Overview and Resources

On April 11, 2025, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2026 proposed rule for the Medicare Inpatient Prospective Payment System (IPPS). The proposed rule reflects the annual updates to the Medicare fee-for-service (FFS) inpatient payment rates and policies. In addition to the regular updates to wage indexes and market basket, the following policies are being proposed in this rule:

- Utilizing FFY 2024 Medicare Provider and Review (MedPAR) and FFY 2023 Hospital Cost Reporting Information System (HCRIS) data for standard calculations;
- Updates to the Medicare Disproportionate Share Hospital (DSH) payment policies, including hospital eligibility for DSH Uncompensated Care (UCC) payments in FFY 2026 being based on audited FFYs 2020–2022 S-10 data;
- Rebasing and revising the operating market basket and capital input price index (CIPI), including updating the labor-related share, using FFY 2023 Medicare cost report data;
- Discontinuing the low wage index policy and implementing a budget neutral transitional wage index value for providers who were eligible for the low wage index policy in FFY 2024;
- Changes to reclassification policies;
- Updates to the Transforming Episode Accountability Model (TEAM);
- Updates to the Medicare Promoting Interoperability Program;
- Updates to the Value-Based Purchasing (VBP) Program, Readmission Reduction Program (RRP), Hospital Acquired Conditions (HAC) Reduction Program, and Hospital Inpatient Quality Reporting (IQR) Program;
- Removal of the VBP Health Equity Adjustment (HEA) beginning with the FFY 2026 VBP program; and
- Updates to the payment penalties for non-compliance with the Hospital Inpatient Quality Reporting (IQR) and Electronic Health Record (EHR) incentive programs.

Proposed program changes would be effective for discharges on or after October 1, 2025, unless otherwise noted. CMS estimates the overall impact of this proposed rule update to be an increase of approximately $4.0 billion in aggregate payments for acute care hospitals in FFY 2026. This estimate includes increased operating, uncompensated care, and capital payments and decreases due to the expiration of the low-volume and Medicare Dependent Hospital (MDH) programs as of October 1, 2025.

A copy of the proposed rule and other resources related to the IPPS are available on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-proposed-rule-home-page.

An online version of the proposed rule will be available on April 30, 2025 and can be found at https://www.federalregister.gov/d/2025-06271.

Comments on this proposed rule are due to CMS by June 10, 2025 and can be submitted electronically at http://www.regulations.gov by using the website's search feature to search for file code "CMS-1833-P."

Text in italics is extracted from the display version of the proposed rule found in the April 11, 2025 display version of the proposed rule unless otherwise noted.

Request for Information (RFI) – Deregulation

Page 5

"On January 31, 2025, President Trump issued Executive Order (EO) 14192 'Unleashing Prosperity Through Deregulation,' which states the Administration policy to significantly reduce the private expenditures required to comply with Federal regulations to secure America's economic prosperity and national security and the highest possible quality of life for each citizen. We would like public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other interested parties participating in the Medicare program. CMS has made available an RFI at https://www.cms.gov/medicare-regulatory-relief-rfi. Please submit all comments in response to this RFI through the provided weblink."

IPPS Payment Rates

Pages 550–592, 638–644, 749–772, 1112–1168, and 1172–1197

The table below lists the federal operating and capital rates proposed for FFY 2026 compared to the rates currently in effect for FFY 2025. These rates include all market basket increases and reductions as well as the application of proposed annual budget neutrality factors. These rates do not reflect any hospital-specific adjustments (e.g., penalty for non-compliance under the IQR Program and EHR Meaningful Use (MU) Program, quality penalties/payments, DSH, etc.).

	Final FFY 2025	Proposed FFY 2026	Percent Change
Federal Operating Rate	$6,624.39	$6,835.47	+3.19%
Federal Capital Rate	$512.14	$528.95	+3.28%

The following table provides details for the proposed annual updates to the inpatient federal operating, hospital-specific, and federal capital rates for FFY 2026.

Proposed FFY 2026 Update Factor Component	Federal Operating Rate	Hospital Specific Rate	Federal Capital Rate
Market Basket/CIPI Update	+3.2%		+2.6%
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.8 percentage points (PPTs)		–
MS-DRG Reclassification and Recalibration Budget Neutrality (BN) Factor (before cap)	-0.16%		-0.18%
MS-DRG Weight Cap Policy BN	-0.01%		-0.01%
Wage Index/Geographic Adjustment Factor (GAF) BN Factor	+0.13%	-	+1.40%
Geographic Reclassification BN Factor*	+1.47%	-	

Wage Index Cap Policy BN*	-0.61%	-	-0.65%
Transition for the Discontinuation of the Low Wage Index Policy BN	-0.03%	-	
Outlier Adjustment Factor*	0.00%		+0.11%
Rural Community Hospital Demonstration BN*	-0.03%	-	-
Net Rate Update	**+3.19%**	**+2.11%**	**+3.28%**

*Denotes net change after removal of the FFY 2025 adjustment and application of the FFY 2026 adjustment.

The proposed market basket and CIPI update percentages are based on IHS Global Inc.'s fourth quarter 2024 forecast with historical data through third quarter 2024.

Rebasing and Revision of the Acute Care Hospital Market Basket and CIPI

Pages 550–592

CMS rebases the IPPS market basket and CIPI every four years by updating the costs and input price indexes used in the calculation and may make revisions by changing the data sources for price proxies used in the input price index. The last updates to the market basket and CIPI were implemented in FFY 2022 using FFY 2018 cost report data as the base period for the construction of the costs.

For FFY 2026, CMS is proposing to rebase the hospital market basket and CIPI cost weights using FFY 2023 Medicare cost report data as CMS believes FFY 2023 data to be the most recent, complete set. CMS also proposes to use the 2017 Benchmark Input-Output (I-O) "Use Tables/Before Redefinitions/Purchaser Value" tables published by the Bureau of Economic Analysis (BEA) which are available publicly at https://www.bea.gov/industry/io_annual.htm. Data taken from the BEA file are derived from the 2017 Economic Census and, if adopted, would be inflated to 2023 values by CMS. In addition, CMS is proposing to revise several of the price proxies using Bureau of Labor Statistics data.

As a result, CMS proposes to apply a market basket update of 3.2% and a CIPI of 2.6%, both of which are 0.1% lower than if rebasing was not done.

Effects of the IQR and EHR MU Incentive Programs

Pages 638–644 and 1115–1116

The IQR market basket penalty imposes a 25% reduction to the full market basket and the EHR MU penalty imposes a 75% reduction to the full market basket; hence the entirety of the full market basket update is at risk between these two penalty programs. The following table shows the various update scenarios for FFY 2026.

	Neither Penalty	Soley IQR Penalty	EHR MU Penalty	Both Penalties
Net Federal Rate Market Basket Update (3.2% MB less 0.8 PPT productivity adjustment)	+2.4%			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.2%)	–	-0.8 PPT	–	-0.8 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.2%)	–	–	-2.4 PPT	-2.4 PPT
Net Rate Update	**+2.4%**	**+1.6%**	**+0.0%**	**-0.8%**

Outlier Payments

Pages 1139–1166 and 1183–1184

For FFY 2026, CMS proposes to incorporate total outlier reconciliation dollars from the FFY 2020 cost reports into the outlier model using a similar methodology to what was finalized for FFY 2020, modified to reflect the additional cost reports identified due to the new criteria finalized for FFY 2025. Since these new criteria are not effective until the FFY 2025 cost reports, CMS will apply these criteria to FFY 2020 cost reports as if they had been in place at the time of cost report settlement and estimate outlier reconciliation dollars based on these cost reports and other supplemental data collected from MACs.

An analysis done by CMS using this methodology determined operating outlier payments at 5.0% of total IPPS operating payments. However, due to this analysis resulting in reconciled dollars being positive when the result is typically negative, CMS is proposing to hold data constant and use the percentage of total operating outlier reconciliation dollars to total Federal operating payments from the FFY 2025 IPPS final rule. This would result in operating outlier payments at 5.1% of total IPPS operating payments.

CMS determined capital outlier payments to be 4.16% of total capital payments. After considering capital outlier reconciliation, the estimated capital outlier payments are proposed to be 4.13% of total capital payments for FFY 2026.

CMS is proposing an outlier fixed-loss cost threshold of $44,305 for FFY 2026, which includes a charge inflation factor calculated using the March 2024 MedPAR file for FFY 2023 charge data and the March 2025 MedPAR file of FFY 2024 charge data. This threshold is 4.0% lower than the FFY 2025 outlier threshold of $46,152. The outlier fixed-loss cost threshold would be $44,644 without the proposed methodology change.

Additionally, CMS proposes to continue to use the estimated per-discharge Indian Health Service (IHS)/Tribal and Puerto Rico supplemental payments in the calculation of the outlier fixed-loss cost threshold, consistent with the policy of including estimated uncompensated care payments.

Stem Cell Acquisition Budget Neutrality Factor

Pages 1117–1118

CMS proposes to continue to not remove the Stem Cell Acquisition budget neutrality factor from the federal operating rate and to not apply a new factor for FFY 2026 as they do not believe that it would satisfy budget neutrality requirements. CMS intends to consider using cost report data regarding reasonable acquisition costs when it becomes available for future budget neutrality adjustments.

Wage Index and Geographic Adjustment Factor

Pages 486–549, 572–577, 1130–1131, 1134–1137, 1168–1172 and 1185–1189

A complete list of the proposed wage indexes to be used for payments in FFY 2026 is available on the CMS website at https://www.cms.gov/files/zip/fy2026-ipps-nprm-tables-2-3-4a-4b.zip.

Addressing Wage Index Disparities between High and Low Wage Index Hospitals

Pages 537–546 and 1185–1186

In the FFY 2020 IPPS final rule, CMS made a variety of changes to reduce the disparity between high and low wage index hospitals where hospitals with a wage index value in the bottom quartile of the nation would have that wage

index increased by a value equivalent to half of the difference between the hospital's post-rural floor, post-reclassification wage index and the 25th percentile wage index value across all hospitals. As adopted, this policy was to be in effect for a minimum of four years (through FFY 2024) in order to be properly reflected in the Medicare cost report for future years. In the FFY 2025 final rule, CMS adopted to continue this policy for at least three more years, beginning in FFY 2025, in order for sufficient wage data from after the end of the COVID–19 Public Health Emergency to become available.

This policy is subject to litigation (*Bridgeport Hospital, et al., v. Becerra*) in which the court found that the Secretary did not have the authority to adopt this low wage index policy and has ordered additional briefing on an appropriate remedy. On July 23, 2024, the U.S. Court of Appeals for the D.C. Circuit affirmed the lower court's ruling, holding that this policy for FFY 2020 was unlawful and that CMS had no statutory authority to issue it. As a result, the court ordered that the rule be vacated and that hospitals affected by the budget neutrality adjustment are entitled to back-payments, including interest.

In the FFY 2025 interim final rule with comment period (IFC), CMS recalculated the IPPS hospital wage index to remove the low wage index policy and the associated budget neutrality for FFY 2025 and implemented a transitional exception payment to providers who were eligible for the low wage index policy in FFY 2024. For hospitals who were eligible for the low wage index policy in FFY 2024, this transition set their wage indexes to 95% of their FFY 2024 wage index, was implemented without a corresponding budget neutrality adjustment, and did not permanently set each eligible provider's FFY 2025 wage index to this value.

For FFY 2026 and subsequent years, CMS is proposing to discontinue the low wage index hospital policy and associated budget neutrality. In order to mitigate the impact ending this policy would have on hospitals, CMS is proposing a transitional policy to be applied to hospitals that benefited from the low wage index policy in FFY 2024. If a hospital's FFY 2026 wage index would be more than a 9.75% decrease from their FFY 2024 wage index, the FFY 2026 wage index would be set to 90.25% of the FFY 2024 wage index. This proposed transition would be applied after the application of the 5% cap on FFY 2026 wage index values compared to those in FFY 2025. This transition is proposed to be budget neutral for both the federal operating and capital rates.

Permanent Cap on Wage Index Decreases

Pages 539–540 and 1186–1188

CMS applies a 5% cap on any decrease to the IPPS wage index, compared with the previous year's final wage index. The cap is applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an IPPS provider's prior FFY wage index is calculated with the application of the 5% cap, the following year's wage index would not be less than 95% of the IPPS provider's capped wage index in the prior FFY and will be applied to the final wage index a hospital would have on the last day of the prior FFY. For FFY 2026 CMS is proposing that this would be the wage index published in the FFY 2025 IFC, irrespective of the FFY 2025 transitional payment exception wage index value.

If a hospital reclassifies as rural under 42 CFR §412.103 with an effective date after this day, the policy applies to the reclassified wage index instead. Additionally, a new IPPS is paid the wage index for the area in which it is geographically located for its first full or partial FFY with no cap applied, because a new IPPS will not have a wage index in the prior FFY.

Outmigration Adjustments

Pages 534–537

For FFY 2026 and onward, CMS proposes to continue updating out-migration adjustments based on a custom tabulation of the American Community Survey utilizing data from 2016–2020. This is consistent with methodology used for determining FFY 2012 out-migration adjustments. Proposed out-migration adjustments can be found in Table 2 released with this proposed rule.

Occupational Mix Adjustment

Pages 511–515

CMS proposes the use of the calendar year (CY) 2022 Occupational Mix Survey for the calculation of the wage index for FFY 2026. The FFY 2026 occupational mix adjusted wage indexes based on this survey can be found in Table 2 on CMS's IPPS website. Additionally, CMS is proposing a FFY 2026 occupational mix adjusted national average hourly wage of $57.63.

Reclassification Policy Updates

Pages 516–528

Current regulations allow a hospital that has been reclassified by the Medicare Geographic Classification Review Board (MGCRB) to withdraw their application any time before the MGCRB issues a decision, within 45 days of the date of filing for public inspection of the proposed rule, or within seven days of receiving a decision, whichever is later. A hospital may also terminate an existing approved reclassification, effective for the second and third year of the three-year reclassification period, provided the request for termination is received within 45 days of the date of filing for public inspection of the proposed rule, or within seven days of receiving a decision, whichever is later. These withdrawal and termination requests may be cancelled by submitting a request by the next application deadline for MGCRB application. A provider can also cancel an eligible withdrawal or termination in order to make the reclassification effective for any remaining years of the three-year reclassification period, referred to as a request for reinstatement.

CMS is proposing to clarify this policy and revise the definitions in a more straightforward manner. Currently *"…Termination refers to the termination of an already existing 3-year MGCRB reclassification where such reclassification has already been in effect for 1 or 2 years, and there are 1 or 2 years remaining on the 3-year reclassification. A termination is effective only for the full fiscal year(s) remaining in the 3-year period at the time the request is received. Requests for terminations for part of a fiscal year are not considered. Withdrawal refers to the withdrawal of a 3-year MGCRB reclassification that has not yet gone into effect or where the MGCRB has not yet issued a decision on the application."* CMS is proposing to modify the definition of a withdrawal to only include requests made prior to a decision made by the MGCRB and to modify the definition of termination to encompass all post-decision actions to forgo the upcoming years of approved reclassification. CMS is also proposing that reinstatements would only apply to a termination, not to a withdrawal. However, CMS is proposing that a termination of a 3-year reclassification is not eligible to be reinstated if the hospital has a different MGCRB in subsequent years. Additionally, when an approved reclassification goes into effect, CMS would terminate all other previously approved reclassifications.

CMS believes that all parties in a county group reclassification must participate in any action prior to the effective date of a group reclassification in order to reduce the possibility of one or more parties withdrawing from a reclassification to the benefit or detriment of other hospitals reclassified to that labor market. Therefore, CMS is

proposing to modify the current regulation to state that the proposed modified withdrawal requests and proposed modified termination and reinstatement requests made prior to the effective date of the reclassification (that is, any request made prior to the first year the reclassification goes into effect), must include all parties to the application.

Labor-Related Share

Pages 546–549, 572–577, and 1169

The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. CMS is proposing to rebase and revise the IPPS market basket to reflect a 2023 base year and thus is proposing to recalculate the labor-related share using this proposed market basket. For FFY 2026, CMS proposes to apply a labor-related share of 66.0% for hospitals with a wage index of more than 1.0. By law, the labor-related share for hospitals with a wage index less than or equal to 1.0 will remain at 62%.

Cost-of-Living Adjustment (COLA)

Pages 1169–1172

Typically, CMS updates to the COLA factors applied to the nonlabor-related share of the federal operating and capital rates for hospitals in Alaska and Hawaii whenever the labor-related share of the IPPS market basket is updated. Using current methodology, CMS found that these COLA factors would decrease for FFY 2026. Due to this decrease, CMS is proposing to maintain the current factors for FFY 2026 and seeks comment on any possible data sources or new methodology which should be considered for developing these COLA factors.

Area	FFYs 2022–2025 (Proposed FFY 2026)	Potential FFY 2026 Updated Factors
Alaska:		
City of Anchorage and 80-kilometer (50-mile) radius by foot	1.22	1.18
City of Fairbanks and 80-kilometer (50-mile) radius by foot	1.22	1.18
City of Juneau and 80-kilometer (50-mile) radius by foot	1.22	1.18
Rest of Alaska	1.24	1.20
Hawaii:		
City and County of Honolulu	1.25	1.25
County of Hawaii	1.22	1.21
County of Kauai	1.25	1.25
County of Maui and County of Kalawao	1.25	1.25

DSH and UCC Payments

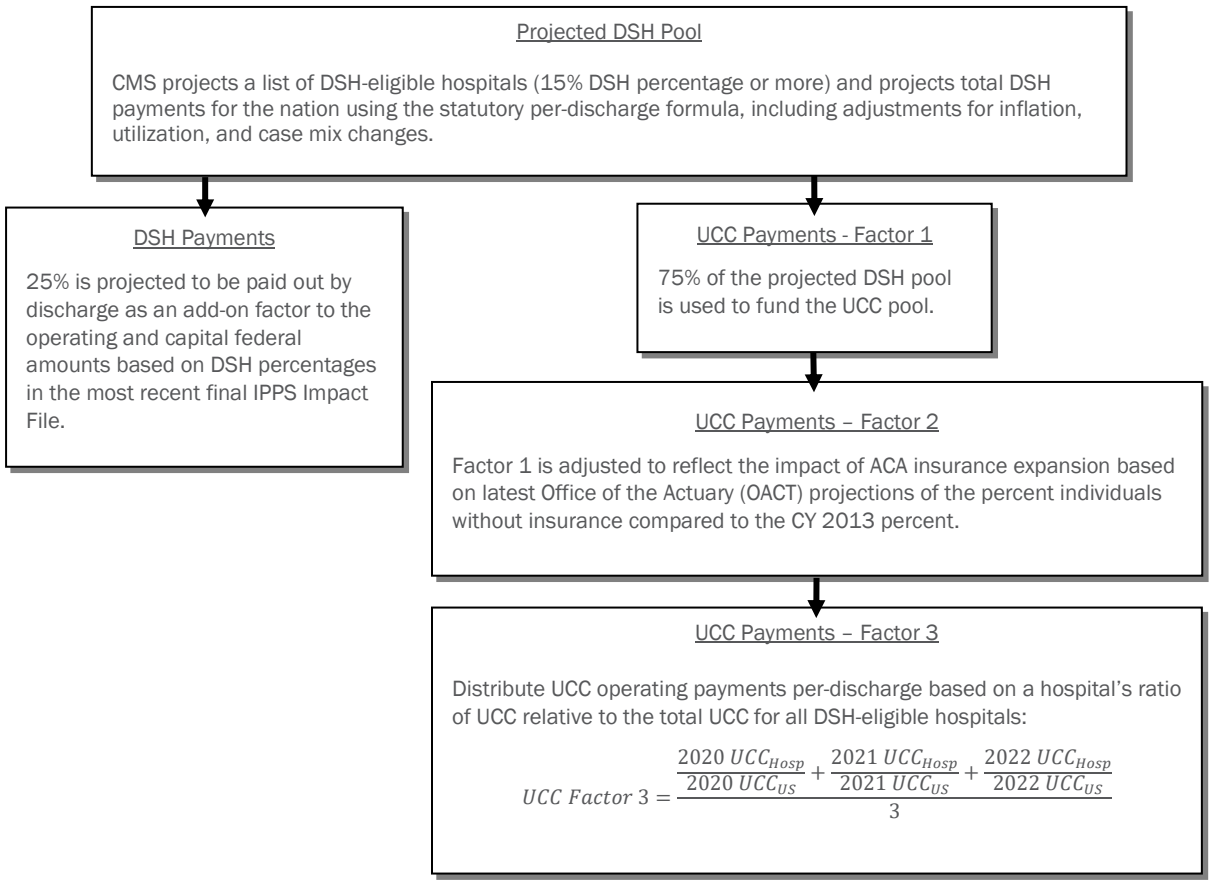
Pages 593–629

The ACA mandates the implementation of Medicare DSH calculations and payments to address the reductions to uncompensated care as coverage expansion takes effect. By law, 25% of estimated DSH funds must continue to be paid to DSH-eligible hospitals using the statutory method. The remaining 75% of the funds, referred to as the UCC pool, are subject to reduction to reflect the impact of insurance expansion under the ACA. This UCC pool is distributed to hospitals based on each hospital's proportion of UCC relative to the total UCC for all DSH-eligible hospitals.

The following table details the total DSH pool and each factor of the UCC pool.

	Final FFY 2025	Proposed FFY 2026	Percent Change
Projected Total DSH Pool	$14,013,000,000	$15,682,000,000	+11.91%
UCC Factor 1 – Base Funding (75% of Total DSH Pool)	$10,509,750,000	$11,761,500,000	+11.91%
UCC Factor 2 – Available Pool	$5,705,743,275 54.29% Factor 1 reduction	$7,140,406,650 60.71% Factor 1 reduction	+25.14%
UCC Factor 3 – Distribution	Audited FFYs 2019–2021 S-10 Line 30 Data (Trimmed)	Audited FFYs 2020–2022 S-10 Line 30 Data (Trimmed)	

The following schematic describes the DSH payment methodology mandated by the ACA:



Actual DSH Eligibility is determined at cost report settlement. Unless a merger occurs, there would be no update to a hospital's UCC payment or UCC factors as published in the FFY 2026 IPPS final rule Impact File. CMS may recoup DSH and UCC payments if a hospital is determined to be ineligible for DSH at the time of settlement. Conversely,

CMS will apply DSH and UCC payments if a hospital is determined to be eligible for DSH payments at cost report settlement, but not prior.

CMS uses the most recent three years of audited cost report data in the determination of Factor 3. Specifically, for FFY 2026 CMS proposes to use FFYs 2020–2022 for this determination. Hospitals that do not have data for all three years would have their Factor 3 determined based on the average of the available data for the appropriate years. In the rare case when CMS uses a cost report that starts in one FFY and spans the entirety of the subsequent FFY, the same cost report would not be used to determine UCC costs for the earlier FFY. As an alternative for the earlier FFYs, the most recent prior cost report that spans some portion of that FFY would be used. To ensure that total UCC payments for all eligible hospitals are consistent with the total estimated UCC amount made available to hospitals, a scaling factor would be applied to the Factor 3 values for each of these hospitals. For each DSH-eligible hospital, this scaling factor is calculated as:

$$\frac{1}{Actual\ sum\ of\ all\ hospital\ Factor\ 3\ values}.$$

This quotient is then multiplied by the UCC payment determined for each DSH-eligible hospital to obtain a scaled UCC payment amount. This process ensures that the sum of the scaled UCC payments for all hospitals is consistent with the estimate of the total amount available to make UCC payments.

For new hospitals, CMS proposes to continue the policy that if the hospital has a preliminary projection of being eligible for DSH it may receive interim DSH payments but would not receive interim UCC payments. Factor 3 values for new hospitals would use a denominator based solely on UCC costs from cost reports for the most recent year for which audits have been conducted. The resulting Factor 3 adjustment would then have a scaling factor applied to it to ensure that the total UCC pool is paid out. This also applies to newly merged hospitals with data based on the surviving hospital's CCN. If the hospital's cost reporting period is less than 12 months, the data from the newly merged hospital's cost report is annualized.

CMS proposes to continue to trim cost-to-charge ratios in the calculation of Factor 3. If a hospital's unaudited UCC costs for a FFY are greater than 50% of total operating costs for that FFY, then a ratio of UCC costs to the hospital's total operating costs for the other year is be applied to the total operating costs of the aberrant year. Additionally, for hospitals that have not had their FFY 2020, FFY 2021, and/or FFY 2022 cost reports audited, CMS proposes to continue the policy for an alternative trimming methodology using a threshold of three standard deviations from the mean ratio of insured patients' charity care costs to total uncompensated care costs, and a dollar threshold that is the median total uncompensated care cost reported on most recent audited cost reports for hospitals that were projected to be DSH-eligible, including IHS, Tribal, and Puerto Rico hospitals. Specifically, in cases where a hospital's insured patients' charity care costs are greater than $7 million and the ratio of the hospital's cost of insured patient charity care to total UCC costs is greater than 60%, CMS excludes the hospital from the prospective Factor 3 calculation. For hospitals subject to this alternate trim and determined to be DSH-eligible at cost report settlement, CMS would continue to apply its policy where those hospitals' UCC payments will be calculated after their MACs have reviewed the UCC information reported on worksheet S-10, subject to the previously mentioned scaling factor.

CMS is projecting that 2,385 hospitals may be eligible for DSH UCC payments in FFY 2026 based on audited FFYs 2020–2022 S-10 data. CMS provides a file that includes estimated DSH UCC eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH UCC payment methodology. The file is available at https://www.cms.gov/files/zip/fy2026-ipps-nprm-medicare-dsh-supplemental-data-file.zip.

Hospitals have 60 business days from the date of public display of the IPPS proposed rule to review and submit issues related to mergers and/or potential upload discrepancies of Worksheet S-10 data published along with the proposed rule. Comments regarding issues that are specific to data and supplemental data files for the proposed rule can be submitted to Section3133DSH@cms.hhs.gov. Any changes to distribution amounts will be posted on the CMS website prior to the beginning of the FFY.

Indirect and Direct GME Payments

Pages 663–677

In this proposed rule, CMS is providing public notification of the closure of two teaching hospitals for the purposes of the established application process for the resident slots attributed to this hospital.

CCN	Provider Name	City/State	CBSA	Terminating Date	IME Cap (includes all adjustments)	Direct GME Cap (includes all adjustments)
120004	Wahiawa General Hospital	Wahiawa, HI	46520	April 2, 2024	17.16	14.31
220017	Carney Hospital	Boston, MA	14454	August 31, 2024	63.15	61.14

The IME adjustment factor will remain 1.35 for FFY 2026.

Updates to the MS-DRGs

Pages 35–485, 630–637, 690–694, 1127–1130, and 1189–1190

Each year CMS updates the MS-DRG classifications and relative weights to reflect changes in treatment patterns, technology, and any other factors that may change the relative use of hospital resources. CMS proposes to utilize ICD-10 claims data from the September 2024 update of the FFY 2024 MedPAR file and the December 2024 update of the FFY 2023 Medicare costs reports to determine FFY 2026 MS-DRGs and recalibration of relative weights.

CMS will only accept MS-DRG classification requests via the Medicare Electronic Application Request Information System™ (MEARIS™) and will not accept requests via email. MEARIS™ can be accessed at https://mearis.cms.gov/, which contains links and documentation related to this system. MS-DRG change requests, feedback, and other suggestions for FFY 2027 must be submitted by October 20, 2025.

Updates to MS-DRG relative weights are calculated to be budget neutral before the application of the 10% reduction cap. As such, CMS proposes to apply a budget neutrality factor of 0.998422 to the operating rate and 0.9982 to the capital rate.

CMS previously adopted a permanent 10% cap on reductions to a MS-DRG's relative weight in a given year compared to the weight in the prior year, implemented in a budget neutral manner. As such, CMS proposes to continue this policy and apply a budget neutrality adjustment of 0.999938 to the operating rate and 0.9999 to the capital rate in FFY 2026. This cap policy will only apply to a given MS-DRG if it retains its MS-DRG number from the prior year and will not apply to the relative weight for any new or renumbered MS-DRGs for the year.

CMS proposes there to be 772 payable DRGs for FFY 2026 (compared to 771 for FFY 2025), with 78.7% of DRG weights changing by less than +/- 5%, 15.4% changing at least +/-5% but less than +/- 10%, 5.9% changing +/-10%

or more, 3.5% that are affected by the relative weight cap on reductions, and 0.9% being new MS-DRGs. The five MS-DRGs with the greatest proposed year-to-year change in weight, taking into account the relative weight cap, are:

MS-DRG	MS-DRG Title	Final FFY 2025 Weight	Proposed FFY 2026 Weight	Percent Change
783	CESAREAN SECTION WITH STERILIZATION WITH MCC	1.8421	2.4547	33.26%
624	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC	1.0031	1.2622	25.83%
508	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES WITHOUT CC/MCC	1.2906	1.6023	24.15%
804	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITHOUT CC/MCC	1.1056	1.3567	22.71%
257	UPPER LIMB AND TOE AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS WITHOUT CC/MCC	0.8919	1.0900	22.21%

When CMS reviews claims data, they apply several criteria to determine if the creation of a new complication or comorbidity (CC) or major complication or comorbidity (MCC) subgroup within an MS-DRG is needed. A subgroup must meet five criteria in order to warrant creation. Beginning in FFY 2021, CMS expanded the criteria to also include NonCC subgroups with the belief that this would better reflect resource stratification and promote stability of MS-DRG relative weights by avoiding low volume counts for the NonCC level MS-DRGs. CMS found that applying these criteria to all MS-DRGs would cause major changes in the list of MS-DRGs. These updates would have also impacted relative weights and payments rates. Due to the PHE and concerns about the impact that implementing major changes to the list of MS-DRG changes at one time, in the FFYs 2022–2025 final rules CMS adopted delays of the application of the NonCC subgroup criteria for these MS-DRGs. CMS is not proposing to delay this policy for FFY 2026.

The full list of the proposed FFY 2026 MS-DRGs, MS-DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy2026-ipps-nprm-table-5.zip. For comparison purposes, the final FFY 2025 DRGs are available in Table 5 on the CMS website at https://www.cms.gov/files/zip/fy-2025-ipps-final-rule-table-5.zip.

Chimeric Antigen Receptor (CAR) T-Cell Therapies

Pages 47–55, 210–217, and 690–694

In the FFY 2021 final rule, CMS assigned cases reporting ICD-10-PCS procedure codes XW033C3 or XW043C3 to a new MS-DRG 018 [Chimeric Antigen Receptor (CAR) T-cell Immunotherapy]. As additional procedure codes for CAR-T cell therapies are created, CMS will use its established process to assign these procedure codes to the most appropriate MS-DRG.

As providers do not typically pay the cost of a drug for clinical trials, CMS proposes to continue the adjustment to the payment amount for clinical trial cases that would group to MS-DRG 018. The proposed adjustment of 0.23 would be applied to the payment amount for clinical trial cases that would both group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6, contain standardized drug charges of less than $373,000, or when there is expanded access use of immunotherapy. In order to capture these payments within the relative weight methodology, CMS is

also proposing to exclude claims with standardized drug charges below the median standardized drug charge of claims identified as clinical trials in MS-DRG 018 when calculating the average cost for MS-DRG 018. For this proposed rule, the median standardized charge would be $29,819. This policy is proposed to be in effect for two years (FFY 2026 and 2027), until claims data reflects the addition of the code indicating that the immunotherapy product is not purchased in the usual manner. If adopted, the median would also be updated based on more recent data for the final rule.

New Technology

Pages 221–485

CMS states that numerous new medical services or technologies are eligible for add-on payments outside the PPS. Table II.E.-01.A on page 243 shows the 11 technologies that are proposed to continue to receive add-on payments for FFY 2026 since their three-year anniversary date will occur on or after April 1, 2026. Table II.E.-01.B on pages 243–244 shows the 15 technologies that are proposed to continue receive add-on payments for FFY 2026 since their three-year anniversary date will occur on or after to October 1, 2025. Table II.E.-02 on page 247 shows the 13 technologies proposed to no longer receive add-on payments for FFY 2026 since their three-year anniversary date will occur prior to April 1, 2026.

CMS is proposing new technology add-on payments for 14 technologies under the traditional pathway and 29 under alternative pathways. CMS previously adopted that, beginning with new technology add-on payments for FFY 2026 for those technologies first approved for the add-on in FFY 2025 or a subsequent year, new technology payments could be extended for an additional fiscal year when the three-year anniversary date occurs on or after October 1 of that federal fiscal year. This extension will be part of the assessment on whether to continue the new technology add-on payment. Additionally, based on the variability and the timing of and reasons underlying hold statuses with FDA marketing authorizations, for new technology add-on payment applications for FFY 2026 and forward, a hold status will no longer be considered an inactive status for the purposes of eligibility for the new technology add-on payment.

MS-DRG Changes

Pages 55–203 and 630–637

Based on the analysis of FFY 2024 MedPAR claims, CMS is proposing changes to a number of MS-DRGs effective for FFY 2026. Specifically, CMS is proposing the following:

- *"Adding ICD-10-PCS codes describing restriction and replacement of the thoracic aorta, and bypass and occlusion of the subclavian and carotid arteries, to proposed new MS-DRG 209 (Complex Aortic Arch Procedures).*
- *Adding ICD-10-PCS codes describing restriction of the abdominal aorta and restriction of the iliac artery to proposed new MS-DRG 213 (Endovascular Abdominal Aorta with Iliac Branch Procedures).*
- *Reassigning ICD-10-PCS codes describing extirpation of matter from coronary arteries to proposed new MS-DRG 318 (Percutaneous Coronary Atherectomy without Intraluminal Device).*
- *Reassigning ICD-10-PCS codes describing extirpation of matter from coronary arteries and adding ICD-10-PCS codes describing dilation of coronary arteries and insertion of an intraluminal or other device to proposed new MS-DRGs 359 and 360 (Percutaneous Coronary Atherectomy with Intraluminal Device with MCC and without MCC, respectively).*

- *Adding ICD-10-CM diagnosis codes describing periprosthetic joint infection and ICD-10-PCS procedure codes describing hip or knee procedures to proposed new MS-DRGs 403 and 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC and without MCC, respectively).*
- *Deleting MS-DRGs 294 and 295 (Deep Vein Thrombophlebitis with CC/MCC and without CC/MCC, respectively) and reassigning the ICD-10-CM codes to MS-DRGs 299, 300, and 301 (Peripheral Vascular Disorders with MCC, with CC, and without CC/MCC, respectively).*
- *Deleting MS-DRG 509 (Arthroscopy) and reassigning the ICD-10-PCS codes describing inspection of various anatomic sites to their respective clinically appropriate MSDRGs.*
- *Adding ICD-10-CM diagnosis codes describing the insertion of a radioactive element into the brain to MS-DRG 023 (Craniotomy with Major Device Implant or Acute Complex CNS Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator).”*

The table on page 636 details which of these proposed new or revised MS-DRGs would be subject to the post-acute care transfer policy for FFY 2026. The table on page 637 details which of these proposed new or revised MS-DRGs would be subject to the MS-DRG special payment policy for FFY 2026.

Low-Volume Hospital Adjustment

Pages 650–658

Legislative action by Congress over the past several years mandated changes to the low-volume hospital adjustment criteria, allowing more hospitals to qualify for the adjustment and modifying the amount of the adjustments. The Full-Year Continuing Appropriations and Extensions Act of 2025 extended the current criteria through FFY 2025. The current payment adjustment formula for hospitals located more than 15 miles from another subsection (d) hospital, with between 500 and 3,800 total discharges is:

$$\text{Low Volume Hospital Payment Adjustment} = \frac{95}{330} - \frac{Total\ Discharges}{13{,}200}$$

Providers with less than 500 total discharges will receive a 25% payment increase. On October 1, 2026, and subsequent years, the criteria for the low-volume hospital adjustment will return to more restrictive, statutory levels. To receive a low-volume adjustment under the statutory policy, subsection (d) hospitals will need to meet the following criteria:

- Be located more than 25 road miles from another subsection (d) hospital; and
- Have fewer than 200 total discharges (All Payer) during the fiscal year.

For a hospital to acquire low-volume status for FFY 2026, consistent with historical practice, CMS proposes that a hospital must submit a written request for low-volume hospital status to its MAC that includes sufficient documentation to establish that the hospital meets the applicable mileage and discharge criteria for low volume hospital status. The MAC must receive a written request by September 1, 2025 in order for the adjustment to be applied to payments for its discharges beginning on or after October 1, 2025. For hospitals whose request is received after September 1, 2025, if accepted, the adjustment would be applied prospectively within 30 days of low-volume hospital determination.

A hospital that qualified for the low-volume hospital payment adjustment for FFY 2025 may continue to receive the adjustment for FFY 2026 without reapplying if it meets both the more restrictive discharge and mileage criteria applicable for FFY 2026.

Rural Referral Center (RRC) Status

Pages 645–649

Hospitals that meet a minimum case-mix and discharge criteria (as well as one of three optional criteria relating to specialty composition of medical staff, source of inpatients, or referral volume) may be classified as RRCs. This special status provides an exemption from the 12% rural cap on statutory DSH payments and exemption from the proximity criteria when applying for geographic reclassification. Each year, CMS updates the minimum case-mix index and discharge criteria related to achieving RRC status (for hospitals that cannot meet the minimum 275 bed criteria). The proposed FFY 2026 minimum case-mix and discharge values by region are available on the pages listed above.

Medicare-Dependent, Small Rural Hospital (MDH) Program

Pages 658–662

The MDH program has been extended multiple times since its creation for FFY 2012, with the most recent extension being through FFY 2025 as granted by the Full-Year Continuing Appropriations and Extensions Act of 2025. Beginning October 1, 2025, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based on the IPPS federal rate. Hospitals that will lose this status may apply for Sole Community Hospital status in advance of the expiration of the MDH program.

Transforming Episode Accountability Model (TEAM)

Pages 959–1045

In the FFY 2025 IPPS final rule, CMS adopted a new five-year mandatory episode-based payment model with the goal of improving quality of care while reducing Medicare spending for beneficiaries undergoing certain high-expenditure, high-volume surgical procedures. The procedures included in this model will be:

- Lower Extremity Joint Replacement;
- Surgical Hip/Femur Fracture Treatment;
- Spinal Fusion;
- Coronary Artery Bypass Graft; and
- Major Bowel Procedure.

This model is mandatory and will last for five years, beginning on January 1, 2026. Hospitals required to participate were determined by CBSA, with CMS selecting 188 CBSAs using a stratified random sampling methodology from a list of 803 eligible CBSAs. These hospitals will continue to bill Medicare FFS but will receive hospital and beneficiary risk-adjusted target prices by episode category and region. These target prices will be based on historic Medicare episode spend with a quality performance adjustment. A 2% discount factor is applied for the Lower Extremity Joint

Replacement, Surgical Hip/Femur Fracture Treatment, and Spinal Fusion episode categories; and a 1.5% discount factor is applied for the Coronary Artery Bypass Graft and Major Bowel Procedure episode categories.

A full discussion of TEAM, including details on how CBSAs were chosen, adopted episodes, quality measures and reporting, and other details can be found in the FFY 2025 final rule.

In FFY 2025 rulemaking there were certain policies proposed that were not finalized due to public concerns or needing further consideration. In this rule, CMS is proposing several of those policies again and additional modifications to TEAM:

- A limited deferment period for new hospitals located in a mandatory CBSA (pages 962–970).
- Linking Track 2 participation eligibility for hospitals with a Medicare Dependent Hospital (MDH) designation to the expiration of the MDH program (pages 970–975)
- Aligning the reporting period for the Hybrid Hospital-Wide Readmission Measure with the Hospital IQR Program (pages 981–982)
- Adding the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) for outpatient episodes (pages 982–986)
- Applying a neutral quality measure score for TEAM participants with insufficient quality data (pages 986–988)
- A methodology to construct target prices when there are coding changes (pages 993–998)
- Including US territories in Census Division 9 (pages 998–999)
- Reconstructing the normalization factor and trend factor (pages 999–1009)
- Replacing the Area Deprivation Index (ADI) with the Community Deprivation Index (CDI) in beneficiary economic risk adjustment factor (pages 1009–1013)
- Using a 180-day lookback period beginning the day prior to episode initiation for Hierarchical Condition Categories (HCC) under version 28 for beneficiary risk adjustment (pages 1013–1021)
- Aligning baseline, performance year, and reconciliation time periods for episode attribution (pages 1028–1031)
- Removing voluntary reporting of health equity plans and health-related social needs screening data (pages 1035–1037)
- Expanding the Skilled Nursing Facility (SNF) 3-Day Rule Waiver (pages 1041–1044)
- Removing the voluntary Decarbonization and Resilience Initiative (pages 1044–1045)

CMS is also soliciting comments, but not proposing updates, in the following policy areas:

- Indian Health Service (IHS) hospital outpatient episodes (pages 975–978)
- Low volume hospitals (pages 1021–1028)
- Standardized prices and reconciliation amounts (pages 1031–1035)
- Primary care services referral requirement (pages 1037–1041)

Updates to the IQR Program and Electronic Reporting Under the Program

Pages 832–874

Tables in the proposed rule on pages 864-867 outline the previously adopted Hospital IQR Program measure set for FFYs 2027–2029 payment determination.

Updates to the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity (MORT-30-STK) Measure

Pages 835–843

Beginning with the CY 2025 reporting period/FFY 2027 payment determination, CMS is proposing to modify the MORT-30-STK measure. CMS recognizes the increase in enrollment of Medicare beneficiaries in Medicare Advantage (MA) plans and CMS is proposing modifications to the current MORT-30-STK measure in the hospital IQR program to expand the measure's inclusion criteria to include MA patients. The cohort for the modified measure would include admissions for patients ages 65 years or older discharged from the hospital with a principal diagnosis of acute ischemic stroke, who were enrolled in Medicare FFS or MA for the 12 months prior to the date of admission, as well as enrolled in Medicare FFS or MA during the index admission. The proposed modifications to the measure would still be calculated using a risk-standardized mortality rate.

CMS notes the proposed updates to the MORT-30-STK measure exclude all the following admissions from its cohort:

- Patients with inconsistent or unknown vital status, or other unreliable demographic data (for example, age and gender)
- Patients who were transferred from another acute care facility
- Patients enrolled in the Medicare hospice program any time in the 12 months prior to the index hospitalization
- Patients who were discharged against medical advice

CMS is also proposing to shorten the performance period from the current period of three years to a period of two years for this measure. This proposed implementation would begin with the FFY 2027 program year and the new reporting period for the measure would change from July 1, 2022–June 30, 2025 to July 1, 2023–June 30, 2025. CMS states that they found the measure could achieve a satisfactory level of reliability with the proposed two-year reporting period while improving the timeliness of the data.

As administrative claims data is used for the measure, CMS states hospitals would not be required to submit additional data for measure calculations. This measure would be calculated and publicly reported on an annual basis using a rolling 24 months of prior data for the measurement period on Care Compare beginning in July 2026 or sooner if feasible.

CMS is also making technical updates to the MORT-30-STK measure including updating the risk adjustment model to use individual ICD-10 codes instead of the current Hierarchical Condition Categories (HCCs) in the methodology. The current risk adjustment strategy groups ICD-10 diagnosis codes from CMS's HCC system into clinically relevant categories and then evaluates HCCs for statistical association with the measure's outcome. CMS states that using individual ICD codes in place of HCCs would improve the model performance of mortality measures.

Modifications to Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP-HIP-KNEE) Measure

Pages 843–856

CMS is proposing to modify the COMP-HIP-KNEE measure beginning with the CY 2025 reporting period/FFY 2027 payment determination. As with the MORT-30-STK measure, CMS is proposing to expand the measure's inclusion criteria to include MA patients and shorten the performance period from three years to two years. If finalized, CMS would remove the updated COMP-HIP-KNEE measure in the Hospital IQR Program beginning with the FFY 2030 payment determination as outlined in the FFY 2024 IPPS final rule to prevent duplicative reporting of the measure in the quality reporting program and Value Based Purchasing (VBP) Program.

CMS is also proposing technical updates to the COMP-HIP-KNEE measure including updating the risk adjustment model to use individual ICD-10 codes instead of HCCs to improve the measure's risk adjustment methodology in line with their reasoning for the MORT-30-STK measure.

For the proposed updated COMP-HIP-KNEE measure, the outcome would be a complication occurring during the index admission (not coded as POA) through 90 days post-date of the index admission and counted if they occur during the index hospital admission or during a readmission.

Modifications to the Hybrid Hospital-Wide Readmission (HWR) and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) Measures

Pages 869–872

CMS is proposing to modify the Hybrid HWR and Hybrid Hospital-Wide Mortality HWM measures. For both IQR program measures, hospitals are currently required to report core clinical data elements (CCDEs) on 90% of discharges and to submit four linking variables on 95% of discharges in a reporting period beginning with a mandatory reporting period for the FFY 2028 payment determination. Hospitals must report 13 CCDEs for the Hybrid HQR measure and ten CCDEs for the Hybrid HWM measure.

As a result of the 2024 voluntary reporting period for both the Hybrid HWR and Hybrid HWM measures CMS found that three-fourths of the hospitals that submitted measure data during the period did not meet submission thresholds (90% of discharges for the CCDEs and 95% of discharges for the linking variables).

Based on an internal analysis and feedback from commenters received in the CY 2025 OPPS/ASC final rule, CMS is proposing to reduce the submission threshold for both CCDE and linking variables to at least 70% of discharges for both the Hybrid HWR and Hybrid HWM measures. CMS is also proposing to lower the number of required CCDE data elements in both measures to allow for up to two missing laboratory results and up to two missing vital signs.

Removals in the Hospital IQR Program Measure Set

Pages 856–864

Beginning with the CY 2024 reporting period/FFY 2026 payment determination, CMS is proposing to remove the following measures in the IQR program:

- Hospital Commitment to Health Equity (HCHE)
- COVID–19 Vaccination Coverage among HCP (HCP COVID-19 Vaccination)

- Screening for Social Drivers of Health (SDOH-1)
- Screen Positive Rate for Social Drivers of Health (SDOH-2)

In addition, CMS is planning to remove the COVID-19 exclusion from the following measures in the IQR program beginning with the FFY 2027 program year:

- COMP-HIP-KNEE
- MORT-30-STK
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction (AMI) (AMI Excess Days)
- Excess Days in Acute Care after Hospitalization for Heart Failure (HF) (HF Excess Days)
- Excess Days in Acute Care after Hospitalization for Pneumonia (PN) (PN Excess Days)
- Hybrid HWR

This update would modify the above measures to remove the exclusion of COVID-19 diagnosed patients from the index admissions and readmissions, including the removal of the exclusion of certain ICD-10 codes that represent patients with a secondary diagnosis of COVID-19, and history of COVID-19 risk variable. CMS believes that hospitals have had adequate time to adjust to the presence of COVID-19 as an ongoing virus. In an internal analysis using data from July 2020–June 2024 CMS states that there has been a decline over time of the number of patients excluded from the various measure cohorts.

Request for Information – Well-being and Nutrition

Pages 832–834

CMS is seeking public input on measure concept for future years in the Hospital IQR program for the Well-being and Nutrition measures. The Well-being measure is a comprehensive approach that emphasizes person-centered care by promoting the well-being of patients and family members. CMS seeks input and comments on the applicability of tools and constructs that assess for the integration of complementary and integrative health, skill building, and self-care.

CMS adopted the Malnutrition Care Score (MCS) eCQM in the Hospital IQR program in the FFY 2023 IPPS final rule. This measure assessed adults 65 years of age and older admitted to inpatient hospital services who received care appropriate to their level of malnutrition risk and malnutrition diagnosis and was later expanded to include patients 18 years of age and older. CMS is seeking comments on tools and measures that assess optimal nutrition and preventive care in the Hospital IQR Program.

CMS intends to use input on both measures to inform the future measure development efforts.

Modifications to the ECE policy

Pages 712–714, 737–739, 745–748, and 872–874

In the Hospital IQR, VBP program, RRP, and HAC reduction program, CMS is proposing to update and codify the ECE policy to include extensions of time as a form of relief and to further clarify the policy, as well as to align the Hospital IQR program with the quality reporting programs. Specifically, the proposals note:

- *"…CMS may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance—defined as an event beyond the control of a hospital (for example a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the hospital comply with one or more applicable reporting requirements with respect to a fiscal year.*
- *…a hospital may request an ECE within 30 calendar days* [down from the current 90 days] *of the date that the extraordinary circumstance occurred. Under this proposed policy, we clarify that CMS retains the authority to grant an ECE as a form of relief at any time after the extraordinary circumstance has occurred.*
- *…we propose that CMS notify the requestor with a decision, in writing, via email. In the event that CMS grants an ECE to the hospital, the written decision will specify whether the hospital is exempted from one or more reporting requirements or whether CMS has granted the hospital an extension of time to comply with one or more reporting requirements*
- *…we propose that CMS may grant an ECE to one or more hospitals that have not requested an ECE, if CMS determines that: a systemic problem with CMS data collection system directly impacted the ability of the hospital to comply with a quality data reporting requirement; or that an extraordinary circumstance has affected an entire region or locale. As is the case under our current policy, any ECE granted will specify whether the affected hospitals are exempted from one or more reporting requirements or whether CMS has granted the hospitals an extension of time to comply with one or more reporting requirements."*

Quality-Based Payment Programs

Pages 695–748

For FFY 2026, IPPS payments will be adjusted for quality performance under the VBP program, RRP, and the HAC Reduction Program. Details on the FFY 2026 programs, payment adjustment factors, and new policies CMS is proposing quality-based payment programs are below.

VBP Program

Pages 715–741

FFY 2026 Payment Adjustment

The FFY 2026 program will include hospital quality data for 20 measures in four domains: safety; clinical outcomes; person and community engagement; and efficiency and cost reduction. By law, the VBP program must be budget neutral and the FFY 2026 program will be funded by a 2.0% reduction in IPPS payments for hospitals that meet the program eligibility criteria (estimated at $1.7 billion). Hospitals can earn back some, all, or more than their individual 2.0% reduction.

While the data applicable to the FFY 2026 VBP program is still being aggregated, CMS has calculated and published proxy factors based on the historical baseline and performance periods used in the FFY 2025 program. Hospitals should use caution in reviewing these factors as they do not reflect updated performance periods/standards, nor changes to hospital eligibility.

The proxy factors published with the proposed rule are available in Table 16A on the CMS website at https://www.cms.gov/files/zip/fy2026-ipps-nprm-table-16a.zip.

CMS anticipates making actual FFY 2026 VBP adjustment factors available in the fall of 2025. Details and information on the program are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hvbp.

Baseline periods, performance periods, and performance standards were previously adopted for a subset of measures for the FFYs 2027–2031 programs. Pages 731–737 outline the new performance standards for FFYs 2027–2031.

CMS had already adopted VBP program rules through FFY 2026 and some program policies and rules beyond FFY 2026. CMS is proposing further program updates through FFY 2033, described below.

Future Program Years

Beginning with the FFY 2026 program year, CMS is proposing to remove the HEA from the Hospital VBP Program originally adopted in the FFY 2024 IPPS final rule. The HEA rewards top performing hospitals that serve higher proportions of patients with dual eligibility status and who perform well on quality measures in the VBP program.

Beginning with FFY 2033 program year, CMS is proposing to adopt updates to the COMP-HIP-KNEE measure. The proposals include updating the measure cohort to include MA beneficiaries and in conjunction update the applicable period from three years to two years. These proposed updates in the VBP program are contingent on whether CMS adopts the same updates to the measure for use in the Hospital IQR Program beginning with the FY 2027 payment determination. If finalized, CMS will post the measure data on Care Compare beginning in July 2026. CMS is proposing to use the current calculation methodology for the performance standards for the updated measure.

In addition to the proposals mentioned above, CMS is notifying the public of multiple updates in the VBP program. For the COMP-HIP-KNEE measure. CMS is updating the risk adjustment model beginning with the FFY 2027 program year. As described in the hospital IQR program update for the measure, CMS is updating the risk adjustment model to use individual ICD-10 codes instead of HCCs to improve the measure's risk adjustment methodology.

CMS is providing notice that it intends to remove the COVID-19 exclusion from the five condition-and procedure-specific mortality measures and one procedure-specific complication measure in the VBP program beginning with FFY 2027 program year.

This update would modify the specifications to include the ICD-10 codes that identify patients with a principal or secondary diagnosis of COVID-19 in the measure denominators for the following measures:

- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization (MORT-30-AMI)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT-30-CABG)
- Hospital 30-Day, All-Cause, Risk Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT-30-COPD)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following HF Hospitalization (MORT-30-HF)
- Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following PN Hospitalization (MORT-30-PN)

This update will also modify the specifications of the COMP-HIP-KNEE measure to include the ICD-10 codes that identify patients with a principal or secondary diagnosis of COVID-19 in both the measure numerator and

denominator. In all six measures in the VBP program the update would also remove the covariate adjustment for patient history of COVID-19 in the 12 months prior to the admission.

For the CDC NHSN HAI measures in the VBP program CMS is notifying hospitals of the upcoming changes to the standard population data, also known as a "baseline," as a part of routine measure maintenance. In the VBP program a hospital's improvement points are calculated using comparisons between data collected from a hospital's baseline period and data collected in a hospital's performance period. Currently CMS uses the CY 2015 baseline data but has determined that it cannot equally compare CDC's new baseline data to the current baseline data to calculate improvement points. To address this CMS intends to use the 2015 baseline data to calculate performance standards and calculate and publicly report measure scores until the FFY 2029 program year. Beginning with the FFY 2029 program year, CMS will then use the CY 2022 baseline data to calculate performance standards and calculate and publicly report measure scores. TABLE VI.L.-09 on page 730 outlines the CDC baseline data for FFY 2026–2029 in the VBP program years.

RRP

Pages 695-714

FFY 2026 Payment Adjustment

The FFY 2026 RRP will use data from July 1, 2021–June 30, 2024 and evaluate hospitals on six conditions/procedures: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA) and total knee arthroplasty (TKA), and coronary artery bypass graft (CABG).

The RRP is not budget neutral; hospitals can either maintain full payment levels or be subject to a penalty of up to 3.0%.

Hospitals are grouped into peer groups (quintiles) based on their percentage of full-benefit dual-eligible patients as a ratio of total Medicare FFS and Medicare Advantage (MA) patients during the same three-year period as the program performance period. Hospital excess readmission ratios are compared to the median excess readmission ratio of all hospitals within their quintile for each of the measures. A uniform modifier is applied such that the adjustment is budget neutral nationally.

The data applicable to the FFY 2026 RRP program is still being reviewed and corrected by hospitals, and therefore CMS has not yet posted factors for the FFY 2026 program in Table 15. CMS expects to release the final FFY 2026 RRP factors in the fall of 2025.

Details and information on the RRP currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hrrp.

Future Program Years

Beginning with FFY 2027 program year. CMS is proposing to refine all six readmission measures to expand the inclusion criteria to include MA beneficiaries in each measure. The current measure denominator for the program includes beneficiaries "Enrolled in Medicare FFS Part A and Part B for the first 12 months prior to the date of admission and enrolled in part A during the index admission." CMS is proposing to modify the measure cohort to "Enrolled in Medicare FFS and/or MA for the 12 months prior to the date of admission; and enrolled in FFS or MA

during the index admission." CMS believes that the addition of the MA data to the measures would double the cohort size which more accurately reflects the quality of care for both FFS and MA beneficiaries.

As CMS would use administrative data, hospitals would not be required to submit additional data for measure calculations. CMS would continue to publicly report readmission rates and readmission measure results for hospitals on Care Compare and in the Provider Data Catalog.

In tandem with the proposal to include MA beneficiaries, CMS is proposing to modify the "applicable period" definition from a three-year period to a two-year period. This includes the period from which data are being collected to calculate excess readmission ratios (ERRs) and payment adjustment factors for the fiscal year as well as the aggregate payments for excess readmissions and aggregate payments for all discharges used in the calculation of the payment adjustment. The "applicable period" would be the two-year period starting one year after the previous program fiscal year's start of the "applicable period." For example, the FFY 2027 program determination the applicable period would then be July 1, 2023–June 30, 2025. The "applicable period for dual eligibility" would continue to correspond to the "applicable period." CMS believes reducing the applicable period would allow for more recent data when assessing performance. CMS states that in testing the measures showed better between-hospital variance using the two-year FFS and MA combined cohort compared to the current three-year period and FFS-only cohort.

As a result of CMS's proposal to include MA beneficiaries in the RRP measure cohort, CMS is also proposing to modify the calculation of the aggregate payments for excess readmissions (the numerator) to include payment data for MA beneficiaries in addition to Medicare FFS. CMS would rely on the MedPAR and/or the latest available data source that provides the most up-to-date comprehensive information on payment information for Medicare FFS and MA beneficiaries.

An analysis of the proposals to include MA data, the proposed two-year applicable period, and the proposed updates to the calculations for aggregate payments for each condition to include MA data can be found on pages 707–711.

As with the VBP program, CMS is also proposing an update to re-specify the risk model for each measure in the RRP to primarily use individual ICD-10 codes in place of the previously used HCCs. CMS cites that the update would improve the performance of risk adjustment models for condition- and procedure-specific mortality and complication measures.

Similar to the proposal in the Hospital IQR program, CMS is proposing to remove the COVID-19 exclusion from all six readmission measures in the RRP beginning with FFY 2027 program year. This proposal includes the removal of exclusion of COVID-19 diagnosed patients from the index admission and readmissions, as well as certain ICD-10 codes that represented patients with a secondary diagnosis of COVID-19, and history of COVID-19 risk variable. CMS will make an updated measure methodology report available in May 2026 at https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.

HAC Reduction Program

Pages 742–748

FFY 2026 Payment Adjustment

The FFY 2026 HAC reduction program will evaluate hospital performance on six measures: the AHRQ Patient Safety Indicator (PSI)-90 (a composite of ten individual HAC measures), Central Line-Associated Bloodstream Infection (CLABSI) rates, Catheter-Associated Urinary Tract Infection (CAUTI) rates, the Surgical Site Infection (SSI) Pooled

Standardized Infection Ratio (SIR), Methicillin-resistant Staphylococcus Aurea (MRSA) rates, and Clostridium difficile (C.diff.) rates. The HAC reduction program is not budget neutral; hospitals with a total HAC score that falls within the worst performing quartile for all eligible hospitals will be subject to a 1.0% reduction in IPPS payments. Total HAC scores are calculated by applying an equal weight to each measure for which a hospital has a score.

CMS uses a continuous z-score methodology for HAC which eliminates ties in the program and enhances the ability to distinguish low performers from top performers.

Details and information on the HAC currently are available on CMS' QualityNet website at https://qualitynet.cms.gov/inpatient/hac.

Future Program Years

While CMS is not proposing to add or remove any measures in the HAC reduction program, CMS is providing notice of upcoming changes to the standard population data, also known as the baseline, used to calculate the SIR for the Center for Disease Control and Prevention (CDC) National Health Safety Network (NHSN) measures.

In this update HAI SIR calculations of infections reported beginning in CY 2025 will reflect the use of both the new 2022 baseline and the 2015 baseline. CMS anticipates the new 2022 baseline will affect the program beginning with FFY 2028 program year when both years of the two-year performance period (CY 2025 and CY 2026) will use the 2022 update to the baseline.

CMS anticipates that the HAI measures using the 2022 update to the baseline in the FFY 2028 program dataset would be publicly reported on the Provider Data Catalog in early 2028. In addition, the HAI measures using the 2022 updated to the baseline will begin to be publicly reported on CMS' Care Compare tool in fall 2026 using four quarters of CY 2025 data and will continue to display on a quarterly basis calculated from a rolling four quarters of data. Details on the timelines associated with the public reporting periods can be found on the tables on page 745.

Promoting Interoperability Program

Pages 907–958

The Medicare Promoting Interoperability program provides incentive payments and payment reductions for the adoption and meaningful use of certified EHR technology.

In the FFY 2024 IPPS final rule, CMS established the CY 2025 EHR reporting period as a minimum of any continuous 180-day period within CY 2025. For CY 2026 and subsequent years, CMS is proposing to maintain the EHR reporting period for a payment determination as a minimum of any continuous 180-day period within the calendar year. CMS states this would provide consistency with the EHR reporting period established for CY 2025 and allow eligible hospitals and critical access hospitals (CAHs) the flexibility they may need to work with their chosen EHR vendors on continuing to develop, update, implement, and test their EHR systems to maintain effective use of certified electronic health record technology (CEHRT).

CMS previously adopted the Security Risk Analysis measure, which requires eligible hospitals and CAHs to attest "yes" or "no" as to whether they have conducted or reviewed a security risk analysis, as required under the HIPAA Security Rule implementation specification for risk management. The HIPAA Security Rule implementation specification for risk management also requires the implementation of security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level. While the current Security Risk Analysis measure does not account for this, beginning CY 2026 CMS is proposing to modify the measure to require eligible hospitals and CAHs

to also attest "yes" to having conducted security risk management. The proposal to modify the Security Risk Analysis measure would not change the current scoring approach and would not contribute any points towards the eligible hospital or CAH's total score for the objectives and measures.

CMS is also proposing to modify the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure. Currently, eligible hospitals and CAHs are required to attest "yes" to conducting an annual self-assessment using all nine of the 2016 SAFER Guides to be considered a meaningful EHR user.

In January 2025, the SAFER Guides were edited and contain new recommendations that are similar and overlap in function or intent with the 2016 SAFER Guides. Table X.F.-01 on pages 917–918 compare the 2016 SAFER Guides to the 2025 SAFER guides. CMS is proposing to modify the SAFER Guides measure in requiring eligible hospitals and CAHs to attest "yes" to completing an annual self-assessment using all eight 2025 SAFER Guides to be considered a meaningful EHR user, beginning with the EHR reporting period in CY 2026. CMS encourages eligible hospitals and CAHs to begin to familiarize themselves with the 2025 SAFER Guides during CY 2025 and invites public comment on this proposal.

Lastly, there are currently eight measures under the Public Health and Clinical Data Exchange objective. Six of these measures are required under the objective, while two are optional bonus measures. Eligible hospitals and CAHs may receive a total of 5 bonus points for reporting on one or both optional bonus measures. CMS is proposing to modify the Public Health and Clinical Data Exchange Objective beginning with the CY 2026 HER reporting period to adopt an optional bonus measure for public health reporting using the Trusted Exchange Framework and Common Agreement (TEFCA).

Specifically, CMS is proposing to add an optional Public Health Reporting Using TEFCA measure. In this proposal, an eligible hospital or CAH would be able to claim five bonus points under the Public Health and Clinical Data Exchange objective if the eligible hospital or CAH has attested that they are in active engagement with a PHA to submit electronic production data for one or more of the measures under the Public Health and Clinical Data Exchange objective using TEFCA.

The bonus measure would only be available where the eligible hospital or CAH is in active engagement with a PHA to transfer health information for one or more of the measures under the Public Health and Clinical Data Exchange objective. To attest "yes" for this optional bonus measure, an eligible hospital or CAH must be a signatory to a TEFCA Framework Agreement and is not suspended under the respective agreement. An eligible hospital or CAH must also transmit electronic health information for at least one measure under the Public Health and Clinic Data Exchange objective using TEFCA and must also use the functions for CEHRT to engage in exchange with a PHA.

The table below outlines the proposed performance-based scoring methodology for EHR Reporting periods beginning with CY 2026.

Proposed Performance-Based Scoring Methodology Beginning with the CY 2026 EHR Reporting Period			
Objectives	**Measures**	**Maximum Points**	**Redistribution if Exclusion Claimed**
Electronic Prescribing (e-Prescribing)	e-Prescribing	10 points	10 points to Health Information Exchange (HIE) Objective

	Query of Prescription Drug Monitoring Program	10 points	10 points to e-Prescribing measure
HIE	Support Electronic Referral Loops by Sending Health Information	15 points	No exclusion
	Support Electronic Referral Loops by Receiving and Reconciling Heath Information	15 points	No exclusion
	Or		
	HIE Bi-Directional Exchange measure	30 points	No exclusion
	Or		
	Enabling Exchange under TEFCA	30 points	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	
Public Health and Clinical Data Exchange	Required with yes/no response • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Reportable Laboratory Result Reporting • AU Surveillance Reporting • AR Surveillance Reporting	25 points	If an exclusion is claimed for all 5 measures, 25 points redistributed to Provide Patients Electronic Access to their Health Information
	Optional to report one of the following • Public Health Registry Reporting • Clinical Data Registry Reporting • Public Health Reporting Using TEFCA **(proposed for CY 2026+)**	5 points (bonus)	

Request for Information – Digital Quality Measurement (dQM) in the CMS Quality Programs

Pages 815–826

CMS is soliciting comments on the approach to the use of Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) in electronic clinical quality measure (eCQM) reporting. To explore the potential application of the FHIR® standards for reporting and use of different quality measurement data, CMS is seeking responses to the questions listed on page 821.

For data standardization to submit Bulk FHIR® data, CMS is seeking responses to questions listed on page 824. CMS is also considering a transition period for reporting options and seeks responses to questions listed on page 825. Lastly, for measure development and the development of reporting tools CMS is seeking responses to the following questions listed on page 826.

Request for Information – Query of Prescription Drug Monitoring Program (PDMP) Measure

Pages 943–952

CMS is seeking public comment on changing the Query of PDMP measure from an attestation-based measure (“yes” or “no”) to a performance-based measure (numerator and denominator). Specifically, CMS is seeking responses to questions listed on page 948-949.

CMS is also requesting feedback on a broader set of performance-based measurement concepts that could help to advance priorities with respect to the use of PDMPs to support the prevention and treatment of opioid use disorders. Specifically, CMS is interested in creating performance-based measures that allow eligible hospitals and CAHs to leverage technology to improve care and reduce burden and is seeking responses to questions listed on pages 949-950.

Lastly, CMS is seeking public comment and feedback on possible future expansion of the Query of PDMP measure to include all Schedule II drugs (rather than only including Schedule II opioids), Schedule III, and Schedule IV drugs in future rulemaking. CMS is seeking responses to questions listed on page 952.

Request for Information – Performance-based Measures

Pages 952–957

CMS is interested in new measure concepts for public health that would allow better focus on aspects of the data quality of public health reporting. Specifically, CMS is seeking public comment on the questions listed on page 954.

As part of an exploration of alternative measure concepts to assess performance on different aspects of the Public Health and Clinical Data Exchange objective measures, CMS is considering revising the approach to scoring the measures under the objective and is seeking public comment on questions listed on page 955.

CMS and partner agencies plan to continue to explore opportunities to leverage Fast Healthcare Interoperability Resources (FHIR) based capabilities within certified health IT to support public health reporting. CMS is seeking comments on how such future updates could impact the potential measure strategies with questions listed on page 956.

Request for Information – Data Quality

Pages 957–958

CMS is seeking public comments on improvements in the quality and completeness of health information with questions listed on page 958.

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