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Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2026 Rates; Changes to the FY 2025 IPPS Rates Due to Court Decision; Requirements for Quality Programs; and Other Policy Changes; Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization

August 18, 2025

Background & Summary

On July 31, the Centers for Medicare & Medicaid Services (CMS) issued the annual final 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) ("Final Rule") (fact sheet available here). CMS finalized a 2.6 percent increase of 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. Based on various policy changes and circumstances described in the Final Rule, CMS anticipates hospital payments will increase by $5 billion in FY 2026.

The Final Rule contains a range of finalized policies, including discontinuing the low wage index hospital policy, modest changes to the mandatory Transforming Episode Accountability Model (TEAM) and several changes related to hospital quality programs, including the addition of Medicare Advantage data in the Hospital Readmissions Reduction Program (HRRP) measures beginning FY 2027. While not included in the proposed rule, the Final Rule also includes the Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization (HTI-4) Final Rule, which finalizes certain proposals from the HTI-2 Patient Engagement, Information Sharing, and Public Health Interoperability proposed rule, including new and updated health IT certification criteria for electronic prior authorization, electronic prescribing and real-time prescription benefit information.

Most policies provided the Final Rule will go into effect on October 1, 2025.

Final IPPS Payment Rate Updates for FY 2026

After accounting for adjustments required by law, the Final Rule increases IPPS operating payment rates by 2.6 percent in FY 2026 for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful Electronic Health Record (EHR) users. The 2.6 percent increase is 0.2% higher than proposed, as shown in Table 1. In the Final Rule and as shown in Table 1, CMS finalized updating the 2018-based IPPS market basket to reflect a 2023 base year and includes a market basket update of 3.3 percentage points, minus 0.7 percentage points for productivity as mandated by the Affordable Care Act (ACA). CMS also finalized using 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.[1]

Table 1. Proposed and Final IPPS Payment Rate Updates for FY 2026

	Proposed Average Impact on Payments (Rate)		Final Average Impact on Payments (Rate)
Estimated market basket update	3.2%		3.3%
Productivity Adjustment	-0.8%		-0.7%
Estimated payment rate update for FY 2026 (before applying budget neutrality factors)	**2.4%**		**2.6%**

In addition, CMS finalized four applicable percentage increases applied to the standardized amount,[2] 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 EHR user. CMS also applies a 0.7 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. Final 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
Market basket rate-of-increase	3.3	3.3	3.3	3.3
Adjustment for not submitting quality data	0	0	-0.825	-0.825
Adjustment for not being a Meaningful EHR User	0	-2.475	0	-2.475
Productivity Adjustment*	-0.7	-0.7	-0.7	-0.475
Applicable percentage increase applied to standardized amount	**2.6**	**0.125**	**1.775**	**-0.7^**

*In the Final Rule, CMS notes that the U.S. Department of Labor's Bureau of Labor Statistics (BLS) replaced the term multifactor productivity adjustment (MFP) with total factor productivity (TFP).
^ 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.

[1] CMS indicated in the Proposed Rule, 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.
[2] Tables on the Final Rule website provide the FY 2026 Operating and Capital National Standardized Amounts.

Payment Adjustment for Medicare Disproportionate Share Hospitals (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.

As noted in the Final Rule, CMS estimated Medicare DSH expenditures for FY 2026 to be $16.550 billion.

For Factor 1, CMS estimates the empirically justified Medicare DSH payments for FY 2026 to be approximately $4.14 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2026). Therefore, final Factor 1 for FY 2026 is $12.412 billion (approximately 75% of the total amount of estimate Medicare DSH payments for FY 2026).

For Factor 2, CMS considered OACT's projections for the percentage of individuals without insurance in recent years (e.g., CY 2025: 7.9%, CY 2026: 9.0%), finding the final Factor 2 to be 62.14%. Based on this, the final FY 2026 uncompensated care payment amount is $ 7.713 billion. According to a CMS Fact Sheet, CMS estimates a projected increase in Medicare uncompensated care payments to disproportionate share hospitals in FY 2026 of approximately $2.0 billion.

For Factor 3, CMS continues to use the three most recent years (i.e., FYs 2020-2022) of audited cost report data, a scaling factor and various trim methodology policies.

Since FY 2014, CMS has made interim uncompensated care payments during the FY on a per-discharge basis. In the FY 2025 IPPS Final Rule, CMS also finalized a policy to use a 3-year average of the most recent years of available historical discharge data to calculate a per-discharge payment amount that would be used to make interim uncompensated care payments to each projected DSH-eligible hospital during FY 2026 and subsequent fiscal years. For FY 2026, CMS plans to continue this policy.

In addition, CMS provides a FY 2026 IPPS Final Rule Medicare DSH supplemental data file on the Final Rule website.

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

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 and generally, if the procedure was not expected to require the use of the operating room, the patient would be considered medical (non-O.R.). Currently, this list is developed using physician panels which classify each procedure code and its effect on consumption of hospital resources. However, in the Final Rule, CMS indicates 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 and that it believes performance of a procedure in an O.R. should not be

the sole factor considered for the designation of an O.R. procedure. The agency plans to share more information on its analysis and methodology in future rulemaking and continues to encourage public feedback regarding this issue.

Complication or Comorbidity (CC) Exclusions List

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.[3] In the Final Rule, for FY 2026, CMS finalized the proposed changes to the Exclusion List related to chronic kidney disease, end stage renal disease and other diagnosis codes.[4] CMS intends to continue this type of internal review to ensure all the other Principal Diagnosis Collection lists reflect the appropriate codes in connection with the CC/MCC secondary diagnosis code that is excluded from acting as a CC/MCC. Any proposed changes to the lists will be discussed in future rulemaking.

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 Final Rule, CMS reiterated its openness to future input on MS-DRG mapping for emerging therapies and the broader topic of MS-DRG mappings of cell and gene therapy products. CMS intends to address any potential modifications to the MS-DRGs through future notice and comment rulemaking.

In the Final Rule, as the agency did for FY 2025, CMS finalized the use of an adjustor to the transfer-adjusted case count for MS-DRG 018. Specifically, CMS finalized an adjustor of 0.16 which is applicable to clinical trial and expanded access use immunotherapy cases, and other cases where the immunotherapy product is not purchased in the usual manner (e.g., obtained at no cost). CMS uses this adjusted case count for MS-DRG 018 in calculating the national average cost per case, which is used in the calculation of the relative weights.

Add-On Payments for New Services and Technologies for FY 2026

As noted in the CMS fact sheet, CMS estimates that additional payments for inpatient cases involving new medical technologies will increase by approximately $192 million in FY 2026, primarily driven by the continuation of new technology add-on payments (NTAPs) for several technologies. Tables in the Final Rule (pg. 354-355, 365, 2020-2021) provide information about products with NTAPs, including discontinuations, during FY 2026.

Outlier Payments

Costs incurred by a hospital for a case are evaluated to determine whether the hospital is eligible for an additional payment as an outlier case. To qualify for outlier payments, a case must have costs greater than the sum of the prospective payment rate for the MS-DRG, any IME and DSH payments, uncompensated care payments, any new technology add-on payments and the “outlier

[3] 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.

[4] The finalized CC Exclusions List as displayed in Tables 6G.1, 6G.2, 6H.1, 6H.2, and 6K, associated with this Final Rule reflect the additions, deletions, and complete list of CC exclusions under Version 43 of the ICD-10 MS-DRGs

threshold" or "fixed-loss" amount. For FY 2026, CMS aims to pay approximately 5.1 percent of aggregate payments under IPPS as outlier payments and finalized an outlier fixed-loss cost threshold of $40,397.

Changes to the Hospital Wage Index for Acute Care Hospitals

For FY 2026, CMS is updating the wage index values based on the most recent available data (e.g., data from cost reporting periods beginning during FY 2022) and using the revised core-based statistical area (CBSA) labor market area delineations (based on the new Office of Management and Budget Delineations). Also, CMS finalized the transition policy for hospitals negatively impacted by the discontinuation of the low wage index hospital policy. On the CMS Website, the agency has provided FY 2026 Wage Index Public Use Files.

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 which labor-related share, the 62% or HHS's estimate, results in a higher payment. For FY 2026, based on the FY 2023 IPPS market basket, CMS finalized the proposal 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.[5]

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

For FY 2026 and beyond, CMS finalized its proposal to discontinue the low wage index hospital policy after considering the D.C. Circuit court's decision in *Bridgeport Hosp. v. Becerra.*[6] This case ruled that HHS lacked authority to adopt a previously finalized low wage index hospital policy and that both the policy and the related budget neutrality adjustment must be vacated. 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. CMS also finalized 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. This policy is adopted in a budget neutral manner and 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.

Changes in 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. Since the MDH program is not authorized by statute beyond September 30, 2025, absent congressional action, beginning October 1, 2025, 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. The MDH program has currently not been extended by law as of the release of the Final Rule.

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[5] In the Final 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.

[6] https://cases.justia.com/federal/appellate-courts/cadc/22-5249/22-5249-2024-07-23.pdf?ts=1721746878

Indirect and Direct Graduate Medical Education

Payment for Indirect and Direct Graduate Medical Education Costs

The calculation of both Medicare Indirect and Direct Graduate Medical Education (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 how to determine the total DGME and IME FTE counts for purposes of these two payment methodologies. As a result, in the Final Rule, CMS restates and clarifies the FTE counting policy (e.g., non-12-month cost-reporting periods). Information related to these clarifications is available in the Final Rule (pg. 957-965).

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 decision in favor of hospitals, regarding the order of operation for determining "net costs" under regulation, CMS proposed regulatory changes to the calculation of net cost of NAH education programs. However, due to stakeholder comments and reconsideration of this issue, CMS decided not to finalize the proposed changes and indicated it expects to address this issue in future rulemaking.

Quality Programs

Changes to the Extraordinary Circumstance Exception (ECE) Policy for the Hospital Readmissions Reduction Program (HRRP), Hospital Inpatient Quality Reporting (IQR) Program, Hospital Value Based Purchasing (VBP) Program, and Hospital-Acquired Conditions Reduction Program (HACRP)

To provide greater reporting flexibility for hospitals and to 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 finalized that the agency may grant an ECE with respect to reporting requirements in the event of an extraordinary circumstance[7] that affected the ability of the hospital to comply with one or more applicable reporting requirements with respect to a fiscal year. CMS proposed 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). However, due to concerns raised regarding hospitals' ability to complete the ECE request within 30 days of the extraordinary circumstance, CMS modified the timeframe to allow for 60 days to submit an ECE request.

CMS also finalized the proposal for the agency to grant an ECE to one or more hospitals that have not requested an ECE, if CMS determines that: a systemic problem with CMS data collection system directly impacted the ability of the hospital to comply with a quality data reporting requirement; or that an extraordinary circumstance has affected an entire region or locale.

Hospital Readmissions Reduction Program

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

[7] Defined as an event beyond the control of a hospital (for example a natural or man-made disaster such as a hurricane, tornado, earthquake, terrorist attack, or bombing).

Currently, the HRRP measure set[8] does not include MA beneficiaries despite the growth of the MA program. As a result, beginning with the FY 2027 Program Year[9], CMS finalized policy to update the HRRP measure set to integrate MA beneficiaries into each measure's cohorts. CMS clarifies it will 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. Also, CMS indicates it may provide data regarding payer type for hospitals to review through annual confidential feedback reports provided as part of participation in the HRRP. CMS clarifies that potential public reporting of stratified measure data would be through future notice and comment rulemaking.

To calculate the aggregate payment for excess readmissions, CMS did not finalize a proposal to include payment data for MA beneficiaries.[10] This was due to stakeholder concern with the proposal to use the information-only claims for MA enrollees to calculate aggregate payments for excess readmissions, potentially leading to some types of hospitals being more likely to be subject to increased penalties under the HRRP than other hospital types.

Readmission Time Period

CMS stated that the agency will evaluate a shorter 7- or 14-day readmission time period and review the criteria to include care provided in ambulatory settings and its applicability to each measure within the HRRP measure set.

Modification of the Applicable Period for the Hospital Readmissions Reduction Program Measures Set

To allow for more recent data when assessing performance, CMS finalized modifying the definition of "applicable period" from a three-year period to a two-year period, beginning for the FY 2027 program determination, for claims/encounter data with admissions dates beginning July 1, 2023, through June 30, 2025. For all subsequent years, CMS would advance this two-year period by one year unless otherwise specified through notice and comment rulemaking.

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. For FY 2026 discharges, CMS estimates that the total amount available for value-based incentive payments is approximately $1.7 billion.

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

[8] 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

[9] 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.

[10] 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. TABLE VI.K-01in the Final Rule (pg. 1015-1016) assesses the impact of the proposed changes.

CMS finalized expanding the measure inclusion criteria 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) to include MA patients and shorten the performance period from three years to two years, beginning with the FY 2033 program year. CMS notes that the measure was not re-endorsed by the consensus-based entity (CBE) in February 2025 but believes an exception to the requirement to utilize CBE-endorsed measures applies.

Newly Established and Estimated Performance Standards

A table in the Final Rule (pg. 1061) 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 Final Rule (pg. 1063) provides estimated performance standards for the FY 2028 Program Year for the Person and Community Engagement Domain. Information regarding performance standards for FYs 2029-2031 is available in the Final Rule (pg. 1064-1066).

Removal of the Health Equity Adjustment

CMS previously adopted a Health Equity Adjustment (HEA), beginning with the FY 2026 program year. To simplify the Hospital VBP Program's scoring methodology, CMS finalized the proposal to remove the HEA from the program's scoring calculations in the FY 2026 program year.

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

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). CMS did not propose to add or remove any measures for the HACRP. However, related to technical changes, 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.

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 of the Department of Health and Human Services (HHS) for each fiscal year. Tables X.C.2, X.C.3, and X.C.4 in the Final Rule (pgs. 1250-1254) summarize the newly modified and previously finalized Hospital IQR Program measure sets for the FY 2027-2029 payment determinations and subsequent years.

MORT-30-STK Measure

Regarding the MORT-30-STK measure, CMS finalized updates beginning with the FY 2027 payment determination. Specifically, CMS finalized 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.

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 finalized proposals expanding the measure's inclusion criteria to include MA patients and shortening the performance period from 3 years to 2 years.[11] A table in the Final Rule (pg. 1221) summarizes the reporting of the COMP-HIP-KNEE measure in the Hospital IQR and VBP Programs.

Removals in the Hospital IQR Program Measure Set

CMS finalized removal of 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 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.

Reporting and Submission Requirements for Hybrid Measures

CMS finalized 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. Specifically, CMS finalized reducing the submission thresholds for both core clinical data elements (CCDE) and linking variables to at least 70 percent of discharges for both the Hybrid HWR and Hybrid HWM measures. Also, CMS lowered 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 indicates reporting will be mandatory beginning with the FY 2028 payment determination.

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). 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.

EHR Reporting Period in CY 2026 and Subsequent Years

As finalized in the FY 2024 IPPS Final 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. For CY 2026 and subsequent years, CMS finalized their proposal 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 clarifies that 180 days would be the minimum length, and CMS encourages eligible hospitals and CAHs to use longer periods, up to and including the full calendar year.

[11] 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.

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.[12] 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.

CMS finalized their proposal, with slight modifications, to revise the Security Risk Analysis measure beginning with the EHR reporting period in CY 2026. Specifically, eligible hospitals and CAHs are required to attest "yes" to having conducted security risk management in addition to the current requirement under the measure for eligible hospitals and CAHs to attest "yes" to having conducted or reviewed a security risk analysis as required by the HIPAA Security Rule. Eligible hospitals and CAHs would need to separately attest "yes" to both components to be considered a meaningful EHR user.

Modifying 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. CMS finalized their proposal 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.

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

CMS finalized the proposal to add an optional bonus measure 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). Beginning with the EHR reporting period in CY 2026, an eligible hospital or CAH can earn a maximum of 5 bonus points if it attests "yes" to one of the following optional bonus measures: the Public Health Reporting Using TEFCA measure, the Public Health Registry Reporting measure, or the Clinical Data Registry Reporting measure—in addition to earning points for fulfilling the requirements of the required measure(s). Eligible hospitals and CAHs may attest "yes" to more than one but can only earn a total of 5 bonus points even if the attesting "yes" to multiple bonus measures.

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. The Final Rule finalizes several updates to 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

[12] 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.

area (CBSA)).[13] In addition, CMS finalized the proposal to monitor specifically for the potential shifting of patients with high anticipated episode spending from TEAM participants to non-participant hospitals.
- CMS finalized the proposal to discontinue a hospital's TEAM participation the day the hospital no longer meets the definition of TEAM participant.
- Medicare dependent hospitals' (MDHs) eligibility for Track 2 is determined based on the hospitals' status in the MDH program on the date CMS requires TEAM participants to submit their track selections for the upcoming Performance Year (PY).
- Excluding Indian Health Service (IHS)/Tribal hospitals from TEAM by modifying the TEAM participant definition to state that a TEAM participant must be paid under the IPPS and OPPS.
- For the Hybrid Hospital-Wide Readmission (HWR) measure, utilizing CY 2025 for the PY1 Composite Quality Score (CQS) baseline period and using July 1, 2024 – June 30, 2025 as the measure performance period for the Hybrid HWR measure (a change from the Proposed Rule). TEAM will maintain alignment with the Hospital IQR Program.[14]
- Adding the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) for all Team outpatient episodes beginning in PY3 with a CY 2027 CQS baseline period. This is outlined further in a table in the Final Rule (pg. 1437).
- Applying a neutral quality measure score (a scaled quality measure score of 50) for TEAM participants with insufficient quality data.
- Reconstructing the normalization factor and prospective trend factor, as outlined in the Final Rule (pg. 1459-1473).
- Changing the construction of the social need risk adjustment factor (renamed the beneficiary economic risk adjustment factor)[15] by replacing the Area Deprivation Index (ADI) with the Community Deprivation Index (CDI), which standardizes the variables used in the construction of the ADI[16], and removing a measurement of deprivation at the state level.
- 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 Final Rule (pg. 1490-1492).
    - CMS recognized commenters that supported a 365-day lookback period, arguing it would align with Medicare Advantage and the CJR model. However, CMS responded that TEAM was more robust and did not need to be aligned with other models. CMS also did not believe extending the lookback period to 365 days would provide significantly more patient risk information or significantly impact pricing, citing their study that only 2 of 29 risk-adjusted benchmark prices changed by more than 2 percent when extending the lookback period from 180 to 365 days.
- A low volume threshold policy, which applies if a TEAM participant did not meet the low volume threshold of at least 31 episodes in a given baseline period for a given episode category. While CMS would still reconcile the participant's episodes, the participant would

[13] CMS establishes 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 (at least one full performance year of participation deferment) before being required to participate in TEAM. Rather, these hospitals would be required to participate in TEAM starting on January 1st of the subsequent performance year.

[14] Given that CMS has extended the voluntary reporting of the core clinical data elements and linking variables for the Hybrid HWR measure through June 30, 2025, this means that for PY1, CMS will use the claims-only portion of the Hybrid HWR measure in the CQS calculation. In subsequent TEAM performance years, the complete Hybrid HWR Measure—incorporating both claims data and core clinical data elements—may be utilized once the core clinical data elements transition from voluntary to required reporting.

[15] CMS finalized their proposal to rename the social needs risk adjustment factor to be the beneficiary economic risk adjustment factor.

[16] 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.

not be held accountable (i.e., CMS would be waiving downside risk) for any performance year episode spending that exceeded the reconciliation target price for MS-DRG/HCPCS episode types in that given episode category during the applicable PY.
- Aligning the date range in the baseline and performance years and timing of reconciliation. Tables XI.A.-15 and XI.A.-16 (pg. 1521 and 1522) in the Final Rule provide examples of when episodes would be reconciled based on the episode end date and the anchor hospitalization/anchor procedure discharge date.
- Removing the health equity plan and health-related social needs data policies, including all references to health equity plans.[17]
- Allowing TEAM participants to use the TEAM Skilled Nursing Facility (SNF) 3-Day Rule Waiver for TEAM beneficiaries discharged to hospitals and CAHs providing post-acute care under swing bed requirements.
- Removing the Decarbonization and Resilience Initiative.

What's Next?

Most provisions of the Final Rule go into effect October 1, 2025, with a notable exception being the implementation of the TEAM on January 1, 2026.

Vizient's Office of Public Policy and Government Relations looks forward to hearing continued member feedback on this Final Rule. Please direct your feedback to Jenna Stern, VP, Regulatory Affairs and Public Policy in Vizient's Washington, D.C. office.

[17] CMS clarifies it is not changing prior policy to voluntarily collect demographic data. However, CMS proposes to update the "gender" variable and rename it "sex".