NEWS & INSIGHTS

CMS publishes CY 2027 MA and Part D proposed rule

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News & Insights

CMS released the contract year (CY) 2027 Medicare Advantage (MA) and Part D proposed rule to detail potential updates to quality measures, drug coverage, enrollment processes, and more.

The agency is proposing significant changes to the Medicare Star Ratings system, including halting its plans to implement the Excellent Health Outcomes for All reward in the 2027 Star Ratings. This reward is designed to incentivize MA plans for providing high-quality care to patients with certain social risk factors. Additionally, for the 2027 measurement year, CMS is looking to remove 12 measures and add a new depression screening/follow-up measure to address behavioral health gaps.

CMS is also proposing improvements to enrollment processes through two key provisions. The agency is calling to modify a special enrollment period (SEP) for enrollees to change plans when one or more of their providers are leaving their plan's network. This change would remove the limitation on the existing SEP requiring MA organizations and CMS to deem the network change to be "significant." The second proposal is to codify existing policy that states certain SEPs require prior approval from CMS.

For Part D, CMS is hoping to codify several prescription drug benefit changes that are currently authorized through 2026 via the Inflation Reduction Act. These changes include eliminating the coverage gap phase, establishing a reduced annual out-of-pocket threshold, implementing the Manufacturer Discount Program, and more.

CMS is proposing several changes to comply with a recent executive order, including the following:

- Exempting health reimbursement arrangements and other account-based plans from creditable coverage disclosure requirements
- Removing the requirement for MA quality improvement programs to include activities that reduce health disparities
- Eliminating health equity requirements for MA utilization management committees

To get input on MA program enhancements and opportunities to better serve dually eligible beneficiaries, CMS added three requests for information in the proposed rule on the following topics:

- Risk adjustment and quality bonus payment changes to promote competition
- Concerns and solutions regarding the significant growth in enrollment in chronic condition special needs plans
- Well-being and nutrition policy changes that could improve preventive care

Comments on the rule are due by January 26, 2026. Revenue cycle professionals can view CMS' fact sheet and press release on the CY 2027 MA and Part D proposed rule for more information.

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Medicare news

Q&A: Sorting through problem lists for the principal diagnosis

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Q: What considerations should coders keep in mind when referring to problem lists for determining the principal diagnosis and proper sequencing of all documented conditions in the inpatient setting?

A: Historically, problem lists were created to help providers document a patient's chronic condition(s) that were often overlooked in later visits, such as chronic respiratory failure and chronic heart failure. A problem list is now considered to be an ongoing summary of a patient's current and past health issues. The focus of inpatient treatments will always remain the principal diagnosis, not the diagnosis listed first on a problem list, but because diagnoses on the list can be pulled from previous inpatient visits and listed randomly, these lists do not often align with the principal diagnosis.

Some coders may look at the list and say they cannot code from it, while others may say that they can code for a diagnosis from the list if the diagnosis is still valid and currently being treated. But just because the diagnosis is listed on a problem list doesn't mean the provider actually addressed it during the present encounter, either, leaving coders and CDI specialists to scrutinize diagnoses on the problem list to determine whether they are currently valid. This may require a query to the provider to clinically validate a diagnosis, rule out a diagnosis, or even rule in and garner greater specificity for a diagnosis.

Providers could also end up documenting something along the lines of "see previous day's problem list" or "see previous day's notes." This may be acceptable for one day's progress note, but if at any time treatment plans change or a diagnosis is not in subsequent progress notes (i.e., it was only documented once), the diagnosis may be subject to a denial based on the question of whether the diagnosis truly met the criteria of a diagnosis. Referring to prior documentation with such phrases does not meet compliance standards and may be considered fraudulent if ever reviewed by the Office of Inspector General.

The difficulty of using problem lists is further complicated when the list isn't updated, and it becomes difficult to tell which conditions are associated with each admission. It can also become very long, as many of the listed diagnoses may no longer pertain to the patient. A patient's historical problem list may vary across encounters and should not be assumed to apply universally. It is the attending physician's or the attending provider's responsibility to determine and document which diagnoses are relevant to that current visit or current admission. If a recurring condition is still clinically valid for a current encounter, then the provider needs to document that the diagnosis is current and still being monitored, evaluated, and treated in each visit's notes. Looking at a diagnosis from a previous record without current documentation or provider confirmation is inappropriate, which could lead to inaccurate coding.

An example of when coding becomes complicated by the problem list is when a patient's BMI is provided on the problem list instead of a diagnosis or a condition. Providers do this to try to avoid having terms in a patient's record that can be considered offensive, such as obesity or morbid obesity, which flows into their patient portal. Some patients find this extremely insulting, and providers are sensitive to that situation. Yet, the practice of only using a BMI and not an associated diagnosis can lead to noncompliant reporting and coding.

Technology may help flag a diagnosis that lacks appropriate clinical indicators or diagnostic findings to support a diagnosis, and a review will be an essential component to ensure the diagnoses are clinically supported and coded. Let's say a patient is admitted for a fractured hip. They currently have pneumonia on the problem list, but since it isn't dated, it is unclear whether the pneumonia is current for the encounter. Then it turns out the patient was actually admitted for pneumonia three months prior. Current chest X-rays are clear, no antibiotics are being prescribed, and vital signs and labs are normal. It is determined that the diagnosis of pneumonia that is on the problem list is not a valid diagnosis for this visit. If it is believed that documentation could lead to incorrect coding, a query should be sent for clinical validation and greater specificity. If a diagnosis is being monitored, evaluated, and treated, it can be captured as a codable diagnosis.

Editor's note: *This Q&A originally appeared on* JustCoding *and was answered by* ***Lynette Byerly, BSN, RN, CCDS, CCS,*** *a CDI education specialist with HCPro and ACDIS, on an episode of The ACDIS Podcast.*

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Report: Hospitals are seeing improvements in patient safety, outcomes

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News & Insights

The American Hospital Association (AHA) recently released a report that found patient safety in hospitals and health systems across the nation has continued to improve. The report, which used data analyzed by Vizient, examined key safety and quality metrics from the fourth quarter of 2019 to the second quarter of 2025. It found that despite caring for a sicker patient population, the focus on safety has led to improved patient outcomes and reduced infections.

The primary analysis was based on more than 1,300 hospitals, with data on more than 10 million inpatients and 180 million outpatients annually. A cohort of 705 general, acute care hospitals were identified to have a complete dataset from the fourth quarter of 2019 to the second quarter of 2025. Among the key findings from the data of these hospitals, five improvements were recognized, including:

- Hospitals improved patient outcomes: Hospitalized patients in the second quarter of 2025 were on average nearly 30% more likely to survive than expected given the severity of their illnesses compared to the fourth quarter of 2019.
- Hospitals saved more lives: It is estimated that hospitals' efforts to improve safety led to more than 300,000 Americans hospitalized from April 2024 through March 2025 surviving episodes of care they would not have in 2019.
- Hospitals cared for more patients with greater complexity: Hospitals cared for more patients in the second quarter of 2025 compared to the fourth quarter of 2019, with increases in volume by 4%. Patients in 2025 also had more complex and severe conditions.
- Hospitals reduced infections: Hospitals' central line-associated bloodstream infections and catheter-associated urinary tract infections in the second quarter of 2025 were at lower rates (24% and 25%, respectively) than in the fourth quarter of 2019.
- Hospitals significantly increased preventive cancer screenings: Key screenings for breast and colorectal cancer increased 95% from the fourth quarter of 2019 to the second quarter of 2025.

A critical but often unseen contributor to these improvements is accurate medical coding, which transforms clinical documentation into standardized data that drives everything from care coordination and quality measurement to patient safety initiatives. When diagnoses, procedures, and outcomes are coded correctly, hospitals gain reliable data to identify trends, reduce errors, support clinical decision-making, and improve overall patient outcomes.

More details on AHA's findings can be found in their published report.

Editor's note: *This article originally appeared on JustCoding.*

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ODACS to begin January 1

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News & Insights

CMS is preparing to conduct the Outpatient Prospective Payment System (OPPS) Drug Acquisition Cost Survey (ODACS) to collect specific acquisition costs for outpatient drugs and biologicals purchased by hospitals paid under the OPPS. The agency established the survey in the 2026 OPPS final rule in response to a recent executive order.

The ODACS is set to run from January 1 to March 31, 2026, and CMS will conduct the survey via the Fee-for-Service Data Collection System. The agency will take the survey results into consideration when determining future payment rates and policies, beginning with the upcoming 2027 OPPS proposed rule.

Hospitals that received OPPS payments for outpatient drugs between July 1, 2024, and June 30, 2025, must complete the survey and report all payable outpatient drugs purchased during this period, according to CMS. A list of the National Drug Codes (NDC) for which the agency is collecting will be available in a template within the Survey Data Collection System. For each outer NDC, hospitals will need to report the total units purchased and total net acquisition costs for both 340B and non-340B drugs.

Hospitals with Part B claims meeting certain criteria were identified as candidate survey participants and notified beginning in September. CMS released a fact sheet to help hospitals prepare for registration and data submission ahead of the survey's launch, and it is also hosting a webinar on December 11 to provide additional information and support. Revenue cycle professionals can view CMS' FAQs for more details on ODACS data collection, calculation, and more.

Editor's note: *A version of this article originally appeared in* Revenue Integrity Insider*, NAHRI's weekly e-newsletter*

Related Topics:
Medicare news, OPPS

Housekeeping needed as post-shutdown payments clear

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As Medicare payment ramps back up after the recent government shutdown, Ahzam Afzal, CEO and co-founder of Puzzle Healthcare in Detroit, points out some things to watch for as the claims and payments come through.

Afzal says you "may see brief timing variability with the Medicare Administrative Contractors (MAC) as queues clear, but this is essentially a return to standard cash flow. Medicare fee-for-service payments come from the Medicare Trust Funds (HI/SMI) — not annual discretionary appropriations — so Medicare claim operations generally continued even when other parts of the government slowed down."

As claims return to normal, pay attention to these details:

- Closely watch MAC bulletins and remittance advice as the backlog clears for any processing quirks
- Make sure the claims you submit are clean: modifiers are accurate, National Provider Identifiers and Taxpayer Identification Numbers match, and medical necessity is well-documented
- Monitor days in accounts receivable for the next few cycles; small timing swings are standard as contractors normalize
- If you held claims, stage releases over 24-48 hours to prevent avoidable rejections due to volume spikes
- Coordinate with revenue cycle management teams and clearinghouses so that auto-postings and reconciliations track to catch up electronic funds transfers (EFT)
- Follow cash-flow discipline and avoid large disbursements until your first two Medicare EFTs land as expected

Note also, Afzal says, that in the wake of the shutdown "telehealth will need closer eligibility and coding checks given the post-waiver landscape," and act accordingly.

***Editor's note**: This article originally appeared on Part B News.*

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