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CMS releases FY 2026 IPPS final update

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Policy Update

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Summary
On July 31, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2026 Inpatient Prospective Payment System (IPPS) final rule. This final rule updates Medicare payment policies and quality reporting programs relevant for inpatient hospital services.

A CMS fact sheet on the final rule is available here. The rule was published in the *Federal Register* on August 4, 2025.

The IPPS final rule incorporates a final rule from the Assistant Secretary for Technology Policy (ASTP/ONC) addressing real-time prescription benefit and electronic prior authorization.

The final rule also updates the Long-Term Care Hospital Prospective Payment System; those policies are not summarized here.

Key takeaways

- CMS finalized a 2.6% increase to operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the hospital inpatient quality reporting (IQR) program and are meaningful electronic health record (EHR) users. This increase is based on a projected FY 2026 hospital market basket percentage increase of 3.3%, reduced by a 0.7 percentage point productivity adjustment.
- CMS finalized its proposal to create new Medicare severity diagnosis-related group (MS-DRG) 209 for complex aortic arch procedures, MS-DRG 213 for endovascular abdominal aorta and iliac branch procedures, MS-DRGs 359 and 360 for percutaneous coronary atherectomy with intraluminal device, and MS-DRG 318 for percutaneous coronary atherectomy without intraluminal device. CMS also finalized its proposal to delete hypertensive encephalopathy MS-DRGs 077, 078, and 079.
- For new technology add-on payment (NTAP) applications for FY 2027 onward, CMS will require resubmissions to have an acknowledgement letter from the US Food and Drug Administration (FDA) to demonstrate that FDA review has been restarted and is active. CMS also broadened the application details that it will publicly post online (starting with FY 2027 applications).
- CMS signaled future quality measure concepts supporting the administration's Make America Healthy Again priorities of well-being and nutrition, and finalized proposals to remove quality measures on health equity and social determinants of health.
- CMS will discontinue the low wage index policy but will implement a transitional policy to phase out the low wage index adjustment for affected hospitals.
- Finalized uncompensated care payments (UCP) and supplemental payments for FY 2026 total $7.8 billion, a 35.2% increase from the FY 2025 total of $5.78 billion.
- CMS finalized technical changes to the calculation of full-time-equivalent (FTE) resident counts, caps, and three-year rolling averages for direct graduate medical education (DGME). CMS did not finalize proposed technical changes to the calculation of net nursing and allied health education (NAHE) costs.
- While Congress typically extends the Medicare-dependent hospital (MDH) program and low-volume hospital payment adjustment, both are set to expire on September 30, 2025, and Congress has not yet acted to extend them further. CMS therefore could not assume that these programs will continue for FY 2026, and the final rule reflects this.

- CMS largely finalized the Transforming Episode Accountability Model (TEAM) policies as proposed; however, the agency added a new low-volume hospital policy in response to extensive stakeholder feedback. The policy removes downside risk for any episode category in which a hospital had fewer than 31 episodes during the three-year baseline.
- The IPPS rule includes the Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization Rule (HTI-4), which outlines new and revised standards and certification criteria for prescription benefit information and prior authorization.

McDermott+ has developed an interactive dashboard that shows total Medicare fee-for-service volume and the average cost per inpatient stay by MS-DRG, as calculated by CMS for the FY 2026 IPPS final rule. This information can illuminate trends in inpatient volume and payments and identify the resource costs to hospitals for providing care for individual MS-DRGs.

Read on for a summary and analysis of the final rule.

Standardized amount

Key takeaway: CMS finalized a 2.6% increase for hospitals that successfully participate in CMS reporting programs.

The standardized amount is the dollar-based base unit used to determine payments to hospitals for inpatient services furnished to Medicare beneficiaries. Each year, CMS updates the standardized amount for inflation based on the hospital market basket index, then applies various other statutorily mandated or inspired adjustments. The 2.6% increase to the standardized amount for FY 2026 reflects a 3.3% market basket update, a negative 0.7 percentage point productivity adjustment, and other budget neutrality adjustments.

The applicable standardized amount also varies based on individual hospital participation in the IQR and EHR programs. Hospitals that fail to submit quality data are subject to a negative 0.825 percentage point adjustment, and hospitals that fail to be meaningful EHR users are subject to a negative 2.475 percentage point adjustment. The FY 2026 standardized amount for hospitals that successfully participate in both programs is $6,752.61.

The FY 2026 standardized amounts, shown in the table below, are the sum of the labor-related and non-labor-related shares, without adjustment for geographic and other factors, and apply to hospitals other than those in Puerto Rico. The labor-related share reflects the proportion of the federal base payment that is adjusted by a hospital's wage index.

	Hospital submitted quality data and is a meaningful EHR user	Hospital submitted quality data and is NOT a meaningful EHR user	Hospital did NOT submit quality data and is a meaningful EHR user	Hospital did NOT submit quality data and is NOT a meaningful EHR user
FY 2026 final standardized amount	$6,752.61	$6,589.72	$6,698.31	$6,535.43

Medicare severity diagnosis-related group updates

Key takeaway: CMS finalized its proposal to create new MS-DRG 209 for complex aortic arch procedures, MS-DRG 213 for endovascular abdominal aorta and iliac branch procedures, MS-DRGs 359 and 360 for percutaneous coronary atherectomy with intraluminal device, and MS-DRG 318 for percutaneous coronary atherectomy without intraluminal device. CMS also deleted hypertensive encephalopathy MS-

DRGs 077, 078, and 079 as proposed.

CMS is required by statute to adjust MS-DRG classifications and relative weights at least annually to reflect changes in treatment patterns and technology, and any other factors that may change the relative use of hospital resources.

In evaluating MS-DRG changes and setting MS-DRG relative weights, CMS relies on claims data captured in the MedPAR file and cost report data captured in the Healthcare Cost Report Information System (HCRIS) file. CMS will set FY 2026 MS-DRG relative weights using FY 2024 (October 1, 2023 – September 30, 2024) Medicare claims data and the March 2025 update of the FY 2023 HCRIS file.

CMS finalized the following changes to the MS-DRG system for FY 2026:

- Adding 66 diagnosis codes to the hemorrhage principal diagnosis logic list and 57 procedure codes for intracranial vascular procedure MS-DRGs 020, 021, and 022.
- Adding procedure codes 00H001Z, 00H005Z, 00H031Z, and 00H041Z for insertion of radioactive element into brain to the chemotherapy implant logic list in craniotomy MS-DRGs 023 and 024, and changing the name of the chemotherapy implant logic list to the antineoplastic implant list.
- Deleting hypertensive encephalopathy MS-DRGs 077, 078, and 079 and reassigning cases for ICD-10-CM I67.4 (hypertensive encephalopathy) to other cerebrovascular disorders MS-DRGs 070, 071, and 072.
- Creating new base MS-DRG 213 for endovascular abdominal aorta and iliac branch procedures.
- Creating new MS-DRG 359 for percutaneous coronary atherectomy with intraluminal device with major complication or comorbidity (MCC), MS-DRG 360 for percutaneous coronary atherectomy with intraluminal device without MCC, and MS-DRG 318 for percutaneous coronary atherectomy without intraluminal device.
- Deleting deep vein thrombophlebitis MS-DRGs 294 and 295 and reassigning the 35 diagnosis codes describing deep vein thrombophlebitis to peripheral vascular disorders MS-DRGs 299, 300, and 301.
- Deleting MS-DRG 509 for arthroscopy and reassigning 47 procedure codes describing arthroscopy of various anatomic sites to clinically appropriate MS-DRGs:
    - Reassigning eight procedure codes describing arthroscopy of the shoulder or elbow joint to MS-DRGs 510, 511, and 512 for shoulder, elbow, or forearm procedures, except major joint procedures, with MCC, with complication or comorbidity (CC), and without CC/MCC, respectively.
    - Reassigning 10 procedure codes describing arthroscopy of the hand or wrist joint to MS-DRGs 513 and 514 for hand or wrist procedures, except major thumb or joint procedures with CC/MCC and without CC/MCC, respectively.
    - Reassigning the 29 procedure codes describing arthroscopy of various vertebral joints and other musculoskeletal joints to MS-DRGs 515, 516, and 517 for other musculoskeletal system and connective tissue OR procedures with MCC, with CC, and without CC/MCC, respectively.
- Correcting an inconsistency in the logic for spinal fusion MS-DRGs 456, 457, and 458 to add 47 diagnoses to the spinal curvature/malignancy/infection logic list for those same MS-DRGs.
- Removing six diagnoses for collapsed vertebra not elsewhere classified and two osteoporosis diagnoses from the spinal curvature/malignancy/infection logic list.
- Reassigning ICD-10-CM diagnosis code Z45.31 from MS-DRGs 091, 092, and 093 to MS-DRG 123 for neurological eye disorders.
- Reassigning ICD-10-CM diagnosis codes Z45.320, Z45.321, and Z45.328 from MS-DRGs 091, 092, and 093 to MS-DRGs 154, 155, and 156 for other ear, nose, mouth, and throat diagnoses with MCC, with CC, and without CC/MCC, respectively.

CMS finalized its proposal to create new MS-DRG 209 for complex aortic arch procedures, with the modification of assigning additional ICD-10-PCS codes that describe complex aortic arch procedures to the new MS-DRG.

Consistent with these changes, CMS finalized its proposal to change the title of the following MS-DRGs:

- MS-DRG 023 from “craniotomy with major device implant or acute complex central nervous system principal diagnosis with MCC or chemotherapy implant or epilepsy with neurostimulator” to “craniotomy with major device implant or acute complex central nervous system principal diagnosis with MCC or antineoplastic implant or epilepsy with neurostimulator.”
- MS-DRGs 070, 071, and 072 from “nonspecific cerebrovascular disorders” with MCC, with CC, and without CC/MCC, respectively, to “other cerebrovascular disorders” with MCC, with CC, and without CC/MCC, respectively.
- MS-DRGs 067 and 068 from “nonspecific CVA and precerebral occlusion without infarction” with MCC and without MCC, respectively, to “precerebral occlusion without infarction” with MCC and without MCC, respectively. CMS chose to maintain “transient ischemia without thrombolytic” as the current title for MS-DRG 069.

CMS **did not finalize** the following proposals:

- To change the title of MS-DRG 024, which for FY 2026 will remain “craniotomy with major device implant or acute complex central nervous system principal diagnosis without MCC.”
- To add 114 procedure code combinations to a new intracranial neurostimulator implant logic list for MS-DRGs 020, 021, and 022. Accordingly, CMS will maintain the major device implant list, epilepsy principal diagnosis list, and neurostimulator logic lists for MS-DRGs 023 and 024.
- To change the titles of MS-DRGs 020, 021, and 022, which for FY 2026 will remain “intracranial vascular procedures with principal diagnosis hemorrhage” with MCC, with CC, and without CC/MCC, respectively.
- To create new MS-DRGs 403 and 404 for hip or knee procedures with principal diagnosis of periprosthetic joint infection.

CMS did not receive any requests to change the severity level designations of specific ICD-10-CM diagnosis codes related to housing and housing instability, and therefore did not propose any severity designations for FY 2026. For new diagnosis codes approved for FY 2026, CMS will designate a severity level (MCC, CC, or no CC) based on a review of predecessor code designation, severity of illness, treatment difficulty, and complexity of service and resources used in the diagnosis or treatment of the condition.

To see how the average costs for individual MS-DRGs have changed over time, see our public dashboard, which shows total volume and average cost per inpatient stay by MS-DRG, as calculated by CMS for the FY 2026 IPPS final rule.

New technology add-on payments

NTAP policies for FY 2026

Key takeaway: For applications for FY 2027 onward, CMS will require resubmissions to have an acknowledgement letter from the FDA to demonstrate that the FDA review has been restarted and is active. CMS also broadened the application details that it publicly posts online.

In the last two rulemaking cycles, CMS made changes to NTAP eligibility criteria in part because of the increase in applications and because a subset of those applications lacked critical information necessary to evaluate the technology. Recent policy changes include the following:

- Applicants whose technology has not yet received FDA approval or clearance prior to applying for an NTAP must have a complete market authorization request at the FDA, and that application must be in active status at the time of the NTAP application submission. Active status means that the application has not been withdrawn, refused by the FDA, or subject to a complete response letter.
- Devices or drugs under consideration for NTAP must receive FDA approval or clearance by May 1 prior to the start of the FY for which the applicant is applying.
- Technologies approved for NTAP will be eligible for a third year if their three-year anniversary falls at any point in the upcoming FY. Previously, the extension was limited to technologies with approval in the

latter half of the upcoming FY. CMS changed the policy in light of stakeholder feedback and the May 1 deadline for FDA authorization.

For FY 2025, CMS also increased the maximum NTAP amount from 65% to 75% for two gene therapies approved for FY 2025 that involve treatment of sickle cell disease (SCD), based on feedback from stakeholders. This change is consistent with the maximum amount for qualified infectious disease products that qualify for NTAP. CMS stated that the basis for the change is the limited treatment options for sickle cell disease, the treatments' high cost, and hospitals' ability to absorb a potential financial loss when providing them. Stakeholders requested that CMS not limit this increase to SCD products, but CMS maintained the policy's applicability as proposed and did not increase the maximum amount for non-SCD products.

For FY 2026, CMS finalized two proposals:

- For applicants seeking NTAP approval whose new drug application or biological license application to the FDA is a resubmission, CMS will require a resubmission acknowledgement letter from the FDA to demonstrate that the FDA review has been restarted and is active. CMS noted that in specific circumstances not discussed in the rule, it is the applicant's responsibility to provide CMS with up-to-date documentation that the FDA has deemed the submission complete, allowing for "substantive review by the FDA."

- CMS expanded the application details that it posts online. CMS began posting application materials (omitting cost and volume information) online starting with the FY 2024 NTAP cycle in an effort to increase transparency. The publication allows interested parties to review the details that CMS considers when evaluating technologies. For FY 2027 applications submitted in October 2025, CMS will publish applicants' narratives on the cost criterion methodology, optional comments by the applicant, and details on the case weighted threshold and final inflated case weighted standardized charge per case. This level of detail is already discussed in the rule itself. CMS will not publish the cost analysis spreadsheet or other cost or charge values. Publishing this additional information will allow CMS to be more succinct in its summaries while ensuring transparency to stakeholders who seek to comment on the applications.

These policies are effective for NTAP applications submitted for FY 2027 and beyond.

Technologies with continuing NTAP period

Key takeaway: CMS finalized, as proposed, continued NTAP eligibility for 27 technologies for FY 2026 based on its existing newness policy.

NTAP designation normally includes the first two to three years that a product is on the market, after which CMS reasons that the costs of the new technology are captured and reflected in the MS-DRG weights. CMS evaluates new technologies' eligibility for this additional payment annually based on their newness date (typically defined as the date of market entry). Under a policy finalized in the FY 2025 rulemaking cycle, CMS only extends add-on payments for an additional year if the three-year anniversary of the newness date occurs in the upcoming FY.

For FY 2026, 27 existing drugs and devices remain eligible for NTAP (see Tables II.E.-01.A and II.E-01.B), while NTAP eligibility for 12 technologies (six drugs and six devices) expires at the end of FY 2025 (see Table II.E.-02).

NTAP applications for FY 2026

Key takeaway: CMS reviewed 35 NTAP applications, which are available online.

In the proposed rule, CMS discussed 43 NTAP applications. Several were subsequently withdrawn or were ineligible because they failed to meet the May 1 FDA authorization date. As a result, CMS reviewed and discussed 35 NTAP applications in the final rule:

- 13 drugs and devices applied through the traditional pathway.
- 22 went through the alternate pathway, including 20 devices with breakthrough status and two qualified

infectious disease products.

The number of FY 2026 applications reviewed in this rule represents an increase over the 21 applications reviewed for FY 2025.

CMS approved or conditionally approved all 22 products that went through the alternative pathway, including the two qualified infectious disease products. Of the 13 products that went through the traditional pathway, five (all drug products) were newly approved as eligible for FY 2026.

CMS estimates that the total NTAP for FY 2026 (for both new technologies approved and existing technologies continuing under NTAP) will be $961.1 million. This represents an increase of nearly 25% in payments, driven by several factors, including the number of drugs and technologies approved for NTAP, existing drugs and technologies maintaining NTAP eligibility for FY 2025, and the continued increased payment for gene therapies for the treatment of SCD.

Quality data reporting requirements

Hospital quality reporting program changes

Key takeaway: CMS signaled future quality measure concepts supporting the administration's Make America Healthy Again priorities of well-being and nutrition, and finalized proposals to remove quality measures on health equity and social determinants of health.

CMS monitors, rewards, and penalizes quality performance in the inpatient setting through several quality incentive programs. In this rule, CMS finalized several changes with minor modifications, including shortening performance periods, updating risk adjustment methods, and removing measures related to social determinants of health and COVID-19 vaccination.

The following chart outlines specific finalized changes to each of the quality programs.

Hospital IQR program *Hospitals are required to report data on measures to receive the full annual percentage increase for IPPS services.*

CMS finalized its proposals to:
• Modify two quality measures to add Medicare Advantage (MA) patients to the current cohort of patients, shorten the performance period from three to two years, and change the risk adjustment methodology:
  ○ Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).
  ▪ Beginning with the April 1, 2023 – March 30, 2025, reporting period/FY 2027 payment determination.
  ○ Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity.
  ▪ Beginning with the July 1, 2023 – June 30, 2025, reporting period/FY 2027 payment determination.
• Lower the submission thresholds for two quality measures by allowing for up to two missing laboratory results and up to two missing vital signs, reducing the core clinical data elements submission requirement to at least 70% of discharges, and reducing the submission requirement of linking variables to at least 70% of discharges, beginning with the July 1, 2025 – June 30, 2026, reporting period/FY 2028 payment determination:
  ○ Hybrid Hospital-Wide Readmission (HWR).
  ○ Hybrid Hospital-Wide Mortality.
• Remove four measures related to hospital commitment to health equity, COVID-19 vaccination, and screening for social determinants of health beginning with the calendar year (CY) 2024 reporting period/FY 2026 payment determination.

CMS finalized with modification its proposal to:

- Update and codify the extraordinary circumstances exception (ECE) policy so that CMS has the discretion to grant an extension in response to an ECE request from a hospital. In the final rule, CMS clarified that it retains the authority to grant an ECE as a form of relief at any time after the extraordinary circumstance has occurred. CMS originally proposed that a hospital be permitted to request an ECE within 30 calendar days of the date that the extraordinary circumstance occurred. Commenters expressed concerns about hospitals' ability to complete an ECE request within 30 days of the extraordinary circumstance, and in response CMS modified the timeframe to allow 60 days to submit an ECE request.

CMS sought comments in the FY 2026 IPPS proposed rule regarding measure concepts related to well-being and nutrition for future consideration. Specifically, CMS sought input on the applicability of tools and constructs that assess integrative health, self-care, and nutrition and preventive care measures. In the final rule, CMS stated that the comments received will be used to inform potential future policy development

CMS stated that it will make two technical updates to the Hospital-Level, RSCR Following Elective Primary THA and/or TKA and Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity measures, beginning with the FY 2027 payment determination:

- Updating the risk adjustment model to use individual international classification of diseases (ICD-10) codes instead of hierarchical condition categories (HCCs) to improve the measure's risk adjustment methodology.
- Removing the exclusion of patients with a secondary diagnosis code of COVID-19 coded as present on admission on the index admission claim.

Hospital readmissions reduction program

This program reduces payments to hospitals with excess readmissions of selected applicable conditions.

For the FY 2027 program year, CMS finalized its proposals to:

- Remove the COVID-19 diagnosed patients measure denominator exclusion from all six readmission measures.
- Refine all six readmission measures to add MA patient cohort data.
- Reduce the applicable period from three years to two years and update codified regulation language.

CMS finalized with modification its proposal to:

- Update and codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital. After reviewing public comments, CMS extended the length of time to submit an ECE request from the proposed 30 days to 60 days.

CMS did not finalize its proposal to include MA cases in the DRG ratios and aggregate payment amount for the payment adjustment calculation. Stakeholders expressed concern that this proposed policy change, which would have driven $41 million in savings to Medicare, only captured variation in utilization and patient mix, not actual performance in reducing readmissions. Without including MA cases in the DRG ratios and aggregate payment amount, the impact of the hospital readmissions reduction program policy changes dropped to about $6 million in savings to Medicare. CMS stated that it will continue to assess data consistency across hospital types.

CMS finalized its proposal to make a nonsubstantive update that would re-specify the risk model for each measure to primarily use individual ICD-10 codes in place of the previously used HCCs.

Hospital value-based purchasing program

This program withholds participating hospitals' Medicare payments by 2% and uses these reductions to fund incentive payments based on a hospital's performance on a set of outcome measures.

CMS finalized its proposals to:

- Modify one measure beginning with the FY 2033 program year:
  - Hospital-Level RSCR Following Elective Primary THA and/or TKA, in alignment with updates in the hospital IQR program.
- Remove the health equity adjustment from the hospital value-based purchasing program's scoring methodology beginning with the FY 2026 payment determination. CMS codified this change by removing the definition of "health equity adjustment bonus points" in Section 412.160 and revising Section 412.165(b) to remove the calculation and addition of health equity adjustment bonus points from the total performance score calculation beginning with the FY 2026 program year.

CMS finalized with modifications its proposal to:

- Update the program's ECE policy to align with other quality programs and to clarify that CMS has the discretion to grant an extension, rather than only an exception, in response to ECE requests. After reviewing public comments, CMS extended the length of time to submit an ECE request from the proposed 30 days to 60 days.

CMS provided notice of technical updates to the Hospital-Level RSCR Following Elective Primary THA and/or TKA measure's risk adjustment model to use ICD-10 codes instead of HCCs.

CMS also provided notice of a technical update to the five Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) healthcare-associated infection (HAI) measures beginning with the FY 2029 program year, and a technical update to remove the COVID-19 exclusion from the six measures in the clinical outcomes domain beginning with the FY 2027 program year.

CMS provided updates to the CDC NHSN HAI chart-abstracted measures with the new 2022 baseline, and previously and newly established performance standards for the FY 2027 – 2031 program years for the hospital value-based purchasing program.

Hospital acquired condition reduction program

Hospitals report on a set of measures on hospital-acquired conditions. Hospitals with scores in the worst performing quartile are subject to a 1% payment reduction.

CMS finalized its proposal with modification to:

- Update and codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital. After reviewing public comments, CMS extended the length of time to submit an ECE request from the proposed 30 days to 60 days.

CMS also provided notice that it will update the NHSN HAI chart-abstracted measures with the new 2022 baseline. During this update, HAI standardized infection ratio calculations for infections reported in CY 2025 onward will utilize both the new 2022 standard population data and the 2015 standard population data. CMS expects that the new 2022 standard population data will affect the hospital acquired condition reduction program beginning with the FY 2028 program year, when both years of the applicable period, CY 2025 and CY 2026, will use the 2022 update to the standard population data for the CDC's NHSN measures. These changes will occur as part of routine measure maintenance.

Prospective payment system (PPS)-exempt cancer hospital quality reporting program *The Affordable Care Act established this quality reporting program for PPS-exempt cancer hospitals.*

CMS finalized its proposals to:
• Remove three existing measures beginning with the CY 2024 reporting period/FY 2026 payment determination:
  ○ Hospital Commitment to Health Equity.
  ○ Screening for Social Drivers of Health.
  ○ Screen Positive Rate for Social Drivers of Health.
• Publicly report PPS-exempt cancer hospital data on both the Provider Data Catalog and Care Compare, and make corresponding changes to regulatory text to replace references to "Provider Data Catalog" with "CMS website."
 	
CMS also will update and codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital. After reviewing public comments, CMS extended the length of time to submit an ECE request from the proposed 30 days to 60 days.

Medicare promoting interoperability program *The Medicare and Medicaid EHR incentive programs are now known as the promoting interoperability program.*

CMS finalized its proposals to:
• Continue to define the reporting period as 180 continuous days.
• Modify two measures beginning with the EHR reporting period in CY 2026:
  ○ Security Risk Analysis, to require eligible hospitals and critical access hospitals (CAHs) to attest "yes" to having conducted security risk management in addition to the existing measure requirement to attest "yes" to having conducted security risk analysis.
  ○ SAFER Guides, to require eligible hospitals and CAHs to attest "yes" to completing an annual self-assessment using the eight SAFER Guides published in January 2025.
• Add an optional bonus measure under the public health and clinical data exchange objective for data exchange to occur with a public health agency using the Trusted Exchange Framework and Common Agreement®, beginning with the EHR reporting period in CY 2026.

Wage index

Key takeaway: CMS will discontinue the low wage index policy but will implement a transitional policy to phase out the low wage index adjustment for affected hospitals.

Medicare payments to hospitals (and various other provider types) are adjusted by a wage index intended to account for geographic differences across labor markets (*e.g.*, the perceived cost of labor is higher in New York City than in rural Oklahoma). CMS updates the wage index annually based on hospital cost report data and other inputs and policies.

Low wage index hospital policy

In FY 2020, CMS finalized a policy that boosts the wage index for hospitals with a wage index value below the 25th percentile. CMS stated that it intended this policy to be effective for at least four years. Affected hospitals had their wage index value increased by half the difference between the otherwise applicable wage index value for a given hospital and the 25th percentile wage index value across all hospitals.

In the FY 2025 rulemaking, CMS announced that it would continue the low wage index hospital policy for at least the next three FYs. However, in July 2024, the US Court of Appeals for the District of Columbia Circuit vacated the policy in *Bridgeport Hosp. v. Becerra*. In an October 3, 2024, interim final rule, CMS announced that in light of the *Bridgeport* decision, it would discontinue the low wage index policy and recalculate wage index values for FY

2025. CMS also deployed a transition for certain hospitals that were substantially affected by the loss of this protection.

For FY 2026, consistent with last year's interim final rule, CMS finalized its proposal to fully discontinue the low wage index adjustment policy and the accompanying budget neutrality adjustments that prompted the litigation. CMS will buttress hospitals that benefited from the low wage index policy and would be adversely affected by its end with a transitional exception. For hospitals that benefitted from the FY 2024 low wage index policy, CMS will compare the hospital's proposed FY 2026 wage index to the hospital's FY 2024 wage index; if the result is a decrease of more than 9.75%, then for FY 2026 that hospital's wage index will be 90.25% of its FY 2024 wage index.

CMS will implement this transitional exception in a budget-neutral manner as proposed. While CMS explained that it has authority to impose budget neutrality adjustments to support this policy (different from the authorities it relied on to support the low wage index adjustment policy), those who disfavored the budget neutrality adjustments arising from the low wage index policy may disagree and choose to challenge the agency.

CMS is finalizing these policies as proposed: it will discontinue the low wage index adjustment and implement a companion transitional support mechanism for hospitals negatively affected by the decision to discontinue the low wage index adjustment.

Uncompensated care payment and supplemental payments

Key takeaway: Finalized UCPs and supplemental payments for FY 2026 total $7.8 billion, a 35.2% increase from the FY 2025 total of $5.78 billion.

CMS distributes a prospective UCP to Medicare disproportionate share hospitals based on their relative share of uncompensated care nationally. As required by statute, the UCP amount is equal to 75% of total estimated Medicare disproportionate share hospital payments (factor 1), adjusted for the change in the rate of uninsured individuals (factor 2). For FY 2026, the finalized UCP and supplemental payment is $7.8 billion. This is an increase of about $2 billion from CMS's estimate of the UCP and supplemental payments distributed in FY 2025. It is also an increase compared to the proposed rule amount of $7.29 billion.

While CMS finalized a net increase in the total amount available to be distributed in UCP and supplemental payments. The projected payment varies by hospital type. Overall, urban hospitals are projected to receive a 35.3% increase in payments, while rural hospitals are projected to receive a 32.6% increase in payments. Rural hospitals with zero to 99 beds are projected to receive a larger-than-average increase of about 31.6%, while rural hospitals with 100 to 249 beds are projected to receive a 34.5% increase and rural hospitals with more than 250 beds are projected to receive 30.8%. Urban hospitals with more than 250 beds are projected to receive a 36.5% increase in payments, while urban hospitals with 100 to 249 beds are projected to receive a 33.0% increase. Urban hospitals with zero to 99 beds are projected to receive a 27.3% increase.

Graduate medical education

Key takeaway: CMS finalized technical changes to the calculation of FTE resident counts, caps, and three-year rolling averages for DGME. CMS did not finalize proposed technical changes to the calculation of net NAHE costs.

Using a methodology established under the Social Security Act, Medicare makes payments to hospitals for the direct costs of approved graduate medical education programs. In general, Medicare DGME payments are calculated by multiplying the hospital's base per resident amount by the weighted number of FTE residents working in all areas of the hospital complex (and at nonprovider sites, when applicable) and the hospital's Medicare share of total inpatient days.

Medicare also makes an indirect medical education (IME) adjustment under the IPPS for hospitals that train residents in an approved graduate medical education program to account for the higher indirect patient care

costs of teaching hospitals relative to nonteaching hospitals. A hospital's IME adjustment applied to DRG payments under the IPPS is calculated based on the ratio of the number of FTE residents training in either the inpatient or outpatient departments of the IPPS hospital (and at nonprovider sites, when applicable) to the number of inpatient hospital beds.

The calculation of both DGME payments and the IME payment adjustment is therefore affected by the number of FTE residents that a hospital is allowed to count, subject to a statutory cap and counted using a three-year rolling average.

In this rule, CMS finalized as proposed steps for calculating FTE resident counts, caps, and three-year rolling averages for cost reporting periods other than 12 months. CMS provided examples of how its steps for these calculations will work for cost reporting periods of various lengths. CMS explained that a hospital's DGME count represents the number of FTE residents working in the healthcare complex over the course of an entire cost reporting period, and the total DGME payment is based on the hospital's per resident amount, which reflects the average costs incurred per resident during a 12-month base period or equivalent. Accordingly, CMS stated that the DGME FTE count, cap, and rolling average must be prorated to reflect the length of a short or long cost reporting period. However, CMS explained that because the size of a hospital's DRG payments already reflects the amount of patient care furnished during a short or long cost reporting period, it is unnecessary to prorate the IME FTE count, cap, or rolling average in the same manner as for DGME.

In addition to DGME and IME, Medicare makes payments to providers for Medicare's share of the costs they incur in connection with approved educational activities, including additional payments to hospitals for costs of NAHE associated with services to MA enrollees. Annually, CMS proposes rates necessary to calculate each eligible hospital's NAHE payments. In this rule, CMS finalized the rates as proposed, with updates based on the latest available cost report data.

CMS proposed technical changes to the calculation of the net cost of NAHE programs in response the US District Court for the District of Columbia's decision in *Mercy Health – St. Vincent Medical Center LLC d/b/a Mercy St. Vincent Medical Center, et al. v. Becerra.* However, in response to comments, CMS decided not to finalize those proposals. CMS expects to revisit the treatment of the net cost of NAHE programs in future rulemaking.

Special designations

Key takeaway: While Congress typically extends the MDH program and low-volume hospital payment adjustment, both are set to expire on September 30, 2025, and Congress has not yet acted to extend them. CMS therefore could not assume these programs will continue for FY 2026, and the final rule reflects this.

Medicare-dependent hospital and low-volume adjustment programs

The MDH designation is available to hospitals that have a disproportionately high Medicare patient mix. Qualifying hospitals are eligible for higher IPPS payments. The low-volume adjustment is available to hospitals with very low inpatient volumes. Qualifying hospitals receive enhanced payments that increase as volumes decrease. Both programs are typically extended by Congress, but both are currently set to expire on September 30, 2025.

These programs enjoy longstanding bipartisan support on Capitol Hill and are likely to be extended for some duration later this year. CMS could not assume that Congress will extend them, however, and the FY 2026 IPPS final rule reflects this.

Because the MDH program is not authorized by statute beyond September 30, 2025, the final rule states that beginning with discharges occurring on or after October 1, 2025, absent further congressional action, all hospitals that previously qualified for MDH status will be paid based on the IPPS federal rate. The final rule also states that, absent further congressional action, beginning October 1, 2025, the low-volume hospital qualifying criteria and payment adjustment will revert to the statutory requirements that were in effect prior to FY 2011. The low-

volume hospital payment adjustment methodology and qualifying criteria implemented in FY 2005 also will resume.

Transforming Episode Accountability Model

Key takeaway: Although CMS largely finalized the TEAM policies as proposed, the agency added a new low-volume hospital policy in response to extensive stakeholder feedback. The policy removes downside risk for any episode category in which a hospital had fewer than 31 episodes during the three-year baseline.

In the FY 2025 IPPS final rule, CMS finalized TEAM as a five-year mandatory episode-based payment model for acute care hospitals in selected core-based statistical areas (CBSAs). Beginning January 1, 2026, selected hospital participants will be held accountable for all Medicare Parts A and B spending for an episode tested under the model, beginning with a trigger hospitalization or procedure and ending 30 days post-discharge. The hospitalizations or procedures that will trigger an episode in the model are coronary artery bypass graft surgery, lower extremity joint replacement, surgical hip/femur fracture treatment, spinal fusion, and major bowel procedures.

In the FY 2026 IPPS final rule, CMS finalized several model components:

- **Limiting deferment for certain hospitals.** CMS finalized without changes the proposal at § 512.508 to provide a limited deferment period that gives hospitals (as identified by CMS certification number) opening in, or newly qualifying within, a mandatory CBSA after December 31 2024, at least one full performance year (PY) before TEAM participation begins. The agency will monitor for any patient-shifting during the deferment period.
- **Determining eligibility for Track 2 via the MDH program.** CMS finalized without changes the proposal to determine a hospital's MDH status (and eligibility for Track 2) based on its status in the MDH program on the date CMS requires hospitals to submit their track selections for the upcoming PY. The MDH program is set to expire on September 30, 2025, unless Congress acts. CMS estimates that four participating hospitals would lose MDH status and not qualify for Track 2 under another designation.
- **Excluding Indian Health Service/Tribal hospitals.** As proposed, CMS will exclude Indian Health Service and Tribal hospitals from mandatory TEAM participation, regardless of episode volume, because they receive an all-inclusive rate for outpatient services, rather than payments under the Outpatient Prospective Payment System.
- **Adjusting the Hybrid HWR measure.** CMS did not finalize the Hybrid HWR measure reporting as proposed. CMS proposed to use the first year of hospital IQR program mandatory reporting (July 1, 2025 – June 30, 2026) as the baseline performance period for PY 1. Instead, CMS will maintain the policy as finalized in the FY 2025 IPPS final rule such that CY 2025 will remain the baseline for PY 1, and July 1, 2024 – June 30, 2025, will remain the measure performance period. Because CMS has extended voluntary reporting of core clinical data elements through June 30, 2025, CMS will use the claims-only portion of the Hybrid HWR measure in the composite quality score calculation. CMS may utilize the complete Hybrid HWR measure in subsequent PYs.
- **Adding the Information Transfer Patient Reported Outcome-based Performance Measure (PRO-PM).** CMS finalized its proposal to include the Information Transfer PRO-PM beginning in PY 3, with a CY 2027 baseline period, to strengthen care transition accountability.
- **Applying a neutral quality measure score for hospitals with insufficient quality data.** CMS finalized a policy to assign a neutral composite-quality score (a scaled score of 50) to hospitals that submit insufficient quality data, preventing automatic penalties while still incentivizing reporting.
- **Adopting a methodology to account for coding changes.** CMS finalized its proposal to implement a three-step approach to adjust target pricing to account for changes in MS-DRG and HCPCS codes that occur between the baseline and applicable PY. First, CMS will identify and map any new or revised MS-DRGs and HCPCS codes to previous codes. Second, CMS will apply a normalization factor to account for shifts in coding practices and case mix. Finally, CMS will apply a prospective trend factor to adjust target prices.

- **Reconstructing the normalization factors.** CMS finalized its proposal to calculate the prospective and final normalization factor at the MS-DRG/HCPCS episode type and regional level rather than at the national level. Both normalization factors will be based on benchmark prices and not target prices.
- **Modifying the calculation of the prospective trend factor.** CMS finalized its proposal to use a log-linear regression model, rather than simply relying on a two-year comparison, to calculate the prospective trend factor. CMS will include two additional trend years, *i.e.*, the two years prior to the three-year baseline, which will only be used for the purpose of setting the prospective trend factor. The calculation of the prospective trend factor will be the average of the regional trend factor and the national trend factor.
- **Replacing the area deprivation index with the community deprivation index.** CMS finalized its proposal to replace the area deprivation index with the community deprivation index for risk-adjustment purposes. CMS will also rename the social needs risk adjustment factor to the beneficiary economic risk adjustment factor.
- **Using a 180-day lookback period for beneficiary risk adjustment.** CMS will use a 180-day look-back period beginning with the day prior to the anchor hospitalization or anchor procedure to capture a more comprehensive picture of the beneficiary's health status.
- **Using HCC version 28 for beneficiary risk adjustment.** CMS finalized its proposal to move to HCC version 28 for beneficiary risk adjustment to align with current MA methodology and clinical categories.
- **Aligning the date range used for episode attribution.** CMS finalized its proposal to align the episode attribution policy between the PYs and baseline years. The date of discharge from an anchor hospitalization or outpatient procedure would determine the PY and baseline year in which the episode is attributed.
- **Broadening the skilled nursing facility three-day rule waiver.** CMS finalized its proposal to allow TEAM participants to discharge beneficiaries to hospitals and CAHs that provide post-acute services via swing bed arrangements.
- **Adopting a new low-volume hospital policy.** CMS finalized a low-volume hospital policy that was not included in the proposed rule. If a TEAM participant hospital does not meet the low-volume threshold of 31 episodes in a given baseline period for a given episode category, that hospital would not be responsible for any downside risk.

CMS finalized its proposal to eliminate stand-alone health equity plan requirements, health-related social needs reporting, and the decarbonization and resilience initiative.

HTI-4 final rule

Key takeaway: The IPPS final rule includes the previously proposed HTI-4 rule, which finalizes certain proposals in ASTP/ONC's HTI-2 proposed rule. The IPPS proposed rule did not include HTI-4.

The final HTI-4 polices include new and revised standards and certification criteria for real-time prescription benefit information, electronic prior authorization, and electronic prescribing.

The rule establishes the following:

- **New real-time prescription benefit certification criterion** that enables prescriber access to prescription benefit information at the point of care and can be used to compare the cost of a drug of a suitable alternative.
- **New certification criteria for modular application program interface (API) capabilities** promoting API functionality.
- **Three new certification criteria for electronic prior authorization** to support more efficient management of electronic prior authorization tasks and reduce administrative burden for providers:
    - Coverage requirements discovery, which enables a healthcare provider to request information from payers about coverage requirements.
    - Documentation templates and rules, which provides a mechanism for clinicians and other EHR users to navigate and quickly assemble the information necessary to support a prior authorization request according to a payer's requirements.
    - Prior authorization support, which enables submission of prior authorization requests from health

IT systems as well as checking the status of a previously submitted request.
- **Revised electronic prescribing certification criterion** that aligns with requirements for Medicare Part D plan sponsors.

These updates enable improvements to workflow automation, reduce the manual effort required to conduct prior authorizations, improve operational workflow, and support more timely and transparent clinical decision-making.

The HTI-4 final rule is effective on October 1, 2025. For more information, see ASTP/ONC's blog post and fact sheet.

Requests for information

Transition toward digital quality measurement in CMS quality reporting programs

Key takeaway: CMS summarized stakeholder comments on the use of the Health Level 7® FHIR® in electronic clinical quality measure (eCQM) reporting in various quality reporting programs.

The IPPS proposed rule included a request for information (RFI) on the transition toward digital quality measurement in various CMS quality reporting programs. CMS solicited input on the use of Health Level 7® FHIR® in eCQM reporting in the hospital IQR program, the hospital outpatient quality reporting program, and the Medicare promoting interoperability program, and for patient assessment reporting in the inpatient psychiatric facility quality reporting program. The CY 2026 Physician Fee Schedule proposed rule included a similar RFI to solicit comments on FHIR®-based eCQM activities in the Medicare Shared Savings Program and the Merit-based Incentive Payment System quality performance category.

The RFI included questions within four broad categories:
- The FHIR®-based eCQM conversion progress.
- Data standardization for quality measurement and reporting.
- The timeline under consideration for FHIR®-based eCQM reporting.
- Measure development and reporting tools.

In the final rule, CMS summarized the input it received but did not respond to specific comments. CMS intends to use the information to inform future digital quality measurement work.

Medicare deregulation (Executive Order 14192)

Key takeaway: CMS continues to seek public input on ways to streamline regulations and reduce administrative burdens across the Medicare program.

In line with President Trump's Executive Order 14192, "Unleashing Prosperity Through Deregulation," CMS included an RFI in the FY 2026 IPPS proposed rule (and in the proposed rules for inpatient psychiatric hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and hospice providers) soliciting input on potential changes to Medicare regulations with the "goal of reducing the costly private healthcare expenditures required to comply with federal regulations."

In the final rule, CMS did not respond to any comments received on the RFI thus far and included a link for stakeholders to continue to submit responses.

The RFI acknowledges that healthcare providers face many regulatory requirements that "often result in duplicative efforts and unnecessary administrative burdens." CMS specifically references conditions of participation and conditions of coverage, which can "create redundancy with existing state requirements or have no measurable impact on improving the quality of patient care." The RFI also states that "reporting and documentation requirements for quality, value-based purchasing programs, and payment policies can necessitate significant additional administrative resources from providers and duplicate private insurance requirements."

The RFI includes questions on three overarching topics:

- Streamlining regulatory requirements.
- Opportunities to reduce administrative burden in reporting and documentation.
- Identification of duplicative requirements.

CMS asks the public to submit any additional recommendations they may have beyond these topics.

Conclusion

The final rule was published in the *Federal Register* on August 4, 2025. Stakeholders seeking to further understand the rule's effects should contact McDermott+ for technical assistance.

For more information, contact Deborah Godes, Devin Stone, Katie Waldo, Kayla Holgash, Marie Knoll, Kristen O'Brien, Parashar Patel, Jeff Davis, Maddie News, Erica Stocker, Simeon Niles, or Eric Zimmerman.

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