Medicare IPPS Final Rule Analysis Description

Federal Fiscal Year 2026 | Version 1

Analysis Description

The federal fiscal year (FFY) 2026 Medicare Inpatient Prospective Payment System (IPPS) Final Rule Analysis is intended to show providers how Medicare inpatient fee-for-service (FFS) payments may change from FFY 2025 to FFY 2026, based on the policies set forth in the FFY 2026 IPPS final rule. The analysis compares the adopted year-over-year change in operating, capital, and uncompensated care IPPS payments and includes breakout sections that provide detailed insight into specific policies that influence IPPS payment changes.

Dollar impacts in this analysis may differ from those provided by other organizations due to differences in source data and analytic methods.

This analysis does not include estimates for outlier payments, payments for services provided to Medicare Advantage (MA) patients (including Indirect Medical Education (IME) payments for MA patients), electronic health record incentive payments, or modifications in FFS payments as a result of hospital participation in new payment models being tested under Medicare demonstration/pilot programs.

FFY 2026 IPPS Final Rule Changes Modeled in this Analysis:

- Provider Type Changes: Changes to inpatient payments resulting from a change in provider type. This includes adjustments to both hospital specific rate (HSR) (if received) and changes to the statutory, rate-based DSH payment calculation for hospitals that change special status. A breakout for the transitional traditional DSH payment is available for providers who's geographic CBSA changed from urban to rural and who are eligible.
- Change in Hospital Specific Rate Payment Status: Reflects the impact to special status hospitals (sole community hospitals (SCH), Medicare dependent hospitals (MDH), or essential access community hospitals (EACH)) where there is a change in payment status (hospital-specific vs federal).
- Market Basket Updates (Includes Budget Neutrality): 3.3% operating market basket increase and 2.8% capital input price index increase. This value also includes budget neutrality factors that decrease the federal operating update by 0.03%; and increase the capital update by 0.42%. Impacts of the following budget neutrality adjustments are broken out separately: Medicare Severity Diagnosis Related Group (MS-DRG) reclassification and recalibration, the 10% cap on reductions to MS-DRG weights, and wage index related budget neutrality adjustments.
- Affordable Care Act (ACA) Mandated Market Basket Adjustment: -0.70 percentage point (PPT) productivity adjustment to the operating market basket authorized by the ACA of 2010.
- Wage Index/Geographic Adjustment Factor (GAF) (Wage Data and Reclassifications): Updated wage index and capital GAF values, including any impact due to new wage data, reclassifications, other adjustments to the wage indexes, and changes in labor share. Impacts due to the changes in the rural floor budget neutrality factor and a provider's payment wage index are broken out for each hospital and includes:
    - removing the FFY 2025 rural floor wage index budget neutrality adjustment of 0.977500 from the wage index of the hospital;

- removing the FFY 2025 rural floor adjusted wage index (if the hospital is eligible);
- change in the pre-rural floor wage index from FFY 2025 to FFY 2026;
- applying a net budget neutrality update of 0.995341 to operating payments and 0.9934 to capital payments to account for changes in hospital wage data and geographic reclassifications;
- incorporating the FFY 2026 rural floor adjusted wage index (if the hospital is eligible); and
- applying the FFY 2026 rural floor wage index budget neutrality factor of 0.973976 to the rural floor-adjusted wage index of the hospital.

Hospitals with a reclassification will see the impact of their wage index changing on the line "Change due to Wage Index and Labor Share (Prior to Rural Floor)".

- Wage Index/GAF (Other Changes): All other changes to the calculation of the wage index values of hospitals adopted for FFY 2026. These changes are broken out below the overall impact and include those impacts due to:
  - removing the FFY 2025 5% stop loss cap for eligible hospitals and the associated budget neutrality adjustments of 0.999166 for operating payments and 0.9992 for capital payments;
  - the inclusion of the FFY 2026 5% stop loss for eligible hospitals and the associated budget neutrality adjustments of 0.999397 for operating payments and 0.999244 for capital payments;
  - the inclusion of a transitional, budget-neutral wage index stop loss for providers who were eligible for the low wage index policy for FFY 2024 and whose FFY 2026 wage index is less than 91.25% of their FFY 2024 wage index; and
  - the inclusion of the low wage index removal transition budget neutrality factors of 0.999726 for operating payments and 0.999656 for capital payments.
- DSH–UCC Payment Changes: Changes to UCC payments under the ACA-mandated DSH payment formula. In this analysis, DSH and UCC payment eligibility are held constant at the eligibility status predicted by CMS in its FFY 2026 IPPS final rule DSH supplemental file. Changes in hospital UCC payments that result from changes in the national UCC pool dollars are isolated to the list of DSH-eligible hospitals in the FFY 2026 IPPS final rule DSH supplemental file. These impacts also include year-to-year changes in hospital-specific UCC payment factors (Factor 3) for these hospitals, the impact of which is displayed separately.
- Change in Hospital-Specific Rate: Reflects the impact where the value of the hospital-specific/federal blend for MDHs is changed due to a variation in uncompensated care payments. MDH status was extended through September 30, 2025 by the Full-Year Continuing Appropriations and Extensions Act of 2025, after which it will expire, and these providers will be paid based solely on the federal standard rate. CMS indicated which providers were previously eligible for the MDH program in the FFY 2026 IPPS final rule impact file.
- MS-DRG Updates: Changes due to updates to the DRG groupings and weights, as well as the impact of budget neutrality adjustments tied to these changes, which are broken out separately. These budget neutrality adjustments are:
  - 0.999897 for operating rates and HSRs; and 0.9999 for capital rates due to the 10% cap on decreases of MS-DRG weights; and
  - 0.998580 for operating rates and HSRs; and 0.9984 for capital rates due to the annual recalibration of MS-DRG weights.
- Quality-Based Payment Adjustments: Year-to-year change in hospital-specific quality performance and subsequent adjustments under the Value-Based Purchasing (VBP), Readmissions Reduction (RRP), and Hospital-Acquired Conditions (HAC) programs.

- Low Volume Hospital (LVH) Adjustment Changes: Reflects the change in overall payments made as a result of the LVH adjustment policy. The Full-Year Continuing Appropriations and Extensions Act of 2025 extended the LVH program through September 30, 2025, after which it will expire, and these providers will only receive a 25% adjustment if they have less than 200 total discharges (all-payer) and are located more than 25 miles from another subsection (d) hospital. CMS provided FFY 2025 and FFY 2026 LVH adjustment factors in the FFY 2026 IPPS final rule Impact File.

The values shown in the impact table do not include the 2.0% sequestration reduction to all lines of Medicare payment authorized by Congress to end in FFY 2032. The estimated sequestration reduction applicable to IPPS-specific payment for FFY 2026 has been calculated separately and is provided below the impact table.

The top MS-DRG report lists the top MS-DRGs (up to 25), ranked by magnitude of difference in estimated payments between FFYs 2025 and 2026. Payments include adjustments for area wage data to base operating and capital rates (where applicable) and post-acute transfers. Payments do not include the following adjustments: outlier amounts; new technology payments, new COVID-19 treatment add-on payments; and clotting factor minus device payments (if applicable). MS-DRGs with total case counts less than 11 have been removed due to CMS privacy rules.

Data Sources

Estimated FFYs 2025 and 2026 IPPS payments are calculated using individual hospital characteristics provided by CMS in its FFY 2026 IPPS final rule Impact File and DSH Supplemental files. These files are available on CMS' website at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page.

The inpatient federal operating and capital rates are from the FFY 2025 interim final rule and FFY 2026 final rule, as published in the *Federal Register*.

Medicare cases and case-mix indexes are from the CMS FFY 2026 final rule Impact File. CMS adopted the use of FFY 2024 claims data for FFY 2026 rate-setting. Thus cases, case-mix indexes, and transfer-adjusted cases utilized in the impact file result from running the FFY 2024 Medicare claims data through the DRG Grouper software program (Grouper version 43 for FFY 2026) and assigning the respective MS-DRG weight.

Wage indexes are based upon information about hospitals' permanent and reclassified wage areas from CMS' FFY 2025 interim final rule and FFY 2026 final rule impact files and the wage index tables released by CMS with each rule.

For providers that have a published HSR in the FFY 2026 final rule Impact File but do not have an HSR in the FFY 2025 interim final rule Impact File, it is assumed an HSR determination was made after the publication of the FFY 2025 interim final rule and is equal to their FFY 2026 HSR adjusted by 0.976146 (removing the estimated FFY 2026 net HSR rate update of 2.44%). Providers CMS labeled as eligible for the MDH program for FFY 2025 in the FFY 2026 IPPS final rule Impact File will use the HSR found in that file.

DSH impact estimates are based on the Impact and DSH Supplemental files published with the FFY 2025 interim final rule and FFY 2026 final rule. The DSH Supplemental files include an indicator of DSH-eligible hospitals, the national UCC pool dollars, and hospital-specific UCC factors/payment amounts. For the purposes of this analysis DSH eligibility is held constant to what is published for FFY 2026.

The impacts of the quality-based payment adjustments are determined as follows:

- The FFY 2026 Readmission Reduction Program adjustment factors are from the FFY 2026 IPPS final rule Impact File, which are proxies based on the FFY 2025 adjustment factors.

- The list of hospitals that could potentially be subject to the FFY 2026 HAC Reduction Program penalty is derived from hospital quality data available with the 1st quarter 2025 update of Care Compare since CMS does not provide this list with the final rule.

- FFY 2026 VBP adjustment factors are estimated based on hospital quality data available with the 1st quarter 2025 update of Care Compare and do not include the health equity adjustment. FFY 2026 VBP proxy adjustment factors released with the final rule are based on a prior program year.

- For FFY 2025, VBP and RRP adjustment factors are from the FFY 2025 IPPS interim final rule and HAC reduction flags are from the 1st quarter 2025 update of Care Compare.

This analysis measures the impact of IPPS policy changes only. Hospitals' provider types, volume, patient mix, factors used to calculate the traditional DSH and IME adjustments, and other factors used to estimate IPPS payments are held constant at the status/value published in the FFY 2026 final rule Impact and DSH Supplemental Files. For example, this analysis will not measure the impact to IME payments for a hospital that has increased the number of interns and residents from the previous year.

The Top MS-DRG Report uses claims data from the FFY 2023 Medicare FFS 100% Inpatient Standard Analytic File as a basis, excluding claims for which no payment was provided. MS-DRG relative weights, descriptions, and post-acute transfer determination are from the FFY 2025 interim final rule and 2026 final rule impact files.

Methods

Calculating Impacts by Component Change

The dollar impact of each component change has been calculated by first estimating FFY 2025 payments. Estimated FFY 2025 payments reflect the wage index, labor-share, DSH, IME, and quality-adjusted federal payment amounts (or hospital-specific for SCHs or blended payment amount for MDHs) multiplied by each hospital's appropriate cases, case-mix index, and low volume adjustment. Using estimated FFY 2025 payments, the adopted policy changes to the IPPS payment rates are applied. The effect of the updated wage index values, MS-DRG groupings and weights, performance under the quality-based payment policies, and DSH policy changes are then calculated by substituting FFY 2025 values with FFY 2026 values and calculating the incremental differences in payments. Percent changes by each component change are derived from the resulting changes in payment.

Each component change is applied sequentially in order to capture the compounded dollar impacts. For example, the change due to the market basket update is applied to the estimated FFY 2025 payments. Then, the change to the ACA-mandated market basket reduction is applied to the dollar result of the first change. This method continues for the remaining changes; creating a compounded effect. The difference between the results after each layered component is the impact of that component. Due to the influence of the DSH uncompensated care pool, which is not tied to the inpatient rate, percentage impacts may not tie to the values listed for component updates (i.e. market basket, ACA, etc.).

Individual percentages and dollars shown in this analysis may not add to the total due to compounding and rounding. Dollar amounts less than $50 and percentages less than 0.05% will appear as zeros due to rounding.

Hospitals with Special Status

MDH/SCH status and federal/hospital-specific payment determinations for MDH/SCHs are based on the status predicted by CMS in its FFY 2025 interim final and FFY 2026 final rule Impact and DSH Supplemental files. If the

HSR is more beneficial than the adjusted operating rate federal rate after wage index, budget neutrality, DSH, IME, and transfer adjustments, then payments in this analysis will be based on the HSR.

This analysis does not factor in the impact of outlier payments (facilities paid at the hospital-specific rate are not eligible for outlier payments). In some cases, the inclusion of outlier payments may make the difference as to whether the federal or the hospital-specific rate is more beneficial.

For SCHs, if the HSR is more beneficial, these hospitals are paid at 100% of the HSR. For MDHs, if the hospital-specific rate is more beneficial, these hospitals are paid at a blend of 75% of the hospital-specific rate and 25% of the federal rate. MDH status was extended through September 30, 2025 by the Full-Year Continuing Appropriations and Extensions Act of 2025, after which this will expire, and these providers will be paid based solely on the federal standard rate unless they have been granted SCH status.