CHAMBER HILL

INSIGHTS

FY 2026 Medicare Hospital Inpatient Prospective Payment System Final Rule

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On July 31, 2025, the Centers for Medicare and Medicaid Services (CMS) released the Fiscal Year 2026 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule. A fact sheet from CMS can be found here. The final rule takes effect on October 1, 2025.

UPDATES TO IPPS PAYMENT RATES

As part of the final rule, CMS finalized a 2.8% increase in payment rates for FY26 under the IPPS for acute care hospitals that meet the Hospital Inpatient Quality Reporting Program and meaningful EHR use requirements, effective for discharges on or after October 1, 2025. This update reflects a projected FY26 hospital market basket increase of 3.3%, reduced by a 0.5% productivity adjustment. The final rule also sets a fixed loss threshold for outlier payments at $43,663 (slightly lower than the FY25 threshold of $46,217) to maintain outlier payments at 5.1% of total IPPS payments. Total IPPS payments are projected to increase by approximately $4 billion, including $1.5 billion in uncompensated care payments to disproportionate share hospitals.

Compared to the proposed rule's 2.4% payment rate increase (based on a 3.2% market basket increase minus a 0.8% productivity adjustment), the final rule's 2.8% update reflects a higher market basket projection of 3.3% and a lower productivity adjustment of 0.5%, incorporating more recent 2024 data. The fixed loss outlier threshold decreased from the proposed $44,305 to $43,663, driven by updated cost and charge data. The $4 billion total payment increase aligns with the proposed rule's estimate, but the uncompensated care payment rise reflects a refined projection of an 8.5% uninsured rate for CY26

MEDICARE-DEPENDENT HOSPITALS (MDHS) AND LOW-VOLUME HOSPITALS

The MDH program provides enhanced payments to small rural hospitals (≤100 beds, not Sole Community Hospitals) where at least 60% of inpatient days or discharges are attributable to Medicare patients, using a blended rate that includes 75% of the federal rate plus 25% of the hospital-specific rate based on historical costs. The low-volume hospital adjustment offers percentage add-ons to IPPS payments for rural hospitals with low annual discharges to offset higher per-case costs, currently on a sliding scale up to 25% for facilities with fewer than 3,800 discharges and more than 15 road miles from another subsection (d) hospital.

Both programs are set to expire at the end of FY25 (September 30, 2025). In the FY26 final rule, CMS notes that if Congress does not extend the Medicare-Dependent Hospital (MDH) program, approximately

150-160 hospitals will lose their MDH payment adjustment. Similarly, failure to renew the low-volume hospital payment adjustment would cause around 600 hospitals to miss out on additional payments in FY26. The combined loss in funding would total approximately $500 million in FY26. At this stage, we anticipate Congress will extend both programs as part of "extenders" legislation addressing expired or soon-to-expire healthcare policies (as Congress has done on a bipartisan basis for both the MDH and low-volume add-ons for several years now). However, there will be some uncertainty around this given the partisan dynamics of the appropriations process and the fact that lawmakers are likely to enact at least one (if not more) continuing resolutions before full-year FY26 appropriations legislation (to which extenders would likely be attached) will be enacted into law.

DISCONTINUATION OF THE LOW-WAGE INDEX HOSPITAL POLICY

The low wage index hospital policy was established in the FY20 IPPS final rule as a temporary, budget-neutral initiative to address wage index disparities, which benefited rural hospitals by raising their wage indices to mitigate lower payment impacts. This policy adjusted the wage index for hospitals in the bottom quartile, setting a floor at the 25th percentile value, which was offset by a corresponding reduction for higher-wage hospitals. However, in July 2024, the U.S. Court of Appeals for the D.C. Circuit in Bridgeport Hosp. v. Becerra ruled that CMS lacked the statutory authority under sections 1886(d)(3)(E) or 1886(d)(5)(I) of the Social Security Act (SSA) to implement this policy, vacating both the policy and its budget neutrality adjustment.

For FY26, CMS finalized the discontinuation of the low wage index hospital policy. To cushion the abrupt payment reductions for affected low-wage hospitals, CMS adopted a budget-neutral narrow transitional payment exception specifically for FY26 IPPS calculations. This exception replicates the interim transitional policy from the FY25 interim final rule with comment period (i.e., if the hospital's FY26 wage index is decreasing by more than 9.75% from the hospital's FY24 wage index, then the transitional payment exception for FY26 for that hospital is equal to the additional FY26 amount the hospital would be paid under the IPPS if its FY26 wage index were equal to 90.25% of its FY24 wage index).

UPDATE TO THE IPPS LABOR-RELATED SHARE

In the IPPS final rule, CMS finalized a reduction in the labor-related share from 67.6% to 66.6% for hospitals with a wage index greater than 1.0 and from 62% to 60.9% for those with a wage index of 1.0 or less, based on a rebased and revised 2023-based IPPS market basket. This adjustment aligns payments more closely with updated labor cost data. Still, it reduces the portion of payments adjusted by the wage index, likely lowering reimbursements for hospitals in high-wage areas.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM

CMS finalized modifications to several existing measures in the Hospital IQR Program:

- For the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization (MORT-30-STK) measure, changes include incorporating Medicare Advantage patients, shortening the performance period to two years (July 1, 2023–June 30, 2025), transitioning to ICD-10 risk adjustment, and removing COVID-19 exclusions, effective for FY27 payment determinations
- The Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (COMP-HIP-KNEE) measure was updated similarly with Medicare Advantage inclusion, a two-year performance period (April 1, 2023–March 31, 2025), ICD10 risk adjustment, and COVID-19 exclusion removal, also effective FY27.
- For the Hybrid Hospital-Wide Readmission (HWR) and Hybrid Hospital-Wide Mortality (HWM) measures, submission thresholds were lowered to 70% for core clinical data elements and linking variables, allowing up to two missing lab results or vital signs, effective for FY28 payment determinations (July 1, 2025–June 30, 2026).

CMS also finalized the elimination of multiple measures from the Hospital IQR Program. The Hospital Commitment to Health Equity (HCHE), COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP), Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health measures were removed effective for the CY24 reporting period and FY26 payment determination.

As part of the final rule, CMS finalized enhancements to the Extraordinary Circumstances Exception (ECE) policy in the Hospital IQR Program to provide greater flexibility and reduce penalties during disruptions. The ECE request submission deadline was extended from 90 to 180 days, and partial exceptions for individual measures were allowed rather than requiring all-or-nothing requests, effective immediately upon final rule publication. Hospitals can now receive ECEs for up to three consecutive years, with exceptions due to public health emergencies and data submission delays. The post-event request deadline was extended to 60 days, and full cost reporting period exceptions were permitted for widespread impacts.

MEDICARE PROMOTING INTEROPERABILITY PROGRAM

As part of the final rule, CMS made several modifications to the Medicare Promoting Interoperability Program:

- CMS finalized the definition of the EHR reporting period for CY26 and subsequent years as a minimum of any continuous 180-day period within the calendar year for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program. This change, codified at 42 CFR 495.4, provides greater flexibility in selecting reporting windows to accommodate operational needs. It maintains consistency with CY25 requirements while supporting EHR vendors in certification processes.

- CMS modified the Security Risk Analysis measure to require eligible hospitals and CAHs to attest "Yes" to both conducting a security risk analysis and performing security risk management activities, in accordance with 45 CFR 164.308(a)(1)(ii)(A) and (B), starting with the EHR reporting period in CY26. This includes addressing the security of data created or maintained by CEHRT, such as encryption under 45 CFR 164.312(a)(2)(iv) and 164.306(d)(3). Attesting "No" to either component results in failing the measure and potential downward payment adjustments. The update enhances cybersecurity practices without adding economic impacts beyond existing requirements.

- CMS updated the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure, mandating eligible hospitals and CAHs to attest "Yes" to completing an annual self-assessment using all eight 2025 SAFER Guides at any point during the calendar year, effective for the EHR reporting period in CY26 and beyond. The 2025 Guides are streamlined to address high-risk issues through technology or practice changes, focusing on foundational, infrastructure, and clinical processes. No specific implementation status is required, and the change does not increase burden estimates. This promotes proactive EHR safety assessments to mitigate common vulnerabilities.

- CMS introduced an optional bonus measure under the Public Health and Clinical Data Exchange objective, allowing eligible hospitals and CAHs to earn five bonus points for exchanging health information with a public health agency using the Trusted Exchange Framework and Common Agreement (TEFCA), beginning with the EHR reporting period in CY26. Requirements include being a signatory to a Framework Agreement, not suspended, submitting data consistent with exchange measures, achieving active engagement under Option 2, and using CEHRT functions. No exclusions were proposed, and attestation is voluntary with no additional burden for those already using TEFCA. This incentivizes advanced interoperability while accommodating varying hospital capabilities.

Separately, CMS reflected on the comments it received in response to three requests for information (RFIs) relating to potential future policy changes regarding the interoperability program:

- Commenters supported transitioning the Query of PDMP measure to a performance-based format for better accountability in tracking queries and preventing opioid misuse and expanding the measure to include additional drug types. However, opponents highlighted increased administrative burdens, especially for rural hospitals, along with concerns over privacy, legal barriers, data accuracy, and interoperability issues with state PDMP systems. Suggestions included phased implementation, technical assistance, EHR integration, federal funding, and pilot testing to ensure smoother adoption.

- Many commenters endorsed moving the Medicare Promoting Interoperability Program's objectives and measures toward performance-based reporting to align with value-based care, reduce administrative burdens, and provide real-time metrics that benefit low-volume hospitals. Opponents raised issues about heightened reporting complexity, resource strains on smaller practices, data reliability, and potential unfair penalties due to readiness disparities. Recommendations focused on phased rollouts, technical support, risk adjustments, clear thresholds, and pilot testing.
- Stakeholders advocated for improvements in health information exchange quality and completeness through standardized APIs, real-time data sharing, and updated standards like USCDI Version 3 and FHIR, which would enhance care coordination, public health reporting, and address technology disparities. Concerns centered on implementation costs, data security/privacy risks, survey fatigue, and the immaturity of certain standards. Suggestions included provider education, incentives for early adopters, robust security measures, phased approaches, and the collection of disaggregated data.

HOSPITAL READMISSIONS REDUCTION PROGRAM

In the final rule, CMS finalized updates to the Hospital Readmissions Reduction Program by modifying all six condition-specific readmission measures (AMI, HF, PN, COPD, THA/TKA, CABG) to include Medicare Advantage (MA) beneficiaries in performance calculations starting FY27, using a shortened two-year applicable period (July 1, 2023–June 30, 2025), while removing COVID-19 diagnosis exclusions and updating risk adjustment to individual ICD-10 codes. Due to concerns about data reliability from commenters, CMS did not finalize including MA data in aggregate payment calculations for excess readmissions. The rule extends the Extraordinary Circumstances Exception (ECE) submission deadline from 30 to 60 days, allowing CMS discretion to grant extensions or exceptions proactively for systemic issues.

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION PROGRAM

For FY26, CMS will maintain the 1% payment reduction for hospitals in the worst-performing quartile based on measures including CMS PSI 90 and CDC NHSN HAI indicators such as CAUTI, CLABSI, SSI, MRSA Bacteremia, and CDI. The rule updates the Extraordinary Circumstances Exception (ECE) policy by extending the submission deadline from 30 to 60 days after public comments, allowing CMS to grant extensions or ECEs proactively for systemic issues, and clarifying notification processes. It also provides notice of rebasing NHSN HAI measures using CY22 data (effective for FY28 program year scoring with CY24-25 performance periods) and removes COVID-19 diagnosis exclusions from PSI 90 and other measures starting FY27. Scoring methodology remains unchanged, with equal weighting of domains and public reporting on Hospital Compare.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM

CMS finalized modifications to several retained measures in the Hospital VBP Program:

- The Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA/TKA (COMP-HIP-KNEE) was updated to include Medicare Advantage beneficiaries, shorten the performance period to two years (April 1, 2023–March 31, 2025), transition to ICD-10 risk adjustment, and remove COVID-19 exclusions, effective for the FY33 program year.
- Similarly, the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke (MORT-30-STK) incorporated Medicare Advantage patients aged 65+, reduced the performance period to two years (July 1, 2023–June 30, 2025), updated risk adjustment to ICD-10 codes, and eliminated COVID-19 exclusions, starting FY27.
- For the Hybrid Hospital-Wide Readmission (HWR) and Hybrid Hospital-Wide Mortality (HWM) measures, submission thresholds for core clinical data elements and linking variables were lowered to 70%, allowing up to two missing lab values or vital signs, effective FY28 with performance periods from July 1, 2025–June 30, 2026.

CMS eliminated several measures from the Hospital VBP Program:

- The Health Equity Adjustment (HEA) was removed effective FY26 to simplify scoring, as its impact on payment adjustments was minimal (0.168% vs. 0.170%).
- Structural measures, including Hospital Commitment to Health Equity (HCHE), COVID-19 Vaccination Coverage Among Healthcare Personnel, Screening for Social Drivers of Health (SDOH1), and Screen Positive Rate for Social Drivers of Health (SDOH-2), were discontinued starting the CY24 reporting period/FY26 payment determination.
- The Medicare Spending Per Beneficiary (MSPB) Hospital measure and Hospital-Level Risk-Standardized Complication Rate Following Elective Primary THA/TKA were eliminated effective FY28 to minimize overlap and address low case volumes with limited scoring impact.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

In the FY26 IPPS final rule, CMS finalized multiple updates to the Transforming Episode Accountability Model (TEAM), effective January 1, 2026, for five-episode categories (CABG, THA/TKA, spinal fusion, major bowel procedure, acute myocardial infarction), including:

- To support hospital participation, CMS introduced a limited deferment period for certain hospitals, excluded Indian Health Service hospitals, and eliminated downside financial risk for low-volume hospitals with fewer than 31 episodes.

- For quality and performance measurement, CMS added the Information Transfer Patient Reported Outcome-based Performance Measure, assigned neutral scores for participants with insufficient quality data, and removed health equity plans and social needs data reporting, alongside eliminating the Decarbonization and Resilience Initiative to streamline reporting.
- Risk adjustment and pricing were refined by adopting a 180-day lookback period with HCC version 28, replacing the Area Deprivation Index with the Community Deprivation Index, reconstructing normalization trend factors, and establishing a methodology for target pricing during coding changes.
- The SNF 3-day rule waiver was broadened to allow TEAM participants to bypass the 3-day inpatient hospital stay requirement for SNF admissions across all episode categories, modifying the primary care services referral requirement, and aligning episode attribution date ranges.

REQUESTS FOR INFORMATION (RFIS)

As part of the final rule, CMS includes an RFI on streamlining regulations and reducing administrative burdens for those participating in the Medicare program (a response to Executive Order (EO) 14192). To that end, CMS encourages interested stakeholders to submit feedback on that matter by September 15, 2025.

We trust you found this summary useful. Please reach out to us with any questions.