Healthcare Regulatory Roundup #113

Spring into 2027:

CMS Proposed Rules and Payment Policy Updates for Providers

May 6, 2026



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Introductions



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Today's Agenda

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

1. FFY 2027 Hospital Inpatient Prospective Payment System Proposed Rule

Comments Due June 9

IPPS Payment Update

- Rebase and revise IPPS operating and capital market basket to reflect 2023 base year
  - 2.4% increase in base rate, based on market basket increase of 3.2% less 0.8 percentage point productivity adjustment (vs. 2.6% increase for FFY 2026)
- 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
- Increase capital payment rate by 3.1% to $545.22 (currently $524.15)
- Increase IPPS outlier threshold by 28% to $51,704 (currently $40,397)
- Proposed uncompensated care payments of $7.56 billion: 3.3% decrease from FY 2026
- Expected increase in new technology add-on payments for $464 million
- **Actual impact based on all proposed changes = 1.2% increase in base rate**

IPPS Payment Rates

TABLE 1A.— PROPOSED 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 PROPOSED RULE

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.0 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.6 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.8 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,598.80	$2,369.07	$4,491.02	$2,313.54	$4,562.87	$2,350.56	$4,455.09	$2,295.04

TABLE 1B.— PROPOSED 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 PROPOSED RULE

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.0 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.6 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.8 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,320.08	$2,647.79	$4,218.83	$2,585.73	$4,286.33	$2,627.10	$4,185.08	$2,565.05

Mandatory Comprehensive Care for Joint Replacement Model – CJR-X

- **Nationwide expansion effective 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
  - Proposed discount factor of 2% reflective if Medicare's portion of potential savings from each episode

- **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

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

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)
- Also proposes adoption of five modified mortality measures effective with FY 2028 payment determination
- Modification of measures related to Excess Days in Acute Care after Hospitalization for acute myocardial infarction, heart failure and pneumonia
  - Effective with FY 2028 payment year
  - Would add Medicare Advantage patients and shorten 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
- Additional mandatory reporting:
  - Malnutrition Care Score eCQM
  - Hospital harm eCQMs after two years of reporting

Hospital Readmission Reduction Program

- Hospitals with higher-than-expected 30-day readmission rates penalized up to 3% of hospital's base Medicare inpatient payments
- Proposed adoption of Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure effective with FY 2029 program year

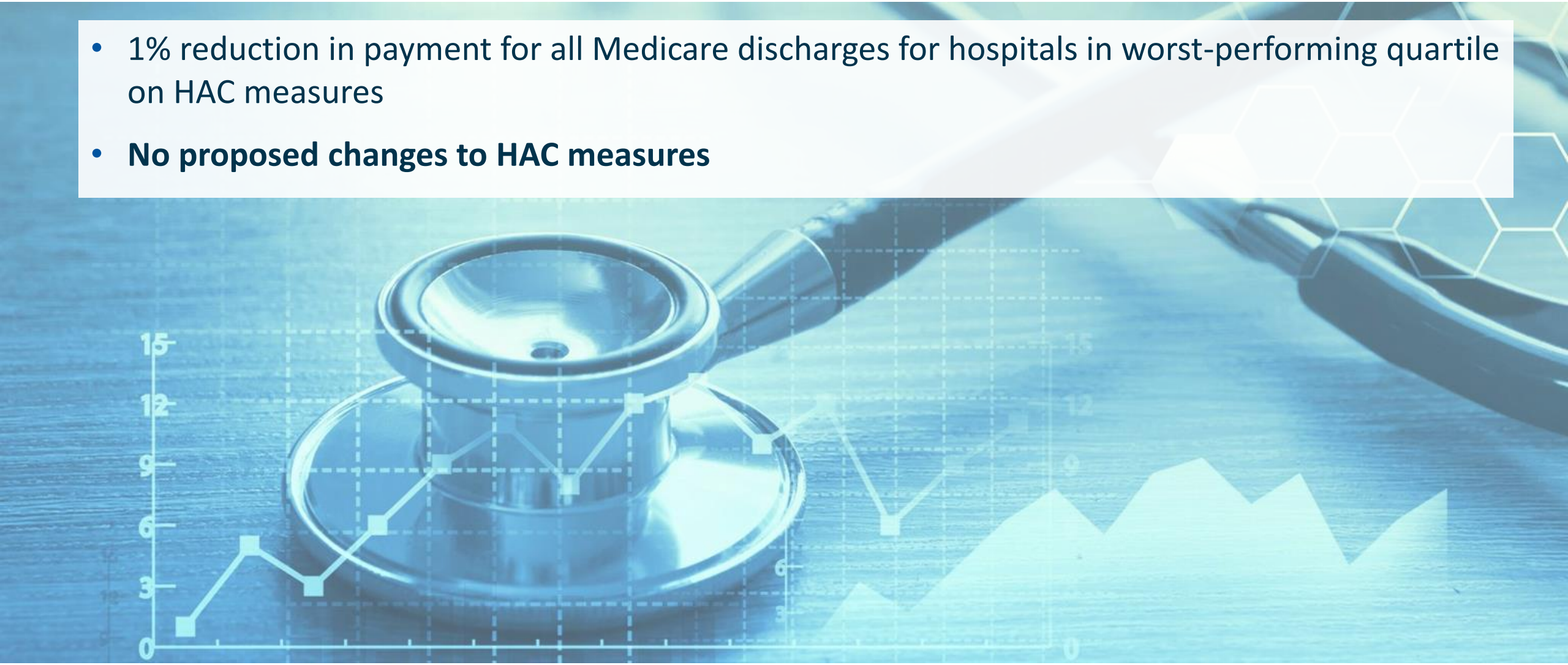


Hospital Value-Based Purchasing Program

- Across-the-board 2% withhold of Medicare payments redistributed to top performers on 14 measures across 4 domains:
  1. Person and community engagement
  2. Safety
  3. Clinical outcomes
  4. Cost savings and efficiency
- Proposed modification to five measures beginning with FY 2032 program year to add Medicare Advantage patients and shorten the performance period:
  1. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization
  2. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization
  3. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization
  4. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization
  5. Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery Acute Ischemic Stroke

Hospital Acquired Condition (HAC) Reduction Program

- 1% reduction in payment for all Medicare discharges for hospitals in worst-performing quartile on HAC measures
- **No proposed 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	Proposed
• If entity did not meet the 35-mile test, 75% test used to show overlap in patients by zip code or at least 75% of patients who require services furnished by the main provider receive those services from that provider	• Limit both options under the 75% test to outpatient departments only • Inpatient facilities limited to geographic (zip code) overlap test

Other Issues

- RFI on TEAM: should this be expanded to ASCs and physician-owned hospitals?
- Expands spinal fusion episodes under TEAM
- Prohibition on discrimination on the basis of race, color, national origin, sex, age, disability, or religion in GME and NAHE programs effective 10/1/26
- Modification to nurse and allied health professional payment formula in the cost report to comply with regulatory formula (should increase payments to providers)
- Calculating DGME and IME following hospital mergers
- Proposes to eliminate the alternative pathway for new technology add-on payments under IPPS and transitional pass-through payments under OPPS

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

Comments Due June 9

LTCH PPS Payment Update

- Update of 2.4% to LTCH PPS
- Maintain outlier threshold at $78,936

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

	Full Update (2.4 Percent)	Reduced Update* (0.4 Percent)
Standard Federal Rate	$52,177.04	$51,157.95

* For LTCHs that fail to submit quality reporting data for FY 2027 in accordance with the LTCH Quality Reporting Program (LTCH QRP), the

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

Comments Due June 1

Payment Update

Update payment rates by 2.4%

(vs. 3.2% update for FFY 2023)

Based on SNF market basket increase of 3.2%, less 0.8 percentage point productivity adjustment

No forecast error included in proposed rate as error <0.5%

(forecast error in 2026 was +0.6%)

Labor-related share of 72%

(currently 71.9%)

SNF Quality Reporting Program

- Proposes to remove two quality measures focused on COVID-19 vaccinations:
  1. COVID-19 Vaccination Coverage among Healthcare Personnel
  2. COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
- Proposes revision to the timeframe for data submission of the SNF Minimum Data (MDS) Set/National Healthcare Safety Network (NHSN) from 4.5 months no later than the 15th day of the second month after the end of each calendar quarter, effective with the FY 2029 SNF QRP
- Proposes to require submission of MDS data on **all** SNF residents, regardless of payer, effective with the FY 2031 SNF QRP
- Requests feedback on adding Advanced Care Planning measure to SNF QRP

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

Comments Due June 1

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 3.1% less 0.8 percentage point productivity adjustment
  - Will use more current data in Final Rule, if available

- Federal per diem rate would increase to $912.58 (now $892.87)
  - Payment for those providers failing to meet quality reporting requirements proposed at $894.74
  - Payment for electroconvulsive therapy would increase to $688.73 (now $673.85)

Payment Update

- Labor-related share of 79.1% (currently 79%)
  - Uses pre-floor, pre-reclassified IPPS hospital wage index with a permanent 5% cap on year-over-year decreases
  - Asks for comment on whether an IPF-specific wage index should be used: are there unique considerations applicable to IPFs
- Additional payment adjustment for rural IPFs of 18%
- Cost outliers: payments intended to limit the financial risk of unusually costly patients
  - Fixed dollar loss threshold would decrease from $39,360 to $37,820
  - Proposes facility-level cap on outlier payments equal to no more than 20% of its total IPF PPS payments effective with cost reporting periods beginning on or after October 1, 2026
    - Would maintain 2 percent aggregate outlier target but distribution could shift
    - While there would be a decrease in overall outlier payments, outliers are concentrated among a small number of facilities

Quality Reporting Program

- Proposes to implement standardized IPF patient assessment instrument
  - Phasing in beginning with a simplified version
- Proposal for completion of IPF-PAI at both admission and discharge for all patients age 18 or older (consistent with CAA, 2023)
  - Requirement to fulfill 100% of the assessment items on 80% of the IRF-PAIs submitted
    - Failure to meet this threshold = 2 percentage point reduction in annual update
- Remove two existing measures for CY 2026 reporting period (impacts FY 2028 payment determination
  - Alcohol Use Brief Intervention Provided or Offered and Alcohol Use Brief Intervention (SUB-2/2a)
  - Tobacco Use Treatment Provided or Offered at Discharge (TOB-3/3a)

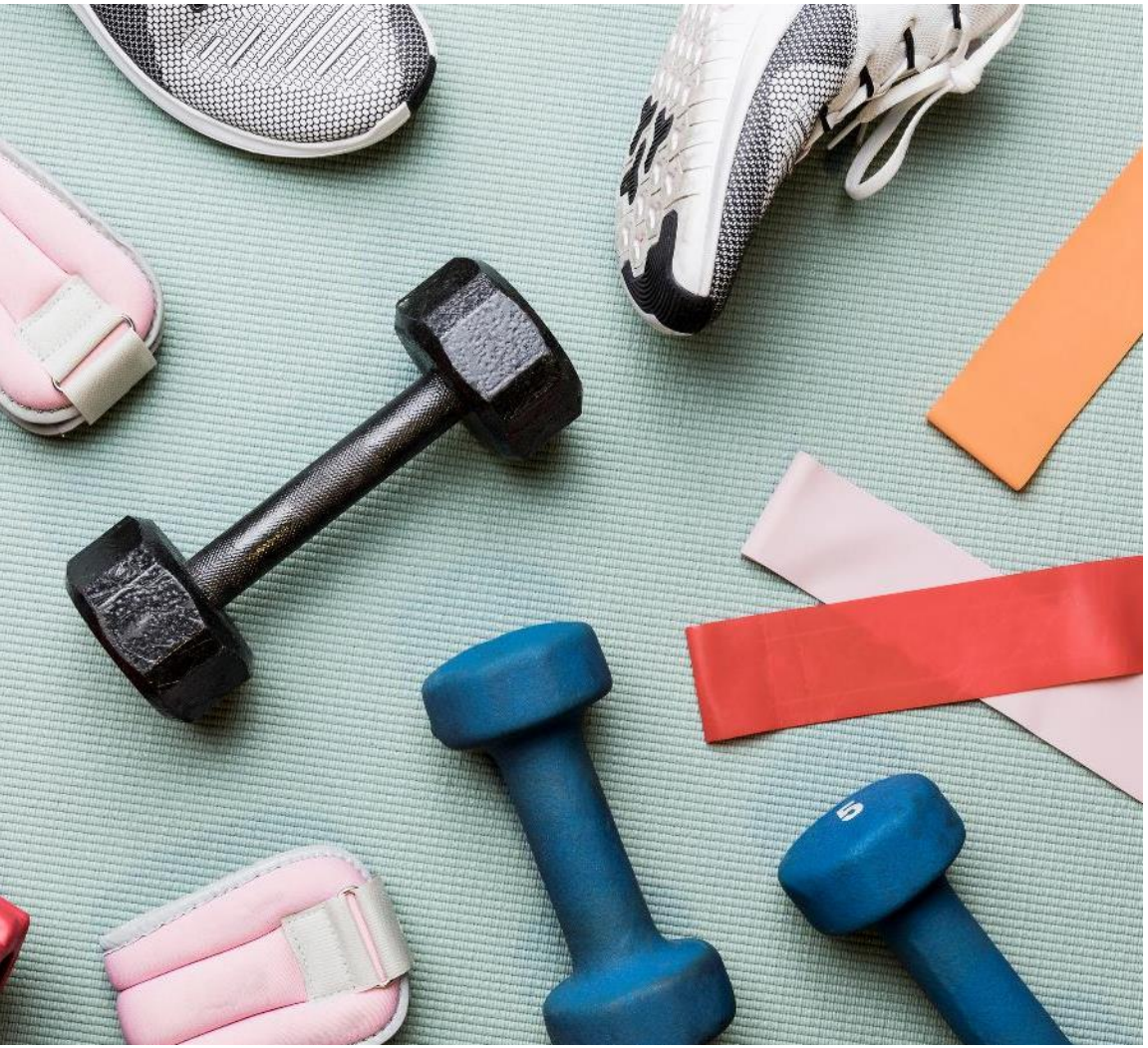
5. FFY 2027 Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule

Comments Due June 1

Payment Update

- Update payment rates by 2.4% (vs. 2.6% update for FFY 2026)
  - Based on IRF market basket increase of 3.2% less 0.8 percentage point productivity adjustment
  - Will use more current data in Final Rule, if available
- Federal base rate would increase to $19,881 (currently $19,371)
- Increase in labor-related share to 74.5% from current level of 74.4%
  - 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
  - Requests feedback on alternative sources of wage data
- Decrease outlier threshold from $10,141 to $8,689
- Requests feedback on enhancements to the IRF PPS such as new/revised clinical categories

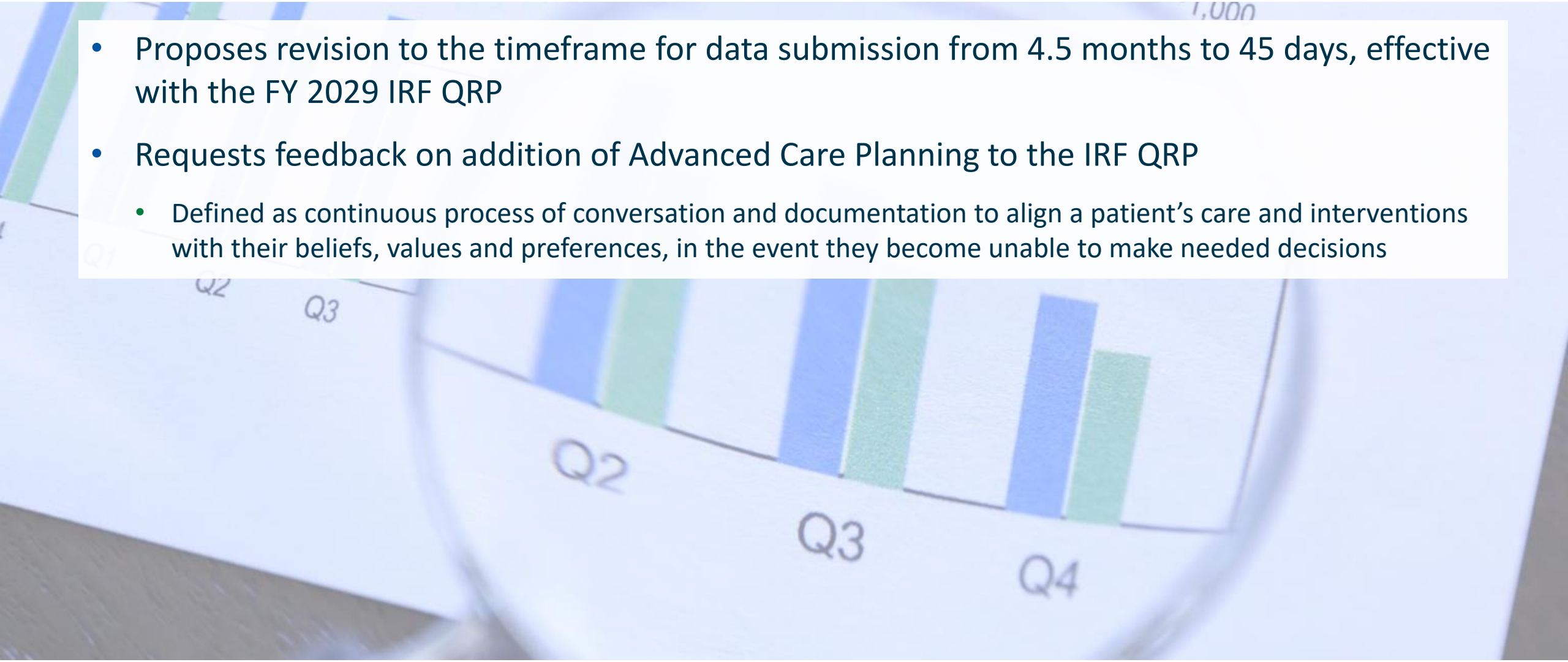
Initiation of Therapy



- Proposed rule would require that **all** therapies be initiated with 36 hours of admission to the IRF
  - Current functional status must be documented at admission (part of pre-admission screening)
- Proposes to revise Interdisciplinary Team (IDT) policy to require initial meeting be completed on or before the fourth day of admission to align with the plan of care
  - Clarifies that subsequent IDT meetings are conducted weekly (within 7 days of the last meeting)

Quality Reporting Program (QRP)

- Proposes revision to the timeframe for data submission from 4.5 months to 45 days, effective with the FY 2029 IRF QRP
- Requests feedback on addition of Advanced Care Planning to the IRF QRP
  - Defined as continuous process of conversation and documentation to align a patient's care and interventions with their beliefs, values and preferences, in the event they become unable to make needed decisions



6. FFY 2027 Hospice Payment Rate Update

Comments Due June 1

Rate Setting

- Update payment rates by 2.4% (vs. 2.6% update for FFY 2025)
  - Based on inpatient PPS market basket less productivity
- Hospices failing to report quality information see a reduction in annual rates
  - Currently about one-fifth of hospices are non-compliant
  - Failure to report will be indicated on Care Compare website
- Increase hospice cap to $36,210.11 (currently $35,361.44)
- Requests feedback on development of a hospice-specific wage index using BLS data

TABLE 1: Proposed 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	Proposed FY 2027 Payment Rates
651	Routine Home Care (days 1-60)	$230.83	0.9999	1.0009	1.024	$236.56
651	Routine Home Care (days 61+)	$181.94	0.9999	1.0013	1.024	$186.53

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

Code	Description	FY 2026 Payment Rates	Wage Index Standardization Factor	FY 2027 Hospice Payment Update	Proposed FY 2027 Payment Rates
652	Continuous Home Care Full Rate = 24 hours of care.	$1,674.29	1.0079	1.024	$1,728.02 $72.00 per hour
655	Inpatient Respite Care	$532.48	1.0022	1.024	$546.46
656	General Inpatient Care	$1,199.86	1.0033	1.024	$1,232.71

Policy Clarifications

- Proposes changes to the hospice election statement regulations:
  - Addendum would be mandatory for all Medicare beneficiaries at the time of hospice election
  - 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
- Proposes 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
- Conforms changes to the hospice telehealth face-to-face policy with the Consolidated Appropriations Act, 2026

Hospice Oversight

- Announces new publicly available hospice scoring system based on indicators of potential inappropriate utilization, quality of care, and compliance concerns
- Development of hospice-specific service and spending variation index (SSVI)
  - Includes:
    - 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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