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Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

April 29, 2025

Background & Summary

On April 11, the Centers for Medicare & Medicaid Services (CMS) issued the annual proposed rule to update the Fiscal Year (FY) 2026 Medicare payment and policies for the hospital inpatient prospective payment system (IPPS) and the long-term care hospital (LTCH) prospective payment system (PPS) ("Proposed Rule") (fact sheet available here). CMS proposes to increase the inpatient payment rate for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users by 2.4 percent. Based on various policy changes and circumstances described in the Proposed Rule, CMS anticipates hospital payments will increase by $4 billion in FY 2026, including a projected increase in Medicare uncompensated care payments to disproportionate share hospitals (DSH) in FY 2026 of approximately $1.5 billion.

In addition to payment updates, the Proposed Rule contains several proposals, including refinements to the Transforming Episode Accountability Model (TEAM) model and changes to the Medicare Promoting Interoperability Program, Hospital IQR Program, Hospital Value Based Purchasing (VBP) Program and the Hospital-Acquired Condition Reduction Program (HACRP).

CMS also provides several requests for information (RFIs) on issues such as opportunities to streamline regulations and reduce burdens in the Medicare program, digital quality measurement, and measure concepts related well-being and nutrition for the Hospital IQR Program.

Comments are due **no later than 5PM on June 10, 2025,** and most policies go into effect on October 1, 2025. Vizient looks forward to working with our provider clients to help inform our letter to the agency.

Proposed IPPS Payment Rate Updates for FY 2026

After accounting for adjustments required by law, the Proposed Rule increases IPPS operating payment rates by 2.4 percent in FY 2026 for hospitals that successfully participate in the Hospital IQR Program and are meaningful EHR users. The Proposed Rule includes an initial market-basket update of 3.2 percentage points, minus 0.8 percentage points for productivity as mandated by the Affordable Care Act (ACA). These changes are reflected in Table 1. It is important to note that CMS proposes to rebase and revise the 2018-based IPPS market based to reflect a 2023 base year.

Table 1. Proposed IPPS Payment Rate Updates for FY 2026*

Proposed Policy	Average Impact on Payments (Rate)
Estimated market-basket update*	3.2%
Productivity Adjustment*	-0.8%
Estimated payment rate update for FY 2026 (before applying budget neutrality factors)	**2.4%**

*The FY 2026 estimated market-basket update and proposed productivity adjustment are based on the 4th quarter 2024 IGI forecast, which was the most recent forecast available at the time of development of the Proposed Rule. CMS indicates it will use more recent data if available for the Final Rule.

In addition, CMS proposes four applicable percentage adjustments applied to the standardized amount, as demonstrated in Table 2. To determine the proposed applicable percentage increase, CMS adjusted the proposed market-basket rate-of-increase by considering (1) whether a hospital submits quality data; and (2) whether a hospital is a meaningful electronic health record (EHR) user. CMS also applies a 0.8 percentage point reduction for the productivity adjustment. For the final payment calculation, hospitals may be subject to other payment adjustments under the IPPS which are not reflected in the below table (e.g., reductions under the pay for performance programs).

Table 2. Proposed FY 2026 Applicable Percentage Increases for the IPPS

FY 2026	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
Proposed market basket rate-of-increase	3.2	3.2	3.2	3.2
Proposed adjustment for not submitting quality data	0	0	-0.8	-0.8
Proposed adjustment for not being a Meaningful EHR User	0	-2.4	0	-2.4
Proposed Productivity Adjustment	-0.8	-0.8	-0.8	-0.8
Proposed applicable percentage increase applied to standardized amount	**2.4**	**0.0**	**1.6**	**-0.8***

* Section 1886(b)(3)(B)(xi) of the Social Security Act states that application of the productivity adjustment may result in the applicable percentage increase being less than zero.

Proposed Payment Adjustment for Medicare DSH for FY 2026

The ACA required changes, which began in 2014, regarding the way disproportionate share hospital (DSH) payments are made to hospitals. Under this payment formula, hospitals receive 25 percent of the Medicare DSH funds that they would have received under the prior formula ("empirically justified"). The other 75 percent flows into a separate pool that is reduced relative to the number of uninsured who received care and then distributed based on the proportion of total uncompensated care each Medicare DSH provides. This pool is distributed based on three factors:

- **Factor 1:** 75 percent of the Office of the Actuary (OACT) estimate of the total amount of estimated Medicare DSH payments;
- **Factor 2:** Change in the national uninsured rates; and
- **Factor 3:** Proportion of total uncompensated care each Medicare DSH provides.

CMS estimates the empirically justified Medicare DSH payments for FY 2026 to be approximately $3.92 billion. Also, for FY 2026, CMS estimates total Medicare DSH and uncompensated care payments will increase by approximately $1.5 billion compared to FY 2025, according to a CMS Fact Sheet.

The uncompensated care payments have redistributive effects, which are based on a hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals that are

projected to be eligible to receive Medicare DSH payments. The calculated payment amount is not directly tied to a hospital's number of discharges.

To calculate Factor 1 and model the impact of this Proposed Rule, CMS describes the various data sources it utilized, including the Office of the Actuary's January 2025 Medicare DSH estimates (based on data from the December 2024 update of the Medicare Hospital Cost Report Information System (HCRIS) and the FY 2025 IPPS Final Rule Impact File). For FY 2026, CMS provides that Factor 1 would be approximately $11.761 billion ($15.682 billion minus $3.92 billion) and notes OACT will use more recent data in the FY 2026 IPPS Final Rule. CMS also indicates that Factor 1 estimates for the IPPS proposed rules are generally consistent with economic assumptions and actuarial analysis used to develop the President's Budget estimates. Consistent with historical practice, CMS will use the Mid-session Review of the President's Budget, which will have updated economic assumptions and actuarial analysis, for the development of Factor 1 in the Final Rule.

For Factor 2, CMS proposes to use a methodology similar to the methodology applied in rulemaking for FYs 2018-2025. To calculate Factor 2, among other sources, CMS relies on OACT estimates that the uninsured rate will be 7.7 percent for calendar year (CY) 2025 and 8.7 percent for CY 2026. Using a weighted average approach to estimate the rate of uninsurance during a fiscal year, CMS finds Factor 2 would be 60.71 percent. The proposed FY 2026 uncompensated care amount, if equivalent to proposed Factor 1 multiplied by proposed Factor 2, equals approximately $7.140 billion.

For FY 2026, to calculate Factor 3, CMS proposes to use the three most recent years of audited cost report data (i.e., FY 2020, 2021, and 2022 cost reports), consistent with the approach used in FY 2025. CMS further clarifies that for the Proposed Rule, the agency used reports from the December 2024 HCRIS extract but intends to use the March 2025 update of HCRIS to calculate the final Factor 3 for the FY 2026 IPPS Final Rule.

In addition, CMS provides a FY 2026 IPPS Proposed Rule Medicare DSH supplemental data file on the Proposed Rule website. **CMS welcomes comments on the proposals noted above to calculate each factor.**

Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights

Under the IPPS, the DRG classifications and relative weights are adjusted (at least annually) to account for changes in resource consumption. Relative weight adjustments aim to reflect changes in treatment patterns, technology and other factors that may alter the relative use of hospital resources. For the Proposed Rule, the MS-DRG analysis was based on ICD-10 claims data from the September 2024 update of the FY 2024 MedPAR file, which contains hospital bills received from October 1, 2023, through September 30, 2024.

CMS proposes several modifications and updates to MS-DRGs (i.e., adding and removing MS-DRGs) as described in the Proposed Rule (pg. 44-220). In addition, the proposed 19 national average cost-to-charge ratios (CCRs) for FY 2026 are provided in the Proposed Rule (pg. 219). These CCRs are used in the methodology CMS uses to determine the proposed relative weights. Table 5, as found on the Proposed Rule website, provides information on proposed MS-DRGs, relative weighting factors, and geometric and arithmetic mean lengths of stay. Also, CMS proposes the Major Diagnostic Category (MDC) and MS-DRG assignments for new diagnosis codes and procedure costs (Tables 6A and 6B), which are found on the Proposed Rule website. **CMS welcomes comments on these proposals.**

Application of the Non-Complication or Comorbidity (NonCC) Subgroup Criteria to Existing MS-DRGs with a Three-Way Severity Level Split

In the Proposed Rule, CMS applies existing criteria to create subgroups (e.g., application of the NonCC subgroup criteria outlined in Table 3) in the annual analysis of MS-DRG classification requests.

In the FY 2025 IPPS Final Rule, CMS finalized policy to delay application of the NonCC subgroup criteria to existing MS-DRGs with a three-way level where there is not a reclassification request. In the Proposed Rule, CMS does not address this previously contemplated policy or update information related to the delay.

Table 3. Criteria for a Three-Way Severity Level Split

Criteria	3-way split (MCC vs. CC vs. NonCC)	2-way split MCC vs. (CC + NonCC)	2-way split (MCC+CC) vs. NonCC
Step 1: 500+ cases in the MCC/CC/NonCC group	500+ cases for MCC group; AND 500+ cases for CC group; AND 500+ cases for NonCC group	500+ cases for MCC group; AND 500+ cases for (CC+NonCC) group	500+ cases for (MCC+CC) group; AND 500+ cases for NonCC group
Step 2: 5%+ of the patients are in the MCC/CC/NonCC group	5%+ cases for MCC group; AND 5%+ cases for CC group; AND 5%+ cases for NonCC group	5%+ cases for MCC group; AND 5%+ cases for (CC+NonCC) group	5%+ cases for (MCC+CC) group; AND 5%+ cases for NonCC group
Step 3: 20%+ difference in the average cost between subgroups	20%+ difference in average cost between MCC group and CC group; AND 20%+ difference in average cost between CC group and NonCC group	20%+ difference in average cost between MCC group and (CC+NonCC) group	20%+ difference in average cost between (MCC+ CC) group and NonCC group
Step 4: $2,000+ difference in average cost between subgroups	$2,000+ difference in average cost between MCC group and CC group; AND $2,000+ difference in average cost between CC group and NonCC group	$2,000+ difference in average cost between MCC group and (CC+NonCC) group	$2,000+ difference in average cost between (MCC+ CC) group and NonCC group
Step 5: The R^2 of the split groups is greater than or equal to 3.0	R^2 > 3.0 for the three-way split within the base MS-DRG	R^2 > 3 for the two-way split (MCC vs (CC+NonCC)) within the base MS-DRG	R^2 > 3 for the two-way split ((MCC+CC) vs NonCC) within the base MS-DRG

Operating Room (O.R.) and Non-O.R. Procedures

Under the IPPS MS-DRGs, CMS has a list of procedure codes that are considered O.R. procedures. This list is developed using physician panels which classify each procedure code and its effect on consumption of hospital resources. CMS notes that surgical patients, which are identified based on the procedure performed, typically have a significant effect on the type of hospital resources used (e.g., operating room, recovery room and anesthesia). If a procedure was not expected to require the use of an O.R., then the patient would be considered medical (non-O.R.). Both O.R. and non-O.R. procedure codes may be further classified, which affects the MS-DRG assignment. In the FY 2020 IPPS proposed rule, CMS indicated plans for a multi-year project to conduct a comprehensive review of the ICD-10-PCS procedure codes and determine when a procedure is considered an O.R. procedure. CMS also notes that it also believes there may be other

factors to consider regarding resource utilization, particularly given the additional detail available in ICD-10 claims data. Due to the COVID-19 public health emergency (PHE), CMS did not establish additional criteria to determine whether a procedure is designated as an O.R. procedure in the ICD-10-PCS classification system because the agency wanted to allow additional time for claims data to stabilize before selecting the timeframe to analyze for this review. In the Proposed Rule, CMS notes that it believes additional time is still needed to develop a process and methodology for the review.

However, in the Proposed Rule, CMS does indicate that it is considering feedback on what factors or criteria to consider in determining whether a procedure is designated as an O.R. procedure in the ICD-10-PCS classification system. **CMS also welcomes information on any other factors in consideration of the agency's refinement efforts to recognize and differentiate the consumption of resources under the ICD-10 MS-DRGs.**

Also in the Proposed Rule, CMS indicates that it received requests to change the designation of specific ICD-10-PCS procedure costs from non-O.R. or O.R. procedures. In reviewing these requests, CMS considered the following factors in evaluating each procedure code:

- Whether the procedure would typically require the resources of an operating room;
- Whether it is an extensive or a non-extensive procedure; and
- To which MS-DRGs the procedure should be assigned.

In cases where CMS proposes changing the designation of procedure codes from non-O.R. procedures to O.R. procedures (e.g., endoscopic drainage of the ureter with drainage device), CMS also proposes one or more MS-DRGs with which these procedures are clinically aligned and to which the procedure code would be assigned. More information regarding these proposed changes is available in the Proposed Rule (pg. 168). **CMS welcomes comments on these proposals.**

Comprehensive CC/MCC Analysis

In the Proposed Rule, CMS is not proposing any severity designation changes for FY 2026 as the agency did not receive any requests to change the severity level designations of specific ICD-10-Clincial Modification (CM) diagnosis codes. Through future rulemaking, CMS may consider proposing changes for other diagnosis codes based on the analysis of the impact on resource use and consideration of the nine guiding principles provided in the FY 2025 IPPS Final Rule.

Proposed CC Exclusions List for FY 2026

CMS created the CC Exclusions List to: (1) preclude coding of CCs for closely related conditions; (2) preclude duplicative or inconsistent coding from being treated as CCs; and (3) ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair. Consistent with existing CMS policy, secondary diagnoses are excluded based on the use of five principles.[1] In response to comments received in the FY 2025 IPPS Final Rule, CMS proposes changes to the Exclusion List related to chronic kidney disease, end state renal disease, and other diagnosis codes. CMS has developed various tables available on the CMS website to outline proposed changes to the ICD-10 MS-DRGs Version 43 Exclusion List.[2]

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[1] 1) Chronic and acute manifestations of the same condition should not be considered CCs for one another. 2) Specific and nonspecific (that is, not otherwise specified (NOS)) diagnosis codes for the same condition should not be considered CCs for one another. 3)Codes for the same condition that cannot coexist, such as partial/total, unilateral/bilateral, obstructed/unobstructed, and benign/malignant, should not be considered CCs for one another. 4) Codes for the same condition in anatomically proximal sites should not be considered CCs for one another; and 5) Closely related conditions should not be considered CCs for one another.

[2] Table 6G.1.--Proposed Secondary Diagnosis Order Additions to the CC Exclusions List--FY 2026; Table 6G.2.-- Proposed Principal Diagnosis Order Additions to the CC Exclusions List--FY 2026; Table 6H.1.- -Proposed Secondary Diagnosis Order Deletions to the CC Exclusions List--FY 2026; and Table 6H.2.--Proposed Principal Diagnosis Order Deletions to the CC Exclusions List--FY 2026

Proposed Changes to the Surgical Hierarchies

Some inpatient stays involve multiple surgeries, and each surgery on its own could lead to a different MS-DRG based on the main diagnosis. A surgical hierarchy, which is an ordering of surgical classes from the most resource-intensive to least resource-intensive, is used to assign cases to a single MS-DRG. For FY 2026, CMS proposes revisions to the surgical hierarchy for MDC 05 (Diseases and Disorders of the Circulatory System) and MDC 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue) illustrated in the Proposed Rule (pg. 189) to reflect updated cost and case frequency data.

MS-DRG 018 Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies

In the FY 2021 IPPS Final Rule, CMS created MS-DRG 018 for cases that include procedures describing Chimeric Antigen Receptor (CAR) T-cell therapies. In the Proposed Rule, CMS stated that a stakeholder requested clarification on the agency's rationale for assigning a non-cancer gene therapy to Pre-MDC MS-DRG 018. CMS notes that this category of therapies continues to evolve, and the agency is in the process of carefully considering the feedback received about ways in which the agency can continue to appropriately reflect resource utilization while maintaining clinical coherence and stability in the relative weights under the IPPS MS-DRGs. **CMS also welcomes feedback on how to appropriately address low volume, high-cost treatments for rare diseases.**

While CMS provides a payment adjustment for clinical trial claims, it has not yet established a mechanism for hospitals to report when a product is not purchased in the usual manner, such as obtained at no cost, for reasons other than participation in a clinical trial or expanded access use. Therefore, beginning in FY 2026, CMS proposes to apply the same payment adjustment when MS-DRG 018 products are provided at no cost outside of the usual purchase process. In addition to potential regulatory changes, CMS intends to issue billing instructions in separate guidance to further implement this policy.

Proposed Changes to MS-DRGs Subject to the Post-acute Care (PAC) Transfer Policy and MS-DRG Special Payments Policies

When proposing changes to MS-DRGs that involve adding, deleting, and reassigning procedure or diagnosis codes between proposed new and revised MS-DRGs, CMS generally evaluates the affected MS-DRGs to determine whether they should be subject to the post-acute care transfer policy. The post-acute care transfer policy provides that a transferring hospital is paid on a per diem rate up to and including the full DRG payment, potentially including a cost outlier payment. Alternatively, the final discharging hospital is paid on the full prospective payment rate, potentially including a cost outlier payment.[3]

[3] According to the Office of the Inspector General, "The intent of this transfer policy is to avoid providing an incentive for a hospital to transfer a beneficiary to a post-acute-care setting early (before the beneficiary's acute condition is stabilized) to minimize its costs while still receiving the full MS-DRG payment. Using a graduated per diem rate, Medicare adjusts the payment to the hospital to approximate the reduced cost for a beneficiary who has been transferred to a post-acute-care setting." … "The post-acute-care transfer policy defines a transfer as having occurred when a beneficiary whose hospital stay was classified within specified MS-DRGs is discharged from an IPPS acute care hospital in one of the following situations:

- The beneficiary is admitted on the same day to a hospital or hospital unit that is not reimbursed under the IPPS.
- The beneficiary is admitted on the same day to a skilled nursing facility.
- The beneficiary receives home health services from a home health agency, the services are related to the condition or diagnosis for which the beneficiary received inpatient hospital services, and the services are provided within 3 days of the date that the hospital discharged the beneficiary.
- The beneficiary is admitted on the same day to a hospice."

For FY 2026, CMS proposes changes to several MS-DRGs as outlined in the Proposed Rule (pg. 632-633) and evaluated these MS-DRGs to determine whether they should be subject to the PAC transfer policy. CMS proposes adding new MS-DRGs 403[4] and 404[5] to the list of MS-DRGs that are subject to the PAC transfer policy. A table listing all proposed new or revised MS-DRGs that were reviewed to be subject to the PAC transfer policy is available in the Proposed Rule (pg. 636).

Proposed Changes to the Hospital Wage Index for Acute Care Hospitals

Current law requires that the HHS Secretary adjust the standardized amounts for area differences in hospital wages by a factor that reflects the relative hospital wage level in the geographic area of that hospital compared to the national average. The wage index reflects data from the Medicare Cost Report and the Hospital Wage Index Occupational Mix Survey. The wage index must be updated annually, and any updates or adjustments must be budget neutral, meaning the overall, aggregate payment to hospitals cannot change. CMS provides wage index tables (Tables 2, 3, 4A and 4B) on the Proposed Rule website.

Core-Based Statistical Areas (CBSAs) for the Wage Index

The wage index is calculated and assigned to hospitals based on the labor market area in which the hospital is located. CMS delineates hospital labor market areas based on U.S. Office of Management and Budget (OMB) established Core-Based Statistical Areas (CBSAs). CMS finalized implementation of the new OMB labor market area delineations for the FY 2025 wage index in the FY 2025 IPPS Final Rule based on 2020 Decennial Census data. For FY 2026, CMS proposes to continue using the OMB delineations adopted beginning with FY 2025 to calculate the area wage indexes.

Worksheet S–3 Wage Data for the FY 2026 Wage Index

The proposed FY 2026 wage index[6] is based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2022. The wage data for the proposed FY 2026 wage index was obtained from Worksheet S-3, for cost reporting periods between October 1, 2021, and October 1, 2022. CMS notes that in previous fiscal years, the agency reviewed and evaluated the audited wage data, and the impacts of the COVID–19 PHE on such data. For FY 2026, CMS did not identify any significant issues with the FY 2022 wage data in terms of audits of this data.

For the FY 2026 wage index, CMS used Worksheet S-3 wage data of 3029 hospitals and occupational mix surveys of 2945 hospitals. For the proposed FY 2026 wage index, CMS removed 7 hospitals that converted to critical access hospital (CAH) status and 5 hospitals that converted to rural emergency hospital (REH) status on or after January 24, 2025, the cut-off date for CAH and REH exclusion from the FY 2026 wage index.

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[4] MS-DRG 403: Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC
[5] MS-DRG 404: Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection without MCC
[6] The proposed FY 2026 wage index includes all of the following categories of data associated with costs paid under the IPPS (as well as outpatient costs): 1) Salaries and hours from short-term, acute care hospitals (including paid lunch hours and hours associated with military leave and jury duty).2) Home office costs and hours. 3) Certain contract labor costs and hours including direct patient care (which includes nursing), certain top management, pharmacy, laboratory, and nonteaching physician Part A services, and certain contract indirect patient care services. 5) Wage-related costs, including pension costs.

Proposed Occupational Mix Adjustment to the FY 2026 Wage Index

CMS uses an occupational mix adjustment to control for the effects of hospitals' choices to employ different combinations of staff to provide care services. There is also a statutory requirement that CMS collect data every three years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program and measure the earnings and paid hours of employment for such hospitals by occupational category. As noted in the FY 2025 IPPS Final Rule, CMS collected data in 2022 to determine the occupational mix adjustment for the FY 2025-FY 2027 wage indexes.

For the FY 2026 wage index, CMS used Worksheet S-3 wage data of 3029 hospitals and occupational mix surveys of 2945 hospitals. CMS notes it had a "response" rate of 97 percent and will apply proxy data for hospitals that did not reply, new hospitals, and hospitals that submitted erroneous or aberrant data, as done in prior years. For FY 2026, CMS proposes to calculate the occupational mix adjustment factor using the same methodology the agency has used since the FY 2012 wage index and to apply the occupational mix adjustment to 100 percent of the FY 2026 wage index.

Proposed Update to the IPPS Labor-Related Share for FY 2026

The labor-related share is used to determine the proportion of the national IPPS base payment rate to which the area wage index is applied. Additionally, current law requires using a 62% labor share and hospitals are paid based on whichever labor-related share, the 62% or HHS' estimate, results in a higher payment. For FY 2026, based on the FY 2023 IPPS market basket, CMS proposes to use a labor related share of 66.0 percent, which is 1.6 percentage points lower than the current labor-related share of 67.6 percent.[7]

Application of the Rural Floor, Application of the Imputed Floor, Application of the State Frontier Floor, Continuation of the Low Wage Index Hospital Policy, and Proposed Budget Neutrality Adjustment

Rural Floor Policy

The "rural floor" policy provides that area wage indexes applied to any hospital that is in an urban area of a state cannot be lower than the area wage index for hospitals in rural areas in that state. In addition, CMS applies a national budget neutrality adjustment when implementing the rural floor policy. Based on the FY 2026 wage index used in the Proposed Rule, CMS estimates that 565 hospitals will receive the rural floor adjustment in FY 2026.

"Imputed Floor" Policy

In the FY 2022 IPPS Final Rule, CMS adopted the American Rescue Plan Act (ARPA) requirements[8] to implement the "imputed floor" policy. For FY 2026, CMS proposes to continue to apply the FY 2022 "imputed floor" policy.

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[7] In the Proposed Rule, CMS indicates that this downward revision to the labor-related share is primarily the result of incorporating the more recent 2023 Medicare cost report data for Wages and Salaries, Employee Benefits, and Contract Labor costs. This is partially offset by an increase in the Professional Fees: Labor-Related cost weight.

[8] From FYs 2005–2018, CMS utilized an imputed floor policy for hospitals in all-urban states, and it was considered as a factor in the national budget neutrality adjustment. Section 9831 of the American Rescue Plan Act (ARPA) requires that for discharges occurring on or after October 1, 2021, the area wage index applicable to any hospital in an all-urban state may not be less than the minimum area wage index for the fiscal year for hospitals in that state established using the methodology that was in effect for FY 2018. Unlike the imputed floor policy that was in effect from FYs 2005–2018, the ARPA provided that the imputed floor wage index shall not be applied in a budget neutral manner.

State Frontier Floor Policy

The ACA requires that the wage index for hospitals in low density states (known as the Frontier Floor Wage Index) cannot be below 1.0000. CMS indicates there are no proposed changes to the frontier floor policy for FY 2026. In the Proposed Rule, 40 hospitals would receive the Frontier Floor value of 1.0000 for their FY 2026 wage index. These hospitals are in Montana, North Dakota, South Dakota, and Wyoming. While Nevada meets the criteria of a frontier State, all hospitals within the State currently receive a wage index value greater than 1.0000.

Discontinuation of the Low Wage Index Hospital Policy and Budget Neutrality Adjustment

In the FY 2020 IPPS Final Rule, CMS finalized a policy that provides certain low wage index hospitals with the opportunity to increase employee compensation without the usual lag for those increases to be reflected in the calculation of the wage index. CMS achieved this by temporarily increasing the wage index values for certain hospitals with low wage indexes and also providing an adjustment to the standardized amount for all hospitals so that the policy was budget neutral.[9] CMS finalized an extension of this policy for three more years in the FY 2025 IPPS Final Rule.

For FY 2026 and beyond, CMS proposes to discontinue the low wage index hospital policy after considering the D.C. Circuit court's decision in *Bridgeport Hosp. v. Becerra.*[10] This case ruled that HHS lacked authority to adopt the low wage index hospital policy and that both the policy and the related budget neutrality adjustment must be vacated. In addition, CMS indicates it will no longer apply a low wage index budget neutrality factor to the standardized amounts based on the proposal to discontinue the low wage index hospital policy.

However, CMS proposes adopting a transitional exception to the calculation of FY 2026 IPPS payments for low wage hospitals significantly impacted by the discontinuation of the low wage index. CMS proposes to implement this transitional exception policy in a budget neutral manner and indicates that it will apply to those hospitals whose proposed FY 2026 wage index is decreasing by more than 9.75 percent from the hospital's FY 2024 wage index.

Cap on Wage Index Decreases and Budget Neutrality Adjustment

In the FY 2023 IPPS Final Rule, CMS finalized a wage index cap policy and associated budget neutrality adjustment for FY 2023 and subsequent fiscal years. Under this policy, a 5-percent cap is applied to any decrease to a hospital's wage index from the prior fiscal year, regardless of the circumstances causing the decline. A hospital's wage index will not be less than 95 percent of its final wage index for the prior fiscal year. For FY 2026, CMS proposes to continue the wage index cap and associated budget neutrality adjustment adopted in the FY 2023 IPPS Final Rule.

Proposed Add-On Payments for New Services and Technologies for FY 2025

Under the IPPS, a service or technology may be considered for a new technology add-on payment (NTAP) if: (1) the medical service or technology is new ("newness" criterion); (2) the medical service or technology is so costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate ("cost" criterion); and (3) the service or technology demonstrates a substantial clinical improvement over existing services or technologies ("substantial clinical improvement" criterion). However, certain transformative new devices and antimicrobial products may qualify under an alternative NTAP pathway. NTAPs are not

[9] Under the FY 2020 policy, CMS increases the wage index for each hospital by half the difference between the otherwise applicable final wage index value for a year for the hospital and the 25th percentile wage index value for that year across all hospitals.
[10] https://cases.justia.com/federal/appellate-courts/cadc/22-5249/22-5249-2024-07-23.pdf?ts=1721746878

budget neutral. As noted in the CMS fact sheet, CMS estimates an increase of $234 million in NTAP payments in FY 2026.

A table in the Proposed Rule (pg. 237) provides a list of 11 technologies for which CMS proposes to continue NTAPs because the three-year NTAP anniversary date will occur on or after April 1, 2026. Another table in the Proposed Rule (pg. 239) lists the 15 technologies for which CMS proposes to continue NTAPs because the three-year NTAP anniversary date will occur prior to October 1, 2025. CMS also lists in the Proposed Rule (pg. 247) the proposed NTAP discontinuations for FY 2026 because the 3-year anniversary date will occur prior to April 1, 2026. Estimates for NTAPs proposed to continue for FY 2026 are available in a table (pg. 1271) in the Proposed Rule.

CMS received 53 applications (34 alternative and 19 traditional) for an NTAP for FY 2026. Of these, three were not eligible for consideration and seven applications were withdrawn before the Proposed Rule was issued. Consistent with prior proposed rules, CMS has not yet determined whether applicants under the traditional pathway will meet the criteria for an NTAP for FY 2026.[11] However, CMS does propose to approve 28 applicants under the alternative pathway.

Extension of the Medicare-Dependent, Small Rural Hospital (MDH) Program

The MDH program was enacted through the Omnibus Budget Reconciliation Act of 1989 to provide an enhanced payment to small, rural hospitals with high shares of Medicare patients. Since then, Congress has extended the MDH Program on several occasions. The Full-Year Continuing Appropriations and Extensions Act, 2025, extended the MDH program to September 30, 2025. Should the MDH program expire, CMS indicates that all hospitals that previously qualified for MDH status will lose MDH status, resulting in their payment to be based on the IPPS Federal rate after September 30, 2025. If the MDH program is extended, depending on the timing of such legislation in relation to the Final Rule, CMS would modify changes to the regulations governing the MDH program and general payment rules to reflect the extension.

Proposed Payment Adjustment for Low-Volume Hospitals

Since FY 2005, due to a statutory requirement, CMS provides an additional payment to each qualifying low-volume hospital under the IPPS. Since then, additional legislation has been needed to provide modifications to the program. The Full-Year Continuing Appropriations and Extensions Act of 2025 extended, through September 30, 2025, the modified definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospitals that had been in effect for FYs 2019 through 2024.[12]

Absent additional legislation, 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, and the FY 2005 low-volume hospital payment adjustment methodology and qualifying criteria will resume.

CMS also proposes that a hospital must submit a written request for low-volume hospital status to its Medicare Administrative Contractor (MAC) that includes sufficient documentation to establish that

[11] If technologies that applied under the traditional pathway are found to be eligible for new technology add-on payments for FY 2026, CMS will discuss the estimated payment impact for FY 2026 in the FY 2026 Final Rule.
[12] A hospital qualifies as a low-volume hospital if it is more than 15 road miles from another subsection (d) hospital (e.g., an acute care hospital that is paid under IPPS) and has less than 3,800 total discharges during the fiscal year. The annual payment adjustment is calculated using a continuous, linear sliding scale ranging from an additional 25 percent payment adjustment for low-volume hospitals with 500 or fewer discharges to a zero percent additional payment for low-volume hospitals with more than 3,800 discharges in the fiscal year.

the hospital meets the applicable mileage and discharge criteria, which are used to determine eligibility. CMS notes that this written verification must be received by a hospital's MAC no later than September 1, 2025.

Education Costs

Payment for Indirect and Direct Graduate Medical Education Costs

In the Proposed Rule, CMS provides an overview of how Medicare Indirect and Direct Graduate Medical Education (DGME) costs are determined. The calculation of both DGME payments and the Indirect Medical Education (IME) payment adjustment is affected by the number of full-time equivalent (FTE) residents that a hospital is allowed to count. However, there are differences in the procedures for determining the total DGME and IME FTE counts for purposes of these two payment methodologies. As a result, in the Proposed Rule, CMS restates and clarifies the FTE counting policy (e.g., non-12-month cost-reporting periods) in the Proposed Rule and indicates it is not proposing changes to the FTE counting policy at this time. Information related to these clarifications is available in the Proposed Rule (pg. 666-674).

Reasonable Cost Payment for Nursing and Allied Health (NAH) Education Programs

Medicare has historically paid providers for the costs providers incur in connection with approved educational activities. In response to a U.S. District Court Rule in favor of hospitals, regarding the order of operation for determining "net costs" under regulation, CMS proposes regulatory changes to the calculation of net cost of NAH education programs.

Quality Programs

Proposal to Update and Codify the Extraordinary Circumstance Exception (ECE) Policy for the HRRP, Hospital IQR Program, Hospital VBP Program, and HACRP

To provide greater reporting flexibility for hospitals and clarify the ECE process, CMS proposes to codify updates to the ECE policy for the HRRP, Hospital IQR Program, Hospital VBP Program and HACRP. Specifically, CMS proposes to specify that an ECE could take the form of an extension of time for a hospital to comply with a data reporting requirement if CMS determines that this type of relief would be appropriate under the circumstances (e.g., an extraordinary circumstance). CMS proposes that the process for requesting or granting an ECE will remain the same (e.g., hospital request made within 30 calendar days of the date that the extraordinary circumstance occurred). Also, CMS clarifies that it retains the authority to grant an ECE as a form of relief at any time after the extraordinary circumstance has occurred.

CMS also proposes that it may grant an ECE to one or more hospitals that have not requested an ECE. Such ECEs would be granted if CMS determines that one of the following circumstances occurred: a systemic problem with CMS data collection system directly impacted the ability of the hospital to comply with a quality data reporting requirement; or an extraordinary circumstance has affected an entire region or locale. Consistent with existing policy, CMS notes that any ECE granted will specify whether the affected hospitals are exempted from one or more reporting requirements or whether CMS has granted the hospitals an extension of time to comply with one or more reporting requirements. **CMS welcomes comments on these proposals.**

Hospital Readmissions Reduction Program (HRRP) Updates and Changes

The HRRP requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions. The 21st Century Cures Act requires comparing

peer groups of hospitals with respect to the number of their Medicare-Medicaid dual-eligible beneficiaries (dual-eligibles) in determining the extent of excess readmissions. CMS proposes various changes to the HRRP, as noted below.

Proposal to Integrate Medicare Advantage (MA) Beneficiaries into the Cohorts of the Hospital Readmissions Reduction Program Measure Set Beginning with the FY 2027 Program Year

Currently, the HRRP measure set[13] does not include MA beneficiaries despite the growth of the MA program. As a result, beginning with the FY 2027 Program Year[14], CMS proposes to update the HRRP measure set to integrate MA beneficiaries into each measure's cohorts. CMS also notes that it may stratify the measures by MA or fee-for-service (FFS) data and provide that information through confidential feedback reports for hospitals.

In addition, to calculate the aggregate payment for excess readmissions, CMS proposes to include payment data for Medicare FFS and MA beneficiaries that meet certain criteria described for each applicable condition/procedure. Based on the agency's analysis, using the proposed methodology (i.e., add MA stays and a 2-year performance period), 1424 hospitals would have a greater penalty amount, and 1547 hospitals would have the same or a lower penalty amount. Also, using the existing methodology, CMS indicates that 82.81% of 2828 hospitals would be penalized. In contrast, using the proposed methodology 84.27% of 2868 hospitals would be penalized. A table in the Proposed Rule (pg. 709-711) compares proposed updates to current methodology in the HRRP by hospital characteristic. **CMS invites comments on these proposals.**

Proposal to Remove the COVID-19 Exclusion from the Readmission Measure Set

CMS proposes to remove the COVID-19 exclusion from the readmission measure set beginning with the FY 2027 program year.[15] CMS indicates that based on internal analyses from June 2020-June 2024, there is a decline over time of the number of patients excluded from the various measure cohorts. CMS believes that removing the COVID-19 exclusion will ensure that these readmission measures continue to account for readmissions and meet the goals of the HRRP.

Proposal to Modify the Applicable Period for the Hospital Readmissions Reduction Program Measures Set

To allow for more recent data when assessing performance, CMS proposes to modify the definition of "applicable period" from a three-year period to a two-year period. Also, given the proposed inclusion of MA patients in the cohort, CMS testing showed better between-hospital variance using the 2-year FFS and MA combined cohort as compared to the current measure specifications of a three-year applicable period and the FFS-only cohort. CMS proposes that this change would begin for the FY 2027 program determination, where claims/encounter data with admissions dates beginning from July 1, 2023, through June 30, 2025, would be used. For all subsequent years, CMS would advance this two-year period by one year unless otherwise specified through notice and comment rulemaking.

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[13] As noted in the Proposed Rule, the HRRP measure set includes: Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization; Hospital 30-Day, All-Cause, RSRR Following Heart Failure (HF) Hospitalization; Hospital 30-Day, All-Cause, RSRR Following Pneumonia (PN) Hospitalization; Hospital-Level, 30-Day, All-Cause, RSRR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization; Hospital 30-Day, All-Cause, RSRR Following Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) Hospitalization; and Hospital 30-Day, All-Cause, RSRR Following Coronary Artery Bypass Graft (CABG) Surgery measures

[14] CMS proposes to use claims and encounter data with admission dates beginning from July 1, 2023 through June 30, 2025, which is associated with the FY 2027 program year.

[15] Hospital Readmissions Reduction Program resources are located at the Resources web page of the QualityNet website (available at: https://qualitynet.cms.gov/inpatient/hrrp/resources). An updated measure methodology report will be made available in May 2026

Proposal to Update the Risk Adjustment Model

CMS proposes to update the risk adjustment model to use individual ICD-10 codes instead of Hierarchical Condition Categories (HCCs). CMS notes that this technical update would improve the performance of the risk adjustment models for condition- and procedure-specific mortality and complication measures. CMS refers to the CMS Measures Management System for more information on the list of ICD-10 codes used in the risk adjustment model.

Hospital Value-Based Purchasing Program

The ACA established the Hospital VBP Program under which value-based incentive payments are made to hospitals that meet performance standards during specific performance periods. There are four Hospital VBP domains: Safety; Clinical Outcomes; Efficiency and Cost Reduction; and Person and Community Engagement. Typically, the applicable incentive payment percentage is required by statute (e.g., 2 percent for the FY 2026 program year). For FY 2026, CMS estimates that the total amount available for value-based incentive payments is approximately $1.7 billion, based on the December 2024 update of the MedPAR file. CMS proposes various changes to the Hospital VBP Program, as outlined below.

Proposed Measure Updates to the Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

CMS proposes to adopt substantive measure updates to the Hospital-level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP-HIP-KNEE measure), beginning with the FY 2033 program year. The proposed updates are to expand the measure inclusion criteria to include MA patients and shorten the performance period from three years to two years. CMS notes that the measure was not re-endorsed by the consensus-based entity (CBE) in February 2025. However, CMS believes that it may specify a measure that is not endorsed if due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary. CMS indicates that it reviewed CBE-endorsed measures and was unable to identify any other CBE-endorsed measures on this topic. Based on this information, CMS believes the exception to the requirement to utilize CBE-endorsed measures applies.

CMS also indicates that, if finalized, the agency would begin posting the updated measure data on the Compare tool beginning in July 2026. This means CMS can publish updated measure data at least a year in advance of the April 1, 2029 to March 31, 2031 performance period, which will be used to determine payments for FY 2033, as legally required. CMS also proposes that the performance standards calculation methodology for the updated COMP-HIP-KNEE measure would be the same as the standards CMS currently uses for the measure. The performance standards for the updated measure for FY 2033 are not yet available. **CMS invites comments on this proposal.**

In addition, CMS proposes to update the measures risk adjustment model to use individual ICD-10 cost instead of HCCs**.** For technical policy updates, CMS uses a subregulatory process to incorporate technical measure specification updates into the relevant measure specifications.

CMS notes that the proposed updates are contingent on CMS adopting the same updates for use in the Hospital IQR Program beginning with the FY 2027 payment determination, as outlined below. A table in the Proposed Rule (pg. 717) summarizes the current and proposed reporting of the COMP-HIP-KNEE measure in the Hospital IQR and VBP Programs.

Technical Update to the Five National Healthcare Safety Network (NHSN) Healthcare Associated Infection (HAI) Measures

CDC's NHSN measures are used to monitor hospital performance on the prevention of HAIs. CDC is making efforts so that HAI standardized infection ratio (SIR) calculations of infections will reflect the use of new 2022 standard population data as well as the 2015 standard population data.[16] In the Proposed Rule, CMS indicates it plans to use the 2015 baseline data to calculate performance standards and calculate and publicly report measure scores until the FY 2029 program year. For the FY 2029 program year and subsequent years, the Hospital VBP Program will use the "new standard population data" (i.e., CY 2022 data) to calculate performance standards and calculate and publicly report measure scores, as shown in a table in the Proposed Rule (pg.730).

Technical Update to Remove the COVID-19 Exclusion from the Five Condition- and Procedure-Specific Mortality Measures and the COMP-HIP-KNEE Measure Beginning with the FY 2027 Program Year

For five condition- and procedure-specific mortality measures and the COMP-HIP-KNEE measure[17], CMS provides notice in the Proposed Rule that it intends to remove the exclusion of admissions with either a principal or secondary diagnosis of COVID-19 present on admission from the measure denominators. CMS notes that this change would begin with the FY 2027 program year. In addition to modifying the technical specifications for the six measures, the technical update will also remove the covariate adjustment for patient history of COVID-19 in the 12 months prior to the administration for all six measures in the Clinical Outcomes domain for the Hospital VBP Program beginning with the FY 2027 program year.

Newly Established and Estimated Performance Standards

Given the technical updates, as described previously, CMS aims to establish new performance standards for the FY 2028 program year. A table in the Proposed Rule (pg. 732-733) highlights the newly established and estimated performance standards for the FY 2028 Program Year for the safety domain, clinical outcomes domain and efficiency and cost reduction domain. Another table in the Proposed Rule (pg. 734) provides estimated performance standards for the FY 2028 Program Year for the Person and Community Engagement Domain. Information regarding performance standards for FY 2029-2031 is available in the Proposed Rule (pg. 735-737).

Proposed Removal of the Health Equity Adjustment from the Hospital VBP Program

CMS previously adopted a Health Equity Adjustment (HEA), beginning with the FY 2026 program year, to reward top performing hospitals that serve higher proportions of patients with dual eligibility status. To simplify the Hospital VBP Program's scoring methodology, CMS proposes to remove the HEA. According to CMS, with the HEA, the average net percentage payment adjustment for FY 2026 is 0.170% and without the HEA, the average net percentage payment adjustment is 0.168%. **CMS welcomes comment on this proposal.**

Hospital-Acquired Condition Reduction Program (HACRP) Updates and Changes

The ACA established the HACRP to reduce the incidence of hospital acquired conditions (HACs) by requiring hospitals to report on a set of measures (CMS PSI 90 and CDC NHSN HAI measures).

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[16] More information about CDC's work related to the 2022 NHSN HAI Rebaseline is available at: https://www.cdc.gov/nhsn/2022rebaseline/index.html

[17] The measures impacted by the technical update are: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization (MORT–30– AMI), Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Coronary Artery Bypass Graft (CABG) Surgery (MORT–30–CABG), Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization (MORT–30 COPD), Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure (HF) Hospitalization (MORT–30–HF), and Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) (COMP–HIP–KNEE) measures.

Under the HACRP, hospitals in the worst performing quartile receive a one percent payment reduction. CMS notes that it is not proposing to add or remove any measures in the Proposed Rule for the HACRP. However, consistent with the policies proposed for the Hospital VBP Program, CMS outlines technical updates to the CDC's NHSN HAI Measures, particularly the standard population data year utilization, that would also be relevant for the HACRP. Table 4 outlines the CDC baseline data in relation to the HACRP program year.

Table 4. CDC Baseline Data in the HACRP

HACRP Program Year	Performance Period for CDC NHSN HAI Measures	Standard Population Data Year	Public Reporting
FY 2025	Jan. 1, 2022, to Dec. 31, 2023	2015	Early 2025
FY 2026	Jan. 1, 2023, to Dec. 31, 2024	2015	Early 2026
FY 2027	Jan. 1, 2024, to Dec. 31, 2025	2015	Early 2027
FY 2028	Jan. 1, 2025, to Dec. 31, 2026	2022	Early 2028

Hospital Inpatient Quality Reporting (IQR) Program

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates. To receive the full payment increase, hospitals must report data on measures selected by the Secretary for each fiscal year.

Proposed Refinements to Current Measures in the Hospital IQR Program Measure Set

CMS proposes refinements to two measures that are currently in the Hospital IQR Program measure set: (1) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization (MORT-30-STK measure) and (2) Hospital-Level, Risk Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure (COMP-HIP-KNEE measure), as outlined below.

MORT-30-STK Measure

Regarding MORT-30-STK measure, CMS proposes updates beginning with the FY 2027 payment determination. Specifically, CMS proposes expanding the measure's inclusion criteria to include MA patients and shortening the performance period from 3 years to 2 years. The proposed new reporting period for the measure for the FY 2027 payment determination would be changed from July 1, 2022, through June 30, 2025, to July 1, 2023, through June 30, 2025.

In addition, CMS notes the following two technical updates beginning with the FY 2027 payment determination for the MORT-30-STK measure: updating the risk adjustment model to use individual ICD-10 codes instead of Hierarchical Condition Categories (HCCs) to improve the measure's risk adjustment methodology; and removing the COVID-19 exclusion. In the Proposed Rule, CMS also indicates that the proposed updates to the measure exclude all the following admissions from the cohort:

- Patients with inconsistent or unknown vital status, or other unreliable demographic data (for example, age and gender).
- Patients who were transferred from another acute care facility.
- Patients enrolled in the Medicare hospice program any time in the 12 months prior to the index hospitalization.
- Patients who were discharged against medical advice.

Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure

Regarding the Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) Measure, beginning with the FY

2027 payment determination, CMS proposes expanding the measure's inclusion criteria to include MA patients and shortening the performance period from 3 years to 2 years.[18] If finalized, CMS would remove the updated COMP-HIP-KNEE measure in the Hospital IQR Program beginning with the FY 2030 payment determination, as finalized in the FY 2024 IPPS Final Rule, to prevent duplicative reporting of the measure in a quality reporting program and value-based program, and to simplify administration of both programs. A table in the Proposed Rule (pg. 855) summarizes the current and proposed reporting of the COMP-HIP-KNEE measure in the hospital IQR and VBP Programs.

For technical updates, consistent with other measures noted in the Proposed Rule, CMS aims to update the risk adjustment model to use individual ICD-10 codes instead of HCCs and will remove the COVID-19 exclusion.

Proposed Removals in the Hospital IQR Program Measure Set

CMS proposes to remove four measures beginning with the CY 2024 reporting period/FY 2026 payment determination: (1) Hospital Commitment to Health Equity; (2) COVID-19 Vaccination Coverage among Healthcare Personnel measure; (3) Screening for Social Drivers of Health; and (4) Screen Positive Rate for Social Drivers of Health measure. CMS states that they are removing these measures because the costs for hospitals to report on these measures outweigh the benefit of their continued use in the program. For these measures, CMS clarifies that, if finalized, hospitals that do not report their CY 2024 reporting data for the measures would not be considered noncompliant for purposes of their FY 2026 payment determination.

Additional Technical Updates to the Hospital IQR Program Measures

CMS also notes that the following technical updates will begin with the FY 2027 Program Year. CMS is removing the COVID-19 exclusion from the following Hospital IQR Program measures:

- MORT-30-STK measure
- Hospital-Level, Risk-Standardized Complication Rate Following Elective Primary THA and/or TKA Measure
- Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction
- 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 Measure (HWR) (note: this measure is proposed for modification in the Proposed Rule
- Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure (HWM) (note: this measure is proposed for modification in the Proposed Rule)

Proposed Changes to Reporting and Submission Requirements for Hybrid Measures

In the Proposed Rule, CMS proposes modifications to the reporting of the hybrid hospital-wide all-cause readmission (HWR) and hybrid hospital-wide all-cause risk standardized mortality (HWM) measures, which CMS previously adopted. The Hybrid HWR and Hybrid HWM measures are calculated using core clinical data elements (CCDEs)[19], linking variables, and claims data. Hospitals are currently required to report CCDEs[20] (both vital signs and laboratory test results) on 90 percent of discharges and to submit four linking variables on 95 percent of discharges for both the Hybrid

[18] Regarding the inclusion of MA patients, the agency's analysis found that the measure could achieve a satisfactory level of reliability (median reliability score 0.801, ranging from 0.560 to 0.997, with the 25th and 75th percentiles 0.683 and 0.891, respectively) with a 2-year reporting period.
[19] CCDEs are a set of clinical variables derived from electronic health records (EHRs) that can be used to risk adjust hospital outcome measures.
[20] Hospitals must report 13 CCDEs (six vital signs and seven laboratory test results) for the Hybrid HWR measure and 10 CCDEs (four vital signs and six laboratory test results) for the Hybrid HWM measure.

HWR and Hybrid HWM measures in a given reporting period, beginning with mandatory reporting for the FY 2028 payment determination.

Based on the agency's monitoring of 2024 voluntary reporting, including findings that most hospitals did not meet the submission thresholds for the measures, the agency proposes to reduce the submission thresholds. Specifically, CMS proposes to reduce the submission thresholds for both CCDE and linking variables to at least 70 percent of discharges for both the Hybrid HWR and Hybrid HWM measures. Also, CMS proposes to lower the number of required CCDE data elements for both the Hybrid HWR and Hybrid HWM measures to allow for up to two missing laboratory results and up to two missing vital signs. **CMS welcomes comment on these proposals which would begin with the FY 2028 payment determination.**

RFI on Well-being and Nutrition

For future years of the Hospital IQR Program, CMS seeks input on well-being and nutrition measures. Related to well-being, **CMS seeks comments on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment**. In addition, **CMS requests comments on the applicability of tools that assess the integration of complementary and integrative health, skill building, and self-care. Regarding nutrition, CMS seeks feedback on tools and measures that assess optimal nutrition and preventive care in the Hospital IQR Program.**

Proposed Changes to the Medicare Promoting Interoperability Program

In 2011, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology (CEHRT). In recent years, the Medicare and Medicaid EHR Incentive Programs have evolved and are now known as the Medicare Promoting Interoperability (PI) Program. Under the Medicare PI Program, downward payment adjustments are applied to eligible hospitals and CAHs that do not successfully demonstrate meaningful use of CEHRT for certain associated EHR reporting periods.

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

As finalized in the FY 2024 IPPS rule, the regulatory definition of "EHR reporting period for a payment adjustment year" for eligible hospitals and CAHs in the Medicare PI Program is a minimum of any continuous 180-day period within CY 2025. To provide consistency in the Medicare PI Program for the EHR reporting period in CY 2026 and subsequent years, CMS proposes to maintain the EHR reporting period for a payment adjustment year as a minimum of any continuous 180-day period within the calendar year. **CMS welcomes comments on this proposal.**

Proposal to Modify the Security Risk Analysis Measure

CMS previously adopted the Security Risk Analysis measure based on the HIPAA Security Rule risk analysis requirements. The Security Risk Analysis measure 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 HIPAA Security Rule.[21] However, the measure does not currently include a requirement to manage security risk conduct or to attest to having implemented security measures to manage their security risk.

[21] An attestation of "no" results in the eligible hospital or CAH not meeting the measure and not satisfying the definition of a meaningful EHR user, further resulting in a downward payment adjustment.

Although CMS acknowledges that the current HIPAA Security Rule does not prescribe a specific methodology for conducting and documenting a risk analysis or managing risk, the agency proposes to modify the Security Rule to require eligible hospitals and CAHs to attest "yes" to having conducted security risk management as required under the HIPAA Security Rule implementation specification for risk management. CMS also refers readers to the Security Risk Assessment Tool for informational purposes. Also, CMS proposes that to meet the requirements of the modified measure, eligible hospitals and CAHs would need to separately attest "yes" to both components of the proposed revised measure to be considered a meaningful EHR user beginning with the EHR reporting period in CY 2026. **CMS welcomes comments on this proposal. CMS is also interested in comments regarding compliance with security risk management requirements, the potential impact the proposed modification to the Security Risk Analysis measure would have on risk management compliance and any potential burden from this proposal.**

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

The SAFER Guides are an evidence-based set of recommendations that present the health IT community, including eligible hospitals and CAHs that use health IT, with best practice recommendations to improve the safety and safe use of EHRs. In January 2025, the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP) published an updated set of SAFER Guides which contains 8 stand-alone, subject-oriented chapters. Previous versions of the SAFER Guides contained 9 guides. In the FY 2024 IPPS Final Rule, CMS changed the SAFER Guides measure beginning with the EHR reporting period in CY 2024.

A table in the Proposed Rule (pg. 917-918), compares that 2016 SAFER Guides and the 2025 SAFER Guides. CMS proposes to modify the SAFER Guides measure by requiring eligible hospitals and CAHs to attest "yes" to completing an annual self-assessment using all eight 2025 SAFER Guides to be considered a meaningful EHR user, beginning with the EHR reporting period in CY 2026. **CMS invites comment on this proposal.**

Proposal to Add an Optional Bonus Measure Under the Public Health and Clinical Data Exchange Objective Beginning with the EHR Reporting Period in CY 2026

CMS proposes to add an optional bonus measure (5 bonus points) under the Public Health and Clinical Data Exchange objective for health information exchange with a public health agency (PHA) that occurs using the Trusted Exchange Framework and Common Agreement (TEFCA). More information regarding the bonus measure can be found in the Proposed Rule (pg. 921-923).

In addition, CMS proposes that an eligible hospital or CAH can claim 5 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(s).

RFI Regarding the Query of the Prescription Drug Monitoring Program (PDMP) Measure

CMS seeks comments to inform future rulemaking for the Query of the PDMP measure. **CMS is specifically interested in feedback related to the following policy considerations: 1) changing the Query of the PDMP measure from an attestation-based measure ("yes" or "no") to a performance-based measure (numerator and denominator), as well as alternative measures designed to more effectively assess the degree to which participants are utilizing PDMPs, and 2) expanding the types of drugs to which the Query of the PDMP measure could apply.** Questions related to this RFI are available in the Proposed Rule (pg. 948-956).

RFI Regarding Data Quality

In the Proposed Rule, CMS highlights the growing importance of high-quality data, particularly as the prevalence of electronic health information continues to grow and as providers and payers

continue to move towards value-based care. **CMS seeks comments on numerous questions related to data quality, as provided in the Proposed Rule (pg. 958), including questions related to data quality challenges health care organizations experience, primary barriers to collecting high-quality data, effective solutions to address data quality and potential steps CMS should consider to improve data quality and usability of information.**

RFI Regarding Digital Quality Measurement in CMS Quality Programs

Building from prior RFIs, CMS aims to continue to gather public input on the transition to digital quality measurement (dQM) for CMS programs. CMS notes that it is collaborating with federal agencies to support data standardization and alignment of requirements for the development and reporting of digital quality measures (dQMs). **CMS seeks comments on the agency's anticipated approach to the use of Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) in eCQM reporting.**

In the Proposed Rule, CMS indicates it is considering a requirement that all measures proposed for addition to CMS programs be specified in FHIR. Specific questions related to this topic are available in the Proposed Rule (pg. 821). Also, CMS discusses the standards and other artifacts which CMS and the Office of the National Coordinator for Health Information Technology (ONC) are evaluating to serve as the basis for new health IT certification criteria supporting FHIR-based quality measurement and reporting.[22] Specific questions related to this topic are available in the Proposed Rule (pg. 824).

Lastly, in the Proposed Rule, **CMS poses questions related to the timeline under consideration for FHIR-based electronic clinical quality measure (eCQM) reporting (pg. 825), measure development and reporting tools (pg. 826), additional FHIR transition activities for ACOs (pg. 827) and a general solicitation of comments (pg. 830-831).**

Proposed Changes to the Transforming Episode Accountability Model (TEAM)

As finalized in prior rulemaking, TEAM is a 5-year mandatory alternative payment model tested by the CMS Innovation Center that will begin on January 1, 2026 and end on December 31, 2030. However, as noted in the FY 2025 IPPS Final Rule, several policies that were initially proposed were not finalized and other policies needed further consideration. As such, the Proposed Rule provides several proposals to update TEAM, including:

- A limited deferment period for certain hospitals (e.g., new hospitals, and hospitals that begin to meet the definition of a TEAM participant and are in a mandatory core-based statistical area (CBSA)).[23]
    - **CMS seeks comments regarding this proposal as noted in the Proposed Rule (pg. 970), including whether this policy could affect the business decision of opening a new hospital in a mandatory CBSA.**

[22] CMS also indicates that a key artifact it is reviewing is the Quality Improvement (QI)-Core Implementation Guide (IG), which defines a set of FHIR profiles within a common logic model for clinical quality measurement and clinical decision support intended for use for multiple use cases across domains. CMS anticipates alignment between the QI-Core IG and the USCDI+ Quality data element list. Among other future plans, CMS is also considering the Data Exchange for Quality Measures (DEQM) IG as part of the framework supporting the transition to FHIR-based eCQMs, in particular for supporting FHIR-based reporting to CMS.

[23] Also, CMS proposes to establish a cutoff date (December 31, 2024) after which new hospitals and hospitals that begin to meet the definition of a TEAM participant and that are located in a mandatory CBSAs, excepting any new hospitals resulting from a reorganization event, would not be required to participate immediately in the model and would have a limited deferment period before beginning their participation in TEAM.

- Aligning with the Hospital IQR Program, including the program's requirement for the Hybrid HWR and mandatory reporting period of July 1, 2025 – June 30, 2026 as TEAM's PY baseline period.
    - **CMS seeks comment on utilizing the first mandatory reporting period of July 1, 2025 through June 30, 2026 as the TEAM Performance Year (PY) 1 quality measure performance period for the Hybrid HWR measure. Additionally, though not proposed, CMS seeks comment on whether TEAM should not align with the Hospital IQR Program and, as during the voluntary reporting period, only use claims-based elements of the Hybrid HWR for quality measurement.**
- Adding the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) as outlined in a table in the Proposed Rule (pg. 985).
    - **CMS seeks comment on the proposal to include the Information Transfer PRO-PM in TEAM starting in PY 3. Also, CMS seeks comment on other quality measures, including options for capturing quality of care in the outpatient setting and other PRO-PMs appropriate for TEAM quality measurement.**
- Applying a neutral quality measure score for TEAM participants with insufficient quality data.
- Reconstructing the normalization factor and prospective trend factor, as outlined in the Proposed Rule (pg. 1000-1008).
- Replacing the Area Deprivation Index (ADI) with the Community Deprivation Index (CDI), which standardizes the variables used in the construction of the ADI[24], and changing the construction of the social need risk adjustment factor for beneficiary-level risk adjustment.[25]
    - **CMS seeks comment on the proposal to use the CDI. Also, while CMS is not proposing to change the inclusion of the dual eligibility variable in the economic risk adjustment factor, CMS seeks comment on whether the removal of this variable to streamline construction of the economic risk adjustment factor would be preferable.**
- Using a 180-day lookback period and Hierarchical Condition Categories (HCC) version 28 for beneficiary risk adjustment (a proposed list of category specific HCCs is available in the Proposed Rule (pg. 1018-1020).
    - **CMS seeks comment on these proposals.**
- Aligning the date range in the baseline and performance years and timing of reconciliation. Tables XI.A.-14 and XI.A.-15 (pg. 1030 and 1031) in the Proposed Rule provide examples of when episodes would be reconciled based on the episode end date and the anchor hospitalization/anchor procedure discharge date.
    - **CMS seeks comment on the proposal to construct baseline year episodes based on the anchor hospitalization or anchor procedure discharge date. Also, CMS seeks comment on the proposal to reconcile episodes based on anchor hospitalization or anchor procedure discharge date.**
- Removing the health equity plan and health related social needs data policies from TEAM, including all references to health equity plans; CMS will consider adding elements that are consistent with the new Administration's focus on making America healthy again (e.g., prevention and health living).[26]

[24] Standardization refers to the process making the individual indicators that comprise the ADI unit to be neutral by subtracting the mean and dividing by the standard deviation before combining them to form a composite measure. Standardization prevents those variables with high nominal values, namely income and home values, from predominating the calculation of the metric. Also, given the work done to standardize the ADI and the ACO REACH models construction methodology, CMS notes that it intends to use a similar approach to more accurately measure areas of deprivation and create alignment across CMS Innovation Center models with similar adjustments.
[25] CMS also proposes to rename the social needs risk adjustment factor be the beneficiary economic risk adjustment factor.
[26] CMS clarifies it is not proposing changes to prior policy to voluntarily collect demographic data. However, CMS proposes to update the "gender" variable and rename is "sex". **CMS seeks comments on this proposal.**

- Allowing TEAM participants to use the TEAM Skilled Nursing Facility (SNF) 3-Day Rule Waiver for TEAM beneficiaries discharged to hospitals and CAHs providing PAC under swing bed requirements.
- Removing the Decarbonization and Resilience Initiative.

While not proposing updates, **CMS solicits comment regarding Indian Health Service (IHS) hospital outpatient episodes, low volume hospitals, standardized prices and reconciliation amounts, and the primary care services referral requirement.**

What's Next?

Comments on the Proposed Rule are due on June 10, 2025. CMS is anticipated to publish the final IPPS regulation around August 1, 2025, with the changes being effective at the beginning of the federal fiscal year (October 1, 2025).

Vizient's Office of Public Policy and Government Relations looks forward to hearing continued client feedback on this Proposed Rule. Stakeholder input plays a major role in shaping future changes to policy. We encourage you to reach out to our office if you have any questions or comments regarding any aspects of this proposed regulation – both positive reactions and provisions that cause you concern. Please direct your feedback to Randi Gold, Director, Hospital Payment Policy and Regulatory Affairs in Vizient's Washington, D.C. office.