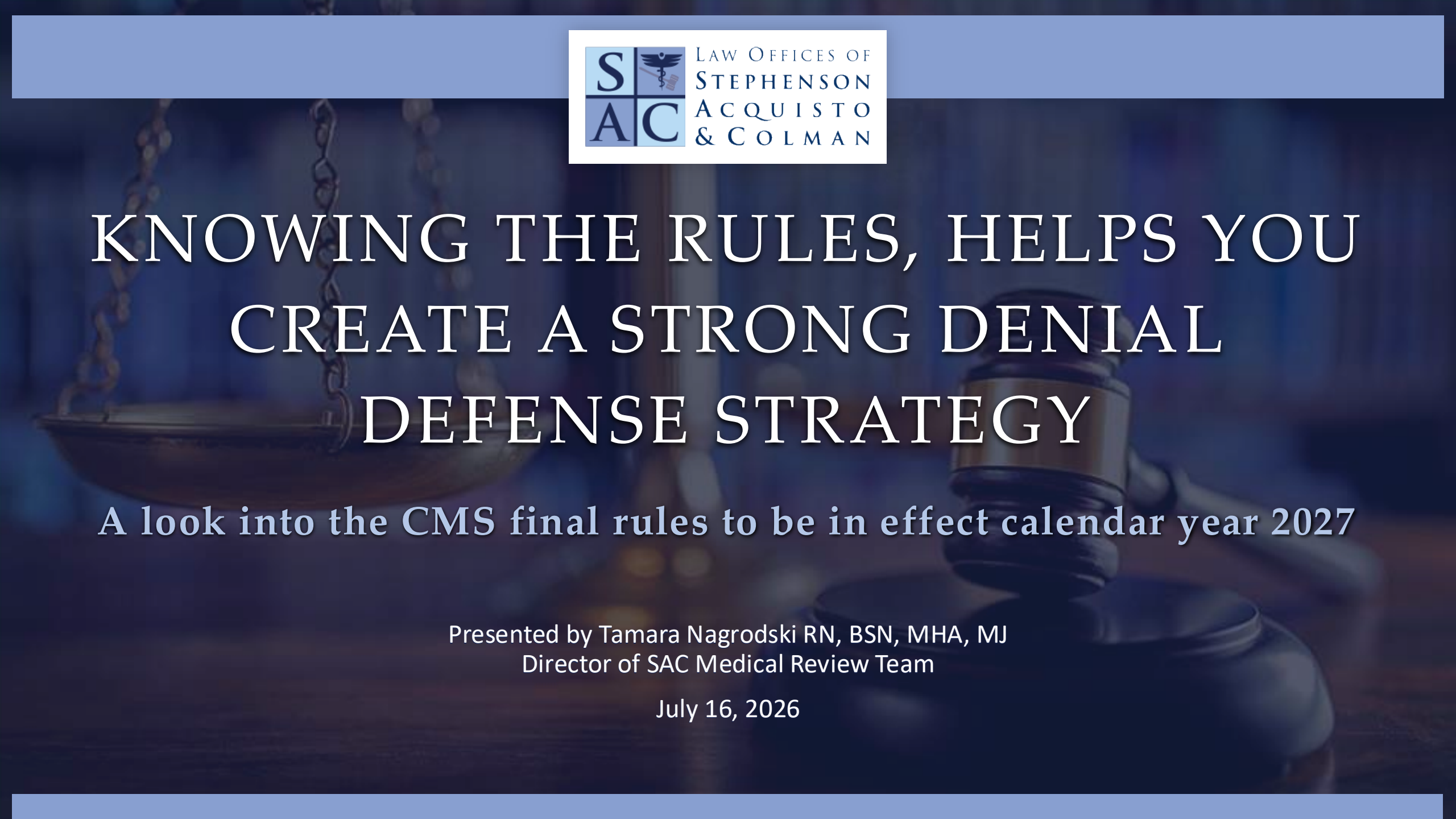

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KNOWING THE RULES, HELPS YOU CREATE A STRONG DENIAL DEFENSE STRATEGY

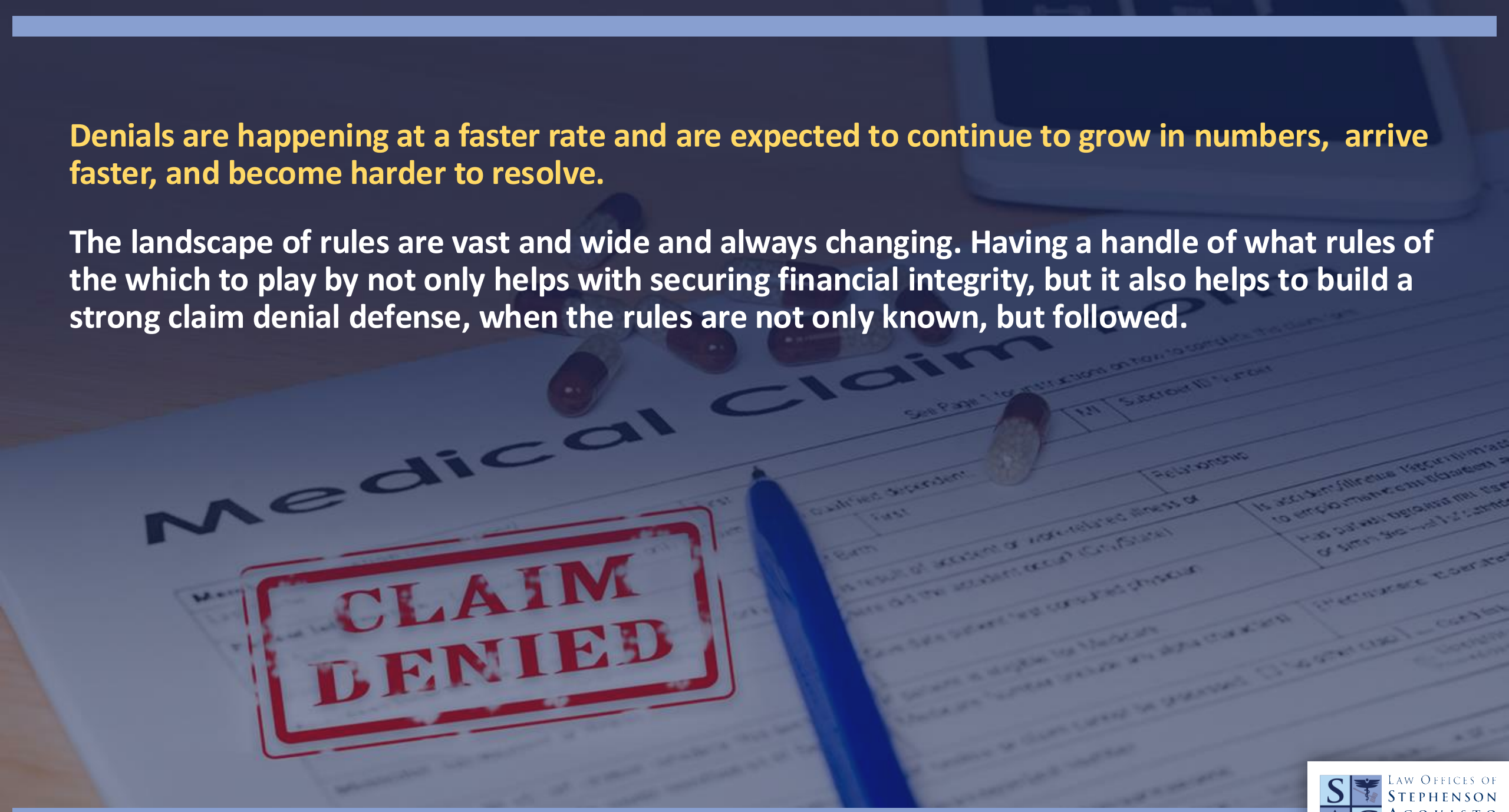
A look into the CMS final rules to be in effect calendar year 2027

Presented by Tamara Nagrodski RN, BSN, MHA, MJ
Director of SAC Medical Review Team

July 16, 2026

Denials are happening at a faster rate and are expected to continue to grow in numbers, arrive faster, and become harder to resolve.

The landscape of rules are vast and wide and always changing. Having a handle of what rules of the which to play by not only helps with securing financial integrity, but it also helps to build a strong claim denial defense, when the rules are not only known, but followed.



What's new in Calendar Year 2027

Annual Rule Updates	Medicare Advantage Plan- Part C & Medicare Drug Plan- Part D	IPPS+ LTAC	OPPS + ASC's
Rule and Rule Status **F= Final Rule** **P= Proposed Rule**	4208-F3 & 4212-F	1849-P	1850-P
Release Date **FR = Final Rule** **PR = Proposed Rule**	April 2, 2026 (FR)	April 10, 2026 (PR)	July 2, 2026 (PR)
Expected Date for Final Rule Release	FR was released April 2, 2026	August 1, 2026	November 1, 2026
Effective Date	January 1, 2027	October 1, 2026	January 1, 2027

Medicare Advantage

CMS 4208 F3 & 4212 F- CY 2027- Final

STAR RATINGS:

Two -Part C appeals measures are being removed beginning with the 2029 Star Ratings.

- Plan Makes Timely Decisions about Appeals and
- Reviewing Appeals Decisions

These are the measures tied to how plans handle denied claims and their independent review.

Per CMS, the reason they decided to removed these measures, is that they [CMS] found the Health Plan performance is consistently high with limited variation. CMS 4208 F3

Here is CSM stats documented in the federal registry:

2015-2025

- Timely Decisions rose 90%→96%
- Reviewing Appeals Decisions 88%→95%
- and for 2026 Star Ratings averages were 98% and 97%, "so they no longer function effectively as quality measures and are better suited to compliance oversight."

ANYONE REMEMBER JUST 2 YEARS AGO the OIG findings of the MA Audit and the resulting CMS 4208 because of the OIG FINDINGS?

CMS addressed extensive opposition.

Commenters argued the appeals measures are the primary accountability mechanism for inappropriate denials, care delays, and utilization-management problems, and warned removal could lead plans to deny more services with less scrutiny — a concern heightened for vulnerable populations.

Anti-gaming posture. CMS acknowledged commenter concerns that high scores may be inflated by tactics such as overturning denials early to avoid independent review or misclassifying appeals. It "strongly objects" to such practices, noted it had implemented scaled reductions to ensure requisite appeals reach the IRE, and stated that moving the measures to the display page is intended to reduce gaming incentives while preserving transparency; CMS will continue to address inappropriate denials outside the Star Ratings and QBP programs.

OPPS- CY 2027 (P)

Outpatient- Acute Hospital & Ambulatory Surgery Centers

Comment period is in effect until August 31st.

Inpatient only list

- Removing 637 services

Ambulatory Surgery Center (ASC)

- Adding 618 codes

Off-Campus Outpatient Department

- Proposes to add a new definition of Off-Campus Outpatient Department
- Attestation timing requirements
- New attestation process
- Attestation documentation requirements
- Verification and oversight

OPPS- CY 2027 (P)

Outpatient- Acute Hospital & Ambulatory Surgery Centers

Comment period is in effect until August 31st.

Price Transparency

CMS issues a Request for Information (RFI) on approaches to improve the standardization and comparability of price transparency data in machine-readable files and consumer-friendly displays. Areas of particular interest include:

- **reporting of complex contracting mechanisms (outlier payments, stop-loss provisions, rate tiering, and carve-outs);**
- **whether to modify or eliminate the deemed-compliance policy for internet-based price estimator tools;**
- **updating the required shoppable services list;**
- **and clarifying which ancillary and bundled items are reflected in displayed prices.**

OPPS- CY 2027 (P)

Outpatient- Acute Hospital & Ambulatory Surgery Centers

Comment period is in effect until August 31st.

Device Pass-Through & New Technology

- **CMS flags that, in the FY 2027 IPPS/LTCH PPS proposed rule, it has proposed to repeal the alternative pathway for both new technology add-on payments and OPPS device pass-through. If finalized, applications received on or after October 1, 2026 (including the remainder of the CY 2028 cycle through March 1, 2027) would have to demonstrate substantial clinical improvement under § 419.66(c)(2)(i). Applications submitted as of September 30, 2026 for Breakthrough-designated devices could still be approved under the alternative pathway, and existing category codes would keep their 2-to-3-year eligibility. The change would take effect October 1, 2026 if finalized.**

IPPS-CY 2027 (P)

Inpatient -Acute Hospital and LTAC

Comment period closed June 9th.

Hospital Readmissions Reduction (HRRP)

- **Adopt the 30-Day Risk-Standardized Readmission Following Sepsis Hospitalization measure (early look FY 2028, use beginning FY 2029); no financial impact for FY 2027**

New Technology Add On Payments (NTAP)

- **Evaluation of FY 2027 applicants for NTAP, including alternative-pathway applicants for certain devices and antimicrobial products**
- **Proposed Classification changes**
  - Cardiac Pacemaker devices
  - Other circulatory system O.R. Procedures
  - Spinal Fusion
  - Islet cell/pancreas transplant
  - Uterine and adnexa procedures for malignancy
- **Repeal of the alternative pathway for NTAP and OPPS device pass-through applications; all applicants would instead have to demonstrate they meet all standard eligibility requirements**

IPPS-CY 2027 (P)

Inpatient -Acute Hospital and LTAC

Comment period closed June 9th.

Payment Adjustments

- **Proposed update/revision to the payment adjustment for certain immunotherapy cases**
- **Proposed Classification changes**
  - CAR-T cells, Non CART-T cells

TEAMS

- **Covering CABG, lower extremity joint replacement, major bowel, surgical hip/femur fracture, and spinal fusion episodes. Proposed refinements: add MS-DRGs that trigger a spinal fusion anchor hospitalization**
  - 30 days post discharge – acute hospital share cost of care
  - For the Comprehensive Care Joint- expanding to 90 days post discharge
- **Expanding from US 50 States to include U.S. Territories**

CMS-0057

Interoperability and Prior Authorization

2024- Final Rule- full details to this rule were covered in SAC program year 2024

Parts of the rule take are tiered in over the years starting to "be in effect" in 2025- 2039

2027 – rules to be in effect- but will the rule be enforced?

Starting January 1, 2027- *Payer Requirements:*

- **Patient Access API**
  - Patients will have access to their authorization status.
- **Provider Access API**
  - Allows providers to share patient data with "in-network" providers in which patient has treatment sharing relationship.
  - Payers are required to develop an attribution process to associate patients with their providers to ensure that a payer only sends data to providers for patients with whom they have a treatment relationship.
- **Payer to Payer API**
  - Payers must implement and maintain a payer-to-payer API to make the same data available to other payers.- particularly prior authorizations and other claim data.
  - This is important for promoting good care coordination for patients who change health plans.
- **Prior Authorization API- must maintain 3 parts**
  - Identifying whether an item or service requires prior authorization
  - Payer specific documentation requirements
  - Exchanging prior authorization requests and responses.

THANK YOU

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