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CMS Releases FY 2026 IPPS Proposed Rule

Policy Update

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Summary

On April 11, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2026 Inpatient Prospective Payment System (IPPS) proposed rule. The rule would update Medicare payment policies and quality reporting programs relevant for inpatient hospital services.

A CMS fact sheet on the proposed rule is available here. The proposed rule is scheduled to be published in the *Federal Register* on April 30, 2025, and comments are due on June 10, 2025.

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

Key Takeaways

- CMS proposes a 2.4% increase in operating payment rates for general acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users. This reflects a projected FY 2026 hospital market basket increase of 3.2%, less a 0.8 percentage point productivity adjustment.
- CMS proposes creating new Medicare severity diagnosis-related group (MS-DRG) 209 for complex aortic arch procedures, MS-DRG 213 for endovascular abdominal aorta and iliac branch procedures, MS-DRGs 359 and 360 for percutaneous coronary atherectomy with intraluminal device, MS-DRG 318 for percutaneous coronary atherectomy without intraluminal device, and MS-DRGs 403 and 404 for hip or knee procedures with principal diagnosis of periprosthetic joint infection. CMS proposes to delete hypertensive encephalopathy MS-DRGs 077, 078, and 079.
- CMS proposes several updates to the Transforming Episode Accountability Model (TEAM), including a limited deferment for certain hospitals, neutral scoring on quality for hospitals with insufficient quality data, changes to the payment methodology and risk adjustment, and expansion of the skilled nursing facility (SNF) three-day rule waiver. The basic tenets of the model remain the same: it is a five-year mandatory model that will begin on January 1, 2026.
- While Congress typically extends the Medicare-dependent hospital (MDH) program and low-volume hospital payment adjustment, both are set to expire on September 30, 2025, and Congress has not yet acted to extend them further. Because CMS could not assume the continuation of these programs for purposes of the FY 2026 proposed rule, CMS states that as of October 1, 2025, hospitals that previously qualified for MDH status will be paid based on the federal rate. On the same date, both the qualifying criteria and the payment adjustment methodology for the low-volume adjustment will revert to the statutory requirements that were in effect prior to FY 2011.
- For new technology add-on payment (NTAP) applications for FY 2027 and beyond, CMS proposes one minor policy change and proposes to broaden the application details that it publicly posts online.
- The proposed rule signals future quality measures supporting Make America Healthy Again priorities of well-being and nutrition, and proposes to remove quality measures on health equity and social determinants of health.
- CMS proposes to discontinue the low wage index policy and to use a different transition policy to phase out the policy for affected hospitals.
- The total proposed uncompensated care payment (UCP) to eligible disproportionate share hospitals (DSH) for FY 2026 is $7.29 billion, an increase from the $5.78 billion finalized in FY 2025.
- CMS proposes technical changes to the calculation of full-time-equivalent (FTE) resident counts, caps, and three-year rolling averages for direct graduate medical education (DGME). CMS also proposes technical changes to the calculation of net nursing and allied health education (NAHE) costs.
- CMS solicits comments on the use of the Health Level 7® Fast Healthcare Interoperability Resources®

(FHIR®) in electronic clinical quality measure (eCQM) reporting in various quality reporting programs.
- CMS seeks public input on ways to streamline regulations, reduce administrative burdens, and identify duplicative requirements across the Medicare program. Responses should be submitted through a web-based form, separate from other comments on the proposed rule.
- The proposed rule notably does not include anticipated provisions on hospital conditions of participation related to gender-affirming care.

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

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

Standardized Amount

Key Takeaway: CMS proposes a 2.4% increase for hospitals that successfully participate in CMS reporting programs.

The standardized amount is the dollar-based base unit used to determine payments to hospitals for inpatient services furnished to Medicare beneficiaries. Each year, CMS updates the standardized amount for inflation based on the hospital market basket index, then applies various other statutorily mandated or inspired adjustments. The 2.4% increase to the standardized amount reflects a 3.2% market basket update, less a 0.8% productivity adjustment, plus other budget neutrality adjustments.

The applicable standardized amount also varies based on an individual hospital's participation in the IQR and EHR programs. Hospitals that fail to submit quality data are subject to a -0.8 percentage point adjustment, and hospitals that fail to be meaningful EHR users are subject to a -2.4 percentage point adjustment. The proposed FY 2026 standardized amount for hospitals that successfully participate in both programs is $6,835.47.

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

	Hospital Submitted Quality Data and Is a Meaningful EHR User	Hospital Submitted Quality Data and Is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User
FY 2026 Proposed Standardized Amount	$6,835.47	$6,675.26	$6,782.06	$6,621.86
Percentage Increase Applied to Standardized Amount	2.4%	0%	1.6%	-0.8%

Medicare Severity Diagnosis-Related Group Updates

Key Takeaway: CMS proposes to create MS-DRG 209 for complex aortic arch procedures, MS-DRG 213 for endovascular abdominal aorta and iliac branch procedures, MS-DRGs 359 and 360 for percutaneous coronary atherectomy with intraluminal device, MS-DRG 318 for percutaneous coronary atherectomy without intraluminal device, and MS-DRGs 403 and 404 for hip or knee procedures with principal

diagnosis of periprosthetic joint infection. CMS proposes to delete hypertensive encephalopathy MS-DRGs 077, 078, and 079.

CMS is required by statute to adjust MS-DRG classifications and relative weights at least annually to reflect changes in treatment patterns and technology, and any other factors that may change the relative use of hospital resources. Providers and other stakeholders can submit MS-DRG change requests for CMS to consider in the annual rate setting process. For FY 2027, all MS-DRG requests must be submitted by October 20, 2025, via the Medicare Electronic Application Request Information System™ (MEARIS™).

In evaluating MS-DRG changes and setting MS-DRG relative weights, CMS relies on claims data captured in the MedPAR file and cost report data captured in the Healthcare Cost Report Information System (HCRIS) file. For FY 2026 rate setting, CMS proposes to set MS-DRG relative weights using FY 2024 Medicare claims data and the December 2024 update of the FY 2023 HCRIS file.

Proposed changes to the MS-DRG system include:

- Deleting the “major device implant,” “epilepsy principal diagnosis,” and “neurostimulator” logic lists from craniotomy MS-DRGs 023 and 024.
- Adding procedure codes 00H001Z, 00H005Z, 00H031Z, and 00H041Z for insertion of radioactive element into brain to the “chemotherapy implant” logic list in craniotomy MS-DRGs 023 and 024.
- Changing the name of the “chemotherapy implant” logic list to be the “antineoplastic implant” list.
- Adding 114 procedure code combinations to a new “intracranial neurostimulator implant” logic list, 57 procedure codes to the existing “intracranial vascular procedures” logic list, and 66 diagnosis codes to the “hemorrhage principal diagnosis” logic list for intracranial vascular procedure MS-DRGs 020, 021, and 022.
- Deleting hypertensive encephalopathy MS-DRGs 077, 078, and 079 and reassigning cases for ICD-10-CM I67.4 (hypertensive encephalopathy) to other cerebrovascular disorders MS-DRGs 070, 071, and 072.
- Creating new base MS-DRG 213 for “endovascular abdominal aorta and iliac branch procedures.”
- Creating new MS-DRG 359 for percutaneous coronary atherectomy with intraluminal device with major complication or comorbidity (MCC), MS-DRG 360 for percutaneous coronary atherectomy with intraluminal device without MCC, and MS-DRG 318 for percutaneous coronary atherectomy without intraluminal device.
- Creating new MS-DRG 209 for complex aortic arch procedures.
- Deleting deep vein thrombophlebitis MS-DRGs 294 and 295 and reassigning the 35 diagnosis codes describing deep vein thrombophlebitis to peripheral vascular disorders MS-DRGs 299, 300, and 301.
- Creating new MS-DRGs 403 and 404 for hip or knee procedures with principal diagnosis of periprosthetic joint infection with MCC and without MCC, respectively.
- Reassigning eight procedure codes describing arthroscopy of the shoulder or elbow joint to MS-DRGs 510, 511, and 512 for shoulder, elbow, or forearm procedures, except major joint procedures, with MCC, with complication or comorbidity (CC), and without CC/MCC, respectively.
- Reassigning 10 procedure codes describing arthroscopy of the hand or wrist joint to MS-DRGs 513 and 514 for hand or wrist procedures, except major thumb or joint procedures, with CC/MCC and without CC/MCC, respectively.
- Reassigning the 29 procedure codes describing arthroscopy of various vertebral joints and other musculoskeletal joints to MS-DRGs 515, 516, and 517 for other musculoskeletal system and connective tissue OR procedures with MCC, with CC, and without CC/MCC, respectively.
- Correcting an inconsistency in the logic for spinal fusion MS-DRGs 456, 457, and 458 to add 47 diagnoses to the “spinal curvature/malignancy/infection” logic list for those same MS-DRGs.
- Removing six diagnoses for collapsed vertebra not elsewhere classified and two osteoporosis diagnoses from the “spinal curvature/malignancy/infection” logic list.
- Reassigning ICD-10-CM diagnosis code Z45.31 from MS-DRGs 091, 092, and 093 to MS-DRG 123 for neurological eye disorders.
- Reassigning ICD-10-CM diagnosis codes Z45.320, Z45.321, and Z45.328 from MS-DRGs 091, 092, and 093

to MDC 03 MS-DRGs 154, 155, and 156 for other ear, nose, mouth, and throat diagnoses with MCC, with CC, and without CC/MCC, respectively.

Consistent with these proposed changes, CMS proposes to change the title of:

- MS-DRG 023 from "craniotomy with major device implant or acute complex central nervous system principal diagnosis with MCC or chemotherapy implant or epilepsy with neurostimulator" to "craniotomy with acute complex central nervous system principal diagnosis with MCC or antineoplastic implant."
- MS-DRG 024 from "craniotomy with major device implant or acute complex central nervous system principal diagnosis without MCC" to "craniotomy with acute complex central nervous system principal diagnosis without MCC."
- MS-DRGs 070, 071, and 072 from "nonspecific cerebrovascular disorders, with MCC, with CC, and without CC/MCC, respectively" to "other cerebrovascular disorders with MCC, with CC, and without CC/MCC, respectively."
- MS-DRGs 067, 068, and 069 from "nonspecific CVA and precerebral occlusion without infarction with MCC, with CC, and without CC/MCC, respectively" to "precerebral occlusion without infarction with MCC, with CC, and without CC/MCC, respectively."

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

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

New Technology Add-On Payments

NTAP Policy Proposals for FY 2026

Key Takeaway: For applications for FY 2027 and beyond, CMS proposes one minor policy change and proposes to broaden the application details that it publicly posts online.

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

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

For FY 2025, CMS also increased the maximum NTAP amount from 65% to 75% for two gene therapies approved for FY 2025 that involve treatment of sickle cell disease (SCD), based on feedback from stakeholders. This change is consistent with the maximum amount for qualified infectious disease products that qualify for NTAP. CMS stated that the basis for the change is the limited treatment options for sickle cell disease, the

treatments' high cost, and the hospital's ability to absorb a potential financial loss when providing them. Stakeholders requested that CMS not limit this increase to SCD products, but CMS maintained the policy's applicability as proposed and did not increase the maximum amount for non-SCD products.

For FY 2026, CMS puts forth two proposals:

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

- CMS began posting application materials (omitting cost and volume information) online starting with the FY 2024 NTAP cycle in an effort to increase transparency. The publication allows interested parties to review the details that CMS considers when evaluating technologies. For FY 2026, CMS proposes to publish applicants' narratives on the cost criterion methodology (but not the cost or volume information itself). This information would be in addition to the details on the ICD-10-CM, ICD-10-PCS, and MS-DRG codes published for each application.

If finalized, these policies would become effective for NTAP applications submitted on or after October 1, 2026.

Technologies With Continuing NTAP Period

Key Takeaway: CMS proposes to continue NTAP eligibility for 27 technologies for FY 2026 based on its existing newness policy.

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

For FY 2026, 27 existing drugs and devices would remain eligible for NTAP (see Tables II.E.-01.A and II.E-01.B), while NTAP eligibility for 16 technologies (nine drugs and seven devices) would expire at the end of FY 2025 (see Table II.E.-02).

NTAP Applications for FY 2026

Key Takeaway: CMS reviews 43 NTAP applications, which are available online.

In the proposed rule, CMS discusses 43 NTAP applications. Excluding applications withdrawn prior to the proposed rule's publication and those deemed ineligible due to their status at the FDA 14 drugs and devices applied through the traditional pathway, and 29 went through the alternate pathways (27 devices with breakthrough status and two qualified infectious disease products). The number of FY 2026 applications reviewed in this rule represents a slight increase over applications reviewed for FY 2025.

Per its policy finalized in the FY 2023 rulemaking cycle, CMS posted the applications and supporting documentation for the FY 2026 cycle online. The public postings exclude certain cost and volume information, and any information that an applicant noted as confidential or proprietary. The agency did not post applications withdrawn before publication of the FY 2026 proposed rule. The narrative in the proposed rule, with these postings, focuses primarily on outstanding concerns or questions that the Agency seeks the applicants to address in their comment letters.

Quality Data Reporting Requirements

Hospital Quality Reporting Program Changes

Key Takeaway: CMS signals future quality measure concepts related to the Make America Healthy Again priorities of well-being and nutrition, and proposes to remove quality measures on health equity and social determinants of health.

CMS monitors, rewards, and penalizes quality performance in the inpatient setting through several quality incentive programs, including the Hospitals IQR Program, Hospital Readmissions Reduction Program (HRRP), Hospital Value-Based Purchasing (HVBP) Program, Hospital Acquired Condition (HAC) Reduction Program, Medicare and Medicaid Promoting Interoperability Programs, and Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting (PCHQR) Program.

In this rule, CMS proposes several changes, including shortening performance periods, updating risk adjustment methods, and removing measures related to social determinants of health and COVID-19 vaccination. CMS states: "Our priority is a re-focus on measurable clinical outcomes as well as identifying quality measures on topics of prevention and well-being."

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

Hospital IQR Program

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

CMS proposes to:

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

CMS seeks comments regarding measure concepts related to well-being and nutrition for future consideration. Specifically, CMS seeks input on:

- The applicability of tools and constructs that assess the integration of complementary and integrative health, skill building, and self-care.
- Tools and measures that assess relevant aspects of optimal nutrition and preventive care in the Hospital IQR Program.

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

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

Hospital Readmissions Reduction Program

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

CMS proposes to remove the COVID-19 diagnosed patients measure denominator exclusion from all six readmission measures beginning with the FY 2026 program year.

CMS proposes the following changes for the FY 2027 program year:

- Refine all six readmission measures to add Medicare Advantage patient cohort data.
- Reduce the applicable period from three years to two years and update codified regulation language.
- Modify the DRG payment ratios in the payment adjustment formula to include MA beneficiaries.
- Update and codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital.

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

Hospital Value-Based Purchasing Program

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

CMS proposes to:

- Modify one measure beginning with the FY 2033 program year:
  - Hospital-Level RSCR Following Elective Primary THA and/or TKA measure in alignment with, and contingent upon, updates proposed in the Hospital IQR Program.
- Remove the health equity adjustment from the Hospital Value-Based Purchasing Program's scoring methodology beginning with the FY 2026 payment determination.
  - CMS proposes to codify this change by removing the definition of "health equity adjustment bonus points" in § 412.160 and revising § 412.165(b) to remove the calculation and addition of health equity adjustment bonus points from the total performance score calculation beginning with the FY 2026 program year.
- Update the program's ECE policy to align with other quality programs and to clarify that CMS has the discretion to grant an extension, rather than only an exception, in response to ECE requests.

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

CMS also provides notice of a technical update to the five Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) healthcare-associated infection (HAI) measures beginning with the FY 2028 program year, and a technical update to remove the COVID-19 exclusion from the six measures in the clinical outcomes domain beginning with the FY 2027 program year.

CMS provides updates to the CDC NHSN HAI chart-abstracted measures with the new 2022 baseline, and previously and newly established performance standards for the FY 2028 – 2031 program years for the Hospital VBP Program.

Hospital Acquired Condition Reduction Program

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

CMS proposes to update and codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital.

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

PPS-Exempt Cancer Hospital Quality Reporting Program

The Affordable Care Act established this quality reporting program for Prospective Payment System (PPS)-exempt cancer hospitals.

CMS proposes to remove three existing measures, beginning with the CY 2024 reporting period/FY 2026 payment determination:

- Hospital Commitment to Health Equity.
- Screening for Social Drivers of Health.
- Screen Positive Rate for Social Drivers of Health.

CMS also proposes to update and codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital.

CMS proposes to publicly report PPS-exempt cancer hospital (PCH) data on both the Provider Data Catalog and Care Compare, and to make corresponding changes to regulatory text to replace references to "Provider Data Catalog" with "CMS website."

Medicare Promoting Interoperability Program

The Medicare and Medicaid EHR Incentive Programs are now known as the Promoting Interoperability Program.

CMS proposes to:

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

Wage Index

Key Takeaway: CMS proposes to discontinue the low wage index policy and to use a different transition policy to phase out the policy for affected hospitals.

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

Low Wage Index Hospital Policy

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

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

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

CMS would implement this transitional exception in a budget-neutral manner. While CMS explains that it has authority to impose budget neutrality adjustments to support this policy (different from the authorities it relied on to support the low wage index adjustment policy), those who disfavored the budget neutrality adjustments arising from the low wage index policy may disagree and choose to challenge the agency if the policy is finalized for FY 2026.

Disproportionate Share Hospital Payment/Uncompensated Care Payment

Key Takeaway: The total proposed UCP to eligible DSHs for FY 2026 is $7.29 billion, an increase from the $5.78 billion finalized in FY 2025.

CMS distributes a prospective UCP to Medicare DSH hospitals based on their relative share of uncompensated care nationally. As required by statute, the UCP amount is equal to 75% of total estimated Medicare DSH payments (factor 1), adjusted for the change in the rate of uninsured individuals (factor 2). For FY 2026, the total proposed UCP is $7.29 billion. This would be an increase of about $1.5 billion from CMS's estimate of the UCP to be distributed in FY 2025.

While CMS proposes a net increase in the total amount available to be distributed in UCP and supplemental payments, each hospital's share of the UCP is determined by its amount of uncompensated care relative to the total (factor 3). The projected payment varies by hospital type. Overall, urban hospitals are projected to receive a 26.1% increase in proposed payments, while rural hospitals are projected to receive a 24.73% increase in proposed payments. Rural hospitals with zero to 99 beds are projected to receive a larger-than-average increase of about 26%, while rural hospitals with 100 to 249 beds are projected to receive a 25.5% increase and rural hospitals with more than 250 beds are projected to receive 14.1%. Urban hospitals with more than 250 beds are

projected to receive a 27% increase in payments, while urban hospitals with 100 to 249 beds are projected to receive a 24.5% increase. Urban hospitals with zero to 99 beds are projected to receive a 20.6% increase.

Graduate Medical Education

Key Takeaway: CMS proposes technical changes to the calculation of FTE resident counts, caps, and three-year rolling averages for DGME. CMS also proposes technical changes to the calculation of net NAHE costs.

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

Medicare also makes an indirect medical education (IME) adjustment under the IPPS for hospitals that train residents in an approved graduate medical education program to account for the higher indirect patient care costs of teaching hospitals relative to nonteaching hospitals. A hospital's IME adjustment applied to DRG payments under the IPPS is calculated based on the ratio of the number of FTE residents training in either the inpatient or outpatient departments of the IPPS hospital (and at nonprovider sites, when applicable) to the number of inpatient hospital beds.

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

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

CMS announces the closure of two teaching hospitals in Boston and Wahiawa, Hawaii, triggering a process to redistribute the residency slots allocated to those hospitals. Applications from hospitals that want to receive these slots are due by July 10, 2025.

In addition to DGME and IME, Medicare makes payments to providers for Medicare's share of the costs they incur in connection with approved educational activities, including additional payments to hospitals for costs of NAHE associated with services to Medicare Advantage enrollees. As it does annually, in this rule CMS proposes rates necessary to calculate each eligible hospital's NAHE payments. CMS also proposes technical changes to the calculation of the net cost of NAHE programs in response the US District Court for the District of Columbia's decision in *Mercy Health – St. Vincent Medical Center LLC d/b/a Mercy St. Vincent Medical Center, et al. v. Xavier Becerra.*

Special Rural Designations

Key Takeaway: While Congress typically extends the MDH program and low-volume hospital payment adjustment, both are set to expire on September 30, 2025, and Congress has not yet acted to extend them further. CMS therefore could not assume the continuation of these programs for purposes of the FY 2026 proposed rule.

Medicare-Dependent Hospital and Low Volume Adjustment Programs

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

These programs enjoy longstanding bipartisan support on Capitol Hill and are likely to be extended for some duration later this year. Nonetheless, CMS cannot assume that Congress will extend the MDH program and low-volume adjustment, and the proposed IPPS rule for FY 2026 reflects this.

Because the MDH program is not authorized by statute beyond September 30, 2025, the proposed rule states that beginning October 1, 2025, hospitals that previously qualified for MDH status will be paid based on the IPPS federal rate. Regarding the low-volume adjustment, the proposed rule also states that absent further congressional action, beginning October 1, 2025, the low-volume hospital qualifying criteria and payment adjustment will revert to the statutory requirements that were in effect prior to FY 2011. The low-volume hospital payment adjustment methodology and qualifying criteria implemented in FY 2005 also will resume.

Transforming Episode Accountability Model

Key Takeaway: Proposed updates to TEAM include a limited deferment for certain hospitals, neutral scoring on quality for hospitals with insufficient quality data, changes to the payment methodology that adopt HCC version 28, and an expansion of the SNF three-day rule waiver. The basic tenets of the model remain the same: it is a five-year mandatory model that will begin on January 1, 2026.

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

In this rule, CMS proposes several changes to the model, including the following:

- **Adding a limited deferment period.** Under CMS's proposal, hospitals within selected CBSAs that newly meet the eligibility criteria for TEAM after December 31, 2024, would have at least one full performance year (PY) deferment, with required participation beginning on January 1 of the PY following the deferment.
- **Addressing the expiration of the MDH program.** Hospitals that participate in the MDH program may participate in Track 2 of TEAM up to PY 3. However, the MDH program is set to expire on September 30, 2025. If Congress does not extend the program, then beginning October 1, 2025, all hospitals that previously qualified for MDH will lose that status, which may jeopardize their ability to participate in Track 2. CMS estimates that four participating hospitals would lose MDH status and not qualify for Track 2 under another designation. CMS proposes to determine a hospital's MDH status (and eligibility for Track 2) based on its status in the MDH program on the date CMS requires hospitals to submit their track selections for the upcoming PY.
- **Addressing participation of Indian Health Services (IHS)/Tribal Hospitals.** IHS and Tribal hospitals are paid under IPPS for inpatient care but receive an all-inclusive rate for outpatient services, rather than

payments under the Outpatient Prospective Payment System. CMS did not propose a specific policy for IHS and Tribal hospitals in the FY 2025 rulemaking cycle, and the agency now seeks comment on policies that it considered in the FY 2026 rulemaking cycle and other potential approaches.

- **Adjusting the Hybrid HWR measure.** CMS proposes to align the Hybrid HWR measure with the Hospital IQR Program by using the first mandatory reporting period (July 1, 2025 – June 30, 2026) as the performance period for PY1 quality measurement under TEAM. This represents a shift from the FY 2025 IPPS final rule, in which CMS planned to use the earlier period of July 1, 2024 – June 30, 2025.
- **Adding Information Transfer Patient Reported Outcome-based Performance Measure (PRO-PM).** CMS proposes adopting the Information Transfer PRO-PM to evaluate whether patients report receiving and understanding essential information about their recovery and follow-up care after discharge. If finalized, the measure would be used in PY 3 (CY 2028), with CY 2027 as the baseline year.
- **Applying a neutral quality measure score for hospitals with insufficient quality data.** CMS proposes assigning a scaled quality score of 50 (the midpoint on a zero to 100 scale) for each missing measure. CMS believes that the neutral score would ensure hospitals are neither penalized nor rewarded for incomplete data.
- **Adopting an approach to account for coding changes.** CMS outlines a three-step approach to adjust target pricing to account for changes in MS-DRG and HCPCS codes that occur between the baseline and applicable PY. First, CMS proposes to identify and map any new or revised MS-DRGs and HCPCS codes to previous codes. Second, CMS would apply a normalization factor to account for shifts in coding practices and case mix. Third, CMS would apply a prospective trend factor to adjust target prices.
- **Reconstructing the normalization factor.** CMS proposes calculating the normalization factor at the MS-DRG/HCPCS regional level rather than nationally. The normalization factor would be applied in both preliminary and reconciliation target prices. CMS proposes to clarify that both the prospective and final normalization factors would be based on benchmark prices and not target prices. Hospitals participating in TEAM would receive two preliminary target prices: one that reflects the regional average, and one that reflects hospital-specific risk adjustment and the applicable regional normalization factor.
- **Modifying the calculation of the prospective trend factor.** CMS proposes to use a log-linear regression model, rather than simply relying on a two-year comparison, to calculate the prospective trend factor. CMS also proposes to include two additional trend years, *i.e.*, the two years prior to the three-year baseline, which will only be used for the purposes of setting the prospective trend factor.
- **Replacing the area deprivation index (ADI) with the community deprivation index (CDI).** CMS proposes replacing the ADI with the national-level CDI rankings. Each beneficiary will be assigned a CDI score from 1 to 100, and those above the 80th percentile will be classified as high deprivation for risk adjustment purposes. CMS also proposes renaming the social needs risk adjustment factor as the beneficiary economic risk adjustment factor.
- **Using a 180-day lookback period for risk adjustment.** CMS proposes to extend the 90-day lookback period to 180 days (or even up to a full year) beginning with the day prior to the anchor hospitalization or anchor procedure to capture a more comprehensive picture of the beneficiary's health status.
- **Using HCC version 28 for beneficiary risk adjustment.** CMS proposes replacing HCC version 22 with version 28. CMS expects the number of episode-specific risk adjusters to increase from about 25 per episode category to 30 as a result of this change.
- **Aligning the date range used for episode attribution.** CMS proposes to align the episode attribution policy between the PYs and baseline years. The date of discharge from an anchor hospitalization or outpatient procedure would determine the PY and baseline year in which the episode is attributed.
- **Expanding applicability of the SNF three-day rule waiver.** CMS proposes to allow SNFs to discharge beneficiaries to hospitals and CAHs that provide post-acute services via swing bed arrangements.

CMS also proposes to remove the requirement that participating hospitals submit health equity plans and data on health-related social needs, as well as the option to voluntarily report to the Decarbonization and Resilience Initiative.

CMS solicits comment on (but does not propose updates to) policies about low-volume hospitals, standardized prices and reconciliation amounts, and the primary care services referral requirement.

Requests for Information

Transition Toward Digital Quality Measurement in CMS Quality Reporting Programs

Key Takeaway: CMS solicits comments on the use of the Health Level 7® FHIR® in eCQM reporting in various quality reporting programs.

The proposed rule includes a request for information (RFI) on the transition toward digital quality measurement in various CMS quality reporting programs. CMS solicits input on the use of Health Level 7® FHIR® in eCQM reporting in the Hospital IQR Program, the Hospital Outpatient Quality Reporting Program, and the Medicare Promoting Interoperability Program, and for patient assessment reporting in the Inpatient Psychiatric Facility Quality Reporting Program. CMS anticipates including a similar RFI in the CY 2026 Physician Fee Schedule proposed rule to solicit comments on FHIR®-based eCQM activities in the Medicare Shared Savings Program and the Merit-based Incentive Payment System quality performance category.

The RFI includes questions within four broad categories:

- The FHIR®-based eCQM conversion progress.
- Data standardization for quality measurement and reporting.
- The timeline under consideration for FHIR®-based eCQM reporting.
- Measure development and reporting tools.

Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192)

Key Takeaway: CMS seeks public input on ways to streamline regulations and reduce administrative burdens across the Medicare program.

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

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

The RFI includes questions on three overarching topics:

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

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

Responses to this RFI are to be submitted separately through a dedicated web-based form.

Conclusion

The proposed rule is scheduled to be published in the *Federal Register* on April 30, 2025, and comments are due on June 10, 2025. Stakeholders seeking to comment on the proposed rule or further understand its effects should contact McDermott+ for technical assistance.

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