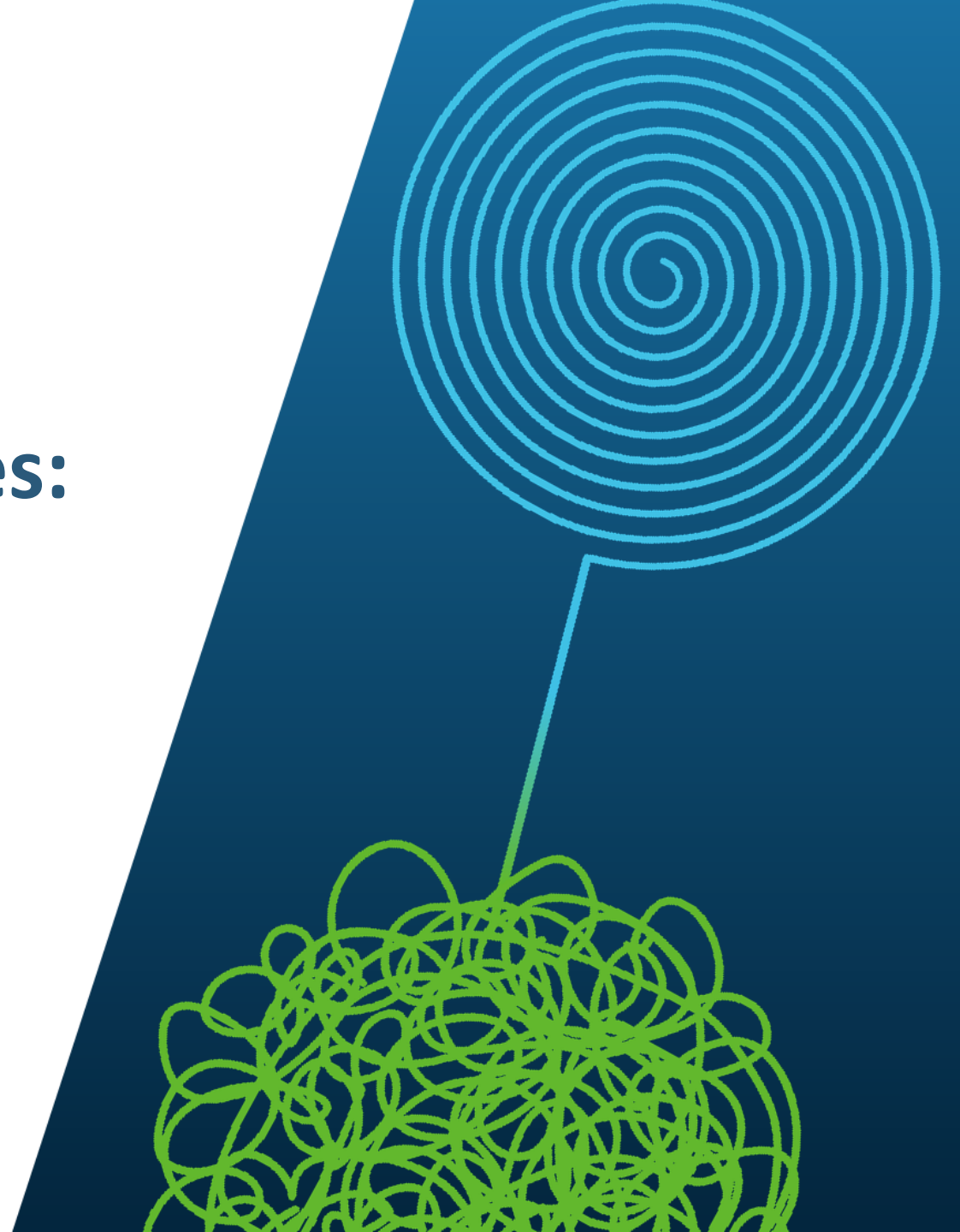
Healthcare Regulatory Roundup #117

FY 2027 Medicare Final Rules:

Inpatient, SNF, Rehab, Psych and Hospice Updates

August 26, 2026



Housekeeping

- Slides, handouts, and forms are available in the **Resources Panel**
- Enter questions in the **Q&A Panel**, questions will be responded to via email after the webinar
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Introductions

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Today's Agenda

1. Federal Fiscal Year (FFY) 2027 Hospital Inpatient Prospective Payment System Final Rule
2. FFY 2027 Long-term Care Hospital Prospective Payment System Final Rule
3. FFY 2027 Skilled Nursing Facility Prospective Payment System Final Rule
4. FFY 2027 Inpatient Psychiatric Facility Prospective Payment System Final Rule
5. FFY 2027 Inpatient Rehabilitation Facility Prospective Payment System Final Rule
6. FFY 2027 Hospice Payment Rate Update

1. FFY 2027 Hospital Inpatient Prospective Payment System Final Rule

IPPS Payment Update

- Finalized a 2.3% IPPS operating and capital market basket to reflect 2023 base year
  - Based on market basket increase of 3.2% less 0.9 percentage point productivity adjustment
  - Had proposed a 2.4% increase reflecting 0.8 percentage point productivity adjustment
- No change in national labor-related share (i.e., portion subject to wage index adjustment)
  - 66% for hospitals with wage index >1.0
  - 62% for hospitals with wage index of ≤1.0
- Capital payment rate set at $540.03 (had proposed $545.22; currently $524.15)
- Increase IPPS outlier threshold to $49,346 (had proposed $51,704; currently $40,397)
- Uncompensated care payments of $7.94 billion: 2.9% increase from FY 2026 payments of $7.71 billion (had proposed a 3.3% decrease - $7.46 billion)
- **Actual impact based on all final changes = 1.7%**

IPPS Payment Rates

TABLE 1A.— NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (66.0 PERCENT LABOR SHARE/34.0 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)--FY 2027 FINAL RULE

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.3 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.1 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.5 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.9 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,520.33	$2,328.65	$4,414.28	$2,274.02	$4,484.98	$2,310.44	$4,378.93	$2,255.81

TABLE 1B.— NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2027 FINAL RULE

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.3 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = -0.1 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.5 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.9 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,246.37	$2,602.61	$4,146.75	$2,541.55	$4,213.16	$2,582.26	$4,113.54	$2,521.20

LVH and MDH Concerns

Low-volume hospitals

- Continue to qualify for the enhanced low-volume hospital payment adjustment if they have fewer than 3,800 discharges and are located more than 15 road miles from another subsection (d) hospital **for the first three months of FY 2027**
- **Absent Congressional action, beginning January 1, 2027, temporary statutory expansion expires**
  - Would limit eligibility to hospitals with fewer than 200 discharges that are located more than 25 road miles from another subsection (d) hospital
- For the first three months for FY 2027, rule finalizes a 25% LVH payment adjustment

Medicare-dependent hospitals

- Absent Congressional action, the MDH program expires December 31, 2026
- Current MDHs would be paid solely under the IPPS rate beginning January 1, 2027

MS-DRG Changes

Final rule reflects new DRGs related to:

- Complex spinal fusion procedures (MS-DRGs 523-525)
- Hip and knee procedures involving periprosthetic joint infections (MS-DRGs 403-404)
- Cardiac pacemaker revision and replacement procedures (MS-DRGs 210-211)

Also includes elimination/modification of some existing MS-DRGs

Reclassifies ICD-10-CM diagnosis codes

- Homelessness, inadequate housing, and housing instability reclassified from complication/comorbidity (CC) to non-CC

New Technology Add-On Payments (NTAP)

- Approved 19 new technologies for NTAP effective for FY 2027
- Continues NTAP eligibility of 41 existing technologies and discontinues for 13 that no longer qualify as new
- Finalized elimination of alternative NTAP qualification pathways
  - Effective with FY 2028 applications
  - Will require all applicants to meet the same statutory standards

Mandatory Comprehensive Care for Joint Replacement Model – CJR-X

- **Nationwide expansion will now be effective January 1, 2028 (had proposed 10/1/27)**
  - Hospitals required to take financial accountability for hip, knee, and ankle replacements
  - Episode of care covers initial surgery, hospital stay, and first 90 days of recovery/therapy
- **Applies to Original Medicare beneficiaries only**

- **Applies to all acute care hospitals paid under both IPPS and OPPS**
  - Exclusions:
    - TEAM hospitals until 2031
    - Hospitals in Maryland
    - Hospitals with fewer than 31 LEJR episodes in the baseline period are treated as low-volume and rely on a regional-based benchmark rather than hospital-specific; also excluded from reconciliation for any performance year in which the hospital does not exceed the exclusion threshold

CJR-X Episodes of Care

MS-DRG 469

Major joint replacement or reattachment of lower extremity with major complications or comorbidities (MCC)

MS-DRG 470

Major joint replacement or reattachment of lower extremity without MCC

MS-DRG 521

Hip replacement with principal diagnosis of hip fracture with MCC

MS-DRG 522

Hip replacement with principal diagnosis of hip fracture without MCC

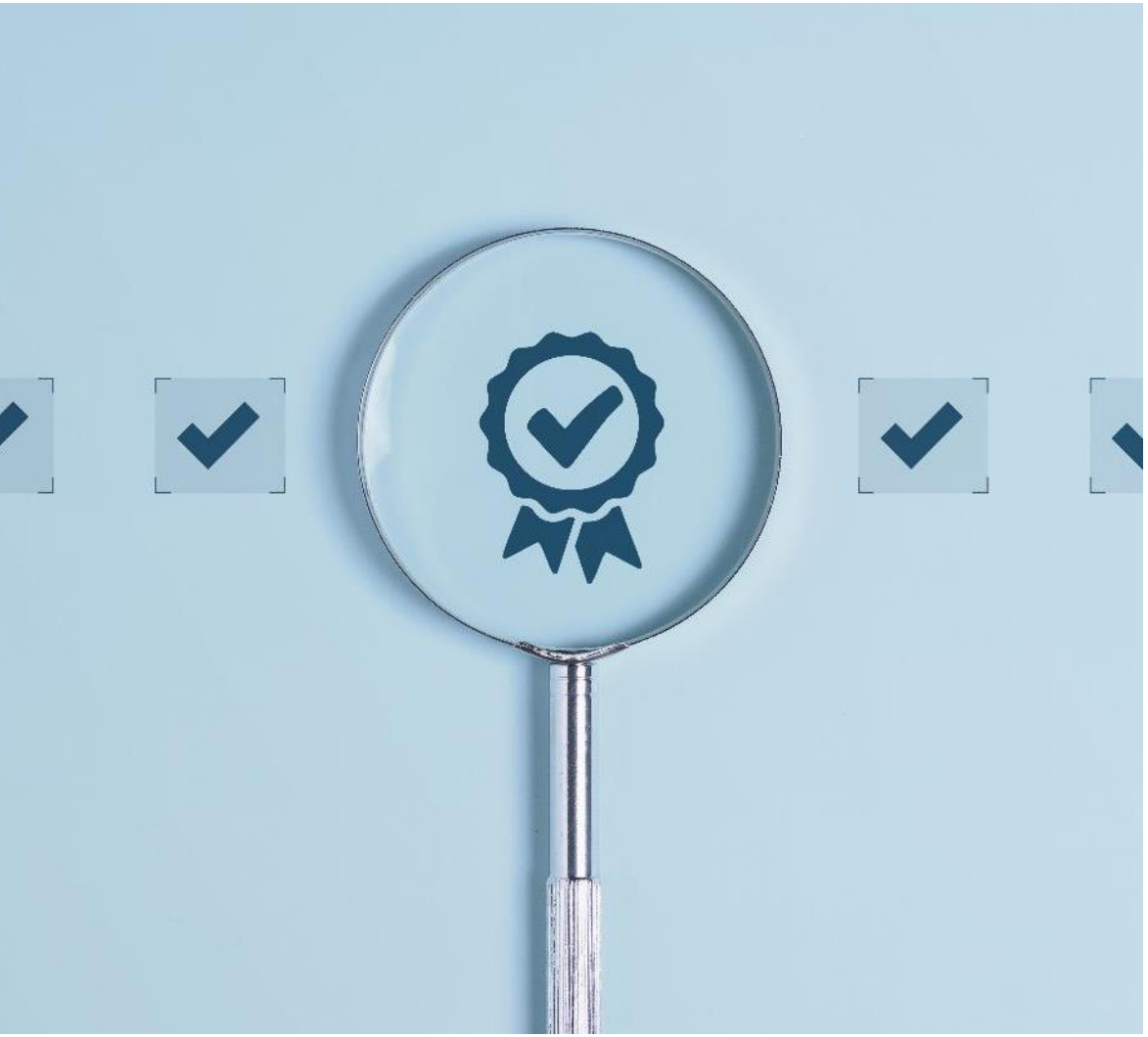
HCPCS 27447

Total knee arthroplasty (TKA)

HCPCS 27130

Total hip arthroplasty (THA)

CJR-X Quality Measures



- Hospital-level Risk-Standardized Complication Rate following elective primary THA and/or TKA
- Hospital visits within seven days of Hospital Outpatient Department (HOPD) Surgery
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey
- Outpatient and Ambulatory Surgery (OAS) CAHPS Survey
- Hospital-Level THA/TKA Patient Reported Outcome (PRO)-based Performance Measure

Calculating the Benchmark

- Three years of baseline data: October 1, 2023, through September 30, 2026, trended forward
- Proposed discount factor of 2% reflective of Medicare's portion of potential savings from each episode
- Benchmark prices calculated at the MS-DRG/HCPCS code level
- At the end of a model performance year –
  - Actual spending for the episode compared to the participant's target price
  - Composite quality scores evaluated
- Would apply a 20% stop-gain/stop-loss limit for most providers
  - Limited to 5% for safety net, rural hospitals, Medicare Dependent Hospitals (MDH) and sole community hospitals (SCH)

Hospital Inpatient Quality Reporting Program

- **Addition** of three new measures:
  1. Excess Days in Acute Care after Hospitalization for Diabetes (beginning with FY 2029 payment determination)
  2. Hospital Harm-Postoperative Venous Thromboembolism eCQM (beginning with FY 2030 payment determination)
  3. Advance Care Planning eCQM (beginning with FY 2030 payment determination)
- Finalized adoption of five modified mortality measures effective with FY 2028 payment determination
  - Measures 30-day, all cause, risk-standardized mortality following hospitalization for acute myocardial infarction, heart failure, CABG surgery, pneumonia and COPD
- Includes Medicare Advantage patients and shortens the performance period from 3 years to 2 years

Hospital Inpatient Quality Reporting Program

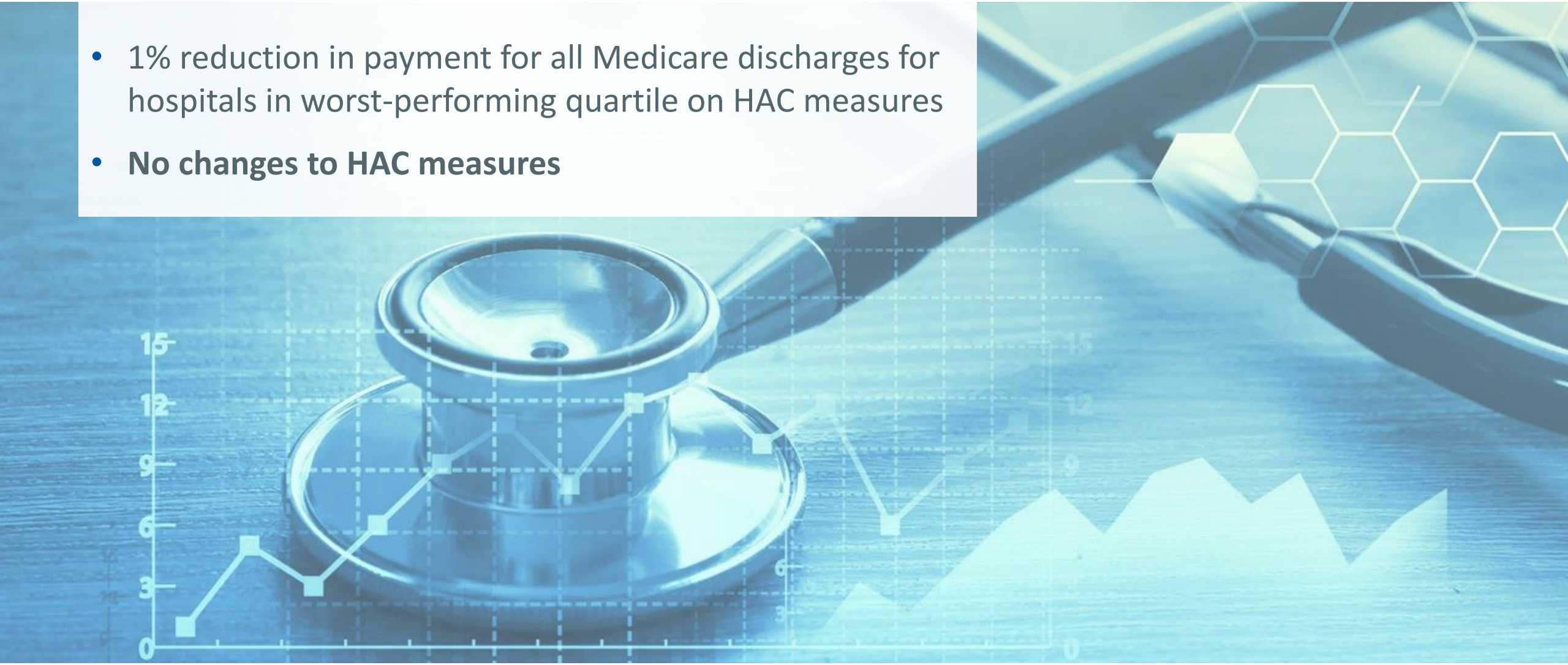
- **Removal** of three measures effective with the FY 2030 payment determination:
  1. Venous Thromboembolism Prophylaxis (VTE-1) eCQM
  2. Intensive Care Unit Venous Thromboembolism Prophylaxis (VTE-2) eCQM
  3. Discharge on Antithrombotic Therapy (STK-02) eCQM
- **Modification** of three measures effective with FY 2028 payment determination:
  1. Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
  2. Excess Days in Acute Care after Hospitalization for Heart Failure
  3. Excess Days in Acute Care after Hospitalization for Pneumonia
- Finalized additional mandatory reporting:
  - Malnutrition Care Score eCQM beginning with FY 2030 payment determination
  - Hospital harm eCQMs after two years of reporting beginning with FY 2030 payment determination

Hospital Readmission Reduction Program

- Hospitals with higher-than-expected 30-day readmission rates penalized up to 3% of hospital's base Medicare inpatient payments
- Finalized adoption of Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure impacting payments starting in FY 2030 (had proposed FY 2029)
- Includes Medicare Advantage patients and shortens the performance period from 3 years to 2 years

Hospital Acquired Condition (HAC) Reduction Program

- 1% reduction in payment for all Medicare discharges for hospitals in worst-performing quartile on HAC measures
- **No changes to HAC measures**



Provider-Based Status

Serves the same patient population:

Currently met by "immediate vicinity" of the main provider, defined as within 35 miles

- If entity does not meet the 35-mile test:
  1. At least 75% of the patients reside in the same zip codes as at least 75% of the main provider's patients

     – OR –

  2. At least 75% of patients who require services furnished by the main provider receive those services from that provider

Finalized

- Limit both options under the 75% test to outpatient departments only
- Inpatient facilities limited to geographic (zip code) overlap test
  - Can no longer rely on the referral-based test

Transforming Episode Accountability Model (TEAM)

- Final rule includes adjustments to episode definitions, attribution methodologies, quality measures, and pricing calculations
  - Expansion of eligible spinal fusion episodes with 3 new MS-DRGs
  - Refinement of attribution methodologies
  - Alignment of quality measures with other CMS programs
  - Updates to target pricing methodologies to incorporate annual OPPS and IPPS updates

2. FFY 2027 Long-Term Care Hospital Prospective Payment System Final Rule

LTCH PPS Payment Update

- Update of 2.3% to LTCH PPS
- Maintains outlier threshold at $78,936

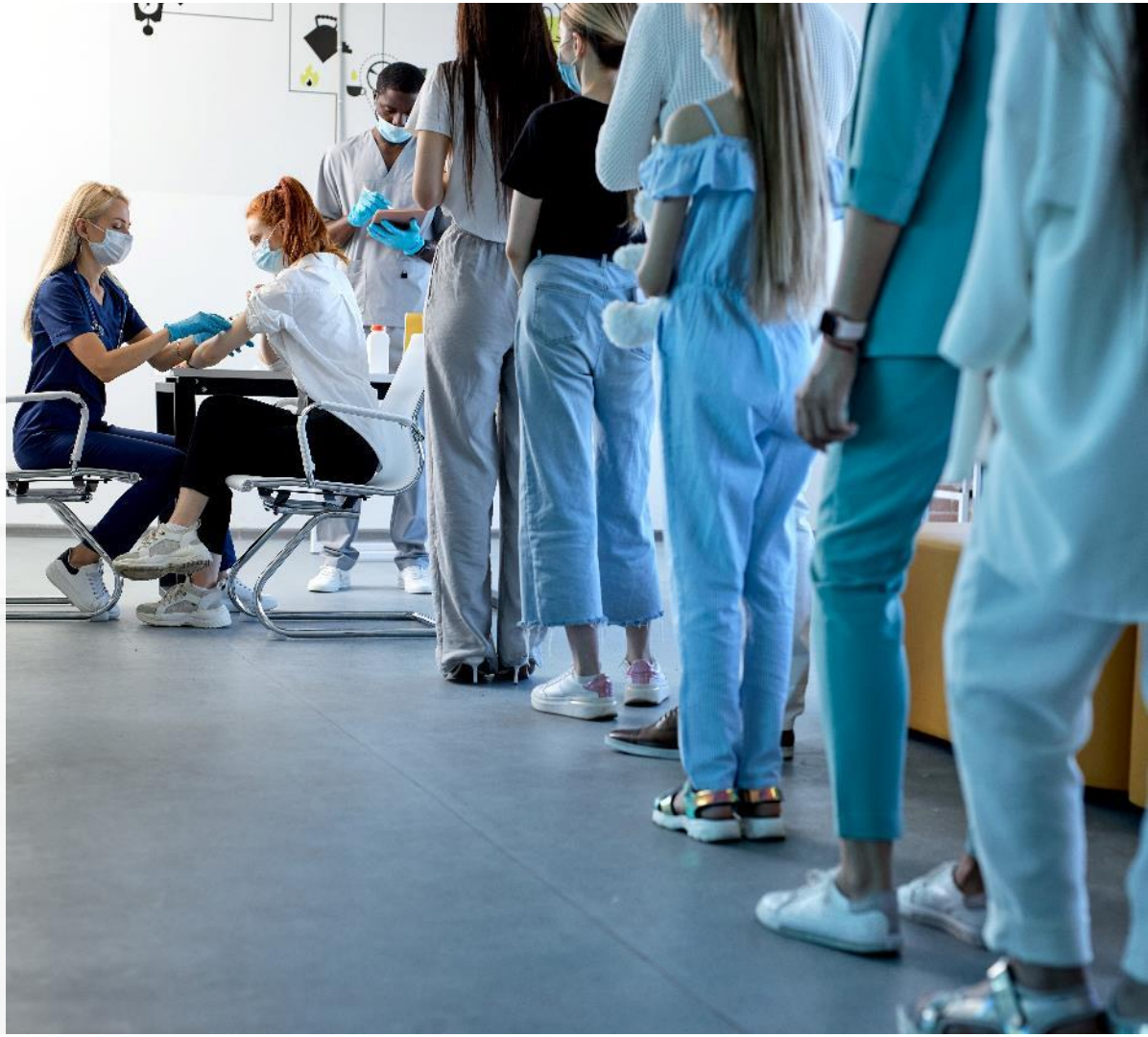
TABLE 1E.— LTCH PPS STANDARD FEDERAL PAYMENT RATE--FY 2027 FINAL RULE

	Full Update (2.3 Percent)	Reduced Update* (0.3 Percent)
Standard Federal Rate	$52,132.76	$51,113.55

* For LTCHs that fail to submit quality reporting data for FY 2027 in accordance with the LTCH Quality Reporting Program (LTCH QRP), the annual update is reduced by 2.0 percentage points as required by section 1886(m)(5) of the Act.

LTCH Quality Reporting Program (LTCH QRP)

- Finalizes removal of two LTCH QRP measures:
  1. COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP)
  2. COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
- Maintains existing LTCH QRP structure and payment penalties for non-compliance
- Finalizes revision to the timeframe for data submission **from 4.5 months after the end of a reporting quarter to 45 days after the quarter ends**, effective with the FY 2029 LTCH QRP



3. FFY 2027 Skilled Nursing Facility Prospective Payment System Final Rule

Payment Update

Updates payment rates by 2.4%

(vs. 3.2% update for FFY 2026)

Based on SNF market basket increase of 3.3%, less 0.9 percentage point productivity adjustment

No forecast error adjustment as the adjustment of 0.2 percent would fall below the 0.5 percent threshold trigger

Labor-related share of 72%

(currently 71.9%)

Concern with SNF "Case Mix Creep"

- **No payment adjustments at this time**, but CMS expressed concern regarding increases in coding for:

- Discussion in the final rule clearly shows **CMS' ongoing scrutiny of PDPM coding patterns**

SNF Quality Reporting Program

Finalized removal of two quality measures focused on COVID-19 vaccinations:

- COVID-19 Vaccination Coverage among Healthcare Personnel
- COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

- SNFs that do not report this data for CY 2026 will not be penalized for the FY 2028 update and any data reported will not be used

Finalized revision to the timeframe for data submission of the SNF Minimum Data (MDS) Set/National Healthcare Safety Network (NHSN) **from 4.5 months after the quarter ends to no later than the 15th day of the second month after the end of each calendar quarter**, effective with the FY 2029 SNF QRP

Minimum Data Set Submission

- Finalized requirement that SNFs submit MDS data on **all** SNF residents, regardless of payer, effective with the FY 2031 SNF QRP
  - Applies to all residents admitted on or after October 1, 2029
  - Addition of MDS items to support this change:
    - Primary payer information
    - Skilled stay start and end dates
    - Indicators for non-Medicare fee-for-service skilled stays

4. FFY 2027 Inpatient Psychiatric Facility Prospective Payment System Final Rule

Payment Update

- Update payment rates by 2.3% based on 2021 data (vs. 2.4% final increase for FFY 2026)
  - Reflects market basket increase of 3.2% less 0.9 percentage point productivity adjustment

- Federal per diem rate increased to $912.40 (now $892.87)
  - Payment for those providers failing to meet quality reporting requirements reduced by 2 percentage points
  - Payment for electroconvulsive therapy would increase to $688.59 (now $673.85)

Payment Update

- Labor-related share updated from 79% to 78.9% (had proposed 79.1%)
  - Changes the impact of the wage index on payments
  - Continues to apply a 5% cap on year-to-year decreases in a provider's wage index
- Additional payment adjustment for rural IPFs of 18% to the federal per diem rate
- Cost outliers: payments intended to limit the financial risk of unusually costly patients
  - Fixed dollar loss threshold would increase from $39,360 to $40,750 (had proposed a decrease)
  - Finalized new facility-level outlier cap, effective October 1, 2027
    - Outlier payments cannot exceed 20% of an IPF's total annual IPF PPS payments
    - Policy applies only to facilities with 50 or more stays annually
    - IPFs exceeding the cap would no longer receive outlier payments

Standardized IPF Patient Assessment Instrument (IPF-PAI)

Mandated by Consolidated Appropriations Act, 2023

Revised assessment tool is intended to:

- Standardize patient assessment data
- Improve quality measurement
- Enhance care planning
- Support future payment and quality initiatives
- Enable broader data collection across psychiatric settings

Voluntary report begins October 1, 2027, with mandatory reporting July 1, 2028

- Payment adjustments for non-compliance would begin with FY 2030

Quality Reporting Program

- Finalized **removal** of two quality measures:
  1. **SUB-2/2a**
     (Alcohol and Other Drug Use Treatment Provided or Offered at Discharge)
  2. **TOB-3/3a**
     (Tobacco Use Treatment Provided or Offered at Discharge)

5. FFY 2027 Inpatient Rehabilitation Facility Prospective Payment System Final Rule

Payment Update

- Update payment rates by 2.3% (had proposed 2.4%; received 2.6% update for FY 2026)
  - Based on IRF market basket increase of 3.2% less 0.9 percentage point productivity adjustment
- Federal base rate would increase to $19,868 (currently $19,371)
- Decrease in labor-related share to 74.3% from current level of 74.4% (had proposed a slight increase)
  - Final year of phase-out of the rural adjustment for IRFs transitioning from rural to urban due to changes in Core-Based Statistical Area delineations
- Decreased outlier threshold from $10,141 to $8,857
  - More cases now expected to qualify for outlier payments, particularly those for medically complex patients
- After incorporating wage index and case mix adjustments, actual payments will increase, on average, about 2.7%

Payment Reform

- No major payment-reform changes finalized, but CMS appears to signal future modifications are being considered:

Patient classification methodology

Comorbidity adjustments

Alternative payment approaches

Potential refinements to rehabilitation case mix categories

Initiation of Therapy

- **All** therapy treatments and/or therapy evaluations identified for the patient must begin withing 36 hours of admission
  - Increases compliance expectations
  - May necessitate adjustments to weekend staffing, therapy scheduling, and admission processes
- Interdisciplinary Team (IDT) meeting requirements
  - Initial meeting must occur on or before day 4 following admission, with the admission day counted as Day 1
  - Subsequent meetings must occur at least weekly

Initiation of Therapy:

What works, what doesn't…

REVISED FIGURE 1: Initial Interdisciplinary Team Meeting Policy in Effect for FY 2027

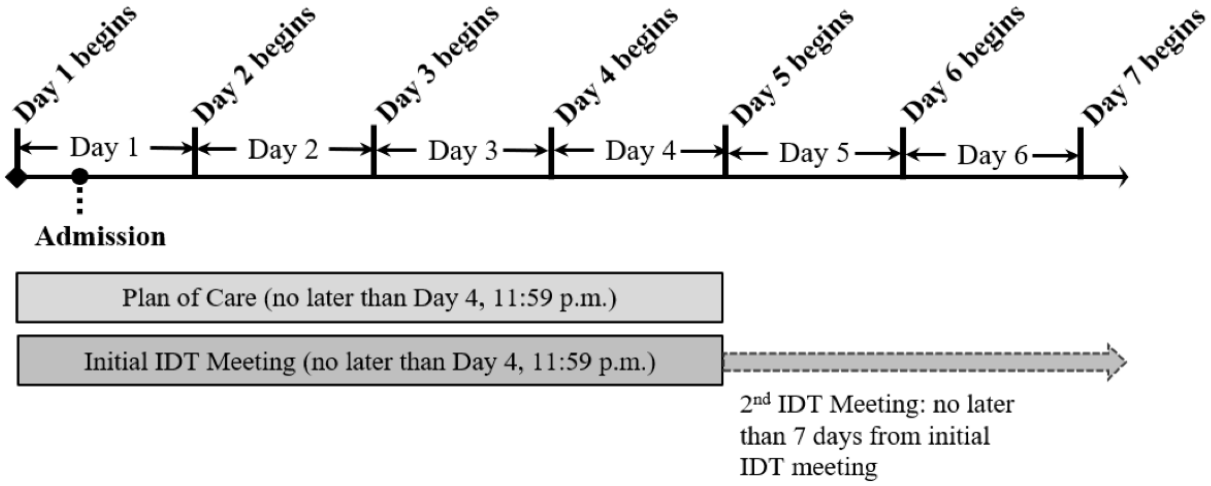


TABLE 8: Compliant and Non-Compliant IRF Patient Examples of IDT Timelines

Patient	Length of Stay	Initial IDT	IDT #2	IDT #3	Compliant?
A	4 days	day 2	N/A	N/A	Yes
B	10 days	day 4	day 9	N/A	Yes
C	6 days	day 2	day 5	N/A	Yes
D	14 days	day 2	day 11	N/A	No – the initial IDT is compliant, but IDT #2 is non-compliant as there are more than 7 days between the initial IDT and IDT #2.
E	20 days	day 4	day 11	day 19	No – IDT #3 is non-compliant as there have been more than 7 days since IDT #2. The initial IDT and IDT #2 are compliant.
F	16 days	day 6	day 13	N/A	No – the initial IDT is non-compliant as there were more than 4 days between admission and the initial IDT.

Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)

Finalizes revision to the timeframe for data submission from 4.5 months after the end of a reporting quarter to **45 days** after the quarter ends, effective with the FY 2029 IRF QRP

6. FFY 2027 Hospice Payment Rate Update

Rate Setting

- Update payment rates by 2.3% (vs. 2.6% update for FFY 2025; had proposed 2.4%)
  - Based on inpatient PPS market basket less productivity
- Finalized a public reporting consequence for hospices that fail HQRP requirements
  - Currently about one-fifth of hospices are non-compliant
  - A hospice that submits no or less than 90% of required data will will be indicated on Care Compare website (implementation no earlier than FY 2028)
- Increases hospice cap to $36,174.75 (currently $35,361.44)

TABLE 1: Final FY 2027 Hospice RHC Payment Rates

Code	Description	FY 2026 Payment Rates	SIA Budget Neutrality Factor	Wage Index Standardization Factor	FY 2027 Hospice Payment Update	FY 2027 Payment Rates
651	Routine Home Care (days 1-60)	$230.83	0.9999	1.0010	1.023	$236.35
651	Routine Home Care (days 61+)	$181.94	0.9999	1.0013	1.023	$186.35

TABLE 2: Final FY 2027 Hospice CHC, IRC, and GIP Payment Rates

Code	Description	FY 2026 Payment Rates	Wage Index Standardization Factor	FY 2027 Hospice Payment Update	FY 2027 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,674.29	1.0080	1.023	$1,726.50 $71.94 per hour
655	Inpatient Respite Care	$532.48	1.0023	1.023	$545.98
656	General Inpatient Care	$1,199.86	1.0034	1.023	$1,231.63

Note: The SIA budget neutrality factors are only applied to the RHC rates, therefore, no SIA budget neutrality factors are used to calculate the rates for CHC, IRC and GIP.

Mandatory Hospice Election Statement Addendum

- Finalizes a requirement that hospices provide the election statement addendum to all Medicare beneficiaries at the time of hospice election, rather than only when requested

Addendum lists and explains what:

- Conditions
- Items
- Services, or
- Drugs

The hospice has determined are **not related** to the beneficiary's terminal illness and related conditions and therefore, **not covered** under the hospice benefit

Intended to provide all beneficiaries:

- Greater transparency into non-covered items, and
- Potentially lead to a decrease in beneficiary out-of-pocket costs

Must ensure:

- Delivery within 5 days of election and
- Updates within 3 days of any plan care changes

Other Provisions

Adopts

- Conforming regulatory changes to the hospice telehealth face-to-face policy with the Consolidated Appropriations Act, 2026
- Preserves telehealth flexibility for required hospice recertification encounters

Finalizes

- Policy to allow a physician designee and the physician member of the interdisciplinary group, in addition to the hospice medical director, to discharge a patient from hospice care
- Reduces administrative burden and increases operational flexibility

Increased Focus on Program Integrity

- Notice highlights the Hospice Service and Spending Variation Index (SSVI)
  - Concern regarding increase in non-hospice spending during a hospice election
    - CMS believes it would unusual and exceptional to see services provided outside the hospice; reiterates that "virtually all" care needed by the terminally ill would be provided by the hospice
  - Uses nine claims-based measures, including:
    - ✓ Non-hospice spending
    - ✓ Percent of beneficiaries discharged with a length of stay of 180 days or more
    - ✓ Average minutes per routine home care day
    - ✓ Percent of live discharges where beneficiaries return to the same hospice in seven days
  - High score represents a potential higher level of concern

Score will be posted at facility level on CMS' Hospice Center webpage
https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/hospice-center

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