SUMMARY OF PROPOSED RULE — May 2025

FFY 2026 Inpatient Prospective Payment System

In the April 30 *Federal Register*, the Centers for Medicare & Medicaid Services (CMS) published its proposed rule describing federal fiscal year (FFY) 2026 policies and rates for Medicare's inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS). The proposed policy and payment provisions — if finalized — would generally be effective for FFY 2026 discharges, beginning Oct. 1, 2025.

The following is a comprehensive summary of the proposed rule's acute care hospital provisions. Payment and policy changes for the FFY 2026 LTCH PPS proposed rule are addressed in a separate summary.

To Comment

Comments are due to CMS on June 10 by 2 p.m. (PT) and can be submitted electronically.

For Additional Information

Questions about this summary should be directed to Michelle Millerick, vice president, federal policy at mmillerick@calhospital.org, or Megan Howard, vice president, federal policy, at mhoward@calhospital.org. Facility-specific CHA DataSuite analyses were sent under separate cover. Questions about CHA DataSuite should be directed to Alenie Reth, data analyst, at areth@calhospital.org.

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Request for Information (RFI) — Deregulation

The proposed rule references Executive Order (EO) 14192, "Unleashing Prosperity Through Deregulation," dated January 31, 2025. Consistent with EO 14192's focus on reducing regulatory compliance costs, the proposed rule requests public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other interested parties participating in the Medicare program. All comments are due on June 10 by 8:59 p.m. (PT) and should be made via CMS' Medicare Regulatory Relief web page.

FFY 2026 Payment Changes

The table below lists the federal operating and capital rates for FFY 2026 compared to the rates in effect for FFY 2025. These rates include all market basket (MB) increases and reductions, as well as the application of annual budget neutrality factors. These rates do not reflect any hospital-specific adjustments (e.g., penalty for non-compliance under the Inpatient Quality Reporting [IQR] Program and Promoting Interoperability Program, quality penalties/payments, disproportionate share hospitals, etc.).

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

The standardized amount does not include the 2% Medicare sequester reduction that began in 2013 and continues under current law. The sequester reduction is applied as the last step in determining the payment amount for submitted claims and does not affect the underlying methodology used to calculate Medicare Severity Diagnosis Related Group (MS-DRG) weights or standardized amounts.

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

Proposed FFY 2026 Update Factor Component	Federal Operating Rate	Hospital Specific Rate	Federal Capital Rate
MB/CIPI Update	+3.2%		+2.6%
Affordable Care Act-Mandated Productivity Adjustment	-0.8 percentage points		–
MS-DRG Reclassification and Recalibration Budget Neutrality (BN) Factor (before cap)	-0.16%		-0.18%

MS-DRG Weight Cap Policy BN	-0.01%		-0.01%
Wage Index/Geographic Adjustment Factor (GAF) BN Factor	+0.13%	-	+1.40%
Geographic Reclassification BN Factor*	+1.47%	-	
Wage Index Cap Policy BN*	-0.61%	-	-0.65%
Transition for the Discontinuation of the Low Wage Index Policy BN	-0.03%	-	
Outlier Adjustment Factor*	0.00%		+0.11%
Rural Community Hospital Demonstration BN*	-0.03%	-	-
Net Rate Update	**+3.19%**	**+2.11%**	**+3.28%**

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

Effects of the IQR and Electronic Health Record (EHR) Incentive Programs

The IQR MB penalty imposes a 25% reduction to the full MB, and the EHR Meaningful Use penalty imposes a 75% reduction to the full MB; combined, these penalties put at risk the entire MB update. The table below displays various update scenarios for FFY 2026:

Updates for Hospitals Failing IQR and/or EHR

	Penalty	Market Basket (MB)	Market Basket Net of Productivity	Reduction (Percentage Points)	Update
No IQR	25% of the MB	3.2	2.4	-0.8	1.6%
No EHR	75% of the MB	3.2	2.4	-2.4	0.0%
No IQR/EHR	100% of the MB	3.2	2.4	-3.2	-0.8%

Impact Analysis

Impacts will vary based on hospital type and geography. CMS' detailed impact estimates are displayed in the proposed rule's Table I, which is partially reproduced below.

Hospital Type	All Final Rule Changes
All Hospitals	3.4%
Urban	3.5%
Urban Pacific	2.9%
Rural	2.5%
Rural Pacific	1.6%

The CHA DataSuite analysis estimates that California hospitals will experience a 1.8% increase in overall Medicare hospital inpatient payments in FFY 2026 compared to FFY 2025.

IPPS FFY 2026 Proposed Rule Analysis
Estimated Change in Medicare Payments
FFY 2026 Proposed Rule Compared to FFY 2025 Final-IF Rule

California

Group Impact Summary	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Estimated FFY 2025 IPPS Payments	$12,690,286,000		$941,819,400		$13,632,105,300	
Estimated FFY 2026 IPPS Payments	$12,914,476,800		$960,031,500		$13,874,508,300	
Total Estimated Change FFY 2025 to FFY 2026	$224,190,900	1.8%	$18,212,100	1.9%	$242,403,000	1.8%

Group Impact Detail	Operating		Capital		Total	
	Dollar Impact	% Change	Dollar Impact	% Change	Dollar Impact	% Change
Provider Type Changes	$0	0.0%	$0	0.0%	$0	0.0%
> Transitional DSH Payment	*$0*	*0.0%*	*N/A*	*N/A*	*$0*	*0.0%*
Change in Hospital Specific Rate Payment Status	$0	0.0%	N/A	N/A	$0	0.0%
Market Basket Update (Includes BN)	$369,932,600	2.9%	$23,516,800	2.5%	$393,449,300	2.9%
ACA-Mandated Market Basket Reduction	($93,226,600)	-0.7%	N/A	N/A	($93,226,600)	-0.7%
MS-DRG Updates	($2,048,400)	0.0%	($413,000)	0.0%	($2,461,400)	0.0%
> MS-DRG Case-Mix Updates	*$18,267,400*	*0.1%*	*$1,402,700*	*0.2%*	*$19,670,100*	*0.1%*
> MS-DRG Reclassification and Recalibration BN	*($19,548,900)*	*-0.2%*	*($1,720,300)*	*-0.2%*	*($21,269,200)*	*-0.2%*
> MS-DRG Weight 10% Reduction Cap BN	*($766,900)*	*0.0%*	*($95,400)*	*0.0%*	*($862,300)*	*0.0%*
WI/GAF (Wage Data and Reclassification)	($35,595,800)	-0.3%	$2,597,700	0.3%	($32,998,100)	-0.2%
> Removal of Previous Rural Floor BN	*$210,010,200*	*1.7%*	*$14,780,300*	*1.6%*	*$224,790,500*	*1.7%*
> Removal of Previous Rural Floor WI	*($889,381,500)*	*-7.0%*	*($65,131,100)*	*-6.9%*	*($954,512,700)*	*-7.0%*
> Change due to WI and LS (Prior to Rural Floor)	*($224,792,100)*	*-1.8%*	*($16,152,400)*	*-1.7%*	*($240,944,400)*	*-1.8%*
> Current Rural Floor WI	*$879,350,500*	*6.9%*	*$65,053,800*	*6.9%*	*$944,404,300*	*6.9%*
> Current Rural Floor BN	*($203,438,700)*	*-1.6%*	*($9,307,400)*	*-1.0%*	*($212,746,000)*	*-1.6%*
> WI and Geographic Reclassification BN	*$192,655,800*	*1.5%*	*$13,354,500*	*1.4%*	*$206,010,300*	*1.5%*
> Change in LS (Isolated from Previous Breakouts)	*($72,600,100)*	*-0.6%*	*N/A*	*N/A*	*($72,600,100)*	*-0.5%*
WI/GAF (Other Changes)	($86,738,100)	-0.7%	($6,159,300)	-0.7%	($92,897,400)	-0.7%
> Expiration of Previous 5% Stop Loss BN	*$10,012,700*	*0.1%*	*$754,100*	*0.1%*	*$10,766,900*	*0.1%*
> Expiration of Previous 5% Stop Loss WI	*($13,758,200)*	*-0.1%*	*($928,800)*	*-0.1%*	*($14,686,900)*	*-0.1%*
> Current 5% Stop Loss WI	*$4,297,400*	*0.0%*	*$301,000*	*0.0%*	*$4,598,400*	*0.0%*
> Current 5% Stop Loss BN	*($84,146,000)*	*-0.7%*	*($6,058,800)*	*-0.6%*	*($90,204,800)*	*-0.7%*
> Low Wage Index Removal Transition	*$0*	*0.0%*	*$0*	*0.0%*	*$0*	*0.0%*
> Low Wage Index Removal Transition BN	*($3,144,100)*	*0.0%*	*($226,800)*	*0.0%*	*($3,370,900)*	*0.0%*
DSH: UCC Payment Changes	$87,480,100	0.7%	N/A	N/A	$87,480,100	0.6%
> DSH UCC Distribution Factor Change	*($14,469,500)*	*-0.1%*	*N/A*	*N/A*	*($14,469,500)*	*-0.1%*
Change in Hospital Specific Rate	$5,300	0.0%	N/A	N/A	$5,300	0.0%
Quality Based Payment Adjustments	$1,636,200	0.0%	($285,800)	0.0%	$1,350,500	0.0%
> VBP	*$5,771,500*	*0.1%*	*N/A*	*N/A*	*$5,771,500*	*0.0%*
> RRP	*($385,200)*	*0.0%*	*N/A*	*N/A*	*($385,200)*	*0.0%*
> HAC	*($3,750,100)*	*0.0%*	*($285,800)*	*0.0%*	*($4,035,900)*	*0.0%*
Net Change due to Low Volume Adjustment	($17,254,500)	-0.1%	($1,044,300)	-0.1%	($18,298,800)	-0.1%

The values shown in the table above do not include the 2.0% sequestration impact to all lines of Medicare payment authorized by Congress through FFY 2032. It is estimated that sequestration will reduce FFY 2026 IPPS-specific payments by: $277,490,200

The values shown in the table above do not include the 2% sequestration impact to all lines of Medicare payment authorized by Congress through FFY 2032. Sequestration will reduce FFY 2026 IPPS-specific payments by an estimated $277,424,200.

Outlier Payments

CMS proposes adopting an outlier threshold for FFY 2026 of $44,305, an increase of 3.6% and $1,555 from the FY 2025 amount. CMS projects that the proposed outlier threshold for FY 2026 will result in outlier payments equal to 5.1% of operating DRG payments and 4.13% of capital payments. Accordingly, CMS is applying adjustments of 0.949 to the operating standardized amounts and 0.958716 to the capital federal rate to fund operating and capital outlier payments respectively.

Following previous years' approaches, CMS will target total outlier payments at 5.10% of total operating DRG payments. CMS' historical practice has been to calculate the outlier threshold based on the latest claims and cost report data. For FY 2026, the latest year of claims data is the FY 2024 Medicare Provider Analysis and Review File (MedPAR) December 2024 update. The latest cost report data is the Provider-Specific File (PSF) December 2024 update.

Medicare Disproportionate Share Hospital (DSH) — Uncompensated Care (UCC)

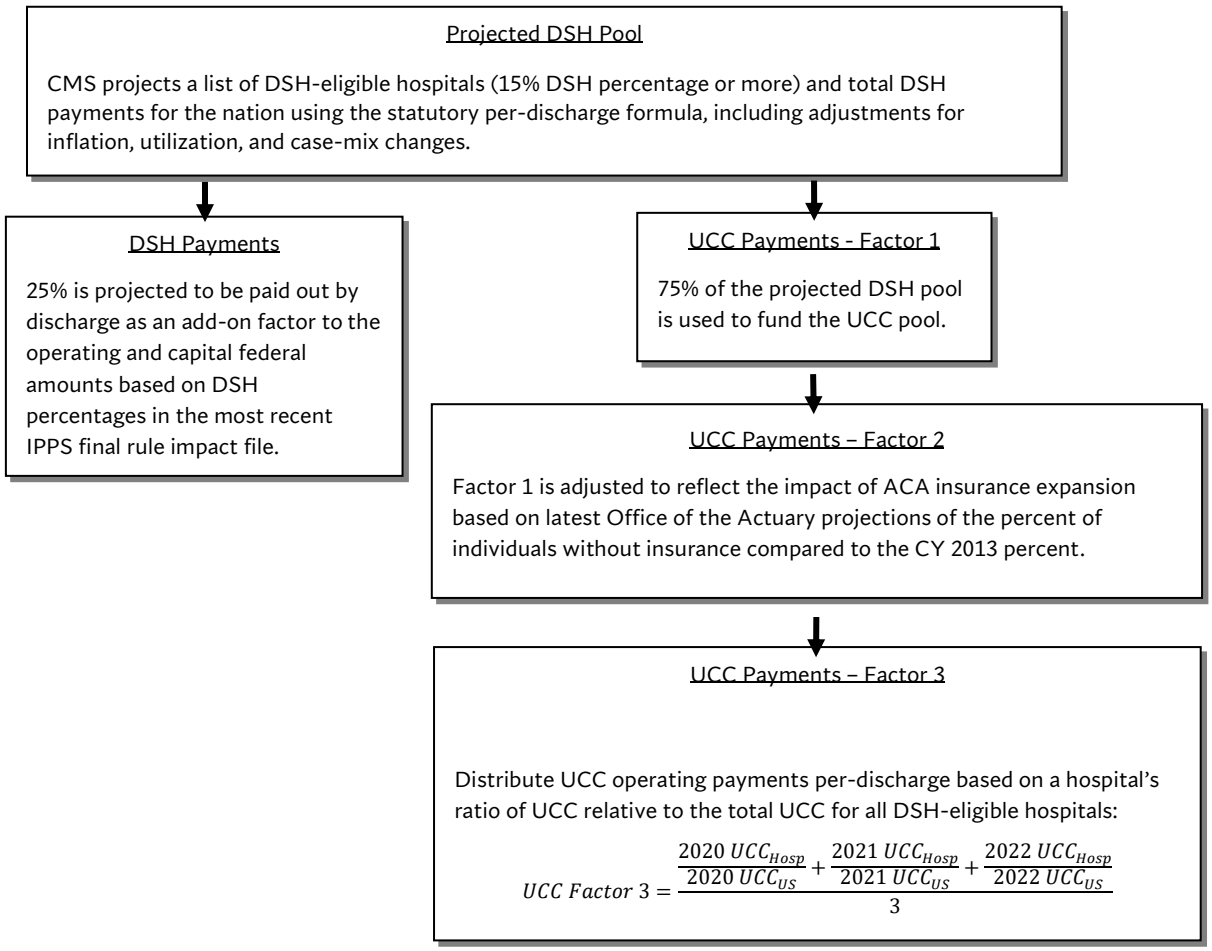
Medicare makes DSH and UCC payments to IPPS hospitals that serve a certain volume of "low-income" patients, defined as Medicare-eligible patients who also receive supplemental security income and Medicaid patients who are not eligible for Medicare. To determine a hospital's eligibility for DSH and UCC payments, CMS uses the proportion of inpatient days for each of these subsets of patients.

Prior to 2014, CMS made only DSH payments. Beginning in FFY 2014, the Affordable Care Act (ACA) required that DSH payments equal 25% of the statutory formula and UCC payments equal the product of three factors:

- Factor 1: 75% of aggregate DSH payments that would have been made under the system in place prior to ACA implementation (set forth in Social Security Act Section (d)(5)(F))
- Factor 2: The ratio of the percentage of the population insured in the most recent year to the percentage of the population insured in a base year prior to ACA implementation
- Factor 3: A hospital's UCC costs for a given period relative to UCC costs over the same period for all hospitals that receive Medicare DSH payments

The statute precludes administrative or judicial review of the secretary's estimates of the factors used to determine and distribute UCC payments. UCC payments are made only to hospitals eligible to receive DSH payments that are paid using the national standardized amount. Therefore, sole community hospitals paid on the basis of hospital-specific rates and hospitals not paid under the IPPS are ineligible to receive UCC payments.

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



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

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

The proposed total amount of UCC payments ($7.14 billion) combined with supplement payments for Indian Health Service/tribal hospitals and Puerto Rico hospitals ($100.6 million) is $7.241 billion. **This is a 25.1% increase ($1.455 billion) from FY 2025 payments**. Changes in FY 2025 payments are driven by proposed increases in Factor 1 and Factor 2. Notably, Factor 2 has changed significantly between the proposed and final rule the past two years and may change again this year based on a re-estimate of the uninsured population in the National Health Expenditure Accounts (NHEA).

The regulatory impact analysis presented in the proposed rule includes the estimated effects of the changes to UCC payments for FFY 2026 across all hospitals by geographic location, bed size, region, teaching status, type of ownership, and Medicare utilization.

CMS projects 2,385 hospitals would be eligible for DSH payments in FFY 2026. CMS has made available a file that includes DSH eligibility status, UCC factors, payment amounts, and other data elements critical to the DSH payment methodology.

Proposed FFY 2026 Factor 1

CMS estimates this figure based on the most recent data available. It is not later adjusted based on actual data. CMS used the Office of the Actuary's (OACT's) January 2025 Medicare DSH estimates, which were based on the December 2024 update of the Healthcare Provider Cost Reporting Information System and the FFY 2025 IPPS final rule impact file. Starting with these data sources, OACT applies inflation updates and assumptions for future changes in utilization and case-mix to estimate Medicare DSH payments for the upcoming fiscal year.

OACT's January 2025 Medicare estimate of DSH payments for FFY 2026 is $15.682 billion. **The proposed Factor 1 amount is 75% of this amount, or $11.761 billion.** The proposed Factor 1 for 2026 is about $1.25 billion more than the final Factor 1 for FFY 2025.

Proposed FFY 2026 Factor 2

Factor 2 adjusts Factor 1 based on the percent change in the uninsured since ACA implementation. For FFYs 2014-17, the statute required CMS to use the Congressional Budget Office's estimate of the uninsured rate in the under 65 population from before ACA enactment. For FFY 2018 and subsequent years, the statute requires Factor 2 to equal the percent change in the number of individuals who are uninsured from 2013 until the most recent period for which data are available, minus 0.2 percentage points for each of FYs 2018 and 2019. In 2018, CMS began using the NHEA's uninsured estimates in place of Congressional Budget Office data to source change in the uninsured population.[1]

For FFY 2026, CMS estimates that the uninsured rate for the baseline year of 2013 was 14%, and the estimated uninsured rate for calendar years (CYs) 2024 and 2025 is 7.7% and 8.7%, respectively. As required, the CMS chief actuary certified these estimates.

1 The NHEA estimate reflects the rate of uninsured in the U.S. across all age groups and residents (not just legal residents) who usually reside in the 50 states or Washington, D.C. The NHEA data are publicly available on the CMS website at: https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/index.html

Using these estimates, CMS calculates the proposed Factor 2 for FFY 2026 (weighting the portion of CYs 2025 and 2026 included in FFY 2026) as follows:

- Percent of individuals without insurance for CY 2013: 14%
- Percent of individuals without insurance for CY 2025: 7.7%
- Percent of individuals without insurance for CY 2026: 8.7%
- Percent of individuals without insurance for FFY 2026 (0.25 times 0.077) + (0.75 times 0.087): 8.5%

Proposed Factor 2 = 1-|((0.085-0.14)/0.14)| = 1 - 0.3929 = 0.6071 (60.71%)

CMS calculated Factor 2 for the FFY 2026 proposed rule to be 0.6071 or 60.71%. The UCC amount for FFY 2026 is calculated to be $11.761 billion x 0.6071, which equals $7.14 billion — about $1.4 billion more than the FY 2025 UCC payment total of about $5.706 billion. This is a percentage increase of 25.1%.

The past two years, CMS' estimates of the change in UCC payment have increased in the proposed rule but decreased in the final rule because of a re-estimate of the factors affecting UCC between the proposed and final rule in the NHEA. As the NHEA is revised each June, there could be a significant difference between the proposed and final rule estimates of the uninsured population.

Factor 3 for FFY 2025

Factor 3 equals the proportion of hospitals' aggregate UCC attributable to each IPPS hospital. CMS continues to define UCC as the amount on line 30 of Worksheet S-10, which is the cost of charity care (line 23) and the cost of non-Medicare bad debt and non-reimbursable Medicare bad debt (line 29). The product of factors 1 and 2 determines the total pool available for UCC payments. This result multiplied by Factor 3 determines the UCC payment each eligible hospital will receive.

CMS will determine Factor 3 for FFY 2026 using the average of the audited FFY 2020, FFY 2021, and FFY 2022 Worksheet S-10 reports.

Per-Discharge Amount of Interim UCC Payments

Consistent with the policy adopted in FFY 2014 and applied in each subsequent fiscal year, CMS calculates a per-discharge amount of interim UCC by dividing the hospital's total UCC payment amount in the proposed rule year by the hospital's three-year average of discharges. This per-discharge payment amount is used to make interim UCC payments to each projected DSH-eligible hospital. These interim payments are reconciled following the end of the year. As finalized in the 2025 IPPS/LTCH PPS final rule, CMS calculates the per-discharge amount for UCC payments using the average of the most recent three years of discharge data.

The risks include interim UCC overpayment and potential for unstable cash flow to hospitals and Medicare Advantage plans. To reduce these risks, CMS continues its voluntary process through which a hospital may submit requests to its Medicare Administrative Contractor (MAC) for a lower per-discharge interim UCC payment amount, including a reduction to zero — once before the beginning of the fiscal year and/or once during the fiscal year. The hospital would have to

provide documentation to support a likely significant recoupment — for example, 10% or more of the hospital's total UCC payment or at least $100,000. The only possible change would be to lower the per-discharge amount either to the amount requested by the hospital or another amount determined by the MAC. This does not change how the total UCC payment amount will be reconciled at cost report settlement.

Process for Notifying CMS of Merger Updates

When each fiscal year's proposed and final IPPS rules are issued, CMS publishes a table on its website containing a list of known hospital mergers and the computed UCC payment for each merged hospital. Hospitals have 60 days from the public display date of each year's proposed rule to review the tables and notify CMS in writing of any inaccuracies.[2]

Proposed Updates to MS-DRGs

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

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

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

CMS proposes there to be 772 payable DRGs for FFY 2026 (compared to 771 for FFY 2025), with:

- 78.7% of DRG weights changing by less than +/- 5%
- 15.4% changing at least +/-5% but less than +/- 10%
- 5.9% changing +/-10% or more
- 3.5% being affected by the relative weight cap on reductions
- 0.9% being new MS-DRGs

The five MS-DRGs with the greatest proposed year-to-year change in weight, taking into account the relative weight cap, are detailed in the table on page 12.

2 Comments on the list of mergers can be submitted to the CMS inbox at Section3133DSH@cms.hhs.gov. CMS notes that this inbox is not intended for Worksheet S-10 audit process related emails, which should be directed to the MACs.

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

The full list of the proposed FFY 2026 MS-DRGs, MS-DRG weights, and flags for those subject to the post-acute care transfer policy are available in Table 5 on the CMS website. For comparison purposes, the final FFY 2025 DRGs are available in Table 5 on the CMS website.

MS-DRG Changes

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

- Adding ICD-10 Procedure Coding System (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
- Adding ICD-10-PCS codes describing dilation of coronary arteries and insertion of an intraluminal or other device to proposed new MS-DRGs 359 and 360 (Percutaneous Coronary Atherectomy with Intraluminal Device with MCC and without MCC, respectively)
- Adding ICD-10-CM diagnosis codes describing periprosthetic joint infection and ICD-10-PCS procedure codes describing hip or knee procedures to proposed new MS-DRGs 403

and 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC and without MCC, respectively)

- Deleting MS-DRGs 294 and 295 (Deep Vein Thrombophlebitis with CC/MCC and without CC/MCC, respectively)
- 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)
- Reassigning the ICD-10-PCS codes describing inspection of various anatomic sites to their respective clinically appropriate MS-DRGs
- 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 Central Nervous System Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator)

The table on page 18265 details which of these proposed new or revised MS-DRGs would be subject to the post-acute care transfer policy for FFY 2026. In addition, the second table on page 18265 details which of these proposed new or revised MS-DRGs would be subject to the MS-DRG special payment policy for FFY 2026.

Cap for Relative MS-DRG Weight Reductions

Beginning in FFY 2023, CMS adopted a permanent 10% cap on reductions to an MS-DRG's relative weight in a given year compared to the prior year's weight, implemented in a budget-neutral manner. CMS is proposing to continue this policy for FY 2026. The cap only applies if an MS-DRG retains its number from the prior year; the cap will not apply to the relative weight for any new or renumbered MS-DRGs for the year.

CAR-T Cell Therapies

Beginning with FY 2021, CMS adopted differential payment for cancer immunotherapy clinical trial and expanded access use cases (also known as compassionate use) where the hospital does not incur costs of the chimeric antigen receptor (CAR)-T product. For FY 2026, CMS proposes to continue its methodology for identifying clinical trial claims and expanded access use claims in MS-DRG 018 by excluding claims:

- With the presence of condition code "90"
- That contain ICD-10-CM diagnosis code Z00.6 without payer-only code "ZC"
- That contain standardized drug charges below the median standardized drug charge of clinical trial cases in MS-DRG 018

CMS notes that MS-DRG 018 appears to include some claims that are either identified as clinical trial cases or involve expanded access use and include drug charges (as do cases where the hospital incurs the drug's full cost). CMS seeks comment on why a hospital would have these charges — generally in revenue center 0891, Cell Therapy Drug Charges — when they receive the drug at no cost.

CMS estimates that the average costs of cases assigned to MS–DRG 018 identified as clinical trials ($88,484) were 23% of the average costs of cases identified as non-clinical trials ($385,147). Accordingly, CMS proposes a payment adjustor of 0.23 to the applicable clinical trial and expanded access use immunotherapy cases. Also for these cases, CMS will use an adjusted case count in determining the relative weight calculation and for purposes of budget neutrality and outlier simulations. The data underlying these adjustments will be updated for the FY 2026 final rule.

Post-Acute Transfer Policy

For a post-acute care transfer occurring prior to the geometric mean length of stay (the average calculated length of stay for patients within an MS-DRG), CMS pays the transferring hospital in one of two ways:

- Twice the per diem amount for the first day, with each subsequent day paid at the per diem amount up to the full MS-DRG payment
- 50% of the full MS-DRG payment, plus the single per diem payment, for the first day of the stay, as well as a per diem payment for subsequent days up to the full MS-DRG payment (known as the "special payment methodology" for types of cases with large costs early in the stay)

If the MS-DRG's total number of discharges to post-acute care equals or exceeds the 55th percentile for all MS-DRGs — and the proportion of short-stay discharges to post-acute care to total discharges in the MS-DRG exceeds the 55th percentile for all MS-DRGs — CMS will apply the post-acute care transfer policy to that MS-DRG and to any other MS-DRG that shares the same base MS-DRG. CMS does not revise the list of DRGs subject to the post-acute care transfer policy annually unless it is also making a change to a specific MS-DRG.

CMS evaluates each proposed new or revised MS-DRG for whether it should be subject or removed from the post-acute care transfer policy list and subject to the special payment methodology. Based on proposed changes CMS is making to the MS-DRGs, it proposes to add MS-DRGs 403 and 404 to the list of MS-DRGs subject to the post-acute care transfer policy. These MS-DRGs were new in FY 2025 and not yet evaluated for post-acute transfer policy. In addition, CMS is proposing to add MS-DRGs 463, 464, and 465 to the special payment methodology.

New Technology Payments

Social Security Act Sections 1886(d)(K)(L) require the U.S. Department of Health and Human Services (HHS) secretary to establish a mechanism for recognizing new medical services and technologies under the IPPS. The HHS secretary is required to establish criteria used to determine if a medical service or technology is new, meaning that the DRG payment rate that would otherwise apply is inadequate. The implementing regulations[3] specify three criteria for a new medical service or technology to receive add-on payments under the IPPS: (1) the medical service or technology must be new; (2) the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology

3 42 CFR 412.87

is determined to be inadequate; and (3) the service or technology must demonstrate a substantial clinical improvement over existing services or technologies. Beginning with FY 2021, certain transformative new devices and Qualified Infectious Disease Products (QIDPs) may qualify for a new technology add-on payment under an alternative pathway.[4] Also, beginning with FY 2022, a drug approved under the FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD pathway) may also qualify for a new technology add-on payment under an alternative pathway.[5]

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 18088 of the proposed rule shows the **11 technologies that are proposed to continue receiving add-on payments for FFY 2026** since their three-year anniversary date will occur on or after April 1, 2026.
- Table II.E.-01.B on pages 18088–18089 shows the **15 technologies that are proposed to continue receiving add-on payments for FFY 2026** since their three-year anniversary date will occur on or after to October 1, 2025.
- Table II.E.-02 on page 18090 shows the **13 technologies proposed to no longer receive add-on payments for FFY 2026** since their three-year anniversary date will occur prior to April 1, 2026.

CMS is proposing new technology add-on payments for 14 technologies under the traditional pathway and 29 under alternative pathways. CMS previously adopted that new technology add-on payments for FFY 2026 — for technologies first approved for the add-on in FFY 2025 or a subsequent year — 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, timing of, and reasons underlying hold statuses with FDA marketing authorizations, a hold status for new technology add-on payment applications for FFY 2026 and forward will no longer be considered an inactive status for the new technology add-on payment's eligibility purposes.

Wage Index

CMS adjusts a portion of IPPS payments to account for area differences in the cost of hospital labor, an adjustment known as the area wage index. Additional details about this methodology can be found in the regulation. A complete list of the proposed wage indexes for payments in FFY 2026 is available in Table 2 on the CMS website.

Worksheet S-3 Wage Data

CMS calculates the final rule FFY 2026 wage index using data from FY 2022 submitted cost reports. CMS does not adopt any changes to the categories of included and excluded costs for FFY 2026 relative to prior years. CMS' calculations of the FFY 2026 wage index are based on wage data of 3,027 hospitals. The data file used to construct the wage index includes FFY 2022 data submitted to CMS as of January 24, 2025.

4 84 Federal Register (FR) 42292 through 42297; regulations at Section 412.87(c) and (d)
5 85 FR 58736

General wage index policies are unchanged from prior years. **CMS calculates an unadjusted national average hourly wage of $57.70**.

Occupational Mix Adjustment

To construct an occupational mix adjustment to the wage index, CMS is required to collect data every three years on the occupational mix of employees for each Medicare participating short-term, acute care hospital. Hospitals were required to submit 2022 occupational mix survey data to CMS by July 1, 2023; CMS will use the 2022 occupational mix survey data for the occupational mix adjustment applied to FY 2025 through FY 2027 IPPS wage indexes. CMS reports having occupational mix data for 97% of hospitals (2,945 of 3,029) used to determine the FY 2026 proposed rule wage index. The FY 2026 national average hourly wage, adjusted for occupational mix, is $57.63. The FFY 2026 occupational mix adjusted wage indexes based on this survey are available in Table 2 on CMS' IPPS website.

Rural Floor

The rural floor prevents an urban wage index from being lower than the wage index for the rural area of the same state. CMS estimates that the rural floor will increase the proposed FY 2026 wage index for 565 urban hospitals requiring a budget neutrality adjustment factor of 0.985942 (-1.41%) applied to hospital wage indexes.

CMS did not propose new policies with respect to calculating the wage index when an urban hospital is reclassified as rural. It does note that an urban to rural reclassified hospital is considered geographically rural for calculation of the pre-reclassified wage index. If that urban to rural reclassified hospital further reclassifies under the Medicare Geographic Classification Review Board (MGCRB) reclassification provisions, the hold harmless provisions with respect to the rural wage index will apply.

Revisions to FFY 2025 Wage Index Based on Geographic Reclassifications

CMS indicates that 1,197 hospitals will be in MGCRB reclassification status for FFY 2026 (with 279 of these hospitals reclassified back to their home area). This figure constitutes 36% of IPPS hospitals and reflects:

- 280 hospitals approved for wage index reclassifications starting in FFY 2024 and continuing through FFY 2026
- 278 hospitals approved for wage index reclassifications starting in FFY 2025 and continuing through FFY 2026
- 639 hospitals approved for wage index reclassification starting in FFY 2026

The deadline to withdraw or terminate an MGCRB-approved wage index reclassification for FY 2026 is whichever comes later: either 45 days from the FY 2026 proposed rule's display date (May 26, 2025) or seven calendar days after receiving an administrator's decision appealing an MGCRB decision.

In addition, while CMS is not making any policy changes, it is proposing the following changes to Title 42, Code of Federal Regulations (CFR) Section 412.273 to make the process for withdrawing or terminating an MGCRB reclassification more understandable:

- "Termination" refers to the termination of an already existing three-year MGCRB reclassification where such reclassification has already been in effect for one or two years, and there are one or two years remaining on the three-year reclassification. A termination is effective only for the full fiscal year(s) remaining in the three-year period at the time the request is received. Requests for terminations for part of a fiscal year are not considered. Once a reclassification is terminated, it may not be reinstated.
- CMS is proposing to modify several references in 42 CFR Section 412.273(d) — from "canceling" or a "cancellation" to "reinstating" or "reinstatement" — to address situations where a hospital is temporarily forgoing a previously approved three-year reclassification that it intends to activate in a subsequent year.
- "Withdrawal" refers to either the withdrawal of a three-year MGCRB reclassification that has not yet gone into effect or an instance where the MGCRB has not yet issued a decision on the application.
- County group reclassification withdrawals must include all parties to the application.

Changes to the wage index by reason of reclassification withdrawals, terminations, wage index corrections, appeals, and the CMS review process will be incorporated into the final FY 2026 wage index values. For more information, CMS refers readers to 42 CFR Section 412.273.

Lugar Hospitals and Counties

A "Lugar" county is a rural county that is adjacent to one or more urban areas and deemed as part of the urban area from which the highest number of its workers commute. A hospital located in a Lugar county is known as a Lugar hospital. A Lugar hospital is treated as reclassified to the urban area from which the highest number of its workers commute. This process is automatic and will occur with no action on the part of the hospital.

The outmigration adjustment is a positive adjustment to the wage index for hospitals located in certain counties that have a relatively high percentage of hospital employees who reside in the county but work in a different county (or counties) with a higher wage index. A hospital can either be reclassified or receive the outmigration adjustment — but not both. As a Lugar reclassification occurs automatically, a Lugar hospital must decline its reclassification using the same process as other hospitals to receive the outmigration adjustment (e.g., notify CMS by 45 days from May 26, 2025, that it is declining its Lugar reclassification).

CMS restates the following policies with respect to how Lugar hospitals may decline their urban status to instead receive the outmigration adjustment:

- Waiving deemed-as-urban status results in the Lugar hospital being treated as rural for all IPPS purposes.
- Waiving deemed-as-urban status can be done once for the three-year period that the outmigration adjustment is effective.
- Waiving its reclassification for three years means it must notify CMS to reinstate its Lugar status within 45 days from the FY 2026 proposed rule's display date (May 26, 2025).

In some circumstances, a Lugar hospital may decline its urban reclassification to receive an outmigration adjustment that it would no longer qualify for once it is reclassified as rural. In these circumstances, CMS will decline the Lugar hospital's request and continue to assign it a higher

urban wage index (which itself could result in the county requalifying for the outmigration adjustment based on data in the final rule).

Outmigration Adjustment

CMS proposes to apply the same policies for the FY 2026 outmigration adjustment that it has been using since FY 2012. This provision is not budget neutral.

Reclassification from Urban to Rural

Hospitals that meet specific criteria in statute may request that a CMS regional office treat an urban hospital as rural for all IPPS payment purposes. Unlike MGCRB reclassifications that are effective based on a fiscal year and only for the wage index, urban to rural reclassifications are effective upon the date the application was submitted to the CMS regional office.

Under the statute, hospitals that reclassify from urban to rural are treated as rural for all IPPS purposes. Such hospitals may apply for geographic reclassification under the MGCRB process using the more favorable rural reclassification rules. When a multi-campus hospital reclassifies from urban to rural, the reclassification applies to all the hospital's campuses. In addition, if a multi-campus urban hospital is reclassified as rural, the rural status will apply to all its campuses for such policies as sole community hospital (SCH), Medicare-dependent hospital (MDH) or rural referral center status.

An approved urban to rural reclassification remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved. For instance, an urban to rural reclassification would no longer be valid if the hospital is no longer located within a rural census tract of an urban county as determined by the Health Resources and Services Administration's Office of Rural Health Policy. CMS encourages all hospitals and critical access hospitals (CAHs) with active urban rural reclassifications to review their original reclassification application and determine whether the reclassification status would still apply.

Reclassifications would be considered canceled for area wage index calculation purposes for any hospital with a terminated CMS Certification Number (CCN) as of the date that hospital ceased to operate with an active CCN. CMS will obtain and review the best available CCN termination status lists when determining the FY 2026 wage index 60 days after the proposed rule is on public display with the Office of the Federal Register (known as the "lock-in" date). Any hospital with a terminated CCN is neither intended to alter or affect the qualification for CAH, SCH, or rural emergency hospital (REH) statuses nor have other effects unrelated to hospital wage index calculations.

Process for Requests for Wage Index Data Corrections

CMS has a long-established, multistep, 15-plus month process for reviewing and correcting the hospital wage data used to create the IPPS wage index for the upcoming fiscal year. The proposed rule describes this process in detail, including when data files were posted and the deadlines for hospitals to request corrections or revisions to audit adjustments. A hospital that fails to meet the procedural deadlines does not have a later opportunity to submit wage index data corrections or dispute CMS' decision on requested changes.

CMS posts the wage index timetable for FFY 2026 on its website. It includes all the public use files made available during the wage index development process.

Labor-Related Share

Social Security Act Section 1886(d)(3)(E) directs the HHS secretary to adjust the proportion of the national standardized amount that is attributable to wages and wage-related costs by a factor that reflects the relative differences in labor costs among geographic areas. This proportion is the national labor-related share. The factor that adjusts for the relative differences in labor costs among geographic areas is the wage index. Social Security Act Section 1886(d)(3)(E) directs the secretary to employ 62% as the labor-related share if doing so would result in higher payments to the hospital than using the national labor-related share. Application of the 62% labor-related share is not subject to wage index budget neutrality.

CMS updates the labor-related share every four years and last did so for FY 2022. CMS is currently using a national labor-related share of 67.6%. As described in the next section, CMS is proposing to rebase and revise the IPPS MB to reflect a 2023 base year beginning in FY 2026. CMS is also proposing to recalculate the labor-related share for discharges occurring on or after October 1, 2025. Using the proposed 2023-based IPPS MB, CMS proposes a labor-related share of 66%. CMS will apply a budget neutrality adjustment for the reduction in the national labor-related share from 67.6% to 66%.

If a hospital has a wage index of less than 1.0, its IPPS payments will be higher with a labor-related share of 62%. If a hospital's wage index is higher than 1.0, its IPPS payments will be higher using the national labor-related share of 66%. Consistent with the statute, CMS is not applying budget neutrality when using the lower 62% labor share when a hospital's wage index is less than 1.0.

Permanent Cap on Wage Index Decreases

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 5% cap, the following year's wage index would not be less than 95% of the IPPS provider's capped wage index in the prior FFY and will be applied to the final wage index a hospital would have on the last day of the prior FFY. For FFY 2026, CMS is proposing that this would be the wage index published in the FFY 2025 interim final rule, irrespective of the FFY 2025 transitional payment exception wage index value.

If a hospital reclassifies as rural under 42 CFR Section 412.103 with an effective date after the last day of the prior FFY, 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.

Discontinuation of the Low-Wage Index Hospital Policy

For FY 2020, CMS adopted a low-wage index policy in which wage indexes below the 25th percentile were increased by one-half the difference between the hospital's otherwise applicable wage index and the 25th percentile wage index value. On July 23, 2024, the Court of Appeals for the D.C. Circuit in *Bridgeport Hosp. v. Becerra* held that the HHS secretary lacked authority to adopt the low-wage index hospital policy for FY 2020 and the related budget neutrality

adjustment.[6] 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.

Additionally, in a legal challenge brought by CHA on behalf of its members, the U.S. Court of Appeals for the 9th Circuit ruled in favor of the hospital plaintiffs in *Kaweah Delta Health Care District, et al. v. Becerra,* finding that the HHS secretary's policy to increase the wage index for hospitals in low-wage areas and the related reduction to the IPPS standardized amount are unlawful and the policy must be vacated.

In both cases, the court remanded the case to HHS to determine an appropriate remedy.

As a result of these court decisions, CMS ended the low-wage index policy beginning with FY 2025 and established a non-budget neutral transitional adjustment to the wage index for low-wage hospitals. CMS justified applying the transitional adjustment without applying budget neutrality because it was being adopted in an interim final rule just prior to October 1, 2024, with insufficient time to implement the *Bridgeport* decision and provide public comments.

The proposed rule does not indicate how CMS plans to remedy prior years where the policy was deemed to lack statutory authority. CHA continues to seek a remedy as part of the litigation on behalf of its members for FFYs 2020-24.

Low-Wage Index Transition Policy

CMS is allowing hospitals with a wage index that was increased by the low-wage index policy to benefit from a transition policy that will mitigate the reduction to their wage indexes. The proposed adjustment is subject to budget neutrality. With more time available for public comment, CMS believes the circumstances are different to justify applying budget neutrality to the transitional wage index for low-wage index hospitals in 2026.

For low-wage index hospitals, the transitional policy will apply by comparing the hospital's wage index proposed for FY 2026 to its wage index under the low-wage index policy in FY 2024. If the hospital's wage index decreases by more than 5% annually (or 9.75% over two years), the hospital would be eligible for the transitional policy. The limit on the reduction in the wage index would be 5% from the otherwise applicable policy that would apply in FY 2026 if the low-wage index policy had continued. CMS proposes to make the increase in the otherwise applicable wage index without the transitional policy subject to budget neutrality. Analogous policies will apply the geographic adjustment factor applied under the capital IPPS.

Rural Referral Center (RRC): Annual Updates to Case-Mix Index and Discharge Criteria

RRCs are hospitals that are either geographically rural or treated as rural for IPPS purposes and subject to special rules for the DSH payment adjustment and geographic reclassification. To qualify as an RRC, a hospital must have more than 275 beds or meet case-mix, discharge, and other criteria for the FFY that ends at least one year prior to the beginning of the cost reporting period for which the hospital seeks RRC status.

6 *Bridgeport Hosp. v. Becerra*, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024)

CMS annually revises case-mix index (CMI) and discharge criteria to qualify for RRC status. For FY 2026, CMS proposes to use FY 2024 data to set the CMI criteria. To qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2025, a hospital may qualify as an RRC if the hospital is rural or treated as rural and has:

- 275 beds or more, *or* more than 5,000 discharges (3,000 for an osteopathic hospital) in its cost reporting period that began during FY 2023
- A CMI greater than or equal to the lower of 1.7802 (national urban hospital CMI excluding teaching hospitals) or the CMI for the hospital's census region (Pacific Census Region is 1.7793)

The median regional CMIs in the proposed rule reflect the FY 2024 MedPAR file's December update containing data from bills received through December 2024. A hospital seeking to qualify as an RRC should get its hospital-specific CMI value (not transfer-adjusted) from its MAC.

Low-Volume Hospital Adjustment

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:

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

Providers with fewer 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:

- Be located more than 25 road miles from another subsection (d) hospital
- Have fewer than 200 total discharges (all payer) during the fiscal year

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

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

Medicare-Dependent Small Rural Hospitals

Since its creation for FFY 2012, the MDH program has been extended multiple times; the most recent extension was through FFY 2025 as granted by the Full-Year Continuing Appropriations and Extensions Act of 2025. However, absent further congressional action, all hospitals that previously qualified for MDH status will, beginning October 1, 2025, no longer have MDH status and will be paid based on the IPPS federal rate. Hospitals that will lose this status may apply for SCH status in advance of the MDH program's expiration.

While the MDH program was set to expire many times previously, Congress has always extended it. Nevertheless, at this time, CMS is advising hospitals of the MDH program's expiration and the potential to ameliorate the associated reduction in payment through becoming an SCH.

Per existing regulations, MDHs may apply for SCH status in advance of the MDH program's expiration. For SCH status to begin the day following the MDH program's expiration, an MDH must apply for SCH status at least 30 days prior to the expiration.

Indirect and Direct Graduate Medical Education Costs

CMS finalizes that the indirect medical education (IME) adjustment factor will remain at 1.35 for FFY 2026. Below is an overview of several IME/graduate medical education (GME) policies discussed in the FFY 2025 IPPS final rule.

Calculating FTE Counts and Caps for Cost Reporting Periods Other than 12 Months

CMS is not proposing any changes to the regulations for how Direct GME (DGME) counts and caps are determined when a Medicare cost report is not equal to 12 months. The full-time equivalent (FTE) counting policy is long established and widely used in existing cost reporting software and the Intern and Resident Information System (IRIS) software. However, CMS is restating and clarifying its FTE counting policy in rulemaking. The proposed rule provides a detailed step-by-step explanation of how the count and caps are determined for non-standard length cost reporting periods separately for DGME and IME.

Notice of Teaching Hospital Closures and Opportunity to Apply for Available Slots

ACA Section 5506 authorizes the secretary to redistribute residency slots after closure of a hospital that trained residents in an approved medical residency program.

CMS is notifying the public of the closure of Wahiawa General Hospital (Wahiawa, Hawaii) and Carney Hospital (Boston, Massachusetts):

Available Resident Cap FTEs

CCN	Provider Name	City and State	CBSA Code	Terminating Date	IME Resident Cap	DGME Resident Cap
120004	Wahiawa General Hospital	Wahiawa, Hawaii	46520	April 2, 2024	17.16	14.31
220017	Carney Hospital	Boston, Mass.	14454	August 31, 2024	63.15	61.14

The application period for hospitals to apply for slots under section 5506 is 90 days following notification to the public of a hospital closure. Therefore, hospitals must submit an application form to the CMS Central Office no later than July 15, 2025, to be eligible to receive slots from this

closed hospital. CMS will only accept applications submitted via its Medicare Electronic Application Request Information System™ platform.

Nursing and Allied Health Education Programs

Medicare Advantage (MA) Payments

Medicare pays for provider-operated nursing and allied health education programs on a reasonable cost basis. Under the reasonable cost payment methodology, a hospital is paid Medicare's share of its reasonable costs. Provisions of law enacted in 1999 and 2000 required that CMS include MA utilization in determining the Medicare share of reasonable cost nursing and allied health education payments. These additional payments for nursing and allied health education attributed to MA utilization are funded through a reduction to analogous payments made to teaching hospitals for DGME and limited to $60 million per year.

CMS uses cost reporting periods ending in the fiscal year that is two years prior to the current calendar year to determine each eligible hospital's share of the $60 million pool each year. Each hospital's payment is based on its relative share of national nursing and allied health education payments and MA utilization.

In the FY 2026 IPPS proposed rule, CMS indicates proposed nursing and allied health education payments and the proposed reduction in MA DGME payments for 2024. CMS proposes using the 4th quarter 2024 update of the 2022 Healthcare Provider Cost Reporting Information System projected forward two years to estimate 2024 payments. For 2024, CMS proposes to distribute the maximum $60 million in nursing and allied health education MA payments with an offset of 2.34% to MA DGME payments. These figures are the result of applying the statutory formula, which leads to capped payments of $60 million for nursing and allied health education MA payments.

Allocation of Indirect Costs

A hospital's reasonable costs for nursing allied health education are the net of revenues received from tuition and student fees. Separately, the Medicare cost report instructions indicate how indirect costs are allocated to individual cost centers. On November 17, 2017, CMS issued cost reporting instructions that revenues from tuition and student fees should be subtracted from the costs of nursing and allied health education prior to allocating indirect costs. On February 9, 2024, the U.S. District Court for the District of Columbia issued a ruling on behalf of five plaintiff hospitals finding that CMS' cost report instruction was inconsistent with 42 CFR Section 413.85, which requires revenues from tuition and fees to be subtracted from the cost of educational activities after the indirect cost allocation is completed.

CMS is proposing to modify 42 CFR Section 413.85(d)(2)(ii) to indicate that revenues received from tuition, student fees, textbooks purchased for resale, and other revenue from or on behalf of students is subtracted before completing the indirect cost allocation, effective October 1, 2025. In a circumstance where revenue from or on behalf of students reduces direct nursing and allied health education costs to zero, there would be no indirect costs to allocate to the nursing and allied health education cost center. However, CMS will allow a hospital to seek permission from their MAC to employ a different allocation method to mitigate the reduction in reasonable cost payment for nursing and allied health education in accordance with the CMS Provider Reimbursement Manual, publication 15-1, chapter 23, section 2313.

The proposed rule indicates that this alternative allocation of indirect costs would focus on only costs directly related to operating approved educational activities under 42 CFR Section 413.85. CMS' examples of such costs are those the hospital would not have in the absence of an educational program. Such costs would not include nursing supervisors who oversee floor nurses and student nurses, expenditures that benefit the hospital as a whole (e.g., admissions or patient registration), or costs of a related organization (such as a home office).

Rate-of-Increase for TEFRA Hospitals

Most hospitals are paid under prospective payment systems. Some hospitals, however, continue to be paid based on reasonable costs subject to a per-discharge limit updated annually under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Hospitals that continue to be paid reasonable costs subject to a limit include 11 cancer hospitals; children's hospitals; hospitals located in the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; and one hospital classified as an extended neoplastic disease care hospital. Religious non-medical health care institutions are also paid reasonable costs subject to a limit.

The annual update to the TEFRA limit is based on IHS Global Inc.'s 2024 fourth quarter forecast of the hospital MB for FY 2026 with historical data through the third quarter of 2024 and is 3.2%. The FY 2026 market reflects CMS' proposal to rebase and revise the hospital MB from a 2018 to 2023 base year.

Transforming Episode Accountability Model (TEAM)

In the FFY 2025 IPPS final rule, CMS adopted a new five-year mandatory episode-based payment model. TEAM's goal is to improve quality of care while reducing Medicare spending for beneficiaries undergoing certain high-expenditure, high-volume surgical procedures, including:

- Lower extremity joint replacement
- Surgical hip/femur fracture treatment
- Spinal fusion
- Coronary artery bypass graft
- 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 core-based statistical area (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 fee-for-service (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; 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 and summary.

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

- A limited deferment period for new hospitals located in a mandatory CBSA (pages 18377–18379)
- Linking Track 2 participation eligibility for hospitals with an MDH designation to the MDH program's expiration (pages 18379–18381)
- Aligning the reporting period for the Hybrid Hospital-Wide Readmission Measure with the hospital IQR program (page 18383)
- Adding the Information Transfer Patient Reported Outcome-Based Performance Measure (Information Transfer PRO-PM) for outpatient episodes (pages 18384–18385)
- Applying a neutral quality measure score for TEAM participants with insufficient quality data (page 18385)
- Developing methodology to construct target prices when there are coding changes (pages 18386–18389)
- Including U.S. territories in Census Division 9 (page 18389)
- Reconstructing the normalization factor and trend factor (pages 18389–18392)
- Replacing the Area Deprivation Index (ADI) with the Community Deprivation Index (CDI) in the beneficiary economic risk adjustment factor (pages 18392–18393)
- Using a 180-day lookback period beginning the day prior to episode initiation for Hierarchical Condition Categories (HCCs) under version 28 for beneficiary risk adjustment (pages 18393–18397)
- Aligning baseline, performance year, and reconciliation time periods for episode attribution (pages 18399–18400)
- Removing voluntary reporting of health equity plans and health-related social needs screening data (pages 18401–18402)
- Expanding the skilled-nursing facility (SNF) three-day rule waiver (pages 18403–18404)
- Removing the voluntary Decarbonization and Resilience Initiative (page 18404)

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

- Indian Health Service hospital outpatient episodes (pages 18381–18382)
- Low-volume hospitals (pages 18397–18399)
- Standardized prices and reconciliation amounts (pages 18400–18401)
- Primary care services referral requirement (pages 18402–18403)

California CBSAs Selected for Mandatory Participation

Acute care hospitals located in the California CBSAs below are required to participate in TEAM.

Mandatory TEAM Markets: California	
CBSA	**CBSA Name**
12540	Bakersfield-Delano
18860	Crescent City
21700	Eureka-Arcata
25260	Hanford-Corcoran
40140	Riverside-San Bernardino-Ontario
41740	San Diego-Chula Vista-Carlsbad
41860	San Francisco-Oakland-Fremont
41940	San Jose-Sunnyvale-Santa Clara
42020	San Luis Obispo-Paso Robles
42220	Santa Rosa-Petaluma

CMS has provided a list of the specific hospitals that will be required to participate in the model, available on the CMS TEAM website.

Hospital Performance-Based Quality Programs

IPPS payments are adjusted for quality performance under the Hospital Readmissions Reduction Program (HRRP), the Hospital Value-Based Purchasing (VBP) Program, RRP, and the Hospital Acquired Conditions (HAC) Reduction Program.

Hospital Readmissions Reduction Program

The HRRP reduces payments to Medicare PPS hospitals if their readmissions exceed an expected level. The HRRP formula includes a payment adjustment floor of 0.9700, meaning that a hospital subject to the HRRP receives an adjustment factor between 1 (no reduction) and 0.9700, for the greatest possible reduction of 3% of base operating diagnosis-related group (DRG) payments. As adopted in the FFY 2018 IPPS final rule, and as required by the 21st Century Cures Act, hospitals are assigned to one of five peer groups based on the proportion of Medicare inpatients who are dually eligible for full-benefit Medicare and Medicaid; the HRRP formula compares a hospital's performance to the median for its peer group.

The payment adjustment for a hospital is calculated using the following formula, which compares a hospital's excess readmissions ratio to the median excess readmissions ratio for the hospital's peer group. "Payment" refers to base operating DRG payments; "dx" refers to an HRRP condition (i.e., acute myocardial infarction [AMI], heart failure [HF], pneumonia [PN], total hip arthroplasty/total knee arthroplasty [THA/TKA], chronic obstructive pulmonary disease [COPD], and coronary artery bypass grafting [CABG]); and the Network Management Module [NMM] is a budget-neutrality factor (neutrality modifier) that is the same across all hospitals and all conditions.

$$P = 1 - \min\{.03, \sum_{dx} \frac{NM_M * Payment(dx) * \max\{(\text{ERR(dx)} - \text{Median peer group ERR(dx)}),0\})}{All\ payments}\}$$

Proposal to Integrate MA Beneficiaries into Cohorts of HRRP Measure Set

Beginning with the FFY 2027 program year, CMS proposes to update the HRRP measure set to include MA beneficiaries in each measure's cohorts. Currently, the inclusion criteria for the measure denominator for each measure in the HRRP measure set includes a criterion that

specifies beneficiaries be enrolled in FFS (both Part A and B) for the first 12 months before the date of admission and enrolled in Part A during the index admission.

CMS proposes to change that inclusion criterion for the denominator to be beneficiaries who are "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." This change would double the cohort size. CMS also proposes a non-substantive modification that would update the risk adjustment model to use individual ICD-10 codes rather than HCCs.

The updated measure set would use the following data:

- Index admission diagnoses and in-hospital comorbidity data from Medicare FFS Part A, MA claims/encounters, or both
- Part A and Part B claims and MA encounters during the 12 months prior to the index admission to assess additional comorbidities before the index admission
- Medicare enrollment data to determine Medicare FFS or MA enrollment status

For the FFY 2027 program year, CMS would use claims and encounter data with admission dates from July 1, 2023, through June 30, 2025. CMS would continue to publicly report the readmission measure results for a fiscal year for each applicable hospital on Care Compare and the Provider Data Catalog.

Technical Updates to the HRRP Measures Specifications

CMS provides notice of a technical measure set update to remove the COVID-19 exclusion from the readmission measures, effective for the FFY 2027 program year. The update will remove (i) the exclusion of COVID-19 diagnosed patients from the index admissions and readmissions, (ii) the exclusion of certain ICD-10 codes that represented patients with a secondary diagnosis of COVID-19, and (iii) the covariate adjustment for patient history of COVID-19 in the 12 months preceding admission.

Proposal to Modify the Applicable Period

Currently, CMS uses a three-year window to define the "applicable period," which refers to the period from which data are collected for purposes of calculating excess readmission ratios and adjustments under the HRRP.

Beginning in FFY 2027, CMS proposes to shorten the applicable period to a two-year period, which would allow for assessing performance using more recent data. Specifically, a fiscal year's applicable period would be the two-year period that begins one year after the start of the previous fiscal year's applicable period. For example, for the FFY 2027 program determination, the applicable period would be July 1, 2023, through June 30, 2025 (meaning hospitals would use claims/encounter data with admission dates beginning during that period). CMS testing found that a two-year applicable period that includes both Medicare FFS and MA beneficiaries showed better between-hospital variance than the current three-year applicable period using Medicare FFS beneficiaries alone.

Proposal to Identify Aggregate Payments for Each Condition/Procedure and All Discharges Beginning for FFY 2027

To calculate the aggregate payments for excess readmissions, CMS determines the base operating DRG payment amount for each individual hospital for the applicable period for each

condition/procedure. The agency does so by using Medicare FFS inpatient claims from the updated MedPAR file with discharge dates within the applicable period. The MedPAR file is updated six months after the end of each fiscal year within the applicable period.

Because CMS is proposing to expand the measure cohorts to include MA beneficiaries, the agency also proposes to include data for Medicare FFS and MA beneficiaries for each applicable condition/procedure. This inclusion would be for calculating the aggregate payments for excess readmission and would use the MedPAR file or the latest available data source (or both) that would provide the most recent comprehensive payment data for FFS and MA beneficiaries.

CMS estimates that the proposed changes will result in an additional 75 hospitals subject to an HRRP penalty (an increase of 3%). Table VI.K-02 of the proposed rule shows the estimated impacts of the proposed updates — compared to the current methodology — by hospital characteristic.

Proposal to Update and Codify the Extraordinary Circumstances Exception (ECE) Policy

Under the current ECE policy, CMS grants exceptions to exclude data from the HRRP payment reduction calculations for extraordinary circumstances, such as natural disasters or systemic problems with CMS data collection systems that directly affect facilities' ability to submit data.

CMS proposes to update its policy to include that an ECE could be a deadline extension to allow a hospital additional time to comply with a data reporting requirement if the agency determines such an extension would be appropriate. The policy would specify that 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 to comply with one or more applicable reporting requirements with respect to a fiscal year."

CMS states that the process for requesting and granting an ECE would remain the same as the current process. A hospital would be able to request an ECE within 30 calendar days of the date the extraordinary circumstance occurred. In the preamble, the agency clarifies that CMS has the authority to grant an ECE at any time after the circumstance. In addition, CMS clarifies that it may grant an ECE to hospitals that have not made a request for one if CMS determines that either a systemic problem with the CMS data collection system directly impacted the hospital's ability to comply with the requirements or if the circumstance has affected an entire region or locale. Any ECE granted would specify whether the hospital is (or hospitals are) exempted from reporting requirements or CMS has granted an extension for compliance.

Hospital VBP Program

As required by law, the available funding pool for the hospital VBP program is equal to 2% of the base operating DRG payments to all participating hospitals. CMS calculates a VBP incentive payment percentage for a hospital based on its total performance score (TPS) for a specified performance period. The adjustment factor may be positive, negative, or result in no change to the payment rate that would apply absent the program. In the FFY 2024 IPPS final rule, CMS adopted changes to the scoring methodology to include a health equity adjustment and to increase the TPS maximum to 110 points, beginning with FFY 2026. In this rule, CMS proposes to eliminate the health equity adjustment.

CMS also proposes measure modifications and technical updates to measures in the VBP measure set and clarifies its ECE policy in alignment with other quality reporting programs. Table 2 in the appendix lists previously adopted measures for the program.

Proposed Updates to Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA/TKA (COMP-HIP-KNEE Measure)

Beginning with the FFY 2033 program year, CMS proposes to update the COMP-HIP-KNEE measure to expand its inclusion criteria to include MA patients and shorten the performance period from three years to two years. As described later in this summary, CMS proposes the same changes for the measure in the IQR program beginning with the FFY 2027 payment determination to meet the statutory requirement that measure data be publicly reported for a year before it is included in the VBP program. CMS would begin posting the updated measure data on *Care Compare* under the IQR program beginning in July 2026. The performance period for the FFY 2033 VBP program would be April 1, 2029, through March 31, 2031.

The proposed updates would use the following data:

- Index admission diagnoses and procedure codes from Medicare FFS claims and MA encounter data to determine cohort inclusion criteria, complications outcomes, and present on admission comorbidities
- Part A inpatient, outpatient, and Part B office visit claims and MA encounters during the 12 months prior to the index admission to assess additional comorbidities before the index admission
- Medicare enrollment data to determine Medicare FFS or MA enrollment status

Technical Updates to COMP-HIP-KNEE Measure Specifications to Update the Risk Adjustment Model Beginning with the FFY 2027 Program Year

CMS provides notice of its intent to make a non-substantive modification to the COMP-HIP-KNEE measure; CMS intends to update the risk adjustment model to use individual ICD-10 codes instead of grouping them into HCCs. CMS cites research that indicates using individual ICD codes for risk adjustment instead of HCCs could improve the risk adjustment model performance with respect to mortality measures.

Technical Updates to the Five Condition- and Procedure-Specific Mortality Measures and COMP-HIP-KNEE Measure Specifications Beginning with the FFY 2027 Program Year

CMS provides notice of a technical measure set update to remove COVID-19 exclusions from certain measures, beginning with FFY 2027.

Specifically, the following changes to the technical specifications will be made:

- The measure denominators for the mortality measure (MORT)-30-AMI, MORT-30-CABG, MORT-30-COPD, MORT-30-HF, and MORT-30-PN will include the ICD-10 codes identifying patients with a principal or secondary diagnosis of COVID-19.
- The numerator and denominator of the COMP-HIP-KNEE measure will include the ICD- codes identifying patients with a principal or secondary diagnosis of COVID-19.
- The covariate adjustment for patient history of COVID-19 in the 12 months prior to admission will be removed for all of the above six measures

Performance and Baseline Periods

Table 3 in the appendix shows the baseline and performance periods for each measure for FFY 2027 through 2031.

Performance Standards

Tables V.L.-11 through V.L.-15 of the proposed rule have previously established and newly estimated performance standards for the measures in the FY 2028-2031 program years.

Technical Update to Five National Healthcare Safety Network (NHSN) Health Care-Associated Infection (HAI) Measures

As part of routine measure maintenance, CMS plans to modify the standard population data used to calculate the standardized infection ratio (SIR) for the Centers for Disease Control and Prevention's (CDC's) NHSN measures. For each of these measures, CDC calculates the SIR. The SIR compares a hospital's observed number of HAIs to the number of infections predicted for the hospital, adjusted for risk factors. The predicted number of infections is determined by using the amount of exposure for a hospital according to the observed risk factors and infection rates for the same combination of risk factors occurring among a standard population during a specified period (i.e., the standardized population data or baseline data). Since 2016, CDC has been using data collected in 2015 to determine the standard population data.

CMS describes that for this CDC baseline update, both new 2022 standard population data and the 2015 standard population data will be used for HAI SIR calculations reported beginning in 2025. Since the hospital VBP program calculates improvement points by comparing data collected during a baseline period and data from a performance period, CMS explains it cannot compare CDC's new 2022 baseline data to the current 2015 baseline data for calculating improvement points. Therefore, CMS will use the 2015 baseline data for calculating performance standards and measure scores until the FY 2029 program year. Beginning with the FY 2029 program year, it will use the new 2022 baseline data.

Proposals to Update the ECE Policy

Under the current ECE policy, CMS grants exceptions from the VBP program requirements for extraordinary circumstances beyond the hospital's control. As stated in this summary's HRRP section, CMS proposes to update the ECE policy for clarification purposes and to include extensions of deadlines as an additional form of relief. The clarifications would specify that CMS may grant an ECE with respect to reporting requirements in the case of an extraordinary circumstance beyond a hospital's control, 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 to comply with one or more applicable reporting requirements with respect to a fiscal year."

CMS states that the process for hospitals to request and CMS to grant an ECE would remain the same as the current process; however, it proposes to modify timelines to align with other quality reporting programs. Specifically, CMS proposes that a hospital would be able to request an ECE within 30 calendar days of the date the extraordinary circumstance occurred (as opposed to the current 90 days). In the rule's preamble, CMS clarifies its authority to grant an ECE at any time

after the circumstance. CMS also notes that it may grant an ECE to hospitals that have not made a request for one if CMS determines that either a systemic problem with the CMS data collection system directly impacted the hospital's ability to comply with the requirements or the circumstance has affected an entire region or locale. Any ECE granted would specify whether the hospital is (or hospitals are) exempted from reporting requirements or CMS has granted an extension for compliance.

Proposed Removal of Health Equity Adjustment

CMS adopted the health equity adjustment in the FFY 2024 IPPS final rule, to be effective beginning with the FFY 2026 program year. The adjustment was intended to reward top-performing hospitals that serve higher proportions of patients with dual eligibility status.

CMS proposes to remove the health equity adjustment because the agency believes that its removal would simplify the VBP program's scoring methodology, make the program more understandable, provide clearer incentives to hospitals, and pursue the administration's priority to streamline regulations and reduce burdens. If finalized, the health equity adjustment would be removed beginning for the FY 2026 program year. This includes the removal of the calculation and addition of health equity adjustment bonus points in the VBP program scoring methodology.

HAC Reduction Program

Under the HAC Reduction Program, which was implemented in FFY 2015, hospitals that fall in the worst-performing quartile are subject to a 1% reduction in IPPS payments. CMS does not propose significant changes to the HAC reduction program, but notifies hospitals of a technical update to the program's measure set and clarifies and codifies its ECE policy consistent with other quality reporting programs. Table 3 in the appendix lists previously adopted measures for the HAC Reduction Program.

Technical Update to CDC's NHSN HAI Measures

As part of routine measure maintenance, CMS is making changes to the standard population data used to calculate the SIR for the CDC's NHSN measures. As noted in this summary's hospital VBP program section, since 2016, the CDC has been using data collected in 2015 to determine the standard population data.

The CDC has updated its data using 2022 standard population data. CMS anticipates the new 2022 data will affect the HAC Reduction Program beginning with the FFY 2028 program year — when both years of the measures' two-year performance period (2025 and 2026) will use the 2022 data. The HAI measures using the 2022 data will begin to be publicly reported on *Care Compare* in fall 2026 using four quarters of 2025 data. The 2028 HAC reduction program dataset with the HAI measures using the 2022 data would be publicly reported in early 2028.

Proposal to Codify ECE Policy

Under the current ECE policy, CMS grants exceptions to HAC Reduction Program quality data reporting requirements when there are extraordinary circumstances beyond the hospital's control. As noted in this summary's HRRP and hospital VBP program sections, CMS proposes to codify the ECE policy and clarify that reporting exceptions could include extensions of deadlines, as an additional form of relief. Specifically, CMS would specify that an ECE may be granted in the

case of extraordinary circumstances, 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 to comply with one or more applicable reporting requirements with respect to a fiscal year."

CMS states that the process for hospitals to request and for CMS to grant an ECE would remain the same as the current process. Specifically, a hospital would be able to request an ECE within 30 calendar days of the date the extraordinary circumstance occurred. CMS also clarifies that it may grant an ECE to hospitals that have not made a request for one if CMS determines that either a systemic problem with the CMS data collection system directly impacted the hospital's ability to comply with the requirements or the circumstance has affected an entire region or locale. Any ECE granted would specify whether the hospital is (or hospitals are) exempted from reporting requirements or if CMS has granted an extension for compliance.

Hospital IQR Program

The hospital IQR program is a pay-for-reporting program under which hospitals that do not submit specified quality data or fail to meet all program requirements are subject to a one-fourth reduction in their annual payment update. Additional information on the IQR measures and reporting processes is available online.

CMS proposes several changes to the IQR program, such as updating two measures that include MA beneficiaries and shortening the measures' performance periods from three years to two years, removing four measures from the measure set, changing the reporting requirements for two hybrid measures to lower the submissions thresholds for core clinical data elements (CCDEs) and linking variables, and adding clarifications regarding the ECE policy. In addition, CMS issues an RFI on future measure concepts. Table 1 in the appendix shows the IQR program's previously adopted and newly finalized measure set for FFY 2026 through FFY 2030.

Proposed Modifications to Current IQR Program Measures

CMS proposes modifications to include MA beneficiaries in the measure cohort for two measures beginning with the FFY 2027 payment determination. CMS also provides notice to make technical updates to these measures to update risk adjustment and remove exclusions of patients with COVID-19 diagnosis.

Proposed Modification of Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization (MORT-30-STK) Measure

CMS proposes to expand the inclusions criteria of the MORT-30-STK measure to include MA beneficiaries beginning with the FFY 2027 payment determination. CMS also proposes to reduce the performance period of the measure from three years to two years because its proposal to include MA patients would double the cohort size, allowing for a shorter performance period. The proposed new reporting period for the FFY 2027 payment determination would be July 1, 2023, through June 30, 2025 (instead of July 1, 2022, through June 30, 2025).

The modified cohort would include admissions for patients aged 65 years or older discharged from the hospital with a principal diagnosis of acute ischemic stroke who are enrolled in Medicare FFS or MA for the 12 months prior to the date of admission and enrolled in FFS or MA during the

index admission. Patients transferred from another acute care facility would still be excluded from the measure cohort, as would patients:

- Admitted with inconsistent or unknown vital status or other unreliable demographic data
- Enrolled in hospice during the 12 months prior to the index hospitalization
- Discharged against medical advice

CMS is making two technical measure updates beginning with the FFY 2027 payment determination. Specifically, CMS will update the risk adjustment model to use the individual ICD-10 codes instead of HCCs and remove the exclusion of patients with a secondary diagnosis code of COVID-19 present on admission. Modified measure results would be publicly reported on *Care Compare* beginning in July 2026 or as soon as feasible.

Proposed Modification to Hospital-Level, Risk-Standardized Complication Rate Following Elective COMP-HIP-KNEE measure

The COMP-HIP-KNEE measure estimates a hospital-level, risk-standardized complication rate associated with elective primary THA and/or TKA procedures. In the FFY 2024 IPPS final rule, CMS adopted the measure in the hospital VBP program and finalized removal of the measure from the hospital IQR program beginning with the FFY 2030 payment determination. Beginning with the FFY 2027 payment determination, CMS proposes to update the measure to expand the inclusion criteria to include MA patients and shorten the performance period from three years to two years. CMS would continue to remove the measure from the IQR program for the FFY 2030 payment determination, and modified measure would first be used for the FFY 2033 VBP program year.

The proposed modified inclusion criteria would include admissions for patients aged 65 years or older having a qualifying elective primary THA or TKA procedure during the index admission, who are enrolled in Medicare FFS or MA for the 12 months prior to the date of admission, and are enrolled in FFS or MA during the index admission. The outcome for the proposed updated COMP-HIP-KNEE measure would be a complication occurring during the index admission (not present on admission) through 90 days past the date of the index admission. The measure would continue to be calculated using a hospital risk-standardized complication rate determined by calculating the ratio of the number of predicted complications to the number of expected complications for each hospital, and multiplying the ratio by the national observed complication rate.

CMS is also making technical updates to the measure beginning with FFY 2027. Specifically, CMS is updating the risk adjustment model to use the individual ICD-10 codes instead of HCCs and removing the exclusion of patients with a secondary diagnosis code of COVID-19 present on admission.

The proposed updates would use the following data to calculate this claims-based measure:

- Index admission diagnoses and in-hospital comorbidity data from Medicare FFS claims and MA claims/encounter data

- Part A inpatient, outpatient, and Part B office visit claims and MA encounters during the 12 months prior to the index admission to assess additional comorbidities before the index admission
- Data from the Medicare Enrollment Database to determine Medicare FFS or MA enrollment status

CMS would calculate and publicly post the updated measure on an annual basis using a rolling 24 months of prior data for the measurement period. The updated measure data would be posted on *Care Compare* beginning in July 2026 or as soon as feasible. The updated measure would apply beginning with claims and encounter data from the April 1, 2023, to March 31, 2025, period associated with the FY 2027 payment determination.

Measure Removals for the IQR Program

CMS removes the following four measures from the IQR program beginning with the 2024 reporting period/FFY 2026 payment determination:

- Hospital Commitment to Health Equity
- COVID-19 Vaccination Coverage Among Healthcare Personnel
- Screening for Social Drivers of Health (SDOH-1)
- Screen Positive Rate for Social Drivers of Health (SDOH-2)

CMS proposes removal of each of these measures on the basis of Removal Factor 8 — the costs associated with achieving a high score and/or reporting data on the measure outweigh the benefits of its continued use in the program. The agency refers to a goal of reducing burden and refocusing its resources on clinical outcome measures and measures on prevention, nutrition, and well-being.

Notably, data for the 2024 reporting period is due before CMS will finalize this proposal. CMS says if the proposed removal of a measure is finalized, hospitals that do not report their 2024 reporting data for that measure would not be considered noncompliant with the measure for the FFY 2026 payment determination, and any data received for that measure by CMS would not be used for public reporting or payment purposes.

Technical Updates to Measure Specifications Beginning with the FY 2027 Program Year to Include Patients Diagnosed with COVID-19

CMS is removing its exclusion of patients with a COVID-19 diagnosis from the following IQR measures:

- MORT-30-STK
- COMP-HIP-KNEE
- Excess days in acute care after hospitalization for acute myocardial infarction (AMI excess days)
- Excess days in acute care after hospitalization for heart failure (HF excess days)
- Excess days in acute care after hospitalization for pneumonia (PN excess days)
- Hybrid Hospital-Wide All-Cause Readmission (HWR)

Form, Manner, and Timing of Quality Data Submission

CMS is not proposing changes to most policies related to quality data submission, collection, and reporting requirements. This includes the requirement that EHRs be certified to all available electronic clinical quality measures (eCQMs), the file format for EHR data; eCQM reporting requirements; sampling and case thresholds for chart-abstracted measures; and data submission and reporting requirements for CDC NHSN measures, structural measures, and PRO-PMs. However, CMS does propose to reduce data reporting thresholds for hybrid measures.

Proposed Modifications to Reporting Requirements for Hybrid Readmission and Mortality Measures

The Hybrid HWR and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) measures use CCDEs, which are a set of clinical variables derived from EHRs that can be used to risk adjust outcome measures and linking variables — which are administrative data that can link or merge the CCDEs with claims data to calculate measures. Under current data submission requirements, hospitals must report CCDEs (vital signs and laboratory test results) on 90% of discharges and submit four linking variables on 95% of discharges for each reporting period, beginning with mandatory reporting for the FY 2028 payment determination. Hospitals are required to report 13 CCDEs for the Hybrid HWR and 10 CCDEs for the Hybrid HWM.

During the 2024 voluntary data submission period, CMS found that 75% of the hospitals that submitted measure data did not meet the required submission thresholds. A CMS analysis found that allowing fewer CCDEs to be submitted, as well as lowering both the percentage of discharges meeting the CCDE lab values and the vital signs threshold to 70% of discharges — and lowering the threshold for linking variables to 70% of discharges — significantly improved hospitals' ability to meet the reporting thresholds while still demonstrating good reliability for measure calculation.

Therefore, CMS proposes the following changes to the hybrid measure data submission reporting requirements beginning with the FFY 2028 payment determination (performance period July 1, 2025, to June 30, 2026):

- Lower the submission thresholds for CCDE and linking variables to require at least 70% (instead of 90% and 95%, respectively) of discharges
- Lower the number of required CCDE data elements to allow for up to two missing laboratory results and up to two missing vital signs

RFI on Measure Concepts Under Consideration for IQR Program in Future Years

CMS issued an RFI to seek feedback on well-being and nutrition measures for future years in the IQR program. The agency describes well-being as a comprehensive approach to disease prevention and health promotion, which integrates mental and physical health and emphasizes preventative and person-centered care. CMS seeks comment on tools and measures that assess "overall health, happiness, and satisfaction in life." CMS is also seeking comments on tools and measures that assess optimal nutrition and preventative care in the IQR program.

ECE Policy

Under the current ECE policy, CMS grants exceptions from the quality data reporting requirements for extraordinary circumstances beyond the hospital's control. CMS proposes to update the ECE policy to include extensions of deadlines as an additional form of relief. CMS clarifies that an extraordinary circumstance would be 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 to comply with one or more applicable reporting requirements with respect to a fiscal year."

CMS states that the process for hospitals to request and for CMS to grant an ECE would remain the same as the current process. CMS proposes that a hospital would be able to request an ECE within 30 calendar days of the date the extraordinary circumstance occurred (as opposed to the current 90 days) in order to align with CMS requirements across quality reporting programs. CMS clarifies its authority to grant an ECE at any time after the circumstance. CMS also proposes that it may grant an ECE to hospitals that have not made a request for one if CMS determines that either a systemic problem with the CMS data collection system directly impacted the hospital's ability to comply with the requirements or the circumstance has affected an entire region or locale. Any ECE granted would specify whether the hospital is (or hospitals are) exempted from reporting requirements or CMS has granted an extension for compliance.

PPS-Exempt Cancer Hospital Quality Reporting Program

In the FFY 2013 IPPS final rule, CMS established a quality reporting program beginning in FFY 2014 for PPS-exempt cancer hospitals (PCHs). The PCH Quality Reporting (PCHQR) Program follows many of the policies established for the hospital IQR program, including the principles for selecting measures and the procedures for hospital participation. No policy was adopted to address the consequences for a PCH that fails to meet the quality reporting requirements; CMS has indicated its intention to discuss the issue in future rulemaking.

For the PCHQR program, CMS proposes to remove three measures, publicly report program data on both the Provider Data Catalog and *Care Compare*, and make clarifications to the ECE policy. Table 4 of the appendix lists the measure set for the program.

Proposed Measure Removals

CMS proposes to remove the following three measures beginning with the 2024 reporting period/FFY 2026 program year:

- Hospital Commitment to Health Equity
- Screening for Social Drivers of Health (SDOH-1)
- Screen Positive Rate for Social Drivers of Health (SDOH-2)

CMS proposes to remove each of these measures on the basis of Removal Factor 8 — the costs associated with achieving a high score and/or reporting data on the measure outweigh the benefits of its continued use in the program. If the proposed removal of a measure is finalized, any data that CMS receives for that measure would not be used for public reporting purposes.

Proposal to Publicly Report PCHQR Data on Provider Data Catalog, Care Compare Website

CMS proposes to change the PCHQR program's public reporting requirements so the agency can publicly report PCHQR program data on both the Provider Data Catalog and *Care Compare* or successor websites. Currently, PCHQR program data is only available on the Provider Data Catalog, which enables analysis and comparison of quality data among PCHs. However, CMS believes the *Care Compare* website is more user-friendly and notes that data for other hospital quality reporting requirements is available via this channel.

ECE Policy Updates

CMS proposes to update the ECE policy for clarification and to include extensions of deadlines as an additional form of relief. The clarifications would specify that CMS may grant an ECE with respect to reporting requirements in the case of an extraordinary circumstance beyond the PCH's control. An extraordinary circumstance would be defined as "an event beyond the control of a PCH (for example, a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing) that affected the ability of the PCH to comply with one or more applicable reporting requirements with respect to a fiscal year."

CMS states that the process for PCHs to request and for CMS to grant an ECE would remain the same as the current process. CMS proposes that a PCH would be able to request an ECE within 30 calendar days of the date the extraordinary circumstance occurred (as opposed to the current 90 days) in order to align requirements across quality reporting programs. CMS clarifies its authority to grant an ECE at any time after the circumstance.

CMS also clarifies that it may grant an ECE to PCHs that have not made a request for one if CMS determines that either a systemic problem with the CMS data collection system directly impacted the ability of the PCH to comply with the requirements or the circumstance has affected an entire region or locale. Any ECE granted would specify whether the PCH is (or PCHs are) exempted from reporting requirements or CMS has granted an extension for compliance.

RFI: Toward Digital Quality Measurement in CMS Quality Programs

CMS includes an RFI seeking feedback on its anticipated approach to use the Health Level Seven® Fast Healthcare Interoperability Resources® (FHIR) in eCQM reporting.

Approach to eCQM Reporting Using FHIR: HIQR, HOQR, and Medicare Promoting Interoperability Programs

For the HIQR, HOQR, and Medicare Promoting Interoperability programs, CMS requests comment on each of the following four components of the digital quality measure transition to FHIR-based eCQMs: (i) eCQM FHIR conversion activities, (ii) data standardization, (iii) timeline for FHIR-based eCQM reporting, and (iv) measure development and reporting tools. CHA refers readers to pages 18324-18326 of the proposed rule for a specific list of questions.

Approach to FHIR Patient Assessment Reporting in the IPFQR Program

Beginning with FFY 2028, inpatient psychiatric facilities (IPFs) will be required to collect and submit standardized patient assessment data using a new standardized patient assessment instrument beginning for rate year 2028. CMS is considering ways to advance FHIR-based reporting of patient assessment data for the IPF patient assessment instrument. Therefore, CMS seeks feedback on many questions regarding use of health information technology (IT) in IPFs. CMS also included this RFI in the FFY 2026 IPF PPS proposed rule. CHA refers readers to pages 18326-18327 of the proposed rule for a list of specific questions.

General Solicitation of Comments

CMS also seeks input on any additional factors or considerations that may help foster data harmonization and reduce reporting burden across entities with regard to FHIR-based quality reporting. In addition, CMS asks several questions related to how the Trusted Exchange

Framework and Common Agreement (TEFCA) could support exchange of FHIR-based quality measures and patient assessment submissions consistent with the FHIR roadmap and how TEFCA could enable use of patient assessment data for treatment and research purposes. CHA refers readers to pages 18327-18328 for a specific list of questions.

Medicare Promoting Interoperability Program

Under the Medicare and Medicaid Promoting Interoperability Program, hospitals not identified as meaningful EHR users are subject to a reduction equal to three quarters of the MB. A CAH that is not identified as a meaningful user is subject to a payment reduction to 100% of reasonable costs, from the 101% of reasonable costs it might have otherwise earned.

CMS proposes several changes to the program, including modifications to existing measures and one new optional measure under the Public Health and Clinical Data Exchange objective. CMS also includes an RFI on several topics to inform future policymaking.

Proposal to Define the EHR Reporting Period in 2026 and Subsequent Years

CMS previously established an EHR reporting period of a minimum of any continuous 180-day period within the calendar year. CMS proposes to maintain the minimum 180-day reporting period for the 2026 promoting interoperability program and in subsequent years. CMS says it will continue to monitor certified EHR technology utilization by hospitals to determine if a longer EHR reporting period may be appropriate in the future.

Proposal to Modify the Security Risk Analysis Measure

CMS previously adopted the Security Risk Analysis measure, which requires eligible hospitals and CAHs to attest "yes" or "no" as to whether they have conducted or reviewed a security risk analysis, as required under the Health Insurance Portability and Accountability Act (HIPAA) Security Rule implementation specification for risk management. This implementation specification also requires implementing security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level; however, the current Security Risk Analysis measure does not assess if hospitals have addressed risk management.

Beginning with 2026, CMS proposes that hospitals would also be required to attest "yes" to having implemented policies and procedures to support analyzing and managing the security risks to ePHI associated with the implementation and use of EHRs as required by the HIPAA Security Rule implementation specifications for risk analysis and risk management. Failure to attest "yes" to either of the two attestation statements under the measure would subject the hospital to a downward payment adjustment for not achieving meaningful use of EHR technology. The proposal to modify the Security Risk Analysis measure would neither change the current scoring approach nor contribute any points toward the eligible hospital or CAH's total score for the objectives and measures.

Proposal to Modify the Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure

Currently, eligible hospitals and CAHs are required to attest "yes" to conducting an annual self-assessment using all nine of the 2016 SAFER Guides to be considered a meaningful EHR user.

In January 2025, the SAFER Guides were edited and contain new recommendations, but they are similar and overlap in function or intent with the 2016 SAFER Guides. CMS proposes to modify the SAFER Guides measure so that to be considered a meaningful EHR user, eligible hospitals and CAHs are required to attest "yes" to completing an annual self-assessment using all eight 2025 SAFER Guides, beginning with the EHR reporting period in 2026.

Proposal to Modify the Public Health and Clinical Data Exchange Objective: Adoption of an Optional Bonus Measure for Public Health Reporting Using the TEFCA

Currently, there are eight measures under the Public Health and Clinical Data Exchange objective, six of which are mandatory and two of which are optional bonus measures. Hospitals may receive a total of five bonus points for reporting on one or both optional bonus measures. Beginning with the 2026 EHR reporting period, CMS proposes to add an optional bonus measure under the Public Health and Clinical Data Exchange objective: using TEFCA for health information exchange (HIE) with a public health agency. As proposed, a hospital could claim five bonus points if it attests that it is in active engagement with a public health agency to submit electronic production data for one or more of the measures under this objective using TEFCA. A hospital could only earn five bonus points even if it attests "yes" to multiple bonus measures under this objective.

The measure would specify that the eligible hospital or CAH:

- Participates as a signatory to a framework agreement (as that term is defined by the common agreement for nationwide health information interoperability as published in the Federal Register and on the U.S. Assistant Secretary for Technology Policy's website)
- Is not suspended
- Submits health information using TEFCA to a public health agency consistent with one or more of the measures under the Public Health and Clinical Data Exchange objective
- Is in active engagement — Option 2 (validated data production) — with a public health agency to transfer health information for one or more of the measures under the Public Health and Clinical Data Exchange objective
- Uses the functions of certified EHR technology to exchange with the public health agency

As with all measures under this objection, hospitals must report their level of active engagement as either Option 1 (pre-production and validation) or Option 2 (validated data production). Under the proposal, the Public Health Reporting Using TEFCA bonus measure would only be available where the hospital is in active engagement — Option 2 — with a public health agency to transfer health information for one or more of the measures under the objective.

CMS also clarifies that if the hospital would use TEFCA to fulfill any of the required measures under the Public Health and Clinical Data Exchange objective, the hospital could claim the five bonus points if it attests "yes" to the Public Health Reporting Using TEFCA bonus measure in addition to earning points for fulfilling the requirements of the required measure or measures.

Proposed Scoring Methodology for the EHR Reporting Period in 2026

In general, CMS does not propose changes to the scoring methodology for the CY 2026 EHR reporting period, except to include policies for the newly proposed Public Health Reporting Using TEFCA optional bonus measure. As previously finalized, the minimum scoring threshold will increase to 80 points in CY 2026, compared to 70 points in 2025.

To be considered a meaningful user of EHR technology in the CY 2026 reporting period, an eligible hospital or CAH will be required to:

- Report on all the required measures across all four objectives, unless an exclusion applies
- Report "yes" on all required yes/no measures, unless an exclusion applies
- Attest to completing the actions included in the modified Security Risk Analysis and SAFER Guides measures
- Achieve a total score of at least 80 points based on the methodology in the table below

Failure to meet any of the first three requirements results in an automatic score of zero.

Performance-Based Scoring Methodology Beginning with the CY 2025 EHR Reporting Period			
Objectives	**Measures**	**Maximum Points**	**Redistribution if Exclusion Claimed**
Electronic Prescribing	e-Prescribing	10 points	10 points to 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	No exclusion
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 • AR Surveillance	25 points	If an exclusion is claimed for all six 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	5 points (bonus)	

	• *Public Health Reporting Using TEFCA (proposed)*		

Note: The Security Risk Analysis measure, SAFER Guides measure, and information blocking attestations required by section 106(b)(2)(B) of the Medicare Access and CHIP Reauthorization Act of 2015 are required but will not be scored; eCQM measures are required but will not be scored.

eCQM Reporting for Hospitals and CAHs Under Promoting Interoperability Programs

Hospitals must report on eCQMs as part of satisfying the definition of being a meaningful EHR user under the Promoting Interoperability Program. These reporting requirements are aligned with the hospital IQR program. CMS proposes no changes to the current eCQM requirements. Table IX.F.-06 of the proposed rule summarizes the previously finalized required and self-selected eCQMs available for hospitals to report for the 2026 reporting period and subsequent years.

RFI: Query of Prescription Drug Monitoring Program (PDMP) Measure

CMS seeks public comment on changing the Query of PDMP measure from an attestation-based measure ("yes" or "no") to a performance-based measure (numerator and denominator). CMS also requests feedback on a broader set of performance-based measurement concepts that could help to advance priorities with respect to the use of PDMPs to support the prevention and treatment of opioid use disorders. Specifically, CMS is interested in creating performance-based measures that allow eligible hospitals and CAHs to leverage technology to improve care and reduce burden. Lastly, CMS seeks public comment and feedback on possible future expansion of the Query of PDMP measure to include all Schedule II drugs (rather than only including Schedule II opioids), CHA refers readers to pages 18371-18374 of the proposed rule for a detailed list of questions.

RFI: Performance-based Measures

CMS seeks comments on new measure concepts for public health that would allow better focus on aspects of the data quality of public health reporting. CMS notes it is considering a revised approach to scoring measures under the Public Health and Clinical Data Exchange objective, such as requiring certain thresholds be met under numerator/denominator performance-based scoring. As part of an exploration of alternative measure concepts to assess performance on different aspects of the measures, CMS also seeks comments on how FHIR-based capabilities within certified health IT could better support public health reporting. CHA refers readers to pages 18374-18375 of the proposed rule for a detailed list of questions.

RFI: Regarding Data Quality

CMS believes poor data quality poses direct threats to patient safety — especially when providers treat patients based on inaccurate or incomplete information — and to public health reporting and clinical research using real world evidence. CMS seeks comments on how to improve the quality and completeness of health information. CHA refers readers to pages 18375-18376 of the proposed rule for a detailed list of questions.

Appendix — Quality Reporting Program Tables

Table 1

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure					
	2026	**2027**	**2028**	**2029**	**2030**
Chart-Abstracted Process of Care Measures					
Severe sepsis and septic shock: management bundle (CBE #500)	X	X	X	X	X
PC-01 Elective delivery < 39 weeks gestation (CBE#0469)	Remove				
Electronic Clinical Quality Measures					
ED-2 Time from admit decision to ED departure for admitted patients (CBE #0497) PC-05 Exclusive breast milk feeding (CBE #0480) STK-02 Antithrombotic therapy for ischemic stroke (CBE #0435) STK-03 Anticoagulation therapy for Afib/flutter (CBE #0436) STK-05 Antithrombotic therapy by end of hospital day 2 (CBE #0438) STK-06 Discharged on statin (CBE #0439) VTE-1 VTE prophylaxis (CBE #0371) VTE-2 ICU VTE prophylaxis (CBE #0372) Safe Use of Opioids – Concurrent Prescribing (CBE #3316c) HH-01 Hospital Harm-Severe Hypoglycemia (CBE #3503e) HH-02 Hospital Harm-Severe Hyperglycemia (CBE #3533e) Hospital Harm Opioid Related Adverse Events HH-ORAE ePC-02 Cesarean Birth ePC-07/SMM Sever Obstetric Complications Global Malnutrition Composite Score GMCS (CBE #3592e) HH-PI Hospital Harm-Pressure Injury (CBE 3498e) HH-AKI Hospital Harm-Acute Kidney Injury (CBE 3713e) Excessive Radiation Does or Inadequate Image Quality for Diagnostic CT in Adults (ExRad) HH-FI Hospital Harm-Falls with Injury (CBE#4120e) HH-RF Hospital Harm-Postoperative Respiratory Failure (CBE#4130e)	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications; AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 HH-01 HH-02 HH-ORAE GMCS	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 HH-01 HH-02 HH-ORAE GMCS HH-PI HH-AKI ExRad	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications; HH-HYPO, HH-HYPER, AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 GMCS HH-PI HH-AKI ExRad HH-ORAE HH-FI HH-RF	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications; HH-HYPO, HH-HYPER, HH-ORAE, AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 GMCS ExRad HH-PI, HH-AKI HH-FI HH-RF	Report: Safe Use of Opioids; Cesarean Birth; Severe Obstetric Complications; HH-HYPO, HH-HYPER, HH-ORAE, HH-PI, HH-AKI AND 3 of the following eCQMs: STK-02 STK-03 STK-05 VTE-1 VTE-2 GMCS ExRad HH-FI HH-RF
Healthcare-Associated Infection Measures					

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure					
	2026	**2027**	**2028**	**2029**	**2030**
Healthcare Personnel Influenza Vaccination (NQF #0431)	X	X	X	X	X
Healthcare Personnel COVID-19 Vaccination	*Proposed Remove*				
CAUTI-Onc (CBE #0138)			X	X	X
CLABSI-Onc (CBE #0139)			X	X	X
Mortality					
Stroke 30-day mortality rate (MORT-30-STK)	X	*X***	X	X	X
Readmission/Coordination of Care					
Hospital-wide all-cause unplanned readmission (CBE #1789)	Remove				
Excess days in acute care after hospitalization for AMI (CBE #2881)	X	X	X	X	X
Excess days in acute care after hospitalization for HF (CBE #2880)	X	X	X	X	X
Excess days in acute care after hospitalization for PN (CBE #2882)	X	X	X	X	X
Claims and Electronic Data Measures (Hybrid)					
*Hybrid HWR (all-cause readmission) (CBE #2879)**	Voluntary	Voluntary	*X**	X	X
*Hybrid HWM (all-cause mortality)**	Voluntary	Voluntary	*X**	X	X
Patient Safety					
PSI-04 Death among surgical inpatients with serious, treatable complications (CBE #0351)	X	Remove			
THA/TKA complications (COMP-HIP-KNEE) (CBE #1550)	X	*X***	X	X	Remove
FTR 30-day Standardized Death Rate among Surgical Inpatients with Complications (Failure-to-Rescue) (CBE #4125)		X	X	X	X
Efficiency/Payment					
AMI payment per 30-day episode of care (CBE #2431)	Remove				
Heart Failure payment per 30-day episode of care (CBE # 2436)	Remove				
Pneumonia payment per 30-day episode of care (CBE #2579)	Remove				
THA/TKA payment per 30-day episode of care	Remove				
MSPB-Hospital	X	X	Remove		
Patient Experience of Care					
HCAHPS survey (CBE #0166)	X	X	X	X	
Patient-Reported Outcome-Based Performance Measure (PRO-PM)					
Hospital-Level THA/TKA PRO-PM		X	X	X	X
Structural Measures					
Maternal Morbidity	X	X	X	X	X
Hospital Commitment to Health Equity (HCHE)	*Proposed Remove*				
Patient Safety			X	X	X

Summary Table: IQR Program Measures by Payment Determination Year X= Mandatory Measure					
	2026	**2027**	**2028**	**2029**	**2030**
Age Friendly Hospital			X	X	X
Process Measures					
SDOH-1 Screening for Social Drivers of Health	*Proposed Remove*				
SDOH-2 Screen Positive Rate for Social Drivers of Health	*Proposed Remove*				

*CMS proposes modifications to the thresholds for linking variables and CCDEs beginning with FFY 2028 payment determination

** CMS proposes refinements to MORT-30-STK and COMP-HIP-KNEE to include MA patients beginning with the FFY 2027 payment determination

Table 2

Summary Table VBP-1: Measures and Domains by Payment Year				
Measure	**CBE #**	**2026**	**2027-2029**	**2030+**
Clinical Outcomes Domain				
Acute Myocardial Infarction 30-day mortality rate	0230	X	X	X
Heart Failure 30-day mortality rate	0229	X	X	X
Pneumonia (PN) 30-day mortality rate	0468	X	X	X
*Complication rate for elective primary total hip arthroplasty/total knee arthroplasty (COMP-HIP-KNEE)**	1550	X	X	*X***
Chronic Obstructive Pulmonary Disease (COPD) 30-day mortality rate	1893	X	X	X
CABG 30-day mortality rate	2558	X	X	X
Safety Domain				
Central Line Associated Blood Stream Infection (CLABSI)	0139	X	X	X
Catheter Associated Urinary Tract Infection (CAUTI)	0138	X	X	X
Colon and Abdominal Hysterectomy Surgical Site Infections (SSI)	0753	X	X	X
Methicillin-Resistant *Staphylococcus Aureus* (MRSA) Bacteremia	1716	X	X	X
Clostridium Difficile Infection (CDI)	1717	X	X	X
Severe Sepsis and Septic Shock: Management Bundle (Sep-1)	0500	X	X	X
Person and Community Engagement Domain				
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)***	0166	X	X Modified FY 2027	X
Efficiency and Cost Reduction Domain				
Medicare Spending per Beneficiary*	2158	X	X	X

* CMS proposes to modify the COMP-HIP-KNEE measure to include MA beneficiaries beginning with the FFY 2033 VBP payment year

Table 3

Baseline and Performance (Perf.) Periods by Measure for the FYs 2027 Through 2031 Program Years										
Measure	**Baseline Period 2027**	**Perf. Period 2027**	**Baseline Period 2028**	**Perf. Period 2028**	**Baseline Period 2029**	**Perf. Period 2029**	**Baseline Period 2030**	**Perf. Period 2030**	**Baseline Period 2031**	**Perf. Period 2031**
Person and Community Engagement Domain										
HCAHPS	1/1/23–12/31/23	1/1/25–12/31/25	1/1/24-12/31/24	1/1/26-12/31/26	1/1/25-12/31/25	1/1/27-12/31/27	1/1/26-12/31/26	1/1/28-12/31/28	1/1/27-12/31/27	1/1/29-12/31/29
Safety Domain										
NHSN Measures*	1/1/23–12/31/23	1/1/25–12/31/25	1/1/24-12/31/24	1/1/26-12/31/26	1/1/25-12/31/25	1/1/27-12/31/27	1/1/26-12/31/26	1/1/28-12/31/28	1/1/27-12/31/27	1/1/29-12/31/29
SEP-1	1/1/23–12/31/23	1/1/25–12/31/25	1/1/24-12/31/24	1/1/26-12/31/26	1/1/25-12/31/25	1/1/27-12/31/27	1/1/26-12/31/26	1/1/28-12/31/28	1/1/27-12/31/27	1/1/29-12/31/29
Clinical Outcomes Domain										
Mortality measures^	7/1/17–6/3/20**	7/1/22–6/30/25	7/1/18-6/30/21**	7/1/23-6/30/26	7/1/19-6/30/22**	7/1/24-6/30/27	7/1/20-6/30/23	7/1/25-6/30/28	7/1/21-6/30/24	7/1/26-6/30/29
COMP-HIP-KNEE	4/1/17–3/31/20**	4/1/22–3/31/25	4/1/18-3/31/21**	4/1/23-3/31/26	4/1/19-3/31/22**	4/1/24-3/31/27	4/1/20-3/31/23**	4/1/25-3/31/28	4/1/21-3/31/24	4/1/26-3/31/29
Efficiency and Cost Reduction Domain										
MSPB	1/1/23–12/31/23	1/1/25–12/31/25	1/1/24-12/31/24	1/1/26-12/31/26	1/1/25-12/31/25	1/1/27-12/31/27	1/1/26-12/31/26	1/1/28-12/31/28	1/1/27-12/31/27	1/1/29-12/31/29

Source: Tables VI.L.-04 through VI.L.-08 in the rule, excerpted and combined by Health Policy Alternatives, Inc.

* NHSN measures include CAUTI, CLABSI, Colon and Abdominal Hysterectomy SSI, CDI, and MRSA Bacteremia

^ Mortality measures include MORT-30-AMI; MORT-30-HF; MORT-30-COPD; MORT-30-CABG; MORT-30-PN

** These baseline periods are impacted by the Extraordinary Circumstances Exception (ECE) granted on March 22, 2020. Qualifying claims will be excluded from the measure calculations for January 1, 2020-March 31, 2020 (Q1 2020) and April 1, 2020-June 30, 2020 (Q2 2020) from the claims-based complication and mortality measures. See the FY 2022 IPPS/LTCH PPS final rule (86 FR 45297-45299).

Table 4

HAC Reduction Program Measures for FFY 2026 and Subsequent Years		
	CBE#	**FFY 2026+**
CMS Patient Safety and Adverse Events Composite (CMS PSI 90)	0531	X
CDC NSHN Measures		
Central Line-associated Blood Stream Infection (CLABSI)	0139	X
Catheter-associated Urinary Tract Infection (CAUTI)	0138	X
Colon and Abdominal Hysterectomy Surgical Site Infections	0753	X
Methicillin-resistant staphylococcus aureus (MRSA)	1716	X
Clostridium difficile (CDI)	1717	X

Table 5

PCHQR Program Measures and Public Display Requirements	
Measure	**Public Reporting**
Safety and Healthcare Associated Infection	
Colon/Abdominal Hysterectomy SSI (NQF #0753)	2019
NHSN CDI (NQF #1717)	2019
NHSN MRSA bacteremia (NQF #1716)	2019
NHSN Influenza vaccination coverage among health care personnel (NQF #0431)	2019
NHSN COVID-19 vaccination coverage among health care personnel	October 2022
NHSN CLABSI (NQF #0139)	October 2022
NHSN CAUTI (NQF #0138)	October 2022
Patient Safety Structural Measure	October 2026
Clinical Process/Oncology Care	
The Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (EOL-Chemo) (NQF #0210)	July 2024
The Proportion of Patients Who Died from Cancer Not Admitted to Hospice (EOL-Hospice) (NQF #0215)	July 2024
Intermediate Clinical Outcomes	
The Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (EOL-3DH) (NQF #0216)	July 2024
The Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (EOL-ICU) (NQF #0213)	July 2024
Patient Experience of Care	
HCAHPS (NQF #0166) *(Modifications proposed FFY 2027)*	2016
Documentation of Goals of Care Discussions Among Cancer Patients	July 2026 or as soon as feasible thereafter
Claims-Based Outcomes	
30-Day Unplanned Readmissions for Cancer Patients (NQF # 3188)	October 2023
Surgical Treatment Complications for Localized Prostate Cancer	July 2024
Health Equity Measures	
Facility Commitment to Health Equity	*Proposed Removal Beginning 2026*
Screening for Social Drivers of Health	*Proposed Removal Beginning 2026*
Screen Positive Rate for Social Drivers of Health	*Proposed Removal Beginning 2026*