria for these measures to include Medicare Advantage (MA) beneficiaries and to shorten the performance period for these measures from three years to two

years. The proposed performance period for the FFY 2028 payment determination would span from July 1, 2024–June 30, 2026. The modified mortality measures would be publicly reported on CMS' Care Compare beginning with the July 2027 update, or sooner if feasible.

As CMS is also proposing the same modifications to the five mortality measures in the VBP program beginning with the FFY 2032 payment determination, these measures would be removed from the IQR program beginning with the FFY 2032 payment determination.

CMS is also notifying the public of technical updates to the risk adjustment methodology for the five modified mortality measures proposed for both the IQR and VBP programs. This update includes the use of individual ICD-10 codes instead of the current hierarchical condition categories (HCCs).

Proposed New Measures, Measure Removals and Measure Modifications in Hospital IQR

Pages 19564–19568 and 19581–19594

CMS is proposing to add three new measures in the IQR program listed below:

- Advance Care Planning eCQM beginning with the FFY 2030 payment determination (pages 19564–19568)
- Excess Days in Acute Care (EDAC) After Hospitalization for Diabetes measure beginning with the FFY 2029 payment determination (pages 19581–19585)
- Hospital Harm-Postoperative Venous Thromboembolism (VTE) eCQM measure beginning with the FFY 2030 payment determination (pages 19585–19588)

Beginning with the FFY 2030 payment determination CMS is proposing to remove the following measures from the IQR program:

- VTE Prophylaxis (VTE-1) eCQM
- Intensive Care Unit VTE Prophylaxis (VTE-2) eCQM
- Discharged on Antithrombotic Therapy (STK-02) eCQM

The proposal to remove the VTE-1 and VTE-2 eCQMs are contingent upon whether CMS adopts the Hospital Harm-Postoperative VTE eCQM for the FFY 2030 payment determination.

Beginning with the FFY 2028 payment determination CMS is proposing to modify the following EDAC measures to expand the measure inclusion criteria to include MA beneficiaries and to update the performance period from three years to two years:

- EDAC after Hospitalization for Acute Myocardial Infarction (AMI EDAC)
- EDAC after Hospitalization for Heart Failure (Heart Failure EDAC)
- EDAC after Hospitalization for Pneumonia (Pneumonia EDAC)

CMS is also notifying the public of technical updates to the EDAC measures mentioned above. Beginning with the FFY 2028 payment determination, the risk adjustment methodology for the three measures will use individual ICD-10 codes instead of the HCCs.

Data Reporting and Submission Requirements for eCQMs and Structural Measures

Pages 19600–19605

CMS is proposing changes to the reporting and submission requirements for some eCQMs and structural measures. In alignment with CMS' strategy to transition to a fully digital quality measurement landscape and focus on well-being and nutrition, CMS is proposing mandatory reporting for the Malnutrition Care Score eCQM beginning with the CY 2028 reporting period/FFY 2030 payment determination. Hospitals would be able to continue to self-select this eCQM for the CYs 2026 and 2027 reporting periods before mandatory reporting begins in CY 2028.
Beginning with the FFY 2030 payment determination CMS is proposing that the Hospital Harm eCQMs that have not been previously finalized for mandatory reporting to become mandatory in the third year of reporting. Under this proposal, newly adopted Hospital Harm eCQMs would require mandatory reporting after two years of reporting in the Hospital IQR Program and Medicare Promoting Interoperability Program. Table IX.C.9 on page 19603 outlines the full list of proposed Hospital Harm eCQM reporting and submission requirements for the FFY 2030 payment determination and subsequent years.

Additionally, Table IX.C.10 on page 19604 outlines proposed eCQM reporting and submission requirements for FFY 2030 payment determination and subsequent years for all eCQMs.

Beginning with the FFY 2028 payment determination CMS is proposing to update the reporting requirements for the Maternal Morbidity Structural measure. This update would require hospitals to report the name of the perinatal quality improvement collaborative program if the hospital answers "yes" to the measure question. A hospital that attests "yes" to the measure question but does not provide the name of the perinatal quality improvement collaborative program in which they participate would not be considered as successfully reporting all requirements for the measure and would be subject to a payment penalty.

RFI—Emergency Care Access and Timeliness eCQM

Pages 19574–19577

CMS is requesting comments on the potential use of the Emergency Care Access and Timeliness eCQM in both the IQR and VBP programs. Specifically, CMS is requesting input on questions listed on page 19577.

RFI—Adult Community-Onset Sepsis Standardized Mortality Ratio measure

Pages 19578–19580

CMS is requesting comments on the potential use of the Adult Community-Onset Sepsis Standardized Mortality Ratio measure in the IQR program. Specifically, CMS is requesting input on questions listed on page 19580.

RFI—Birthing Friendly Hospital Designation Modification to Expand Designation Criteria

Pages 19597–19600

CMS is requesting comments on the potential modifications to the current Birthing Friendly Hospital Designation. These modifications include the following:

- Expanding the designation to include two maternal care quality outcome measures: Cesarean Birth eCQM and Severe Obstetric Complications eCQM;
- Potential new scoring methodology; and
- Potential new tiered approach to awarding the current Birthing-Friendly hospital designation

Specifically, CMS is requesting input on questions listed on page 19600.

Quality-Based Payment Programs

Pages 19527–19547 and 19568–19577

For FFY 2027, IPPS payments will be adjusted for quality performance under the VBP program, RRP, and the HAC Reduction program. Details on the FFY 2027 programs, payment adjustment factors, and new policies CMS is proposing in the quality-based payment programs are discussed below.

VBP Program

Pages 19538–19546 and 19568–19577

FFY 2027 Payment Adjustment

The FFY 2027 program will include hospital quality data for 18 measures in four domains: safety; clinical outcomes; person and community engagement; and efficiency and cost reduction. By law, the VBP program must be budget neutral and the FFY 2027 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria. Hospitals can earn back some, all, or more than their individual 2.0% reduction from the pool, estimated to be approximately $1.9 billion.

While the data applicable to the FFY 2027 VBP program is still being aggregated, CMS has calculated and published proxy factors and the linear exchange function slope of 3.4503276602 based on the historical baseline and performance periods used in the FFY 2026 program and the December 2025 update to the FFY 2025 MedPAR file. Hospitals should use caution in reviewing these factors as they do not reflect updated performance periods/standards, nor changes to hospital eligibility.

The proxy factors and slope published with the proposed rule are available in Table 16 on the CMS website at https://www.cms.gov/files/zip/fy2027-ipps-nprm-table-16.zip.

CMS expects the actual FFY 2027 VBP adjustment factors to be available in Table 16B in fall of 2026. Details and information on the program are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hvbp.

Baseline periods, performance periods, and performance standards were previously adopted for a subset of measures for the FFYs 2027–2032 programs. This information is outlined in the tables found on pages 19539–19546. CMS is proposing further program updates through FFY 2032, described in the next section.

Future Program Years

For a list of the newly established performance standards for FFY 2029 and FFY 2032 program years please refer to tables on pages 19545–19546.

Beginning with FFY 2032 program year, CMS is proposing to modify the five mortality measures in the Clinical Outcomes domain to expand the measure inclusion criteria to include MA beneficiaries and shorten the performance period from three years to two years. These modifications in the VBP program are contingent on CMS adopting the same updates in the Hospital IQR program beginning with the FFY 2028 payment determination, as discussed earlier in this brief.

RRP

Pages 19527–19538

FFY 2027 Payment Adjustment

The FFY 2027 RRP will use data from July 1, 2023–June 30, 2025 and evaluate hospitals on six conditions/procedures: AMI, HF, PN, COPD, THA/TKA, and CABG.

The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

Hospitals are grouped into peer groups (quintiles) based on their percentage of full-benefit dual-eligible patients as a ratio of total Medicare FFS and MA patients during the same two-year period as the program performance period. Hospital excess readmission ratios are compared to the median excess readmission ratio of all hospitals within their quintile for each of the measures. A uniform modifier is applied such that the adjustment is budget neutral nationally.

The data applicable to the FFY 2027 RRP program is still being reviewed and corrected by hospitals, and therefore CMS has not yet posted factors for the FFY 2027 program in Table 15. CMS expects to release the final FFY 2027 RRP factors in the fall of 2026.

Details and information on the RRP are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hrrp.

Future Program Years

Beginning with FFY 2029 program year, CMS is proposing to add the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure (Sepsis Readmission measure). The methodology calculation for this measure would align with the methodology for the current measures in the RRP. Detailed methodology for the Sepsis Readmission measure is available on CMS' QualityNet at https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.

CMS proposes to provide hospitals with an "early look" of their Sepsis Readmission measure results and estimated payment adjustments with the addition of the new measure for the FFY 2028 program year, with an applicable from July 1, 2024 to June 30, 2026. This data would not be publicly reported or used for payment adjustments until the FFY 2029 program year, which would have an applicable period of July 1, 2025 to June 30, 2027.

HAC Reduction Program

Pages 19546–19547

FFY 2027 Payment Adjustment

The FFY 2027 HAC reduction program will evaluate hospital performance on six measures:

- AHRQ Patient Safety Indicator (PSI)-90 (a composite of ten individual HAC measures);
- Central Line-Associated Bloodstream Infection (CLABSI);
- Catheter-Associated Urinary Tract Infection (CAUTI);
- Surgical Site Infection (SSI) Pooled Standardized Infection Ratio (SIR);
- Methicillin-resistant Staphylococcus Aurea (MRSA); and
- Clostridium difficile (C.diff.) rates.

The HAC reduction program is not budget neutral; hospitals with a total HAC score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in total IPPS payments. Total HAC scores are calculated by applying an equal weight to each measure for which a hospital has a score.

CMS uses a continuous z-score methodology for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

Details and information on the HAC currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hac.

Future Program Years

CMS is not proposing any updates to the HAC Reduction Program at this time.

Medicare Promoting Interoperability Program

Pages 19316, 19564–19568 and 19618–19655

The Medicare Promoting Interoperability program provides incentive payments and payment reductions for the adoption and meaningful use of certified EHR (CEHRT) technology.

Beginning with the CY 2028 reporting period CMS is proposing to remove the VTE-1, VTE-2 and STK-02 eCQM measures and add the Advanced Care Planning eCQM in alignment with the hospital IQR program.

In the Health Data, Technology, and Interoperability: ASTP/Office of National Coordinator for Health IT (ONC) Deregulatory Actions to Unleash Prosperity proposed rule (HTI–5 proposed rule) published on December 29, 2025, ONC proposed a number of updates to the ONC Health IT Certification Program that are relevant to the eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program. Table IX.F.-01. on page 19619 outlines the HTI-5 proposed updates and their relevance to the CEHRT definition for the Medicare Interoperability Program. CMS is proposing to revise the definition for CEHRT for the Medicare Promoting Interoperability Program to align the definition with certain proposed modifications to ONC health IT certification criteria in the HTI-5 proposed rule. Specifically, CMS proposes to remove references to the "family health history", "patient health information capture", "automated numerator recording", and "automated measure calculation" certification criteria effective January 1, 2027. CMS does not believe that ONC must finalize its proposed revisions in the HTI–5 proposed rule for CMS to finalize the proposed changes to the CEHRT definition for the Medicare Promoting Interoperability Program.

The Medicare Promoting Interoperability Program currently requires two attestations, the required ONC Direct Review attestation and the optional ONC-Authorized Certification Body Surveillance attestation. At the time these attestations were finalized CMS believed they would complement and strengthen updates to ONC's ability to perform surveillance and direct review activities. CMS no longer believes that the attestation requirements are necessary to demonstrate the meaningful use of CEHRT and is proposing to remove both attestations beginning with the CY 2026 EHR reporting period. Eligible hospitals and CAHs would not have to report these attestations by the March 1, 2027 submission deadline and there would be no effect on their FFY 2028 payment determination or FFY 2026 cost reimbursement, respectively.

The Health Information Exchange (HIE) objective currently includes five measures: Support Electronic Referral Loops by Sending Health Information, Support Electronic Referral Loops by Receiving and Reconciling Health Information, HIE Bi-Directional Exchange, Enabling Exchange Under Trusted Exchange Framework and Common Agreement (TEFCA) measure, and Electronic Prior Authorization.

Under the current policy an eligible hospital or CAH must satisfy the HIE objective by using one of three reporting options:

- Report on the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure
- Report on the HIE Bi-Directional Exchange measure
- Report on the Enabling Exchange under TEFCA measure

To streamline reporting and reduce complexity of multiple measure reporting options for the HIE objective, CMS is proposing to remove the Support Electronic Referral Loops by Sending Health Information and Support Electronic Referral Loops by Receiving and Reconciling Health Information measure beginning with the CY 2028 EHR reporting period. Eligible hospitals and CAHs would fulfill HIE objective requirements by reporting on the HIE Bi-Directional Exchange measure or Enabling Exchange under TEFCA measure in addition to meeting the Electronic Prior Authorization measure requirement. CMS proposes to maintain the same scoring methodology for the two measure options, resulting in a maximum score of 30 points.

CMS is also proposing to make several changes to the Electronic Prior Authorization measure beginning with the CY 2027 EHR reporting period. The proposed changes include modifying text for the measure description to update the phrase “using data from CEHRT” to “using CEHRT” and changing the word “discharge” to “encounter”.

CMS considered whether to propose to revise the measure language so that an eligible hospital or CAH would be able to attest to the measure by using CEHRT to conduct a check for whether an item or service requires prior authorization, regardless of whether the query results in a request and approval of the prior authorization. CMS is requesting comment on whether the added flexibility associated with this alternative approach would make a meaningful difference, especially for eligible hospitals and CAHs seeking to initially focus on adoption of the functionality in the ‘‘provider prior authorization API-coverage requirements discovery’’ criterion. CMS also considered whether to include prior authorization for drugs administered during the hospitalization in the measure and is requesting comment on whether adding drugs to the measure would be of benefit.

In the 2024 CMS Interoperability and Prior Authorization final rule, CMS adopted a requirement for eligible hospitals or CAHs to report the Electronic Prior Authorization measure to be considered a meaningful EHR user for the EHR reporting period in CY 2027. CMS believes hospitals and CAHs may need additional time and flexibility before requiring the measure and is proposing to make the Electronic Prior Authorization measure optional and eligible for bonus points for the CY 2027 EHR reporting period. Eligible hospitals and CAHs that attest ‘‘Yes’’ to the measure would receive the 10 bonus points, and exclusions would not be available for the measure as it would be an optional measure.

Additionally, CMS is proposing that the Electronic Prior Authorization measure would be required for reporting beginning with the CY 2028 EHR reporting period. CMS is also proposing that an eligible hospital or CAH must request a prior authorization electronically using CEHRT to send a request through a payer’s Prior Authorization API for at least one medical item or service (excluding drugs) ordered during a hospital encounter that occurs within the EHR reporting period to attest ‘‘Yes’’ to the measure, or else the eligible hospital or CAH must claim an applicable exclusion. When CMS originally adopted the Electronic Prior Authorization measure a scoring methodology was not specified for CY 2028 and subsequent years. CMS is proposing that the measure would remain unscored for the reporting period in CY 2028 and subsequent years to allow providers to adjust to the new electronic prior authorization APIs.

CMS believes integrating a Unique Device Identifier (UDI) focused measure into the Medicare Interoperability Program *"…would foster consistent workflows for capturing device data as discrete EHR elements and strengthen the ability of eligible hospitals, CAHs, beneficiaries, and public health agencies to use interoperable health information to improve outcomes, manage risk, and respond rapidly to device-related safety concerns."* Therefore, CMS is proposing to add the UDIs for Implantable Medical Devices measure under the Public Health and Clinical Data Exchange objective in the CY 2027 EHR reporting period. Measure details for the proposed measure include the following:

- *"Measure Description: The eligible hospital or CAH uses CEHRT during the EHR reporting period to electronically capture and store, as one or more discrete data elements within the patient's electronic health record, the complete Unique Device Identifier (UDI), which includes the device identifier and, when present on the device label, the production identifier, for each implantable medical device subject to UDI requirements used for patient care delivery.*
- *Reporting Requirements: ''Yes'' or ''No'' attestation.*
- *Exclusion: The eligible hospital or CAH implanted five or fewer medical devices subject to UDI requirements during the calendar year of the applicable EHR reporting period."*

Under this proposal CMS notes that not providing a "yes" or "no" attestation would result in failure to meet the minimum program requirements and subject the provider to a downward payment adjustment. While no points would be assigned to the measure it would be one of seven measures required to satisfy the Public Health and Clinical Data Exchange objective.

Additionally, some devices and custom devices are exempt from the UDI requirements and would be exempt from the proposed measure but CMS notes that they intend to propose modifying the measure in future rulemaking.

The table below outlines the proposed performance-based scoring methodology for EHR Reporting periods for CY 2027 and subsequent years.

Objectives	Measures	Maximum Points	Redistribution if Exclusion Claimed
Electronic Prescribing (e-Prescribing)	e-Prescribing	10 points	10 points to HIE Objective
	Query of Prescription Drug Monitoring Program	10 points	10 points to e-Prescribing measure
HIE	Support Electronic Referral Loops by Sending Health Information **(proposed for removal for CY 2028+)**	15 points	No exclusion
	Support Electronic Referral Loops by Receiving and Reconciling Heath Information **(proposed for removal for CY 2028+)**	15 points	No exclusion
	Or		
	HIE Bi-Directional Exchange measure	30 points	No exclusion
	Or		
	Enabling Exchange under TEFCA	30 points	No exclusion

	Electronic Prior Authorization **(proposed as optional reporting for CY 2027, and mandatory reporting for CY 2028+)**	10 bonus points for CY 2027; Unscored for CY 2028+	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	
Public Health and Clinical Data Exchange	Required with yes/no response • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AU Surveillance • AR Surveillance • UDI **(proposed for CY 2027+)**	25 points	If an exclusion is claimed for all 5 measures, 25 points redistributed to Provide Patients Electronic Access to their Health Information
	Optional to report one of the following • Public Health Registry Reporting • Clinical Data Registry Reporting • Public Health Reporting Using TEFCA	5 points (bonus)	

RFI—Future Potential Performance-Based Measure of Electronic Prior Authorization

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CMS is requesting comments on the potential future updates to the Electronic Prior Authorization measure to incentivize providers to use electronic prior authorization for a more substantial set of the electronic prior authorization requests that they submit over the course of an EHR reporting period. CMS also seeks comments on barriers and challenges small, rural, or under-resourced eligible hospitals and CAHs might face reporting a performance-based electronic prior authorization measure.

RFI—Future Direction of the Proposed UDIs for Implantable Devices Measure and Additional Options for Utilizing UDI

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If the proposed UDIs for Implantable Medical Devices measure is adopted CMS also intends to consider future modifications to the measure and seeks comments on questions outlined on the page listed above.

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