AAOS
American Association of Orthopaedic Surgeons

FY 2026 Hospital Inpatient Prospective Payment (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment Systems Final Rule

On July 31, 2025, the Centers for Medicare & Medicaid Services (CMS) released the Fiscal Year (FY) 2026 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System Final Rule, updating payments and policies for numerous inpatient hospital programs and initiatives. The rule includes a +2.4% increase to hospital inpatient payments, finalizes updates to payment and quality-related policies, and adopts changes to the mandatory Transforming Episode Accountability Model (TEAM) beginning January 1, 2026. AAOS submitted formal comments on the proposed rule on June 6, 2025. The outline below compares what AAOS advocated for to what was finalized.

Transforming Episode Accountability Model (TEAM)		
Topic	**Proposal**	**Finalized Policy**
Transforming Episode Accountability Model (TEAM) Overview	Under TEAM, all acute care hospitals, with limited exceptions, located within the Core Based Statistical Areas (CBSAs) that CMS selected for model implementation will be required to participate in TEAM for five surgical episodes, three of which are orthopedic. This model is set to begin on January 1, 2026. CMS is making several updates to the model, including extending the lookback period to 180-days from the day before the anchor hospitalization.	CMS estimates for the TEAM proposals included in this final rule that there would be no significant change from the savings estimate in the FY 2025 IPPS/LTCH PPS final rule. Therefore, CMS estimates that testing TEAM would result in saving the Medicare program $368 million across the 5 performance years.
Voluntary Opt-in	CMS proposed that there will be no "voluntary opt-in" option. However, CMS sought comment on whether it should create a "voluntary opt-in" performance option for hospitals that currently participate in BPCI Advanced or the CJR model (if not located in a geographic area that would require participation under the TEAM).	Based on comments received from stakeholders, CMS departed from the proposed rule to finalize a voluntary opt-in policy for hospitals that participate in BPCI Advanced and CJR models. • These facilities will be offered a "one time" opportunity to participate • These facilities would not be located in the mandatory CBSAs selected for TEAM • To be eligible to opt-in, these facilities must continue to participate in BPCI Advanced or CJR "until the last day of the last performance period or last performance year of the respective model"

		If the facility opts in, it will be required to participate in all TEAM episode categories. • Once a facility has opted in, it must remain in TEAM for the full performance period (i.e., no voluntary termination even though they voluntarily opted in) • For those facilities eligible, they must opt-in via a written participation letter (as specified by CMS) during the voluntary election period of January 1, 2025 – December 31, 2025. CMS retains the right to not accept the election letter.
Spinal Fusion Episode	CMS stated in the FY 2025 IPPS final rule that it would propose a policy in future rulemaking for how to construct target prices when there are MS-DRG or HCPCS/APC modifications or other payment system changes that may arise over the course of the model. This came in response to stakeholders' concerns around the impact of changes made to the spinal fusion MS-DRGs. As part of the FY 2026 IPPS rule, CMS proposed a standard, three-step approach to account for MS-DRG and HCPCS/APC changes by remapping and adjusting relevant MS-DRG/HCPCS episode types during the baseline period to estimate performance year costs.	Finalized as proposed. CMS also plans to develop, through rulemaking, a method to address in any future year of the model the potential addition or removal of procedures to or from MS-DRGs that are included in the definitions of TEAM episode categories.
Information Transfer PRO-PM and quality measures	Consistent with its goals of incorporating more PRO-PMs and quality measures that capture care in the outpatient setting, CMS proposed to include the Information Transfer PRO-PM beginning in PY 3 (CY 2028) with a CY 2027 CQS baseline period. CMS noted that the measure would be applicable to both LEJR and Spinal Fusion episode categories and would increase the number of PRO-PMs included in the model. CMS also sought comment on other quality measures, including options for capturing quality of care in the outpatient setting and other PRO-PMs appropriate for TEAM quality measurement. In the CY 2025 OPPS, CMS	Finalized as proposed. CMS acknowledged the preference for episode-specific measures among TEAM participants, and they will consider incorporating such measures, including registries, where applicable in future rulemaking. See p. 6 for a chart of all TEAM quality measures.

	adopted the Information Transfer PRO-PM into the Hospital Outpatient Quality Reporting (OQR) Program, beginning with voluntary reporting in CY 2025, followed by mandatory reporting beginning with CY 2026 reporting period. For TEAM, CMS proposed to use the same measure specifications and align with the Hospital OQR program.	
HCC Risk Adjustment	CMS proposed changes to the HCC Risk Adjustment variable in TEAM, including extending the lookback period to 180-days, beginning with the day prior to the anchor hospitalization or anchor procedure.	Finalized as proposed.
Swing Bed Waiver	CMS proposed to expand its 3-Day SNF Rule waiver to allow TEAM participants to use the waiver for TEAM beneficiaries discharged to hospitals and CAHs providing post-acute care under swing bed arrangements.	Finalized as proposed.
Primary Care Referrals	In the FY 2026 IPPS proposed rule, CMS acknowledged that some TEAM participants may be incentivized to refer patients back to suppliers of primary care services that the TEAM participant has a contractual relationship with, rather than the suppliers of primary services with whom the patient has an existing relationship with. CMS sought comment on whether not specifically requiring that beneficiaries be referred back to suppliers with whom they have an existing relationship could disrupt fair competition as well as limit access to high-value care.	CMS finalized a modified policy to add clarifying language stating that a TEAM participant must include in hospital discharge planning a referral to an established supplier of primary care services, as recorded on admission to the hospital or hospital outpatient department, for a TEAM beneficiary, on or prior to discharge from an anchor hospitalization or anchor procedure. In the event an established supplier of primary care services is not recorded on admission, the TEAM participant must include in hospital discharge planning a referral to a supplier of primary care services for a TEAM beneficiary, on or prior to discharge from an anchor hospitalization or anchor procedure.
Inpatient Prospective Payment System Updates		
Hospital Inpatient Quality Reporting (IQR) Program – PRO-PMs	CMS is proposing several changes to the Hospital IQR Program. One of these proposals is to make updates to the Hospital-Level, Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip	Finalized as proposed. CMS is "finalizing modifications of the COMP-HIP-KNEE measure as proposed and implementing the technical updates,

	Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) beginning with the April 1, 2023 – March 20, 2025, Reporting Period/2027 Payment Determination. **AAOS supports the technical update to transition the RSCR risk adjustment methodology from Hierarchical Condition Categories (HCCs) to International Classification of Diseases (ICD)-10 codes as well as the addition of Medicare Advantage beneficiaries to the measure cohort. AAOS continues to urge CMS to analyze THA and TKA outcomes separately.**	beginning with administrative claims and encounter data from April 1, 2023, through March 31, 2025, associated with the FY 2027 payment determination."
Hospital Value-Based Purchasing (VBP) Program	CMS is proposing modifications to the Hospital-Level-Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure beginning with FY 2033 program year: • Expand the measure's inclusion criteria to include MA patients; and • Shorten the performance period from 3 years to 2 years. **AAOS supports the proposed technical updates to the measure and encourages CMS to publish updated performance standards in a timely and transparent manner.**	Finalized as proposed. CMS is "finalizing the updates to the COMP-HIP-KNEE measure's cohort and performance period as proposed beginning with the FY 2033 payment determination."
MCD 08: Hip or Knee Procedures with Periprosthetic Joint Infection (PJI)	CMS received a request that cases be elevated to the highest severity level when there is a principal diagnosis of PJI even when there is no MCC or CC reported. Under current policy, treatment type can drive these cases to an array of different MS-DRGs. CMS agreed that an analysis of a potential new base DRG was warranted. As a result, CMS proposed to assign these cases to the following new MS-DRG 403 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC) and MS-DRG 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection without MCC). **AAOS supports CMS's proposal to assign PJI**	While CMS acknowledged supportive comments on the proposal, CMS did not finalize its proposal to create new MS-DRGs for hip and knee procedures with PJI. CMS cites a stakeholder that discovered unexplained assignments in the GROUPER software leading to MS-DRG assignments not discussed in the proposed rule. Upon investigation, CMS decided that further analysis was needed in order to ensure accuracy and compliance with MS-DRG creation criteria before a new policy can be finalized.

	cases to new MS-DRGs centered around a principal diagnosis of periprosthetic joint infection, recognizing this as a significant positive step toward more accurate and appropriate reimbursement.	
New Technology Add-on Payment (NTAP): Alternative Pathway Policy:	Under the alternative pathway for new technology add-on payments, new technologies that are medical products with a QIDP designation, approved through the FDA LPAD pathway, or are designated under the Breakthrough Device program will be considered not substantially similar to an existing technology (because these products are new in the sense that they are subject to FDA marketing authorization), and will not need to demonstrate that the technology represents a substantial clinical improvement. **AAOS supports the continued availability of the alternative pathway for medical devices designated under the FDA's Breakthrough Devices Program and urges CMS to apply the "substantial similarity" criteria consistently and transparently, particularly when evaluating novel orthopaedic biologics.**	CMS intends to proceed with this provision as proposed, despite concerns discussed in the final rule. As discussed in the final rule, multiple commenters asked CMS to reconsider finalizing or request additional input from interested parties through rulemaking before finalizing the inclusion of certain cost criterion information in the public posting beginning with FY 2027. Concerns primarily centered around the need to maintain confidentiality of this information. Commenters also requested that CMS provide additional details on the guardrails and specific steps CMS would employ to ensure proprietary and market sensitive cost and pricing data provided by new technology add-on payment applicants are not inadvertently publicized, either directly or indirectly.

TABLE XI.A.-04: TEAM QUALITY MEASURES BY PERFORMANCE YEAR

Performance Year	Episode Category	Quality Measure
Performance Year 1-5	All Inpatient Episode Categories	Hybrid Hospital-Wide All-Cause Readmission measure (CMIT ID #356)
Performance Year 1	All Inpatient Episode Categories	CMS Patient Safety and Adverse Events Composite (CMIT ID #135)
Performance Year 1-5	Inpatient Lower Extremity Joint Replacement Episodes	Hospital-Level Total Hip and/or Knee Arthroplasty (THA/TKA) Patient Reported Outcome Based Measure (CMIT ID #1618)
Performance Year 2-5	All Inpatient Episode Categories	Hospital Harm – Fall with Injury (CMIT ID #1518)
Performance Year 2-5	All Inpatient Episode Categories	Hospital Harm -Postoperative Respiratory Failure (CMIT ID #1788)
Performance Year 2-5	All Inpatient Episode Categories	Thirty-Day Risk – Standardized Death Rate among Surgical Inpatients with Complications (Inpatient Surgical Compilations Mortality Rate)) (CMIT ID #134)

Performance Year 3-5	All Outpatient Episode Categories	Information Transfer Patient Reported Outcome Based Measure (CMIT ID #1797)