CMS Finalizes FY 2027 Hospital Inpatient Payment (IPPS) Rule

CMS released the fiscal year 2027 Hospital Inpatient Prospective Payment System and Long-Term Care Hospital final rule July 31, 2026. The rule was published in the Federal Register Aug. 4, 2026, and its provisions are generally effective Oct. 1, 2026. IDSA submitted comments on the proposed rule in June 2026, focusing on antimicrobial stewardship, infection prevention, sepsis quality measurement and access to infectious diseases care.

CMS adopted several IDSA-supported positions: It finalized the technical clarification to the Major Diagnostic Category 25 HIV MS-DRG header, approved a new technology add-on payment for the Bayesian Health sepsis flagging device, and responded in part to IDSA's concerns about the repeal of the alternative NTAP pathway by grandfathering certain Qualified Infectious Disease Product, LPAD and Breakthrough Device technologies through FY 2029. CMS also delayed payment consequences under the new sepsis readmission measure, which will now be used for Hospital Readmissions Reduction Program payment adjustment beginning in FY 2030 following two non-penalty "early look" years.

CMS declined to adopt other IDSA recommendations. It finalized a 2.3% payment update, slightly below the proposed 2.4%; removed the COVID-19 vaccination measures from both the PPS-Exempt Cancer Hospital and Long-Term Care Hospital Quality Reporting Programs; again deferred the comprehensive review of operating room and non-operating room procedure designations without a timeline; finalized the five modified mortality measures as proposed; and retained the broad hospital-wide readmission and patient safety composite measures for payment adjustment in TEAM. The Adult Community-Onset Sepsis Standardized Mortality Ratio measure remains under development, with no policy finalized this year.

Below is a summary of how CMS finalized the provisions IDSA addressed.

FY 2027 payment rates

CMS finalized a 2.3% increase in operating payment rates for general acute care hospitals that submit quality data and are meaningful electronic health record users, slightly below the 2.4% increase in the proposed rule that IDSA supported. Hospitals that do not meet both requirements will receive lower updates, ranging from 1.5% to -0.9%. Overall, CMS estimates payments to acute care hospitals will increase by approximately $2.9 billion in FY 2027. IDSA had urged CMS to maintain at least the proposed update and to reassess whether the productivity adjustment and underlying data adequately capture rising hospital costs, including the cost of recruiting and retaining the infectious diseases workforce.

MS-DRG title clarification for HIV cases

CMS finalized without modification its proposal to remove the word "significant" from the Major Diagnostic Category 25 header, revising it to "principal diagnosis of HIV-related condition." IDSA

supported this technical clarification, which improves consistency with MS-DRG terminology without changing case assignment logic or hospital payment.

New technology add-on payments for sepsis and infectious diseases technologies

CMS approved a new technology add-on payment for the Bayesian Health sepsis flagging device for FY 2027, consistent with IDSA's support for the application. IDSA had also urged CMS to closely monitor real-world performance of algorithmic sepsis tools, including false positive and false negative rates across diverse patient populations, and to require robust post-implementation evaluation to guard against disparities in sepsis recognition and treatment. Across all alternative pathway applications considered for FY 2027, CMS approved 16 and declined or found ineligible the remainder, and it is continuing add-on payments for technologies still within their newness period.

Repeal of the alternative NTAP pathway

CMS finalized its proposal to repeal the alternative pathway for NTAP and for Outpatient Prospective Payment System device pass-through payments, but adopted a limited grandfathering policy in response to stakeholder concerns, including those raised by IDSA. Technologies designated by FDA as a Breakthrough Device or Qualified Infectious Disease Product as of Sept. 30, 2026, and that receive FDA marketing authorization by May 1, 2028, as well as products approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs by May 1, 2028, remain eligible to apply under the alternative pathway for FY 2028 and FY 2029. Qualifying Breakthrough Devices remain eligible for OPPS device pass-through under the alternative pathway for CY 2028 and CY 2029.

Apart from those grandfathered technologies, beginning with FY 2028 applications, all applicants must demonstrate that the technology is new, that the applicable DRG payment is inadequate, and that the technology represents a substantial clinical improvement over existing technologies. CMS also finalized removal of the conditional approval process for antimicrobial products submitted under the alternative pathway; beginning with FY 2028 applications, applicants must obtain FDA marketing authorization by May 1 of the year preceding the fiscal year. IDSA had urged CMS to preserve an appropriately structured alternative pathway, or at minimum an expedited, conditional approval framework, for QIDP, LPAD and other high-priority infectious diseases products. The grandfathering policy provides a transition period but does not preserve a long-term expedited pathway for these products.

Operating room and non-operating room procedure designations

CMS finalized its approach as proposed and again deferred the comprehensive, multiyear review of operating room and non-operating room designations for ICD-10-PCS procedure codes, stating that it needs additional time to develop its process and methodology and will address the issue in future rulemaking. CMS acknowledged comments, including requests for greater transparency on the timeline given how long the review has been deferred. IDSA had encouraged CMS to move from general statements of intent to an actionable framework with a clear timeline, opportunities for specialty society input and explicit evaluation criteria.

Modified mortality measures in the Hospital IQR Program

CMS finalized as proposed the adoption of five modified mortality measures, including MORT–30–PN, in the Hospital Inpatient Quality Reporting Program beginning with the FY 2028 payment determination

through the FY 2031 payment determination, with the measures moving into the Hospital Value-Based Purchasing Program beginning with the FY 2032 program year. The finalized modifications expand the measure population to include Medicare Advantage beneficiaries and shorten the performance period from three years to two years. CMS also proceeded with its technical update to risk adjustment, replacing hierarchical condition categories with individual ICD-10 codes, citing improved model performance in accounting for condition-specific and procedure-specific severity. IDSA had cautioned that these simultaneous changes constitute a fundamental re-specification of the measures and urged CMS to communicate them as materially revised measures with new benchmarks and baselines rather than as continuations of the existing measures.

Adult Community-Onset Sepsis Standardized Mortality Ratio measure

This provision was a request for information, and **CMS did not finalize any policy adopting the Adult Community-Onset Sepsis Standardized Mortality Ratio measure.** CMS summarized public comments without responding to them individually. Many commenters, including IDSA, supported moving from process measures toward outcome-based sepsis measurement and away from continued reliance on SEP-1. Commenters raised concerns about the lack of a standardized national sepsis definition, feasibility and reporting burden (particularly for rural hospitals), attribution and comparability across hospitals, reliance on present-on-admission coding, and the need for robust pilot testing before any transition to FHIR-based reporting. Commenters also supported approaches that limit reliance on billing codes and claims-based cohort identification, consistent with IDSA's recommendation.

Sepsis readmission measure in the Hospital Readmissions Reduction Program

CMS finalized adoption of the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate Following Sepsis Hospitalization measure into the Hospital Readmissions Reduction Program, but with a modification that delays its use for payment. Hospitals will receive an "early look" at their results for the FY 2028 program year (applicable period July 1, 2024, through June 30, 2026) and the FY 2029 program year (applicable period July 1, 2025, through June 30, 2027). The measure will not be used for payment adjustment until the FY 2030 program year (applicable period July 1, 2026, through June 30, 2028). **IDSA opposed adopting the measure into the Hospital Readmissions Reduction Program at this time and recommended an extended non-penalty testing period; the final rule delays financial consequences by one year and adds a second non-penalty year relative to the proposal.**

COVID-19 vaccination measures in the PPS-Exempt Cancer Hospital Quality Reporting Program

CMS finalized as proposed the removal of the COVID-19 Vaccination Coverage Among Healthcare Personnel measure from the PPS-Exempt Cancer Hospital Quality Reporting Program beginning with the CY 2026 reporting period and FY 2028 program year. IDSA strongly opposed this removal, noting that cancer hospitals care for highly immunocompromised patients and that health care personnel vaccination reporting is a low-burden indicator of institutional commitment to infection prevention and patient safety.

COVID-19 vaccination measures in the LTCH Quality Reporting Program

CMS finalized as proposed the removal of both the COVID-19 Vaccination Coverage Among Healthcare Personnel measure and the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure from the Long-Term Care Hospital Quality Reporting Program beginning with the FY 2028 program year. Public display of both measures on Care Compare will end after the September 2026

refresh. **IDSA strongly opposed both removals,** emphasizing that long-term care hospitals serve patients with prolonged stays and high medical complexity, for whom visibility into both workforce and patient vaccination status remains clinically important.

Transforming Episode Accountability Model

CMS finalized several updates to the mandatory Transforming Episode Accountability Model, which begins Jan. 1, 2027.

Episode exclusions: The exclusions IDSA commented on remain in place, including exclusion of Major Diagnostic Category 25 (HIV) admissions, NTAP amounts, OPPS device pass-through payments, and certain high-cost and low-volume Part B drugs and biologicals. IDSA supported excluding clinically unrelated services but urged CMS to monitor how these exclusions operate in practice so they do not inadvertently affect access to infectious diseases services or high-cost anti-infective therapies, and to adjust the exclusions list if problems emerge.

Quality measures: CMS retained the Hybrid Hospital-Wide All-Cause Readmission measure and the CMS Patient Safety and Adverse Events Composite (CMS PSI 90) as pay-for-performance measures, along with the THA/TKA patient-reported outcome measure for lower-extremity joint replacement episodes. For performance year 1, only claims data will be used for the Hybrid readmission measure. CMS also finalized measurement performance periods for the Hospital Harm – Falls With Injury, Hospital Harm – Postoperative Respiratory Failure, and the 30-Day Risk-Standardized Death Rate Among Surgical Inpatients With Complications measures, which are being incorporated into the model. **IDSA opposed use of the Hybrid readmission measure and CMS PSI 90 for payment adjustment in TEAM,** arguing that broad hospital-wide measures are poorly suited to narrowly defined surgical episodes and may obscure infection-specific issues, and recommended that CMS instead develop episode-specific measures such as postoperative infection and sepsis rates, surgical site infection measures and perioperative antimicrobial prophylaxis measures.

Composite quality score baseline: Rather than the proposed sliding historical baseline, CMS finalized a concurrent composite quality score baseline methodology beginning with performance year 1, under which the baseline period for a given performance year is identical to that year's measurement period. CMS also finalized as proposed the shift to July-through-June baseline periods for the Hybrid readmission measure, CMS PSI 90, the THA/TKA measure and the surgical mortality measure, aligning with Hospital IQR and Hospital-Acquired Condition Reduction Program timeframes.

Referral to primary care and access monitoring: The model's requirement that participants include a referral to a primary care supplier in discharge planning remains in place, with CMS having clarified that the requirement is not intended to disrupt existing patient-provider relationships or to replace clinically necessary follow-up with surgeons or other specialists, and that beneficiaries retain freedom of choice in selecting providers. CMS also retains its commitments to monitor for access to care, quality of care and delayed care, including monitoring claims data to determine whether complex patients are being systematically excluded from episodes. **These clarifications are consistent with IDSA's recommendations that TEAM preserve access to infectious diseases consultation, outpatient parenteral antimicrobial therapy and appropriate post-acute placement.**

Future participation: CMS indicated it intends to propose in future rulemaking a policy allowing physician-owned hospitals outside mandatory regions to opt into TEAM.

Concluding points

CMS adopted IDSA-supported positions on the HIV MS-DRG title clarification and the sepsis flagging device add-on payment and partially responded to IDSA's concerns by grandfathering certain QIDP, LPAD and Breakthrough Device products under the alternative NTAP pathway through FY 2029 and by delaying payment consequences under the sepsis readmission measure until FY 2030. CMS did not adopt IDSA's recommendations to retain the COVID-19 vaccination measures in the PPS-Exempt Cancer Hospital and Long-Term Care Hospital Quality Programs, to advance a concrete timeline for the operating room procedure designation review or to replace the broad hospital-wide quality measures used in TEAM. IDSA will continue to engage CMS on sepsis outcome measurement, antimicrobial innovation incentives and access to infectious diseases care in future rulemaking.