Overview and Resources

On July 31, 2025, the Centers for Medicare and Medicaid Services (CMS) released the federal fiscal year (FFY) 2026 final rule for the Medicare Inpatient Prospective Payment System (IPPS). The final 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 adopted 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.

Adopted program changes will be effective for discharges on or after October 1, 2025, unless otherwise noted. CMS estimates the overall impact of this final rule update to be an increase of approximately $5.0 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, and new technology add-on payment changes as of October 1, 2025.

A copy of the final 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-final-rule-home-page.

An online version of the final rule can be found at https://www.federalregister.gov/d/2025-14681.

Text in italics is extracted from the final rule found in the August 4, 2025 *Federal Register* unless otherwise noted.

IPPS Payment Rates

Pages 36859–36879, 36900–36906, 36967–36975, 37187–37190, and 37212–37237

The table below lists the federal operating and capital rates finalized 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	Final FFY 2026	Percent Change
Federal Operating Rate	$6,624.39	$6,752.61 (proposed at $6,835.47)	+1.94% (proposed at +3.19%)
Federal Capital Rate	$512.14	$524.15 (proposed at $528.95)	+2.35% (proposed at +3.28%)

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

Final FFY 2026 Update Factor Component	Federal Operating Rate	Hospital Specific Rate	Federal Capital Rate
Market Basket/CIPI Update	+3.3% (proposed at $+3.2%)		+2.8% (proposed at 2.6%)
Affordable Care Act (ACA)-Mandated Productivity Adjustment	-0.7 percentage points (PPTs) (proposed at -0.8 PPTs)		–
MS-DRG Reclassification and Recalibration Budget Neutrality (BN) Factor (before cap)	-0.14% (proposed at -0.16%)		-0.16% (proposed at -0.18%)
MS-DRG Weight Cap Policy BN	-0.01% (as proposed)		-0.01% (as proposed)
Wage Index/Geographic Adjustment Factor (GAF) BN Factor	+0.15% (proposed at +0.13%)	-	-0.66% (proposed at +1.40%)
Geographic Reclassification BN Factor*	-0.62% (proposed at +1.47%)	-	
Wage Index Cap Policy BN*	+0.02% (proposed at -0.61%)	-	-0.03% (proposed at -0.65%)
Transition for the Discontinuation of the Low Wage Index Policy BN	-0.03% (as proposed)	-	
Outlier Adjustment Factor*	0.00% (as proposed)		+0.41% (proposed at +0.11%)
Rural Community Hospital Demonstration BN*	-0.03% (as proposed)	-	-
Net Rate Update	**+1.94%** (proposed at +3.19%)	**+2.44%** (proposed at +2.11%)	**+2.35%** (proposed at +3.28%)

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

The adopted market basket and CIPI update percentages are based on IHS Global Inc.'s second quarter 2025 forecast with historical data through first quarter 2025.

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

Pages 36859–36879

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 Medicare cost report data as the base period for the construction of the costs.

For FFY 2026, CMS is adopting its proposal 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 is also adopting 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 is inflated to 2023 values by CMS. In addition, CMS is also revising several of the price proxies using Bureau of Labor Statistics data.

As a result, CMS will apply a market basket update of 3.3%, which is the same as was being calculated using 2018-based data, and a CIPI of 2.8%, which is 0.1% lower than if rebasing was not done.

Effects of the IQR and EHR MU Incentive Programs

Pages 36900–36906, 37212–37213, and 37231–37232

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 (3.3% MB less 0.7 PPT productivity adjustment)	+2.6%			
Penalty for Failure to Submit IQR Quality Data (25% of the base MB Update of 3.3%)	–	-0.825 PPT	–	-0.825 PPT
Penalty for Failure to be a Meaningful User of EHR (75% of the base MB Update of 3.3%)	–	–	-2.475 PPT	-2.475 PPT
Net Rate Update	**+2.6%**	**+1.775%**	**+0.125%**	**-0.7%**

Outlier Payments

Pages 37188–37189, 37219–37228, and 37233–37234

For FFY 2026, CMS finalizing their proposal 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 finalizing 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 will result in operating outlier payments at 5.1% (as proposed) 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 adopted to be 4.13% (as proposed) of total capital payments for FFY 2026.

CMS is adopting an outlier fixed-loss cost threshold of $40,397 (proposed at $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 for FFY 2024 charge data. This threshold is 12.5% lower than the FFY 2025 outlier threshold of $46,152. The outlier fixed-loss cost threshold would have been $40,714 without the adopted methodology change.

Additionally, CMS is finalizing 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

Page 37213

CMS will 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 the use of cost report data regarding reasonable acquisition costs when it becomes available for future budget neutrality adjustments.

Wage Index and Geographic Adjustment Factor

Pages 36834–36858, 36869–36873, 37184–37187, 37189–37190, 37216–37218, 37229–37230, and 37234–37235

A complete list of the finalized 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-fr-tables-2-3-4a-4b.zip.

Addressing Wage Index Disparities between High and Low Wage Index Hospitals

Pages 36852–36854, 36855–36857, 37184–37187, and 37218

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

Permanent Cap on Wage Index Decreases

Pages 36854–36855 and 37218

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 will 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 has on the last day of the prior FFY. For FFY 2026, CMS is adopting that this will 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 36851–36852

For FFY 2026 and onward, CMS will 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. Adopted out-migration adjustments can be found in Table 2 released with this final rule.

Occupational Mix Adjustment

Pages 36843–36844

CMS is adopting 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 adopting a FFY 2026 occupational mix adjusted national average hourly wage of $57.86 (proposed at $57.63).

Reclassification Policy Updates

Pages 36844–36848

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 finalizing a clarification of this policy and revising the definitions in a more straightforward manner. Currently the policy states that *"…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 finalizing 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 finalizing that reinstatements will only apply to a termination, not to a withdrawal. However, CMS is finalizing 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 will 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 adopting a modification to the current regulation to state that the modified withdrawal requests and 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 36857–36858, 36869–36873, and 37229

The wage index adjustment is applied to the portion of the IPPS rate that CMS considers to be labor-related. CMS is adopting to rebase and revise the IPPS market basket to reflect a 2023 base year and thus will recalculate the labor-related share using this final market basket. For FFY 2026, CMS is adopting a labor-related share of 66.0% (as proposed) 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 37229–37230

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 adopting their proposal to maintain the current factors for FFY 2026.

Area	FFYs 2022–2025 (Final 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

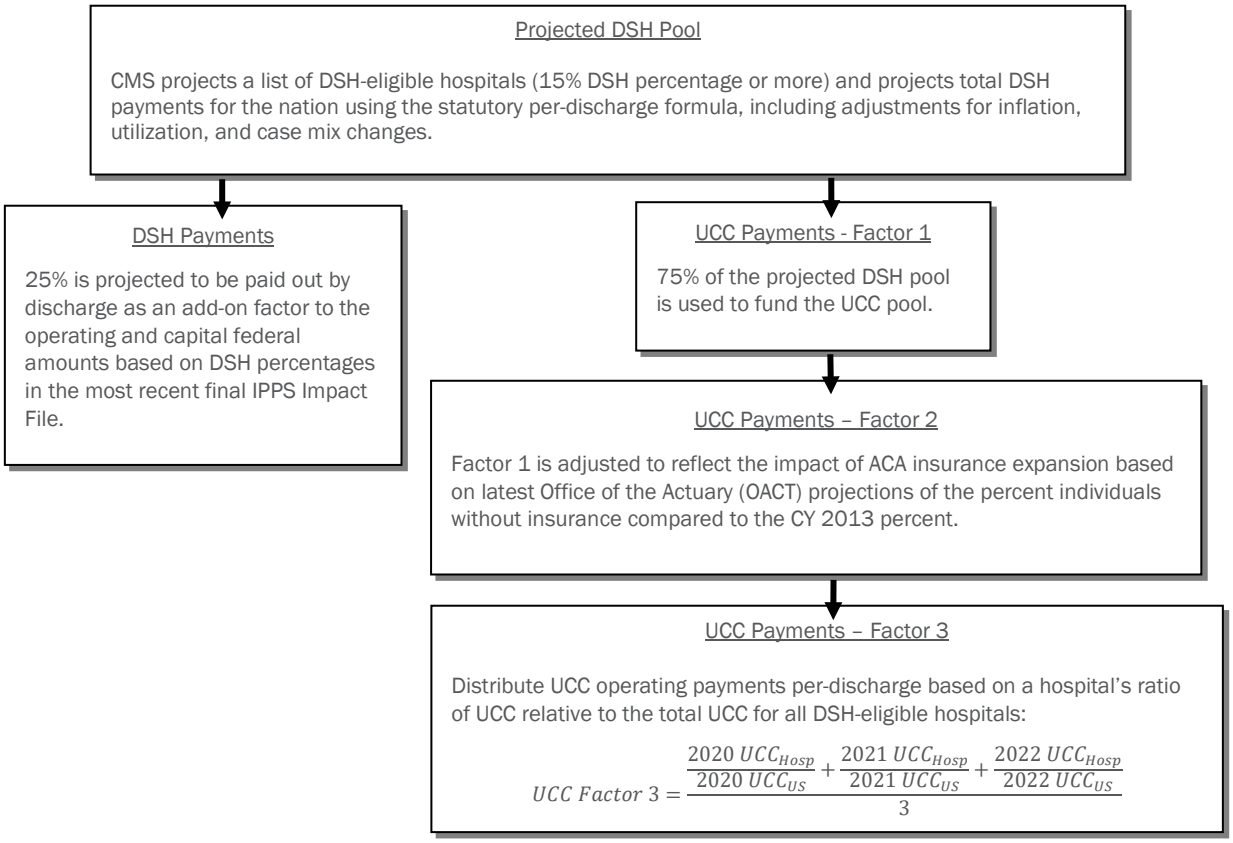
Pages 36879–36896

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	Final FFY 2026	Percent Change
Projected Total DSH Pool	$14,013,000,000	$16,550,000,000 (proposed at $15.682 B)	+18.10%
UCC Factor 1 – Base Funding (75% of Total DSH Pool)	$10,509,750,000	$12,412,500,000 (proposed at $11.762 B)	+18.10%
UCC Factor 2 – Available Pool	$5,705,743,275 54.29% Factor 1 adjustment	$7,713,127,500 62.14% Factor 1 adjustment (proposed 60.71% adjustment)	+35.18%
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 will 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 will use FFYs 2020–2022 for this determination. Hospitals that do not have data for all three years will 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 will 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 will 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 will 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 is finalizing that it will continue the policy that if the hospital has a preliminary projection of being eligible for DSH it may receive interim DSH payments but will not receive interim UCC payments. Factor 3 values for new hospitals will 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 will 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 will 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 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 will 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 will 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 2,364 (proposed at 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-fr-medicare-dsh-supplemental-data-file.zip.

Indirect and Direct GME Payments

Pages 36914–36918

In the proposed rule, CMS provided 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 at 1.35 for FFY 2026.

Updates to the MS-DRGs

Pages 36548–36834, 36896–36900, 36921–36923, 37216, and 37235

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 is adopting the use of ICD-10 claims data from the March 2025 update of the FFY 2024 MedPAR file and the March 2025 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 is adopting a budget neutrality factor of 0.99858 (proposed at 0.998422) to the operating rate and 0.9984 (proposed at 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. CMS will continue this policy and apply a budget neutrality adjustment of 0.999897 (proposed at 0.999938) to the operating rate and 0.9999 (as proposed) 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 is finalizing 770 (proposed at 772) payable DRGs for FFY 2026 (compared to 771 for FFY 2025), with 75.9% of DRG weights changing by less than +/- 5%, 17.2% changing at least +/-5% but less than +/- 10%, 6.9% changing +/-10% or more, 3.9% that are affected by the relative weight cap on reductions, and 0.7% being new MS-DRGs.

The five MS-DRGs with the greatest finalized year-to-year change in weight, taking into account the relative weight cap, are:

MS-DRG	MS-DRG Title	Final FFY 2025 Weight	Final FFY 2026 Weight	Percent Change
499	LOCAL EXCISION AND REMOVAL OF INTERNAL FIXATION DEVICES OF HIP AND FEMUR WITHOUT CC/MCC	1.1608	2.0148	73.57%
783	CESAREAN SECTION WITH STERILIZATION WITH MCC	1.8421	2.4551	33.28%

624	SKIN GRAFTS AND WOUND DEBRIDEMENT FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC	1.0031	1.2519	24.80%
804	OTHER O.R. PROCEDURES OF THE BLOOD AND BLOOD FORMING ORGANS WITHOUT CC/MCC	1.1056	1.3560	22.66%
257	UPPER LIMB AND TOE AMPUTATION FOR CIRCULATORY SYSTEM DISORDERS WITHOUT CC/MCC	0.8919	1.0922	22.46%

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.

The full list of the final 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-fr-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 36554–36561, 36652–36656, 36921–36923, and 37216

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 will continue the adjustment to the payment amount for clinical trial cases that group to MS-DRG 018. The adopted adjustment of 0.16 (proposed at 0.23) will be applied to the payment amount for clinical trial cases that 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 adopting 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. The median standardized charge will be $27,466 (proposed at $29,819). This policy will 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.

New Technology

Pages 36657–36834 and 37260–37262

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 36668 shows the 12 technologies that will 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 page 36669 shows the 15 technologies that will continue to receive add-on payments for FFY 2026 since their three-year anniversary date will occur on or after October 1, 2025. Table II.E.-02 on page 36673 shows the 12 technologies that will no longer receive add-on payments for FFY 2026 since their three-year anniversary date will occur prior to April 1, 2026.

CMS is adopting new technology add-on payments for five (proposed at 14) technologies under the traditional pathway and 22 (proposed at 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 36560–36650 and 36896–36900

Based on the analysis of FFY 2024 MedPAR claims, CMS is adopting changes to a number of MS-DRGs effective for FFY 2026. Specifically, CMS is adopting 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).*
- *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).”*

CMS is not finalizing the proposal to add new MS-DRGs 403 and 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC and without MCC, respectively) and thus not adopting to add any ICD-10-CM diagnosis codes that were proposed to be associated with these MS-DRGs.

The table on page 36899 details which of these finalized new or revised MS-DRGs will be subject to the post-acute care transfer policy for FFY 2026.

Rural Referral Center (RRC) Status

Pages 36906–36908

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 adopted FFY 2026 minimum case-mix and discharge values by region are available on the pages listed above.

Low-Volume Hospital Adjustment

Pages 36908–36912

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 is adopting 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 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 will 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.

Medicare-Dependent, Small Rural Hospital (MDH) Program

Pages 36912–36914

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 37074–37130

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 adopting several of those policies and additional modifications to TEAM:

- A limited deferment period for new hospitals located in a mandatory CBSA (pages 37075–37079)
- Linking Track 2 participation eligibility for hospitals with a Medicare Dependent Hospital (MDH) designation to the expiration of the MDH program (pages 37079–37081)
- Aligning the reporting period for the Hybrid Hospital-Wide Readmission Measure with the Hospital IQR Program (pages 37084–37086) [Adopted alignment for data elementals, but not for reporting period]
- Adding the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) for outpatient episodes (pages 37086–37090)
- Applying a neutral quality measure score for TEAM participants with insufficient quality data (pages 37090–37092)
- A methodology to construct target prices when there are coding changes (pages 37092–37097)
- Including US territories in Census Division 9 (page 37098)
- Reconstructing the normalization factor and trend factor (pages 37098–37102)
- Replacing the Area Deprivation Index (ADI) with the Community Deprivation Index (CDI) in beneficiary economic risk adjustment factor (pages 37102–37105)
- 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 37015–37113)
- Aligning baseline, performance year, and reconciliation time periods for episode attribution (pages 37118–37120)
- Removing voluntary reporting of health equity plans and health-related social needs screening data (pages 37122–37123)
- Expanding the Skilled Nursing Facility (SNF) 3-Day Rule Waiver (pages 37128–37130)
- Removing the voluntary Decarbonization and Resilience Initiative (page 37130)

CMS also solicited comments in the following policy areas and made final determinations for each topic on the pages shown:

- Indian Health Service (IHS) hospital outpatient episodes (pages 37081–37083)
- Low volume hospitals (pages 37113–37118)
- Standardized prices and reconciliation amounts (pages 37120–37122)
- Primary care services referral requirement (pages 37123–37128)

Updates to the IQR Program and Electronic Reporting Under the Program

Pages 36996–37027

The tables on pages 37016–37021 outline the previously adopted and newly modified Hospital IQR Program measure sets for FFYs 2027–2029 payment determination. The measure set for FFY 2029 will also be in effect for all subsequent years.

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 36997–37001

Beginning with the CY 2025 reporting period/FFY 2027 payment determination, CMS is finalizing modifications to the MORT-30-STK measure. CMS recognizes the increase in enrollment of Medicare beneficiaries in Medicare Advantage (MA) plans and CMS is finalizing 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 will 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 modifications to the measure will still be calculated using a risk-standardized mortality rate.

The adopted 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 adopting a shortened the performance period from the current period of three years to a period of two years for this measure. This implementation will begin with the FFY 2027 program year and the new reporting period for the measure will change from July 1, 2022–June 30, 2025 to July 1, 2023–June 30, 2025.

Hospitals will not be required to submit additional data for measure calculations. This measure will 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.

Beginning with the FFY 2027 payment determination, CMS is finalizing 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); and
- Removing the exclusion of patients with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 as present on admission on the index admission claim.

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 37002–37008

CMS is adopting to modify the COMP-HIP-KNEE measure beginning with the FFY 2027 payment determination. As with the MORT-30-STK measure, CMS is expanding the measure's inclusion criteria to include MA patients and

shorten the performance period from three years to two years. CMS will 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.

Similarly to the MORT-30-STK measure, CMS is also making technical updates to the COMP-HIP-KNEE measure including:

- Updating the risk adjustment model to use individual ICD-10 codes instead of the current Hierarchical Condition Categories (HCCs); and
- Removing the exclusion of patients with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 as present on admission on the index admission claim.

For the updated COMP-HIP-KNEE measure, the outcome will 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.

Removals in the Hospital IQR Program Measure Set

Pages 37008–37015

Beginning with the CY 2024 reporting period/FFY 2026 payment determination, CMS is finalizing the removal of the following measures from 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 will 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
- Hybrid HWM

This update will 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.

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

Pages 37021–37025

For both IQR program measures, hospitals are 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 finalizing the proposal 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 lowering 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.

Request for Information (RFI) – Well-being and Nutrition

Pages 36996–36997

CMS summarized comments received on measure concepts for the Well-being and Nutrition measures and the Malnutrition Care Score (MCS) eCQM measure. CMS will consider this feedback for future measure development efforts in the Hospital IQR program.

Quality-Based Payment Programs

Pages 36923–36967

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 adopting in the quality-based payment programs are below.

VBP Program

Pages 36943–36963

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 final rule are available in Table 16A on the CMS website at https://www.cms.gov/files/zip/fy2026-ipps-fr-table-16a.zip.

CMS expects the actual FFY 2026 VBP adjustment factors to be available in Table 16B in 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. This information is outlined in tables found on pages 36950–36954, and 36955.

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

Future Program Years

For a list of the newly established performance standards for FFYs 2028–2031 please refer to tables on pages 36956–36960.

Beginning with the FFY 2026 program year, CMS is finalizing to remove the HEA from the Hospital VBP Program originally adopted in the FFY 2024 IPPS final rule.

Beginning with FFY 2033 program year, CMS is adopting to modify the COMP-HIP-KNEE measure which includes updating the measure cohort to include MA beneficiaries and in conjunction update the applicable period from three years to two years. CMS will post the measure data on Care Compare beginning in July 2026. CMS will use the current calculation methodology for the performance standards for the updated measure.

CMS is notifying the public of multiple updates in the VBP program beginning with the FFY 2027 program year. For the COMP-HIP-KNEE measure, CMS is updating the risk adjustment model to use individual ICD-10 codes instead of HCCs.

Additionally, CMS will remove the COVID-19 exclusion from the five condition-and procedure-specific mortality measures and one procedure-specific complication measure in the VBP program. This update will 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 five condition-and procedure-specific mortality measures.

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 will remove the covariate adjustment for patient history of COVID-19 in the 12 months prior to the admission.

For the Center for Disease Control and Prevention (CDC) National Health Safety Network (NHSN) Healthcare Associated Infection (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. CMS will 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 use the CY 2022 baseline data to calculate performance standards and calculate and

publicly report measure scores. Table VI.L.-09 on page 36955 outlines the CDC baseline data for FFY 2026–2029 in the VBP program years.

RRP

Pages 36923–36942

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: AMI, HF, PN, chronic obstructive pulmonary disease (COPD), THA/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 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 finalizing a refinement to 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 modifying 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."

Hospitals will not be required to submit additional data for measure calculations. CMS will 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 modification to include MA beneficiaries, CMS is finalizing the "applicable period" definition from a three-year period to a two-year period. This includes the period from which data are 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" will 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 will be July 1, 2023–June 30, 2025. The "applicable period for dual eligibility" will continue to correspond to the "applicable period."

After considering public comments, CMS is not adopting the proposal to include payment data for MA beneficiaries in the calculation of aggregate payments for excess readmissions. CMS will continue to use Medicare FFS claims in calculations of aggregate payments for excess readmissions and include MA data only in the ERR calculations.

As with the VBP program, CMS is also finalizing 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.

Similar to the Hospital IQR program, CMS is adopting to remove the COVID-19 exclusion from all six readmission measures in the RRP beginning with FFY 2027 program year. This includes removing the 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. An updated measure methodology report available in May 2026 at https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.

HAC Reduction Program

Pages 36963–36967

FFY 2026 Payment Adjustment

The FFY 2026 HAC reduction program will evaluate hospital performance on six measures:

- AHRQ Patient Safety Indicator (PSI)-90 (a composite of ten individual HAC measures);
- Central Line-Associated Bloodstream Infection (CLABSI);
- Catheter-Associated Urinary Tract Infection (CAUTI);
- the Surgical Site Infection (SSI) Pooled Standardized Infection Ratio (SIR);
- Methicillin-resistant Staphylococcus Aurea (MRSA); 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

Although CMS did not propose to add or remove any measures in the HAC reduction program, CMS is notifying hospitals of upcoming changes to the standard population data, also known as the baseline, used to calculate the SIR for the CDC 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 will 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 36964.

Modifications to the ECE policy

Pages 37025–37027, 36942, 36960–36961, and 36965–36967

In the Hospital IQR, VBP program, RRP, and HAC reduction program, CMS is updating and codifying 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, these updates include:

- *"…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.*
- *… 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*
- *… 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."*

After considering public comments, CMS is finalizing a 60-day deadline for hospitals to request an ECE from the date of the extraordinary circumstance instead of the proposed 30-day deadline.

Promoting Interoperability Program

Pages 37043–37073

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 finalizing to maintain the EHR reporting period for a payment determination as a minimum of any continuous 180-day period within the calendar year.

CMS previously adopted the Security Risk Analysis measure, which requires eligible hospitals and Critical Access Hospitals (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 modifying the measure to require eligible hospitals and CAHs to also attest "yes" to having conducted security risk management, in addition to the current security risk analysis attestation.

CMS is also modifying 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 page 37049 compare the 2016 SAFER Guides to the 2025 SAFER guides. Beginning with the EHR reporting period in CY 2026 CMS is modifying the SAFER Guides measure and 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.

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 five bonus points for reporting on one or both optional bonus measures. CMS is modifying the Public Health and Clinical Data Exchange Objective beginning with the CY 2026 EHR reporting period to adopt an optional bonus measure for public health reporting using the Trusted Exchange Framework and Common Agreement (TEFCA).

In this measure, an eligible hospital or CAH will 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 Public Health Agency (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 will 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 finalized performance-based scoring methodology for EHR Reporting periods beginning with CY 2026.

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

(e-Prescribing)			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 **(finalized for CY 2026+)**	5 points (bonus)	

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