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An Analysis and Commentary on Federal Health Care Issues
by Larry Goldberg

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Final FY 2026 Update to IPPS and LTCH Issued

The Centers for Medicare and Medicaid Services (CMS) have issued a final rule to update the Hospital Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System for Fiscal Year (FY) 2026.

A copy of the 2,182-page document is currently on public display at the ***Federal Register*** office and is scheduled for publication on August 4. The display version is available at: https://public-inspection.federalregister.gov/2025-14681.pdf

The IPPS tables for the FY 2026 rule are available on the CMS website at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page

The LTCH tables are available on the CMS website at: https://www.cms.gov/medicare/payment/prospective-payment-systems/long-term-care-hospital/regulations-notices under the list item for Regulation Number CMS-1833-F.

We have changed the IPPS and LTCH table links from the final rule because they do not take you to the correct sites. CMS does not appear to be getting its web-site links correct.

Comments

There is no table of contents, there is much repetitive unneeded citations, and much unneeded historical information. As is customary, we are adding page numbers based on the display version. In several instances you will see more than 1 page number. We have additional numbers reflecting additional areas the subject item is discussed.

Overall, for FY 2026, CMS expects the final changes in operating and capital IPPS payment rates — in addition to other changes — will generally increase hospital payments by $5 billion. LTCH hospital payments are said to increase by $83 million.

Under current law, additional payments for Medicare-Dependent Hospitals (MDHs) and the temporary change in payments for low-volume hospitals expire September 30, 2025. In the past, legislation has extended these payments.

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This analysis does not follow the rule's organization, nor does it include all aspects cited in the rule. There is just too much to try and summarize.

Many items are fragmented. That is, they appear in several different sections. We have tried to group similar items together, starting with the payment updates.

Many payment issues can be found in the rule's Addendum (beginning on page 1,832).

EXECUTIVE SUMMARY (Page 12)

The rule's executive summary provides a brief and basic discussion of a number of the changes being made. These include:

a. Transition for the Discontinuation of the Low Wage Index Hospital Policy

On July 23, 2024, the Court of Appeals for the D.C. Circuit held that the Secretary lacked authority under section 1886(d)(3)(E) of the Act or under the "adjustments" language of section 1886(d)(5)(I)(i) of the Act to adopt the low wage index hospital policy for FY 2020, and that the policy and related budget neutrality adjustment must be vacated. (Page 764)

CMS is discontinuing the low wage index hospital policy for FY 2026 and subsequent years. In addition, CMS is adopting a budget-neutral narrow transitional exception to the calculation of FY 2026 IPPS payments for low-wage index hospitals significantly impacted by the discontinuation of the low-wage index hospital policy.

If a hospital's FY 2026 wage index is decreasing by more than 9.75 percent from the hospital's FY 2024 wage index, then that hospital wage index would be equal to the additional FY 2026 amount the hospital would be paid under the IPPS if its FY 2026 wage index were equal to 90.25 percent of its FY 2024 wage index.

CMS is making this policy budget neutral through an adjustment applied to the standardized amounts for all hospitals.

b. Update to the IPPS Labor-Related Share (Page 14)

CMS is rebasing and revising the 2018-based IPPS market basket to reflect a 2023 base year. In addition, using the cost category weights from the 2023-based IPPS market basket, CMS has calculated a labor-related share of 66.0 percent, which it will use for discharges occurring on or after October 1, 2025. The labor-related share of 66.0 percent is 1.6 percentage points lower than the current labor-related share of 67.6 percent. This item affects hospitals in large urban areas. (Page 824)

c. Hospital Readmission Reduction Program (Page 14)

The Hospital Readmissions Reduction Program requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions.

CMS is finalizing the following proposals, beginning with the FY 2027 program year: "(1) Refine all six readmission measures to add Medicare Advantage patient cohort data; (2) reduce the applicable period from 3-years to 2-years and update codified regulation language; and (4) update and codify the Extraordinary Circumstances Exception (ECE) policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital with a modification."

[Yes, there is no number 3 above]

CMS is removing the COVID-19 exclusion from all six readmission measures.

CMS is not finalizing the proposal to include payment data for MA beneficiaries in the calculation of aggregate payments for excess readmissions. (Page 982)

d. Hospital Acquired Condition (HAC) Reduction Program (Page 15)

Section 1886(p) of the Act established the HAC Reduction Program under which payments to applicable hospitals are adjusted to provide an incentive to reduce hospital-acquired conditions. CMS is making a technical update to the NHSN Healthcare Associated Infection (HAI) measures baseline. CMS is also updating and codifying the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital. (Page 1,077)

e. Hospital Value-Based Purchasing (VBP) Program (Page 15)

Section 1886(o) of the Act requires the Secretary to establish a Hospital VBP Program under which value-based incentive payments are made in a fiscal year to hospitals based on their performance on measures established for a performance period for such fiscal year.

CMS is finalizing modifications to the THA/TKA Complications measure beginning with the FY 2033 program year [Yes, FY 2033 is correct]. CMS is also providing notice of the technical update to remove the COVID-19 exclusion from the six measures in the Clinical Outcomes domain beginning with the FY 2027 program year and the technical update to the five NHSN Healthcare Associated Infection (HAI) measures beginning with the FY 2029 program year.

CMS is also updating and codifying the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital.

CMS is also finalizing its proposal to remove the Program's Health Equity Adjustment (HEA) adjustment in the FY 2026 program year.

Lastly, CMS provides previously and newly established performance standards for FY 2027 through FY 2031 program years for the Hospital VBP Program. (Page 1,030)

f. Hospital Inpatient Quality Reporting (IQR) Program (Page 16)

CMS is finalizing modifications to four measures currently in the Hospital IQR Program measure set:

> (1) Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) beginning with the April 1, 2023–March 30, 2025 reporting period/2027 payment determination;
>
> (2) Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity beginning with the July 1, 2023–June 30, 2025 reporting period/2027 payment determination;
>
> (3) the Hybrid Hospital-Wide Readmission (HWR) measure beginning with the July 1, 2025, through June 30, 2026 Reporting Period/FY 2028 payment determination; and
>
> (4) the Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) measure beginning with the July 1, 2025, through June 30, 2026 reporting period/FY 2028 payment determination.

CMS is also finalizing the removal of four measures:

(1) the Hospital Commitment to Health Equity (measure beginning with the CY 2024 reporting period/FY 2026 payment determination;

(2) the COVID–19 Vaccination Coverage among HCP measure beginning with the CY 2024 reporting period/FY 2026 payment determination;

(3) the Screening for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 payment determination; and

(4) the Screen Positive Rate for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 payment determination.

CMS is finalizing its proposal to update and codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital with a modification. (Page 1,169)

g. PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program (Page 17)

CMS is finalizing its proposal to publicly report PCH data on both the Provider Data Catalog and on Care Compare and to make corresponding changes to regulatory text to replace references to "Provider Data Catalog" with "CMS website".

CMS is also finalizing its proposals to remove the (1) Hospital Commitment to Health Equity, (2) the Screening for Social Drivers of Health measure; and (3) the Screen Positive Rate for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 program year.

Lastly, CMS is finalizing its proposal to update and codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital with a modification. (Page 1,276)

h. Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (Page 17)

CMS is finalizing its proposal to remove one item from the Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) with respect to patients who have expired in the LTCH. CMS is also finalizing its proposal to the removal of four SDOH standardized patient assessment data elements from the LCDS. CMS is finalizing its proposal to amend the reconsideration request process in the LTCH QRP. (Page 1,289)

Summary of Costs and Benefits (Page 23)

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Transition for the Discontinuation of the Low Wage Index Hospital Policy	As discussed in section III.F.7. of the preamble of this rule, CMS is using its authority under section 1886(d)(5)(I)(i) of the Act to adopt a narrow transitional exception to the calculation of FY 2026 IPPS payments for low wage index hospitals significantly impacted by the discontinuation of the low wage index hospital policy, that would be implemented in a budget neutral manner. CMS is making this policy budget neutral through an adjustment applied to the standardized amounts for all hospitals.

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Update to the IPPS Labor-Related Share	As discussed in section IV. of the preamble of this final rule, CMS is rebasing and revising the 2018-based IPPS market basket to reflect a 2023 base year. In addition, using the cost category weights from the 2023-based IPPS market basket, CMS calculated a labor-related share of 66.0 percent, which will be used for discharges occurring on or after October 1, 2025. The labor-related share of 66.0 percent is 1.6 percentage points lower than the current labor-related share of 67.6 percent. This change is budget neutral
Update to the IPPS Payment Rates and Other Payment Policies	As discussed in Appendix A of this final rule, acute care hospitals are estimated to experience an increase of approximately **$5.0 billion** in FY 2026, primarily driven by the changes in FY 2026 operating payments, uncompensated care payments, and capital payments and the expiration of the temporary changes in the low-volume hospital program and the expiration of the MDH program on October 1, 2025.
Update to the LTCH PPS Payment Rates and Other Payment Policies	As discussed in Appendix A of this final rule, based on the best available data for the 329 LTCHs in CMS' database, CMS estimates that the changes to the payment rates and factors that are presented in the preamble of and Addendum of this final rule, which reflect the update to the LTCH PPS standard Federal payment rate for FY 2026, would result in an estimated increase in payments in FY 2026 of approximately **$83 million**.
Changes to the Hospital Readmission Reduction Program	CMS estimates that the changes for the Hospital Readmissions Reduction Program will result in no financial impact for the FY 2027 payment determination or subsequent years.
Changes to the Value-Based Incentive Payments under the Hospital VBP Program	CMS estimates that there will be no net financial impact to the Hospital VBP Program for the FY 2026 program year in the aggregate because, by law, the amount available for value-based incentive payments under the program in a given year must be equal to the total amount of base operating MS-DRG payment amount reductions for that year, as estimated by the Secretary. The estimated amount of base operating MS-DRG payment amount reductions for the FY 2026 program year and, therefore, the estimated amount available for value-based incentive payments for FY 2026 discharges is approximately **$1.7 billion**.
Changes to the HAC Reduction Program	CMS estimates that its changes for the HAC Reduction Program will result in no financial impact for the FY 2027 payment determination or subsequent years.
Changes to the Hospital IQR Program	Across 3,050 IPPS hospitals, CMS estimates that the changes for the Hospital IQR Program will result in a maximum decrease of 654,477 hours and $17,724,699 to the information collection burden for the FY 2026 payment determination or subsequent years.
Changes to the In the PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR) Program	Across 11 PCHs, CMS estimates that its changes for the PCHQR Program will result in a decrease of 107 hours and $2,921 to the information collection burden for the FY 2026 program year or subsequent years.
Changes to the LTCH QRP	Across 330 LTCHs, CMS estimates that its proposed changes for the FY 2026 LTCH QRP will result in a total information collection burden increase of 4 hours and $187.60 associated with updates to the reconsideration policy.
Changes to the Medicare Promoting Interoperability Program	Across 4,550 eligible hospitals and CAHs, CMS estimates that its changes for the Medicare Promoting Interoperability Program will not result in a change to the information collection burden for the EHR reporting period in CY 2026 and subsequent years.
Transforming Episode Accountability Model (TEAM)	CMS estimates for the TEAM proposals included in this final rule that there would be no significant change from the savings estimate in the FY 2025 IPPS/LTCH PPS final rule. Therefore, CMS estimates testing TEAM would result in saving the Medicare program $368 million across the 5 performance years.
Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit, and Electronic Prior Authorization (HTI-2) HTI-2 Assistant Secretary for	ASTP/ONC estimate that the total annual cost to developers of certified health IT and health IT purchasers for this final rule for the first year after it is finalized (including one-time costs), would result in $50.3 million. The total undiscounted cost over a 10-year period for this final rule (starting in year two) would result in $177.6 million. ASTP/ONC estimate the total costs to developers of certified health IT and health IT purchasers to be $228 million.

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Technology Policy (ASTP)/Office of the National Coordinator for Health Information Technology (ONC) (collectively, ASTP/ONC)	ASTP/ONC estimate the total annual benefit across all entities for progress toward interoperability (progress initiated by adoption of the criteria and standards set forth in this final rule, then implemented with intermediate activities that connect such adoption with the generation of benefits) beginning in 2027, when the associated policies are required to be implemented and expected benefits to be realized, would be on average **$1.0 billion.** ASTP/ONC estimate the total benefits across all entities to be $19.2 billion. This benefits estimate is not comparable with the quantification of costs (totaling $228 million over ten years) because the cost of some intermediate activities has not been estimated and the cost of other intermediate activities has been attributed to other regulatory provisions, such as the ones finalized by CMS at 89 FR 8758.
FY 2025 IFC	In section XI.C. of the preamble of this final rule, CMS finalizes the provisions of the FY 2025 IFC, which implemented revised Medicare wage index values for FY 2025, established a transitional payment exception for low wage hospitals significantly impacted by those revisions, and made conforming changes to the hospital IPPS payment rates for FY 2025. These changes reflect the removal of the low wage index hospital policy following the appellate court decision in Bridgeport Hosp. v. Becerra. That IFC also made conforming changes to IPPS rates and factors used to determine certain payments under the LTCH PPS for FY 2025. CMS estimates that acute care hospitals will experience an increase of approximately $41 million in FY 2025 due to the provisions of the FY 2025 IFC. This change is primarily due to the application of the non-budget neutral transitional payment exception policy

CHANGES TO THE PROSPECTIVE PAYMENT RATES

Changes in the Inpatient Hospital Update for FY 2026 (§ 412.64(d)) (Page 906)
The applicable percentage increase under the IPPS for FY 2026 is equal to the rate-of-increase in the hospital market basket for IPPS hospitals in all areas, subject to the following:

- **A reduction of one-quarter** of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) for hospitals that fail to submit quality information under rules established by the Secretary in accordance with section 1886(b)(3)(B)(viii) of the Act.

- **A reduction of three-quarters** of the applicable percentage increase (prior to the application of other statutory adjustments; also referred to as the market basket update or rate-of-increase (with no adjustments)) for hospitals not considered to be meaningful EHR users in accordance with section 1886(b)(3)(B)(ix) of the Act.

- An adjustment based on changes in economy-wide multifactor productivity (MFP) (the productivity adjustment) of -0.7 percent in accordance with section 1886(b)(3)(B)(xi)(II) of the Act.

Based on more recent data available for this FY 2026 IPPS/ LTCH PPS final rule (that is, IGI's second quarter 2025 forecast of the 2023-based IPPS market basket rate-of-increase with historical data through the first quarter of 2025), CMS estimates that the FY 2026 market basket increase used to determine the applicable percentage increase for the IPPS is **3.3 percent**. It was proposed at 3.2 percent. (Page 913)

For FY 2026, CMS proposed a productivity adjustment of -0.8 percent. Based on newer data the productivity factor is now **-0.7 percent.**

Therefore, the market basket update equals **2.6 percent**. (3.3-0.7=2.6)

CMS displays four possible applicable percentage increases as shown in the following table. (Page 921, and Page 1,855)

FY 2026 Applicable Percentage Increases For the IPPS (Page 1,835)

FY 2026	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data Is But NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data But 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 Failure to Submit Quality Data (Reduction of ¼ of market basket increase)	0.0	0.0	-0.825	-0.825
Adjustment for Failure to be a Meaningful EHR (Reduction of ¾ of market basket)	0.0	-2.475	0	-2.475
MFP Adjustment	-0.7	-0.7	-0.7	-0.7
Applicable Percentage Increase Applied to Standardized Amount	**2.6**	**0.125**	**1.775**	**-0.7**

The current (FY 2025) large urban labor rate (as corrected in the September 30, 2024 ***Federal Register)*** is $4,465.41 and the non-labor rate is $2,140.23 for a total of $6,605.64. The other area labor rate is $4,095.50 and the non-labor component is $2,510.14 also for a total of $6,605.47

The following table (Page 1,901) illustrates the changes from the current FY 2025 national standardized amounts to the final FY 2026 national standardized amounts.

The $6,605.47 amount is adjusted by dividing the outlier, geographic and the rural demonstration reclassification factors, etc. as shown in the table below resulting in a gross payment rate of $7,257.62 for FY 2025. This amount is then further adjusted by multiplying the FY 2026 adjustments.

Please note, we have added the combined labor/ non-labor amounts, and a row reflecting "totals."

Changes from FY 2025 Standardized Amounts to the Final FY 2026 Standardized Amounts (Page 1,901)

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2026 Base Rate after removing: 1. FY 2025 Geographic Reclassification Budget Neutrality (0.962786) 2. FY 2025 Operating Outlier Offset (0.949) 3. FY 2025 Rural Demonstration Budget Neutrality Factor (0.999811) 4. FY 2025 Cap Policy Wage Index Budget Neutrality Factor (0.999166) 5. *Missing a factor*	If Wage Index is Greater Than 1.0000: Labor (66.0%) $4,790.03 Nonlabor (34.0%) $2,467.59 *(Combined labor and nonlabor = $7,257.62)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,499.73 Nonlabor (38%) $2,757.73 *(Combined labor and nonlabor = $7,257.62)*	If Wage Index is Greater Than 1.0000: Labor (66.0%) $4,790.03 Nonlabor (34.0%) $2,467.59 *(Combined labor and nonlabor = $7,257.62)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,499.73 Nonlabor (38%) $2,757.73 *(Combined labor and nonlabor = $7,257.62)*	If Wage Index is Greater Than 1.0000: Labor (66.0%) $4,790.03 Nonlabor (34.0%) $2,467.59 *(Combined labor and nonlabor = $7,257.62)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,499.73 Nonlabor (38%) $2,757.73 *(Combined labor and nonlabor = $7,257.62)*	If Wage Index is Greater Than 1.0000: Labor (66.0%) $4,790.03 Nonlabor (34.0%) $2,467.59 *(Combined labor and nonlabor = $7,257.62)* If Wage Index is less Than or Equal to 1.0000: Labor (62%) $4,499.73 Nonlabor (38%) $2,757.73 *(Combined labor and nonlabor = $7,257.62)*
Proposed FY 2026 Update Factor	**1.0260**	**1.00125**	**1.01775**	**0.993**

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
FY 2026 MS-DRG Reclassification and Recalibration Budget Neutrality Factor Before Cap	0.998580	0.998580	0.998580	0.998580
FY 2026 Cap Policy MS–DRG Weight Budget Neutrality Factor	0.999897	0.999897	0.999897	0.999897
FY 2026 Wage Index Budget NeutralityFactor	1.001531	1.001531	1.001531	1.001531
FY 2026 Reclassification Budget Neutrality Factor	0.956835	0.956835	0.956835	0.956835
FY 2026 Cap Policy Wage Index Budget Neutrality Factor	0.999397	0.999397	0.999397	0.999397
Transition for the Discontinuation of the Low Wage Index Hospital Policy Budget Neutrality Factor	0.999726	0.999726	0.999726	0.999726
FY 2026 RCH Demonstration Budget Neutrality Factor	0.999552	0.999552	0.999552	0.999552
FY 2026 Operating Outlier Factor	0.949	0.949	0.949	0.949
Totals	$6,752.61	$6,675.26	$6,782.06	$6,621.86
National Standardized Amount for FY2026 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (66/34)	**Labor: $4,456.72 Nonlabor: $2,295.89**	**Labor: $4,405.67 Nonlabor: $2,269.59**	**Labor: $4,476.16 Nonlabor: $2,305.90**	**Labor: $4,370.43 Nonlabor: $2,251.43**
National Standardized Amount for FY2026 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $4,186.62 Nonlabor: $2,565.99**	**Labor: $4,138.66 Nonlabor: $2,536.60**	**Labor: $4,204.88 Nonlabor: $2,577.18**	**Labor: $4,105.55 Nonlabor: $2,516.31**

These amounts are before other adjustments such as the hospital value-based purchasing program, the hospital readmission program, and the hospital acquired conditions program.

Comment

For the 2025 year, a budget neutrality adjustment is missing. There were 5 factors shown in the proposed FY 2026 rule. By adjusting the FY 2025 listed 4 factors, you can not achieve the stated amount of $7,257.62. If you accept factor $7,257.62 as being correct and multiply by the 2026 factors, the standardized amounts above are correct.

The errors being made by CMS are simply inexcusable. It's difficult to now believe, if any calculations are correct throughout this document.

Changes to the IPPS for Capital-Related Costs (Pages 1,097 and 1,912)

The national capital Federal rate for FY 2026 is **$524.15**.

Comparison of Factors and Adjustments: FY 2025 Capital Federal Rate and the Final FY 2026 Capital Federal Rate (Page 1,926)

	FY 2025	FY 2026	Change	Percent Change
Update Factor[1]	1.0310	1.0280	1.0260	2.80
GAF/DRG Adjustment Factor[1]	0.9854	0.9918	0.9918	-0.82
GAF Cap/Transition Adjustment Factor[2]	0.9992	0.9989	0.9998	-0.02
Outlier Adjustment Factor[3]	0.9577	0.9616	1.0041	0.41
Capital Federal Rate	$512.14	**$524.15**	1.0235	2.35[4]

1 The update factor and the GAF/DRG budget neutrality adjustment factors are built permanently into the capital Federal rate. Thus, for example, the incremental change from FY 2025 to FY 2026 resulting from the application of the 0.9918 GAF/DRG budget neutrality adjustment factor for FY 2026 is a net change of 0.9918 (or -0.82 percent).
2 For FY 2025 the GAF Cap/Transition budget neutrality adjustment factor reflects only the FY 2025 budget neutrality factor for the 5-percent cap on wage index decreases policy. The GAF Cap/Transition budget neutrality adjustment factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2026 GAF Cap/Transition budget neutrality adjustment factor is 0.9989/0.9992 or 0.9998 (or -0.02 percent).
3 The outlier reduction factor is not built permanently into the capital Federal rate; that is, the factor is not applied cumulatively in determining the capital Federal rate. Thus, for example, the net change resulting from the application of the FY 2026 outlier adjustment factor is 0.9616/0.9577 or 1.0041 (or 0.41 percent).
4 Percent change may not sum due to rounding.

Outlier Payments (Page 1,860)

"Our current estimate, using available FY 2024 claims data, is that actual outlier payments for FY 2024 were approximately 5.17 percent of actual total MS-DRG payments. Therefore, the data indicate that, for FY 2024, the percentage of actual outlier payments relative to actual total payments is higher than we projected for FY 2024. Consistent with the policy and statutory interpretation we have maintained since the inception of the IPPS, we do not make retroactive adjustments to outlier payments to ensure that total outlier payments for FY 2024 are equal to 5.1 percent of total MS-DRG payments." (Page 1,899)

CMS is adopting an outlier fixed-loss cost threshold for FY 2026 equal to the prospective payment rate for the MS-DRG, plus any IME, empirically justified Medicare DSH payments, estimated uncompensated care payment, estimated supplemental payment for eligible IHS/Tribal hospitals and Puerto Rico hospitals, and any add on payments for new technology, plus **$40,397.** The current threshold is $46,217. (Page 1,896)

Comment

Once again, CMS argues that to make retroactive adjustments for errors in forecasting outlier payments "would remove an important aspect of the prospective nature of the IPPS. Because such an across-the-board adjustment would either lead to more or less outlier payments for all hospitals, hospitals would no longer be able to reliably approximate their payment for a patient while the patient is still hospitalized."

As we have said many times before, this rationale is ridiculous and absurd. There is a need to make adjustments for all errors in estimations. They do not have to be made retroactively. The skilled nursing PPS has an error correction process that changes the SNF market basket factors prospectively. CMS should be doing the same for all its PPS programs, including errors in not only outlier payments, but market basket payment updates as well.

Something seems amiss with the FY 2026 outlier threshold. If CMS overpaid for outliers in FY 2025, one would expect the FY 2026 threshold amount would be a higher.

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2026 (Pages 28, 825, 913 and 1,100)

Payments for services furnished in children's hospitals, 11 cancer hospitals, extended neoplastic disease care hospitals, and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (that is, hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa), and Religious nonmedical health care institutions (RNHCIs) are excluded from the IPPS and are paid on the basis of reasonable costs subject to a rate-of-increase ceiling.

The rate of ceiling increase is **3.3 percent**, in accordance with the applicable regulations at 42 CFR 413.40.

CHANGES TO THE HOSPITAL AREA WAGE INDEX FOR ACUTE CARE HOSPITALS (Page 708)

Cost Reporting Periods beginning in FY 2022 for FY 2026 Wage Index (Page 710)

The FY 2026 wage index values are based on the data collected from the Medicare cost reports submitted by hospitals for cost reporting periods beginning in FY 2022 (the FY 2025 wage indexes were based on data from cost reporting periods beginning during FY 2021).

Occupational Mix Adjustment to the FY 2026 Wage Index (Page 733)

The FY 2026 Occupational Mix *Adjusted* National Average Hourly Wage is **$57.92.**

The FY 2026 national average hourly wages for each occupational mix nursing subcategory are as follows:

Occupational Mix Nursing Subcategory	Average Hourly Wage
National RN	$60.47
National LPN and Surgical Technician	$35.05
National Nurse Aide, Orderly, and Attendant	$23.53
National Medical Assistant	$23.16
National Nurse Category	$50.12

Hospital Redesignations and Reclassifications (Page 738)

1. Urban to Rural Reclassification Under Section 1886(d)(8)(E) of the Act, Implemented at § 412.103

A qualifying prospective payment hospital located in an urban area may apply for rural status for payment purposes separate from reclassification through the MGCRB.

2. MGCRB Reclassification Issues for FY 2026 (Page 743)

There are 465 hospitals approved for wage index reclassifications by the MGCRB starting in FY 2026.

Because MGCRB wage index reclassifications are effective for 3 years, for FY 2026, hospitals reclassified beginning in FY 2024 or FY 2025 are eligible to continue to be reclassified to a particular labor market area based on such prior reclassifications for the remainder of their 3-year period. There were 309 hospitals approved for wage index reclassifications in FY 2024 that will continue for FY 2026, and 335 hospitals approved for wage index reclassifications in FY 2025 that will continue for FY 2026.

Of all the hospitals approved for reclassification for FY 2024, FY 2025, and FY 2026, (1,109 hospitals) (approximately 30 percent of IPPS hospitals) are in a MGCRB reclassification status for FY 2026.

Applications for FY 2027 reclassifications are due to the MGCRB by September 2, 2025.

Wage Index Adjustments: Rural Floor, Imputed Floor, State Frontier Floor, Out-Migration Adjustment, Low Wage Index Hospital, and Cap on Wage Index Decrease Policies (Page 754)

Rural Floor

Section 4410(a) of the ***Balanced Budget Act*** of 1997 provides that, for discharges on or after October 1, 1997, the area wage index applicable to any hospital that is located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas in that State.

CMS estimates that 961 hospitals will receive the rural floor in FY 2026.

Imputed Floor (Page 759)

Section 1886(d)(3)(E)(iv)(I) and (II) of the Act provides 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 described in § 412.64(h)(4)(vi) as in effect for FY 2018.

The imputed floor will continue to be applied for FY 2026 in accordance with the policies adopted in the FY 2022 IPPS/LTCH PPS final rule.

Hospitals in such States that will be eligible to receive an increase in their wage index due to application of the imputed floor for FY 2026, are identified in Table 3 (which is available on the CMS website). (Page 760)

State Frontier Floor for FY 2026 (Page 761)

In this rule, 23 hospitals, as opposed to 40 hospitals in the proposed rule, will receive the frontier floor value of 1.0000 for their FY 2026 wage index. These hospitals are located in Montana, North Dakota, South Dakota, and Wyoming. CMS notes that 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 (Page 764)

In the FY 2020 IPPS/LTCH PPS final rule, CMS finalized a temporary budget-neutral policy to address wage index disparities affecting **low-wage index hospitals**, which includes many rural hospitals. On July 23, 2024, the Court of Appeals for the D.C. Circuit held that the Secretary lacked authority under section 1886(d)(3)(E) or 1886(d)(5)(I)(ii) of the Act to adopt the low wage index hospital policy for FY 2020 and that the policy and related budget neutrality adjustment must be vacated. (Bridgeport Hosp. v. Becerra, 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024).

After considering the appellate court's decision, CMS is discontinuing the low wage index hospital policy for FY 2026 and subsequent years.

CMS now is adopting a budget-neutral narrow transitional exception to the calculation of FY 2026 IPPS payments for low-wage index hospitals significantly impacted by the discontinuation of the low-wage index hospital policy.

CMS will compare the hospital's FY 2026 wage index to the hospital's FY 2024 wage index. If the hospital is significantly impacted by the discontinuation of the low wage index hospital policy, meaning the hospital's FY 2026 wage index is decreasing by more than 9.75 percent from the hospital's FY 2024 wage index, then the transitional payment exception for FY 2026 for that hospital would be equal to the additional FY 2026 amount the hospital would be paid under the IPPS if its FY 2026 wage index were equal to 90.25 percent of its FY 2024 wage index. (Page 770)

REBASING AND REVISING OF THE HOSPITAL MARKET BASKETS FOR ACUTE CARE HOSPITALS (Page 786)

CMS spends more than 50 pages detailing its changes by revising and rebasing the hospital market basket. Perhaps the most significant change is to the labor-related share as shown in the table below.

Comparison of the 2018-Based Labor-Related Share and the 2023-Based Labor-Related Share (Page 824)

	2018-Based IPPS Market Basket Cost Weights	2023-Based IPPS Market Basket Cost Weights
Wages and Salaries	41.2	40.6
Employee Benefits	11.7	10.5
Professional Fees: Labor-Related	8.6	10.0
Administrative and Facilities Support Services	1.1	0.8
Installation, Maintenance, and Repair Services	2.4	1.5
All Other: Labor-Related Services	2.6	2.6
Total Labor-Related Share	**67.6**	**66.0**

PAYMENT ADJUSTMENT FOR MEDICARE DISPROPORTIONATE SHARE HOSPITALS (DSHS) FOR FY 2026 (§ 412.106) (Page 841)

Beginning with discharges in FY 2014, hospitals that qualify for Medicare DSH payments under section 1886(d)(5)(F) of the Act receive 25 percent of the amount they previously would have received under the statutory formula for Medicare DSH payments.

Section 1886(r)(2) of the Act provides that, for each eligible hospital in FY 2014 and subsequent years, the remaining estimate of 75 percent of uncompensated care payment is the product of three factors.

Factor (1) 75 percent of the total amount of DSH payments that would otherwise be made under section 1886(d)(5)(F) of the Act.

Factor (2) 1 minus the percent change in the percent of individuals who are uninsured.

Factor (3) The hospital's uncompensated care amount relative to the uncompensated care amount for all hospitals that receive DSH payments, expressed as a percentage

Calculation of Factor 1 for FY 2026 (Page 863)

This factor represents CMS' estimate of 75 percent of the estimate of Medicare DSH payments that would otherwise be made, in the absence of section 1886(r) of the Act, for the fiscal year.

Using the CMS' Office of the Actuary (OACTs) June 2025 OACT estimate for Medicare DSH payments for FY 2026, without regard to the application of section 1886(r)(1) of the Act, is approximately $16.550 billion. This amount was proposed at $15.682 billion.

Therefore, the final Factor 1 for FY 2026 is **$12,412,500,000**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2026 ($16,550,000,000 minus $4,137,500,000).

Calculation of Factor 2 for FY 2026 (Page 872)

The calculation of the Factor 2 for FY 2026 is as follows:

- Percent of individuals without insurance for CY 2013: 14 percent.
- Percent of individuals without insurance for CY 2025: 7.9 percent.
- Percent of individuals without insurance for CY 2026: 9.0 percent.
- Percent of individuals without insurance for FY 2026: (0.25 times 0.079) + (0.75 times 0.09) = 8.7 percent.
- FY 2026's Factor 2 is calculated as 1 minus the percent change in the percent of individuals without insurance between CY 2013 and FY 2026.

- Factor 2 is as follows: 1 – |((0.14 – 0.087)/0.14)| = 1 – 0.3786 = 0.6214

- Factor 2 for FY 2026 will be **62.14 percent**.

The FY 2026 uncompensated care amount is equivalent to Factor 1 multiplied by Factor 2, is **$ 7,713,127,500.**

The following shows the 75 percent yearly amounts for DSH payments.

• The FY 2014 "pool" was	$9.033 billion
• The FY 2015 "pool" was	$7.648 billion
• The FY 2016 "pool" was	$6.406 billion
• The FY 2017 "pool" was	$6.054 billion
• The FY 2018 "pool" was	$6.767 billion
• The FY 2019 "pool" was	$8.273 billion
• The FY 2020 "pool" was	$8.351 billion
• The FY 2021 "pool" was	$8.290 billion
• The FY 2022 "pool" was	$7.192 billion
• The FY 2023 "pool" was	$6.874 billion
• The FY 2024 "pool" was	$5.938 billion
• The FY 2025 "pool" was	$5.706 billion
• The FY 2026 pool will be	$7.713 billion

The pool amount for FY 2026 will be $2.007 billion more than the current FY 2025 amount.

Calculation of Factor 3 for FY 2026 (Page 872)

Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital and each subsection (d) Puerto Rico hospital with the potential to receive Medicare DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive Medicare DSH payments in the fiscal year for which the uncompensated care payment is to be made.

For FY 2026, consistent with § 412.106(g)(1)(iii)(C)(11), CMS is using the most recent 3 years of audited cost reports, from FY 2020, FY 2021, and FY 2022. (Page 883)

OTHER PROPOSED DECISIONS AND CHANGES TO THE IPPS FOR OPERATING COSTS (Page 897)

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (§ 412.96) (Page 927)

A rural hospital with less than 275 beds may be classified as an RRC if—

- The hospital's case-mix index (CMI) is at least equal to the lower of the median CMI for urban hospitals in its census region, excluding hospitals with approved teaching programs, or the median CMI for all urban hospitals nationally; and
- The hospital's number of discharges is at least 5,000 per year, or, if fewer, the median number of discharges for urban hospitals in the census region in which the hospital is located. (The number of discharges criterion for an osteopathic hospital is at least 3,000 discharges.)

Case-mix (Page 930)

If rural hospitals with fewer than 275 beds are to qualify for initial RRC status for cost reporting periods beginning on or after October 1, 2025, they must have a CMI value for FY 2024 that is

- **1.7801** (national--all urban); or
- The median CMI value (not transfer-adjusted) for urban hospitals (excluding hospitals with approved teaching programs as identified in § 413.75) calculated by CMS for the census region in which the hospital is located.

The CMI values by region are set forth in the following table:

Region	e-MixIndex Values
1. New England (CT, ME, MA, NH, RI, VT)	1.4962
2. Middle Atlantic (PA, NJ, NY)	1.5580
3. East North Central (IL, IN, MI, OH, WI)	1.6264
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.7413
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.6352
6. East South Central (AL, KY, MS, TN)	1.5965
7. West South Central (AR, LA, OK, TX)	1.7594
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.8070

Region	e-MixIndex Values
9. Pacific (AK, CA, HI, OR, WA)	1.78045

A hospital must also have the number of discharges for its cost reporting period that began during FY 2023 a figure that is at least—

- 5,000 (3,000 for an osteopathic hospital); or
- If less, the median number of discharges for urban hospitals in the census region in which the hospital is located.

CMS says that because the median number of discharges for hospitals in each census region is greater than the national standard of 5,000 discharges, 5,000 discharges is the minimum criterion for all hospitals, except for osteopathic hospitals for which the minimum criterion is 3,000 discharges.

Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Page 934)

Absent further Congressional action, beginning October 1, 2025, the **low-volume hospital** qualifying criteria and payment adjustment are set to revert to the statutory requirements that were in effect prior to FY 2011, and the preexisting low-volume hospital payment adjustment methodology and qualifying criteria, as implemented in FY 2005 will resume.

Effective FY 2026 and subsequent years, under current policy at § 412.101(b), to qualify as a low-volume hospital, a subsection (d) hospital must be more than 25 road miles from another subsection (d) hospital and have less than **200** discharges (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges) during the fiscal year. For FY 2026 and subsequent years, the statute specifies that a low-volume hospital must have less than **800** discharges during the fiscal year.

Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108) (Page 946)

Beginning with discharges occurring on or after October 1, 2025, absent further Congressional action, all hospitals that previously qualified for MDH status will be paid based on the Federal rate.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83) (Page 953)

This section is devoted to counting of FTEs, Calculating Full-time Equivalent Counts and Caps for Cost Reporting Periods Other than Twelve Months.

Reasonable Cost Payment for Nursing and Allied Health Education Programs (§413.85 and 413.87) (Page 965)

Medicare has historically paid providers for Medicare's share of the costs that providers incur in connection with approved educational activities. The costs of these activities are excluded from the definition of "inpatient hospital operating costs" and are not included in the calculation of payment rates for hospitals or hospital units paid under the IPPS, IRF PPS, or IPF PPS, and are excluded from the rate-of-increase ceiling for certain facilities not paid on a PPS. These costs are separately identified and "passed through" (that is, paid separately on a reasonable cost basis).

For CY 2024, the national rates and percentages, and their data sources, are set forth in the table below.

Final CY 2024 NAH MA Rates	Final CY 2024	SOURCE
NAH Pass-Through	$277,260,868	Cost reports ending in FY 2022 HCRIS
Part A Inpatient Days	75,307,860	Cost reports ending in FY 2022 HCRIS
MA Inpatient Days	16,306,570	Cost reports ending in FY 2022 HCRIS
Part A Direct GME	$3,086,768,889	CY 2022 HCRIS + CPI-U + MA enrollment
MA Direct GME	$2,571,220,535	CY 2022 HCRIS + CPI-U + MA enrollment
Pool (not to exceed $60 million)	$60,000,000	((MA DGME /Part A DGME) * (NAH Pass-through))
Percent Reduction to MA DGME Payments	2.33%	Pool/MA direct GME

Hospital Readmissions Reduction Program Updates and Changes (Page 982)

CMS is modifying the 6 readmission measures to add Medicare Advantage (MA) data. (Page 1,003)

CMS proposed to update the Hospital Readmissions Reduction Program measure set to include integrating MA beneficiaries into each measure's cohorts and reducing the applicable period from a three-year period to a two-year period. (Page 1,012)

CMS is modifying the original proposal to not include MA data in the calculations of aggregate payments for excess readmissions.

CMS is updating and codifying the ECE policy to clarify that CMS has the discretion to grant an extension in response to ECE requests. After reviewing public comments, CMS is modifying the original proposal by extending the length of time to submit an ECE request from the proposed 30 days to 60 days.

Comment

Medicare says "based on our analysis, as shown in TABLE VI.K-03 below, the updated estimated average change in Medicare savings per hospital from the newly finalized updates is $2,265, with 1,305 hospitals having a greater penalty amount and 1,666 hospitals having the same or lower penalty amount. (Page 1,020)

We are unable to reconcile CMS' numbers above and in the table below. However, it does appear that by adding the Medicare Advantage Cohort will result in more hospitals being penalized by this program.

Please refer to table VI.K-02 (page 1,015) and table VI.K-04 (Page 1,023) for more information on this item.

Estimated Total Medicare Savings of Newly Finalized Addition of MA Cohort to Hospital Readmissions Reduction Program Measure Set

	Current methodology FY 2025	Newly Finalized updates	Difference between Finalized and current methodology FY 2025	Percentage difference between Finalized updates and current methodology FY 2025
Estimated total Medicare savings	$316,131,336	$322,109,431	$5,978,095	2%
Number of penalized hospitals	2,342	2,410	68	3%

Hospital Value-Based Purchasing (VBP) Program (Page 1,030)

The Hospital VBP Program is a budget-neutral program funded by reducing participating hospitals' base operating DRG payments each fiscal year by 2.0 percent and redistributing the entire amount back to the hospitals as value-based incentive payments. the estimated amount available for value-based incentive payments to hospitals for FY 2026 remains the same as proposed, approximately $1.7 billion.

CMS is finalizing changes to the COMP-HIP-KNEE measure's cohort to take effect with the FY 2033 Hospital VBP Program year, following their implementation in the Hospital IQR Program beginning with the FY 2027 payment determination. CMS notes that this effective date will provide hospitals with sufficient time to understand if and how the new patient cohort will affect their performance assessment under the Hospital VBP Program. (Page 1,043)

CMS says it intends to remove the COVID-19 exclusions from the five condition- and procedure-specific mortality measures and one procedure-specific complication measure beginning with the FY 2027 program year. This technical update will modify the technical specifications of the MORT–30–AMI, MORT–30– CABG, MORT–30–COPD, MORT–30–HF, and MORT–30–PN measures to include the ICD–10 codes that identify patients with a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 coded as present on admission on the index admission claim. (Page 1,049)

Summary of Previously Adopted Quality Measures for the Hospital VBP Program (Page 1,052)

Beginning on page 1,053 and continuing through page 1,056, CMS provides tables with adopted measures and baseline performance periods.

The following table contains the performance standards for the FY 2027 program year. (Page 1,060)

Measure Short Name	Achievement Threshold	Benchmark
Clinical Outcomes Domain*		
MORT-30-AMI	0.877824	0.893133
MORT-30-HF	0.887571	0.913388
MORT-30-PN	0.844826	0.877204
MORT-30-COPD	0.917395	0.932640
MORT-30-CABG	0.971149	0.980752
COMP-HIP-KNEE**	0.023322	0.017018

There are similar tables for FYs 2028, 2029, 2030, 2031

CMS is finalizing its proposal to remove the Health Equity Adjustment from the Hospital VBP Program effective with the FY 2026 program year. (Page 1,075)

Hospital-Acquired Condition Reduction Program Updates and Changes (HACRP) (Page 1,077)

The HAC Reduction Program creates an incentive for hospitals to reduce the incidence of hospital-acquired conditions by reducing payment by 1.0 percent for applicable hospitals that rank in the worst-performing quartile on select measures of hospital-acquired conditions.

CMS did not propose to add or remove any measures in the proposed rule. CMS estimates 721 hospitals will be impacted negatively. (Page 2,040)

CHANGES TO THE MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Page 39)

Changes to Specific MS-DRG Classifications (Page 42)

Listed below are specific MS-DRG items CMS is addressing in this rule.

- Pre-MDC MS-DRG 018 Chimeric Antigen Receptor (CAR) T-cell and Other Immunotherapies (Page 57)

- Logic for MS-DRGs 023 through 027 (Page 77)

  CMS is finalizing its proposal to add procedure codes 00H001Z, 00H005Z, 00H031Z, and 00H041Z to the "Chemotherapy Implant" logic list in MS-DRGs 023 and 024, without modification, effective October 1, 2025. CMS is also finalizing the change of the description of the logic list in MS-DRGs 023 and 024 from "Chemotherapy Implant" to "Antineoplastic Implant". (Page 84)

  CMS says it believes that further analysis of cases reporting the insertion of a radioactive element into the brain and cases reporting a neurostimulator generator inserted into the skull with the insertion of a neurostimulator lead into the brain (including cases involving the use of the RNS® neurostimulator) and a principal diagnosis of epilepsy is needed prior to generally finalizing further reassignment of these cases to ensure clinical and resource coherence between these cases and the other cases with which they may potentially be grouped. Accordingly, CMS believes it would be appropriate to take additional time to examine the relevant clinical factors and similarities in resource consumption in order to best represent these subsets of patients within the MS–DRG classification and improve the overall accuracy of the IPPS payments. (Page 108)

  CMS is not finalizing its proposal to add 114 procedure code combinations to a "Intracranial Neurostimulator Implant" logic list in MS-DRGs 020, 021, and 022 that describe 1) the insertion of multiple or single array neurostimulator generators with the insertion of a neurostimulator lead into the brain or the cerebral ventricle and 2) the insertion of neurostimulator generator inserted into the skull with the insertion of a neurostimulator lead into the brain. Accordingly, the "Major Device Implant," "Epilepsy Principal Diagnosis,"

  "Neurostimulator" logic lists will be maintained in MS-DRGs 023 and 024 for FY 2026. (Page 110)

  CMS is also not finalizing its proposals to change the titles of MS-DRGs 020, 021, and 022 from "Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage with MCC, with CC, and without CC/MCC, respectively" to "Intracranial Vascular Procedures with Principal Diagnosis Hemorrhage or Intracranial Neurostimulator Implant with MCC, with CC, and without CC/MCC, respectively," to change the title of MS-DRG 023 from "Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator" to "Craniotomy with Acute Complex Central Nervous System Principal Diagnosis with MCC or Antineoplastic Implant," or to change the title of MS-DRG 024 from "Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principal Diagnosis without MCC" to "Craniotomy with Acute Complex Central Nervous System Principal Diagnosis without MCC." (Page 110)

  CMS is finalizing the addition of the 36 ICD-10-PCS procedure code combinations that describe the implantation of a deep brain stimulators (DBS) system with a single array stimulator generator or a rechargeable single array stimulator generator and the insertion of a

neurostimulator lead into the brain to the "Major Device Implant" logic list in MS-DRGs 023 and 024. CMS refers the reader to Table 6P.2b for the list of the 36 ICD-10-PCS procedure code combinations that describe the implantation of a DBS system with a single array stimulator generator or a rechargeable single array stimulator generator and the insertion of a neurostimulator lead into the brain that are being added to the "Major Device Implant" logic list in MS-DRGs 023 and 024. (Page 112)

CMS is finalizing its proposal to add the 57 procedure codes to the "Intracranial Vascular Procedures" logic list, and the 66 diagnosis codes to the "Hemorrhage Principal Diagnosis" logic list of MS-DRGs 020, 021, and 022, with modification, effective October 1, 2025, for FY 2026. Specifically, CMS is also adding ICD-10-PCS codes 057L0DZ, 057L0ZZ, 057L3ZZ, and 057L4ZZ that also describe dilation of an intracranial vein to the list of procedure codes in the "Intracranial Vascular Procedures" logic list of MS-DRGs 020, 021, and 022. The list of ICD-10-PCS procedure codes describing intracranial vascular procedures that CMS is finalizing to add to the "Intracranial Vascular Procedures" logic list of MS-DRGs 020, 021, and 022 are shown in Table 6P.2c..

- Hypertensive Encephalopathy (Page 116)

  CMS is finalizing its proposal to delete MS-DRGs 077, 078, and 079. Additionally, CMS is finalizing its proposal to reassign ICD-10-CM diagnosis code I67.4 (Hypertensive encephalopathy) from MDC 01 MS-DRGs 077, 078, and 079 to MS-DRGs 070, 071, and 072. CMS is also finalizing its proposal to change the titles of MS-DRGs 070, 071, and 072 from "Nonspecific Cerebrovascular Disorders, with MCC, with CC, and without CC/MCC, respectively" to "Other Cerebrovascular Disorders with MCC, with CC, and without CC/MCC, respectively", without modification, effective October 1, 2025, for FY 2026. (Page 125)

  CMS is finalizing its proposal with modification. Specifically, CMS is finalizing its proposal to change the titles of MS-DRGs 067 and 068 from "Nonspecific CVA and Precerebral Occlusion without Infarction with MCC and without MCC", respectively, to "Precerebral Occlusion without Infarction with MCC and without MCC", respectively, effective October 1, 2025. Under this finalization, the title of MS-DRG 069 will be maintained as "Transient Ischemia without Thrombolytic" for FY 2026. (Page 126)

- Encounter for Adjustment and Management of Implanted Devices of the Special Senses (Page 126)

  CMS is finalizing, without modification, its proposal to reassign ICD-10-CM diagnosis code Z45.31 from MDC 01 MS-DRGs 091, 092, and 093 to MDC 02 MS-DRG 123 (Neurological Eye Disorders). CMS is also finalizing its proposal to reassign ICD-10-CM diagnosis codes Z45.320, Z45.321, and Z45.328 from MS-DRGs 091, 092, and 093 to MDC 03 MS-DRGs 154, 155, and 156 (Other Ear, Nose, Mouth and Throat Diagnoses with MCC, with CC, and without CC/MCC, respectively). (Page 128)

- Endovascular Aneurysm Repair (EVAR) with Iliac Branch Procedures (Page 129)

  CMS is finalizing its proposal, without modification, to create new base MS-DRG 213 (Endovascular Abdominal Aorta and Iliac Branch Procedures) for FY 2026. (Page 136)

- Concomitant Single Valve Procedure with Open Surgical Ablation (Page 136)

CMS is finalizing its proposal to maintain the structure of MS-DRGs 216, 217, and 218 for FY 2026, without modification. CMS is also finalizing its proposal to maintain the title of MS-DRGs 216, 217, and 218 as "Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC, with CC, and without CC/MCC, respectively" for FY 2026. (Page 149)

- Transcatheter Aortic Valve Replacement Procedures for Aortic Regurgitation (Page 149)

  CMS is finalizing its proposal to maintain the GROUPER logic for MS-DRGs 266 and 267 for FY 2026, without modification. CMS is also finalizing its proposal to maintain the title of MS-DRGs 215 as "Other Heart Assist System Implant" for FY 2026. (Page 159)

- Percutaneous Coronary Atherectomy (Page 159)

  CMS is finalizing its proposal to create new MS-DRG 359 (Percutaneous Coronary Atherectomy with Intraluminal Device with MCC), new MS-DRG 360 (Percutaneous Coronary Atherectomy with Intraluminal Device without MCC) and new MS-DRG 318 (Percutaneous Coronary Atherectomy without Intraluminal Device) for cases reporting percutaneous or percutaneous endoscopic coronary atherectomy, without modification, for FY 2026.

  CMS refers the reader to Table 6P.4a and Table 6P.4b. (Page 170)

- Complex Aortic Arch Procedures (Page 170)

  CMS is finalizing its proposal to create new MS-DRG 209 (Complex Aortic Arch Procedures), with modification, effective October 1, 2025, for FY 2026. Specifically, CMS is adding 20 ICD-10-PCS codes to the list of procedure codes that describe other complex aortic arch procedures when reported with ICD-10-PCS code 02VX3EZ in the logic for the new MS-DRG 209. (Page 189)

- Deep Vein Thrombophlebitis (Page 190)

  CMS is finalizing, without modification, its proposal to delete MS-DRGs 294 and 295 and reassign the 35 diagnosis codes describing deep vein thrombophlebitis that are currently assigned to MS-DRGs 294 and 295 to MS-DRGs 299, 300, and 301 for FY 2026. (Page 194)

- Hip or Knee Procedures with Periprosthetic Joint Infection (Page 194)

  CMS is not finalizing its proposal to create new MS-DRGs 403 and 404 (Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC and without MCC, respectively) for FY 2026. (Page 206)

- Arthroscopy (Page 206)

  CMS is finalizing, without modification, its proposal to delete MS-DRG 509 and to reassign the 47 procedure codes describing arthroscopy of various anatomic sites to clinically appropriate MS-DRGs, as reflected in Table 6P.7a. (Page 210)

- MS-DRG Logic for MS-DRGs 456, 457, and 458 (Page 210)

  CMS is finalizing, without modification, its proposal to add 47 diagnosis codes to the logic list titled "Spinal Curvature/Malignancy/Infection" in MS-DRGs 456, 457, and 458, effective October 1, 2025 for FY 2026. CMS is also finalizing, without modification, its proposal to

remove the eight codes from the logic list titled "Spinal Curvature/Malignancy/Infection" in MS-DRGs 456, 457, and 458, effective October 1, 2025 for FY 2026. (Page 213)

- Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989 (Page 214)

  CMS is finalizing its proposal to add ICD-10-PCS procedure codes 0W3R0ZZ, 0W3R3ZZ, 0W3R4ZZ, 0W3R7ZZ, and 0W3R8ZZ to MDC 16, without modification, for FY 2026. Under this finalization, cases reporting a procedure code describing the control of bleeding in the genitourinary tract with a principal diagnosis of a hemorrhagic disorder due to extrinsic circulating anticoagulants (diagnosis code D68.32) in MDC 16 would group to MS-DRGs 802, 803, and 804. (Page 217)

  CMS is finalizing its proposal to add ICD-10-PCS code 0WPG33Z to MDC 21 for FY 2026. Under this finalization, cases reporting procedure code 0WPG33Z (Removal of infusion device from peritoneal cavity, percutaneous approach) with a principal diagnosis of an infection and inflammatory reaction due to peritoneal dialysis catheter, initial encounter (diagnosis code T85.71XA) in MDC 21 would group to MS-DRGs 907, 908, and 909. (Page 221)

- Non-O.R. Procedures to O.R. Procedures (228)

  CMS is finalizing its proposal to maintain the current non-O.R. designation of ICD-10-PCS procedure codes 0N9T0ZZ and 0N9V0ZZ, without modification, for FY 2026.

  CMS is finalizing its proposal to change the designation of procedure code 0W950ZZ (Drainage of lower jaw, open approach) from O.R. procedure to non-O.R. procedure, without modification, effective October 1, 2025. Under this finalization, this procedure code would no longer impact MS-DRG assignment. (Page 233)

- Introduction of Paclitaxel-Coated Balloon Catheter Technology (Page 233)

  CMS is finalizing its proposal to maintain the designation of the 16 procedure codes describing use of the AGENT™ Paclitaxel-Coated Balloon Catheter technology as non-O.R. for FY 2026.

- Endoscopic Drainage of the Ureter with Drainage Device (Page 242)

  CMS is finalizing its proposal to change the designation of procedure codes 0T9680Z, 0T9780Z, and 0T9880Z from non-O.R. procedures to O.R. procedures, without modification, effective October 1, 2025. (Page 243)

In association with this FY 2026 IPPS/LTCH PPS final rule, CMS is making the following tables available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html (Page 274) *(This link does not work)*

- Table 6A.—New Diagnosis Codes–FY 2026;
- Table 6B.—New Procedure Codes–FY 2026;
- Table 6C.—Invalid Diagnosis Codes–FY 2026;
- Table 6D.—Invalid Procedure Codes–FY 2026;
- Table 6E.—Revised Diagnosis Code Titles–FY 2026;
- Table 6F.—Revised Procedure Code Titles–FY 2026;
- Table 6G.1.— Secondary Diagnosis Order Additions to the CC Exclusions List–FY 2026;
- Table 6G.2.— Principal Diagnosis Order Additions to the CC Exclusions List–FY 2026;
- Table 6H.1.— Secondary Diagnosis Order Deletions to the CC Exclusions List–FY 2026;

- Table 6H.2.— Principal Diagnosis Order Deletions to the CC Exclusions List—FY 2026;
- Table 6I.— Complete MCC List–FY 2026;
- Table 6I.1.— Additions to the MCC List–FY 2026;
- Table 6J.— Complete CC List–FY 2026;
- Table 6J.1.— Additions to the CC List–FY 2026;
- Table 6J.2.— Deletions to the CC List–FY 2026; and
- Table 6K.— Complete List of CC Exclusions-FY 2026

Comment

This is a long section, extending nearly 300 pages. There are additional DRG changes that have not been addressed. Most involve Changes to the Surgical Hierarchies, Maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems, and Replaced Devices Offered without Cost or with a Credit.

This section is a perfect example where significant reductions of prior history can be reduced. Why does CMS believe it is necessary to explain changes made to the various MS-DRGs over the past decade if not longer.

Changes to MS–DRGs Subject to Post acute Care Transfer Policy and MS–DRG Special Payments Policies (§ 412.4) (Page 897)

CMS is making the following DRG changes with respect to whether or not the DRG changes would be impacted by CMS' post-acute transfer policies.

List of New or Revised MS-DRGs Subject To Review of Post acute Care Transfer Policy Status for FY 2026 (Page 903)

New or Revised MS-DRG	MS-DRG Title	Total Cases	Post acute Care Transfer Cases (55th percentile: 1,028)	Short- Stay Post acute Care Transfer Cases	Percent of Short Stay Post acute Care Transfers to all Cases (55th percentile: 9.5453%)	FY 2025 Post acute Transfer Policy Status	Post acute Care Transfer Policy Status
209	Complex Aortic Arch Procedures	335	187*	26	7.3%*	New	No
213	Endovascular Abdominal Aorta with Iliac Branch Procedures	1,168	186*	0	0%*	New	No
318	Percutaneous Coronary Atherectomy without Intraluminal Device	904	163*	7	0.8%*	New	No
359	Percutaneous Coronary Atherectomy with Intraluminal Device with MCC	30,443	8,487	798	2.6%*	New	No
360	Percutaneous Coronary Atherectomy with Intraluminal Device without MCC	46,131	4,209	0	0%*	New	No
321	Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ arteries/intraluminal devices	3,034	873*	66	2.2%*	No	No
322	Percutaneous Cardiovascular Procedures with Intraluminal Device without MCC	3,953	398*	36	0.9%*	No	No

** Indicates a current post-acute care transfer policy criterion that the MS-DRG did not meet.*
*** As described in the policy at 42 CFR 412.4(d)(3)(ii)(D), MS-DRGs that share the same base MS-DRG will all qualify under the post-acute care transfer policy if any one of the MS-DRGs that share that same base MS-DRG qualifies.*

The post-acute care transfer and special payment policy status of all MS–DRGs is reflected in Table 5, on the CMS website.

REPLACED DEVICES OFFERED WITHOUT COST OR WITH A CREDIT (Page 291)

CMS is finalizing its proposal to add new MS-DRGs 209 and 213 to the list of MS-DRGs subject to the policy for payment under the IPPS for replaced devices offered without cost or with a credit for FY 2026. (Page 295)

The list of MS-DRGs in the rule's table on page 296 will be subject to the replaced devices offered without cost or with a credit policy effective October 1, 2025.

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES FOR FY 2026 (Page 322)

Continuation of Technologies Approved for FY 2025 New Technology Add-On Payments Still Considered New for FY 2026 Because the 3-Year Anniversary Date Will Occur On or After April 1, 2026 (Page 354)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Maximum NTAP Amount for FY 2026	Coding Used to Identify Cases Eligible for NTAP
1	*CYTALUX® (pafolacianine) (lung indication)*	*06/05/2023*	*10/01/2023*	*06/05/2026*	$2,762.50	8E0W0EN, 8E0W3EN, 8E0W4EN, 8E0W7EN, or 8E0W8EN
2	*EPKINLY™ (epcoritamab-bysp) and COLUMVI™ (glofitamab-gxbm)*	*05/19/2023*	*10/01/2023*	*05/19/2026*	$6,504.07	XW013S9, XW033P9, or XW043P9
3	*Aveir™ AR Leadless Pacemaker*	*06/29/2023*	*10/01/2023*	*06/29/2026*	$10,725.00	X2H63V9
4	*Aveir™ Dual-Chamber Leadless Pacemaker*	*06/29/2023*	*10/01/2023*	*06/29/2026*	$15,600.00	X2H63V9 in combination with X2HK3V9
5	*Ceribell Status Epilepticus Monitor*	*05/23/2023*	*10/01/2023*	*05/23/2026*	$913.90	XX20X89
6	*DETOUR System*	*06/07/2023*	*10/01/2023*	*06/07/2026*	$16,250.00	X2KH3D9, X2KH3E9, X2KJ3D9, or X2KJ3E9
7	*DefenCath® (taurolidine/heparin)*	*11/15/2023*	*01/01/2024*	*11/15/2026*	$3,656.10	XY0YX28
8	*Phagenyx® System*	*04/12/2023*	*10/01/2023*	*04/12/2026*	$3,250.00	XWHD7Q7
9	*REZZAYO™ (rezafungin for injection)*	*07/19/2023*	*10/01/2023*	*07/19/2026*	$4,387.50	XW033R9 or XW043R9
10	*TOPS™ System*	*06/15/2023*	*10/01/2023*	*06/15/2026*	$11,375.00	XRHB018 in combination with M48.062
11	*XACDURO® (sulbactam/durlobactam)*	*05/23/2023*	*10/01/2023*	*05/23/2026*	$13,680.00	XW033K9 or XW043K9 in combination with one of the following: Y95 and J15.61; OR J95.851 and B96.83
12	*SAINT Neuromodulation System*	*	*10/01/2023*	*	$12,675.00	X0Z0X18

Continuation of Technologies Approved for FY 2025 New Technology Add-On Payments Still Considered New for FY 2026 Because The 3-Year Anniversary Date Will Occur On or After October 1, 2025 (Page 354)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Maximum NTAP Amount for FY 2026	*Coding Used to Identify Cases Eligible for NTAP*
1	*Annalise Enterprise CTB Triage—OH*	*10/10/2023*	*10/01/2024*	*10/10/2026*	$241.39	XXEOXIA
2	*ASTar® System*	*04/26/2024*	*10/01/2024*	*04/26/2027*	$97.50	XXE5X2A
3	*Edwards EVOQUE™ Tricuspid Valve Replacement System ("EVOQUE™ System")*	*02/01/2024*	*10/01/2024*	*02/01/2027*	$31,850.00	X2RJ3RA
4	*GORE® EXCLUDER® Thoracoabdominal Branch Endoprosthesis (TAMBE Device)*	*01/12/2024*	*10/01/2024*	*01/12/2027*	$47,238.75	X2VE3SA
5	*LimFlow™ System*	*11/01/2023*	*10/01/2024*	*11/01/2026*	$16,250.00	041M3JS, 041N3JS, 041P3JS, 041Q3JS, 041R3JS, 041S3JS, 041T3JS, or 041U3JS
6	*Paradise™ Ultrasound Renal Denervation System*	*11/7/2023*	*10/01/2024*	*11/07/2026*	$14,950.00	XO551329
7	*PulseSelect™ Pulsed Field Ablation (PFA) Loop Catheter*	*12/13/2023*	*10/01/2024*	*12/13/2026*	$6,337.50	02583ZF
8	*Symplicity Spyral™ Multi-Electrode Renal Denervation Catheter*	*11/17/2023*	*10/01/2024*	*11/17/2026*	$10,400.00	X05133A
9	*TriClip™ G4*	*04/01/2024*	*10/01/2024*	*04/01/2027*	$26,000.00	02UJ3JZ
10	*VADER® Pedicle System*	*02/26/2024*	*10/01/2024*	*02/26/2027*	$28,242.50	XRH60FA, XRH63FA, XRH64FA, XRH70FA, XRH73FA, XRH74FA, XRH80FA, XRH83FA, XRH84FA, XRHA0FA, XRHA3FA, XRHA4FA, XRHB0FA, XRHB3FA, XRHB4FA, XRHC0FA, XRHC3FA, XRHC4FA, XRHD0FA, XRHD3FA, or XRHD4FA in combination with one of the following: M46.20, M46.22, M46.23, M46.24, M46.25, M46.26, M46.27, M46.30, M46.32, M46.33, M46.34, M46.35, M46.36, M46.37, M46.39, M46.40, M46.42, M46.43, M46.44, M46.45, M46.46, M46.47, M46.49, M46.50, M46.51, M46.52, M46.53, M46.54, M46.55, M46.56, M46.57, M46.59, M46.80, M46.82, M46.83, M46.84, M46.85, M46.86, M46.87, M46.89, M46.90, M46.92, M46.93, M46.94, M46.95, M46.96, M46.97, or M46.99
11	*ZEVTERA™ (ceftobiprole medocaril); ABSSSI and CABP indications*	*	*10/01/2024*	*	$5,287.50	XW0335A or XW0435A
12	*ZEVTERA™ (ceftobiprole medocaril); SAB indication*	*	*10/01/2024*	*	$16,215.00	XW0335A or XW0435A in combination with

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Maximum NTAP Amount for FY 2026	*Coding Used to Identify Cases Eligible for NTAP*
						R78.81 (in combination with B95.61 or B95.62)
13	*CASGEVY™ (exagamglogene autotemcel); Sickle Cell Disease indication*	*12/08/2023*	*10/01/2024*	*12/08/2026*	$1,650,000.00	*XW133J8 or XW143J8 in combination with one of the following: D57.1, D57.20, D57.40, D57.42, D57.44, or D57.80*
14	*HEPZATO™ KIT (melphalan for injection/hepatic delivery system)*	*01/08/2024*	*10/01/2024*	*01/08/2027*	$118,625.00	*XW053T9 in combination with 5A1C00Z*
15	*LYFGENIA™ (lovotibeglogene autotemcel)*	*12/08/2023*	*10/01/2024*	*12/08/2026*	$2,325,000.00	*XW133H9 or XW143H9*

*CMS notes that as discussed later in this section, CMS is continuing to consider the applicable newness start date for this technology, but that it would continue to be eligible for new technology add-on payment in FY 2026.

Discontinuation of Technologies Approved for FY 2025 New Technology Add-On Payments No Longer Considered New for FY 2026 Because 3-Year Anniversary Date Will Occur Prior to April 1, 2026 (Page 365)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
1	*Thoraflex™ Hybrid Device*	*04/19/2022*	*10/01/2022*	*04/19/2025*	87 FR 48974 through 48975 88 FR 58800 89 FR 69120 through 69126
2	*ViviStim® Paired VNS System*	*04/29/2022*	*10/01/2022*	*04/29/2025*	87 FR 48975 through 48977 88 FR 58800 89 FR 69120 through 69126
3	*GORE® TAG® Thoracic Branch Endoprosthesis*	*05/13/2022*	*10/01/2022*	*05/13/2025*	87 FR 48966 through 48969 88 FR 58800 89 FR 69120 through 69126
4	*CERAMENT® G (bone infection indication)*	*05/17/2022*	*10/01/2022*	*05/17/2025*	87 FR 48961 through 48966 88 FR 58800 89 FR 69120 through 69126
5	*iFuse Bedrock Granite Implant System*	*05/26/2022*	*10/01/2022*	*05/26/2025*	87 FR 48969 through 48974 88 FR 58800 89 FR 69120 through 69126
6	*CYTALUX® (pafolacianine) (ovarian indication)*	*04/15/2022*	*10/01/2023*	*04/15/2025*	88 FR 58804 through 58810 89 FR 69120 through 69126
7	*Lunsumio™ (mosunetuzumab)*	*12/22/2022*	*10/01/2023*	*12/22/2025*	88 FR 58835 through 58845 89 FR 69120 through 69126
8	*REBYOTA™ (fecal microbiota, live-jslm) and VOWST™ (fecal microbiota spores, live-brpk)*	*01/23/2023*	*10/01/2023*	*01/23/2026*	88 FR 58848 through 58868 89 FR 69120 through 69126
9	*SPEVIGO® (spesolimab)*	*09/01/2022*	*10/01/2023*	*09/01/2025*	88 FR 58879 through 58885 89 FR 69120 through 69126
10	*TECVAYLI™ (teclistamab-cqyv) ELREXFIO™ (elranatamab-bcmm) and TALVEY™ (talquetamab- tgvs)*	*11/09/2022*	*10/01/2023* *10/01/202*	*11/09/2025*	88 FR 58885 through 58891 89 FR 69120 through 69126 89 FR 69149 through 69155
11	*TERLIVAZ® (terlipressin)*	*10/14/2022*	*10/01/2023*	*10/14/2025*	88 FR 58891 through 58906 89 FR 69120 through 69126
12	*EchoGo Heart Failure 1.0*	*11/23/2022*	*10/01/2023*	*11/23/2025*	88 FR 58932 through 58935 89 FR 69120 through 69126

FY 2026 Applications for New Technology Add-On Payments (Traditional Pathway)
(Page 366)

CMS received 19 applications for new technology add-on payments for FY 2026 under the new technology add-on payment traditional pathway. Of the 19 applications received, 2 applicants were not eligible for consideration for new technology add-on payment because they did not meet the requirements, 3 applicants withdrew their applications prior to the issuance of the proposed rule, and one applicant withdrew prior to the issuance of this final rule—DuraGraft☐ (Vascular Conduit Solution).

CMS is not approving new technology add-on payments for 8 technologies: (1) AUCATZYL® (obecabtagene autoleucel), (2) COBENFY™ (xanomeline and trospium chloride), (3) FIBRYGA® (fibrinogen (human)), (4) IntelliSep® Test, (5) Neuroguard IEP® 3-in-1 Carotid Stent and Post-Dilation Balloon System with Integrated Embolic Protection, (6) RYSTIGGO® (rozanolixizumab-noli), (7) SYMVESS™ (acellular tissue engineered vessel-tyod), and (8) ZIIHERA® (zanidatamab-hrii).

CMS is approving new technology add-on payments for FY 2026 for the remaining 5 technologies: (1) AURLUMYN™ (iloprost injection), (2) BREYANZI® (lisocabtagene maraleucel), (3) GRAFAPEXTM (treosulfan), (4) IMDELLTRA® (tarlatamab-dlle), and (5) TECELRA® (afamitresgene autoleucel). A discussion of these applications is presented in the following sections

FY 2026 Applications for New Technology Add-On Payments (Alternative Pathways)
(Page 598)

CMS received 34 applications for new technology add-on payments for FY 2026 under the new technology add-on payment alternative pathway. Of the 34 applications received under the alternative pathway, 1 application was not eligible for consideration for new technology add-on payment because it did not meet the requirements; and 4 applicants withdrew their applications prior to the issuance of the proposed rule. Subsequently, prior to the issuance of this final rule, 7 additional applicants ((1) Dexcom G7 Hospital Continuous Glucose Monitoring System, (2) DrugSorb-ATR Device, (3) Nelli Seizure Monitoring System, (4) PearlMatrix P-15 Peptide Enhanced Bone Graft, (5) Provizio® SEM Scanner, (6) Spur Peripheral Retrievable Stent System, and (7) the Ventura® Interatrial Shunt System) withdrew their applications, or did not meet the May 1 deadline for FDA approval or clearance of the technology and therefore are not eligible for consideration for new technology add-on payments for FY 2026.

Of the remaining 22 applications, 20 of the technologies received a Breakthrough Device designation from FDA. Two applications were designated as a QIDP by FDA. CMS did not receive any applications for technologies approved through the LPAD pathway.

1.4WEB Medical Ankle Truss System—CMS is finalizing that the maximum new technology add-on payment for a case involving the use of 4WEB Medical ATS is $15,275 for FY 2026 (that is, 65 percent of the average cost of the technology). Cases involving the use of 4WEB Medical ATS that are eligible for new technology add-on payments will be identified by ICD-10-PCS procedure codes: XRGJ0B9 (Fusion of right ankle joint using open-truss design internal fixation device, open approach, new technology group 9), XRGK0B9 (Fusion of left ankle joint using open-truss design internal fixation device, open approach, new technology group 9), XRGL0B9 (Fusion of right tarsal joint using open-truss design internal fixation device, open approach, new technology group 9), or XRGM0B9 (Fusion of

left tarsal joint using open-truss design internal fixation device, open approach, new technology group 9). (Page 601)

2. AeroPace® System—The maximum new technology add-on payment for a case involving the use of AeroPace® System is $23,650.90. Cases involving the use of AeroPace® System that are eligible for new technology will be identified by ICD-10-PCS procedure code X2H13XB (Insertion of temporary phrenic nerve/diaphragm stimulation electrodes into superior vena cava, percutaneous approach, new technology group 11). (Page 605)

3. AGENT™ Paclitaxel-Coated Balloon Catheter—The maximum new technology add-on payment for a case involving the use of AGENT™ Paclitaxel-Coated Balloon Catheter is $4,013.75. Cases involving the use of AGENT™ Paclitaxel-Coated Balloon Catheter will be identified by one of the 16 ICD-10-PCS procedure codes listed on page 614: (Page 610)

4. alfapump® system—The maximum new technology add-on payment for a case involving the use of the alfapump® system is $21,450. Cases involving the use of the alfapump® system will be identified by ICD-10-PCS procedure code 0W1G3J6 (Bypass peritoneal cavity to bladder with synthetic substitute, percutaneous approach) in combination with 0JH80YZ (Insertion of other device into abdomen subcutaneous tissue and fascia, open approach). (Page 614)

5. aprevo®-C cervical interbody fusion device—The maximum new technology add-on payment for a case involving the use of the aprevo®-C cervical interbody fusion device is $21,125. Cases involving the use of the aprevo®-C cervical interbody fusion device will be identified by one of the following ICD-10-PCS procedure codes: XRG10RB, XRG13RB, XRG14RB, XRG20RB, XRG23RB, XRG24RB, XRG40RB, XRG43RB, and XRG44RB (Page 618)

6. CERAMENT® G—The maximum new technology add-on payment for a case involving the use of CERAMENT® G is $5,687.50. Cases involving the use of CERAMENT® G that are eligible for new technology will be identified by ICD-10-PCS procedure code XW0V0P7 (Introduction of antibiotic-eluting bone void filler into bones, open approach, new technology group 7) without any of the ICD-10-CM diagnosis codes in category M86 (Osteomyelitis). (Page 622)

7. Emily's Care Nourish Test System (Model 1)—The maximum new technology add-on payment for a case involving the use of Emily's Care Nourish Test System (Model 1) is $3,347.50. Cases involving the use of Emily's Care Nourish Test System (Model 1) that are eligible for new technology add-on payments will be identified by ICD-10-PCS procedure code XXEZXAB (Measurement of macronutrient content, computer-aided assessment for nutrition management, new technology group 11) in combination with one of 16 ICD-10-CM diagnosis codes listed on page 638. (Page 626)

8. Esprit™ BTK Everolimus Eluting Resorbable Scaffold System—The maximum new technology add-on payment for a case involving the use of Esprit™ BTK Everolimus Eluting Resorbable Scaffold is $6,922.50. Cases involving the use of Esprit™ BTK Everolimus Eluting Resorbable Scaffold will be identified by one of 6 ICD-10-PCS procedure codes listed on page 643. (Page 639)

9. EUROPA™ Posterior Cervical Fusion System—The maximum new technology add-on payment for a case involving the use of the EUROPA™ Posterior Cervical Fusion System is $80,548. Cases involving the use of the EUROPA™ Posterior Cervical Fusion System will be identified by one of 12 ICD-10- PCS procedure codes listed on page 648. (Page 643)

10. iFuse TORQ TNT™ Implant System—The maximum new technology add-on payment for a case involving the use of the iFuse TORQ TNT™ Implant System is $4,135.95. Cases involving the use of the iFuse TORQ TNT™ Implant System will be identified by one of 12 ICD-10-PCS procedure codes listed on page 656. (Page 649)

11. Merit Wrapsody® Cell Impermeable Endoprosthesis (CIE)—The maximum new technology add-on payment for a case involving the use of the Merit Wrapsody® CIE is $3,770 for FY 2026 (that is, 65 percent of the average cost of the technology). Cases involving the use of the Merit Wrapsody® CIE will be identified by one of the 10 ICD-10-PCS procedure codes listed on page 660. (656)

12. Minima Stent System – The maximum new technology add-on payment for a case involving the use of the Minima Stent System is $22,685. Cases involving the use of the Minima Stent System will be identified by ICD-10-PCS procedure codes: X27339B (Dilation of right pulmonary artery with expandable intraluminal device, percutaneous approach, new technology group 11), X27439B (Dilation of left pulmonary artery with expandable intraluminal device, percutaneous approach, new technology group 11), X27W39B (Dilation of thoracic aorta, descending with expandable intraluminal device, percutaneous approach, new technology group 11), or X27X39B (Dilation of thoracic aorta, ascending/arch with expandable intraluminal device, percutaneous approach, new technology group 11). (Page 660)

13. MY01 Continuous Compartmental Pressure Monitor—The maximum new technology add-on payment for a case involving the use of MY01 Continuous Compartmental Pressure Monitor is $2,112.50. Cases involving the use of MY01 Continuous Compartmental Pressure will be identified by ICD-10-PCS procedure code XX2F3W9. (Page 665)

[Note the above item is also listed as #12. That would make 2 number 12s. We believe it should be number 13. This error continues. Our number 14 below is referenced by CMS as number 13. CMS continues with this misalignment for the rest of the section]

14. Positive Blood Culture (PBC) Separator with Selux AST System—The maximum new technology add-on payment for a case involving the use of the PBC Separator with Selux AST System is $87.78. Cases involving the use of the PBC Separator with Selux AST System will be identified by ICD-10-PCS procedure code XXE5XY9. (Page 668)

15. RECELL® Autologous Cell Harvesting Device—The maximum new technology add-on payment for a case involving the use of the RECELL® Autologous Cell Harvesting Device would be $4,875. Cases involving the use of the RECELL® Autologous Cell Harvesting Device will be identified by one of the following ICD-10-PCS procedure codes, in combination with any of the ICD-10-CM diagnosis codes listed in Table 10.A.-RECELL® Autologous Cell Harvesting Device or ICD-10-PCS procedure codes listed in Table 10.B.-RECELL® Autologous Cell Harvesting Device associated with this final rule. (Page 673)

16. restor3d TIDAL™ Fusion Cage—The maximum new technology add-on payment for a case involving the use of TIDAL Fusion Cage System is $18,196.75. Cases involving the use of TIDAL Fusion Cage System that are eligible for new technology add-on payments will be identified by ICD-10-PCS procedure codes: XRGK0CA (Fusion of left ankle joint using gyroid-sheet lattice design internal fixation device, open approach), XRGM0CA (Fusion of left tarsal joint using gyroid-sheet lattice design internal fixation device, open approach), XRGJ0CA (Fusion of right ankle joint using gyroid-sheet lattice design internal fixation device, open approach), or XRGL0CA (Fusion of right tarsal joint using gyroid-sheet lattice design internal fixation device, open approach). (Page 681)

17. ShortCut™--The maximum new technology add-on payment for a case involving the use of the ShortCut™ is $9,750. Cases involving the use of the ShortCut™ will be identified by ICD-10-PCS procedure code X28F3VA (Division of aortic valve using intraluminal bioprosthetic valve leaflet splitting technology in existing valve, percutaneous approach, new technology group 10). (Page 684)

18. The WiSE CRT System—The maximum new technology add-on payment for a case involving the use of the WiSE CRT System is $41,145. Cases involving the use of the WiSE CRT System that are will be identified by ICD-10-PCS procedure code X2HN37B. (Page 687)

19. TriVerity Test—The maximum new technology add-on payment for a case involving the use of the TriVerity Test is $243.75. Cases involving the use of the TriVerity Test will be identified by ICD-10-PCS procedure code XXE5XBB. (Page 690)

20. VITEK® REVEAL™ AST System—The maximum new technology add-on payment for a case involving the use of the VITEK® REVEAL™ AST System is $81.25. Cases involving the use of the VITEK® REVEAL™ AST System will be identified by ICD-10-PCS procedure code XXE5X4A. (Page 695)

Alternative Pathways for Qualified Infectious Disease Products (QIDPs)

1. EMBLAVEO™ (aztreonam-avibactam) (Page 699)
2. CONTEPO™ (fosfomycin) (Page 702)

REQUIREMENTS FOR AND CHANGES TO THE HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM (Page 1,191)

In the FY 2026 IPPS/LTCH PPS proposed rule, CMS sought input on measure concepts of well-being and nutrition for future years in the Hospital IQR Program. RFI. CMS is not responding to specific comments in response to the RFI, but will take this feedback into consideration for our future measure development efforts for the Hospital IQR Program.

CMS is updating the extraordinary circumstances exception policy.

In the FY 2026 IPPS/LTCH PPS proposed rule, CMS proposed 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, beginning with the July 1, 2023–June 30, 2025 reporting period/FY 2027 payment determination; and

(2) Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) measure beginning with the April 1, 2023–March 31, 2025 reporting period/FY 2027 payment determination. (Page 1,194)

Specifically, CMS proposed to make two substantive updates to the MORT-30-STK measure: (1) CMS would expand the measure's inclusion criteria to include MA patients; and (2) CMS would shorten the performance period from 3 years to 2 years. CMS says the addition of MA encounter data to the measure roughly doubles the cohort size, improves measure reliability, and more accurately reflects the quality of care for both Medicare FFS and MA beneficiaries. (Page 1,197)

CMS is finalizing modifications of the MORT-30-STK measure as proposed beginning with administrative claims and encounter data from July 1, 2023, through June 30, 2025, associated with the FY 2027 payment determination.

CMS also proposed to modify the COMPHIP-KNEE measure with two substantive updates: (1) expand the measure's inclusion criteria to include MA patients; and (2) shorten the performance period from 3 years to 2 years.

CMS is finalizing modifications of the COMP-HIP-KNEE measure as proposed and implementing the technical updates, beginning with administrative claims and encounter data from April 1, 2023, through March 31, 2025, associated with the FY 2027 payment determination. (Page 1,208)

CMS is: (Page 2153)

(1) modifying the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization claims-based measure, beginning with the FY 2027 payment determination, associated with a July 1, 2023 - June 30, 2025 performance period; (Page 1,195)

(2) modifying the Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) claims-based measure beginning with the FY 2027 payment determination, associated with the April 1, 2023 - March 31, 2025 performance period; (Page 1,208)

(3) modifying the reporting requirements of the Hybrid Hospital-Wide Readmission (HWR) measure beginning with the FY 2028 payment determination, associated with a July 1, 2025 - June 30, 2026, performance period; (Page 1,248)

(4) modifying the reporting requirements of the Hybrid Hospital-Wide Mortality (HWM) measure beginning with the FY 2028 payment determination, associated with a July 1, 2025 - June 30, 2026, performance period;

(5) removing the Hospital Commitment to Health Equity measure beginning with the CY 2024 reporting period/FY 2026 payment determination; (Page 1,229)

(6) removing the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure beginning with the CY 2024 reporting period/FY 2026 payment determination; (Page 1,236)

(7) removing the Screening for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 payment determination; (Page 1,241) and

(8) removing the Screen Positive Rate for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 payment determination.

Summary of Hospital IQR Program Measures for the FY 2027 Payment Determination (Page 1,250)

Short Name	Measure Name	CBE Number*
National Healthcare Safety Network Measures		
HCP Influenza Vaccination	Influenza Vaccination Coverage Among Healthcare Personnel	0431
Claims-Based Patient Safety Measures		
ISCMR**	Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications	4125
Claims-Based Mortality/Complications Measures		
MORT-30-STK***	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity	4595
COMP-HIP-KNEE***	Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA and/or TKA	1550
Claims-Based Coordination of Care Measures		
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	2881
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	2880
PN Excess Days	Excess Days in Acute Care after Hospitalization for Pneumonia	2882
Claims-Based Payment Measures		
MSPB	Medicare Spending Per Beneficiary (MSPB)—Hospital	2158
Claims and Electronic Data Measures		
Hybrid HWM****	Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure (HWM)	3502e
Hybrid HWR****	Hybrid Hospital-Wide All-Cause Readmission Measure (HWR)	2879e
Chart-Abstracted Clinical Process of Care Measures		
SEP-1	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
Structural Measures		
Maternal Morbidity	Maternal Morbidity Structural Measure	N/A
Age Friendly Hospital	Age Friendly Hospital Measure	N/A
Patient Safety	Patient Safety Structural Measure	N/A
Electronic Clinical Quality Measures (eCQMs)		
Safe Use of Opioids	Safe Use of Opioids – Concurrent Prescribing	3316e
PC-02	Cesarean Birth	0471e
PC-07	Severe Obstetric Complications	3687e
STK-2	Discharged on Antithrombotic Therapy	0435e
STK-3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436e
STK-5	Antithrombotic Therapy by the End of Hospital Day Two	0438e
VTE-1	Venous Thromboembolism Prophylaxis	0371e
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372e

Short Name	Measure Name	CBE Number*
HH-HYPO	Hospital Harm—Severe Hypoglycemia Measure	3503e
HH-HYPER	Hospital Harm—Severe Hyperglycemia Measure	3533e
HH-ORAE	Hospital Harm—Opioid-Related Adverse Events	3501e
HH-PI	Hospital Harm—Pressure Injury	3498e
HH-AKI	Hospital Harm—Acute Kidney Injury	3713e
MCS*****	Malnutrition Care Score	3592e
IP-ExRad	Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults	3663e
Patient Experience of Care Survey Measures		
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey	0166 (0228)
Patient-Reported Outcome Performance Measures		
THA/TKA PRO-PM	Hospital-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (PRO-PM)	3559

* CMS notes that inclusion of a CBE number neither indicates endorsement or lack of endorsement. More information about current endorsement status can be found on the Partnership for Quality Measurement website: https://p4qm.org/measures.
** The Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications measure short name has been updated to Inpatient Surgical Complications Mortality Rate (ISCMR).
*[No ***, but 2 ****]*
**** CMS is finalizing modifications to the MORT-30-STK and the COMP-HIP-KNEE measures beginning with the FY 2027 payment determination. We refer readers to sections X.C.3.a. and X.C.3.b., respectively, of the preamble of this final rule for more detailed discussion.
**** In this final rule, CMS is finalizing modified reporting thresholds for linking variables and CCDEs beginning with the FY 2028 payment determination and subsequent years. In the FY 2025 OPPS/ASC final rule CMS finalized an extension of voluntary reporting of linking variables and core clinical data elements for the Hybrid HWR measure and the Hybrid HWM measure for the FY 2026 and FY 2027 payment determinations. CMS refers readers to section X.C.7.c. of the preamble of this final rule for more detailed discussion.
***** The eCQM previously named Global Malnutrition Composite Score has been updated to Malnutrition Care Score. The short name has subsequently been updated to MCS eCQM.

CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2026 (Pages 1,117 & 2,764)

Medicare Severity Long-Term Care Diagnosis-Related Group (MS-LTC-DRG) Classifications and Relative Weights for FY 2026 (Page 1,123)

The MS-DRGs (used under the IPPS) and the MS-LTC-DRGs (used under the LTCH PPS) are based on the CMS DRG structure. The LTCH PPS as MS-LTC-DRGs are structurally identical to the MS-DRGs used under the IPPS.

Table 11, which is listed in section VI. of the Addendum is available on the CMS website. It lists the MS-LTC-DRGs and their respective relative weights, geometric mean length of stay, and five-sixths of the geometric mean length of stay (used to identify SSO cases under § 412.529(a)) for FY 2026. (Page 1,145)

Changes to the LTCH PPS Payment Rates and Other Changes to the LTCH PPS for FY 2026 (Page 1,152)

Based on IGI's second quarter 2025 forecast with historical data through the first quarter of 2025, the projected 2022-based LTCH market basket percentage increase for FY 2026 is 3.4 percent, the same increase as in the proposed rule. (Page 1,160)

The current estimate of the productivity adjustment for FY 2026 based on IGI's second quarter 2025 forecast is 0.7 percentage point. (Page 1,168)

CMS is establishing an annual market basket update to the LTCH PPS standard Federal payment rate for FY 2026 of **2.7 percent** (3.4-0.7=2.7). (Page 1,168))
For LTCHs that fail to submit quality reporting data CMS will reduce the annual update to the LTCH PPS standard Federal payment rate by 2.0 percentage points for an overall increase of **0.7 percent**. (Page 1,168)

Comment

In this rule, CMS says that it estimates an increase in LTCH payments of $83 million (as noted previously). In a press release on Monday, August 4, CMS says the increase will amount to $72 million.

Development of the FY 2026 LTCH PPS Standard Federal Payment Rate (Page 1,932)

CMS is applying an update factor of 1.027 to the FY 2025 LTCH PPS standard Federal payment rate of $49,383.26 to determine the FY 2026 LTCH PPS standard Federal payment rate.

CMS has determined a FY 2026 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor of 1.0021275. (Page 1,934)

CMS is establishing an LTCH PPS standard Federal payment rate of **$50,824.51** (calculated as $49,383.26 x 1.027 x 1.0021275) for FY 2026.

For LTCHs that fail to submit quality reporting data for FY 2026, CMS is establishing an LTCH PPS standard Federal payment rate of $49,834.74 (calculated as $49,383.26 x 1.007 x 1.0021275) for FY 2026.

The FY 2025 wage index values are presented in Table 12A (for urban areas) and Table 12B (for rural areas), available on the CMS web site.

Labor-Related Share for the LTCH PPS Standard Federal Payment Rate (Page 1,940)

CMS is finalizing a total labor-related share for FY 2026 of **72.9 percent** (the sum of 69.0 percent for the labor-related share of operating costs and 3.9 percent for the labor-related share of capital-related costs).

Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases (Page 1,951)

CMS is establishing a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2026 of **$78,936** that will result in estimated outlier payments projected to be equal to 7.975 percent of estimated FY 2026 payments for such cases. CMS had proposed a $91,247 amount. The FY 2025 cap is $77,048.

CMS says that actual high-cost outlier payments accounted for 8.8 percent of total LTCH PPS standard Federal payment rate payments in FY 2024.

High-Cost Outlier Payments for Site Neutral Payment Rate Cases (Page 1,972)

CMS says it continues to believe that the most appropriate fixed-loss amount for site neutral payment rate cases for FY 2026 is the IPPS fixed-loss amount for FY 2026. As a result, CMS is establishing a fixed-loss amount for site neutral payment rate cases of **$40,397**.

Changes to the Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (Page 1,289)

CMS is:

- Finalizing its proposal to modify reporting requirements for the Patient/Resident COVID-19 Vaccine measure in the LTCH QRP to exclude patients who have expired in the LTCH beginning with the FY 2028 LTCH QRP.
- Removing four SDOH-standardized patient assessment data elements. Beginning with the FY2028 LTCH QRP, LTCHs will no longer be required to submit data on one item for Living Situation (R0310), two items for Food (R0320A and R0320B), and one item for Utilities (R0330).
- Finalizing its proposal to amend the LTCH QRP reconsideration policy to permit LTCHs to requests an extension to file a reconsideration request and to codify this proposed policy and process at § 412.560(d)(4) and (d)(5).
- Not finalizing changes at this time on several RFIs, specifically: 1) future measure concepts for the LTCH QRP; 2) revisions to the data submission deadlines for assessment data collected for the LTCH QRP; and 3) advancing dQMs in the LTCH QRP.

OTHER ITEMS

Request for Information on the Transition Toward Digital Quality Measurement in CMS Quality Reporting Programs (1,170)

CMS requested comments on continued advancements in digital quality measurement and the use of the Health Level 7® Fast Healthcare Interoperability Resources® (FHIR®). Specifically, CMS sought comment on the anticipated approach to FHIR-based electronic clinical quality measure (eCQM) reporting in quality reporting programs and the potential use of FHIR-based patient assessment instrument reporting in the Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program. A summary of these comments is provided in the final rule and will be used to inform potential future policy development. (From CMS fact sheet)

Medicare Promoting Interoperability Program (Page (1,325)

In 2011, CMS established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (now known as the Medicare Promoting Interoperability Program and the Promoting Interoperability performance category of the Merit-based Incentive Payment System) to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate the meaningful use of certified EHR technology (CEHRT).

In the FY 2026 IPPS/LTCH PPS final rule, CMS will:

- Define the EHR reporting period in CY 2026 and subsequent years as a minimum of any continuous 180-day period within that CY for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program and make corresponding revisions at 42 CFR 495.4.
- Modify the Security Risk Analysis measure for eligible hospitals and CAHs to attest "Yes" to having conducted security risk management in addition to security risk analysis, beginning with the EHR reporting period in CY 2026.
- Modify the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure by requiring eligible hospitals and CAHs to attest "Yes" to completing an annual self-assessment using all eight 2025 SAFER Guides, beginning with the EHR reporting period in CY 2026.

- Add an optional bonus measure under the Public Health and Clinical Data Exchange objective for data exchange to occur with a public health agency (PHA) using the Trusted Exchange Framework and Common Agreement® (TEFCA), beginning with the EHR reporting period in CY 2026.

In addition, the final rule refers readers to the CY 2026 Physician Fee Schedule (PFS) proposed rule, and invites public comments on:

- A proposal to suppress the Electronic Case Reporting measure from scoring in the EHR reporting period in CY 2025.
- A proposal to adopt a measure suppression policy, allowing the suppression of measures from scoring for the EHR reporting period in CY 2026.

CMS did not propose any changes to the previously finalized performance-based scoring threshold of 80 points, beginning with the EHR reporting period in CY 2026.

CMS requested information on:

- Future modifications to the Query of Prescription Drug Monitoring Program (PDMP) measure, including seeking public input on changing the Query of PDMP measure from an attestation-based measure ("Yes" or "No") to a performance-based measure (numerator and denominator), and expanding the types of drugs to which the Query of PDMP measure applies.
- The Medicare Promoting Interoperability Program's objectives and measures moving toward performance-based reporting.
- Improvements in the quality and completeness of the health information eligible hospitals and CAHs are exchanging across systems.

A summary of these comments is included in the final rule, and CMS may consider them to inform potential future policy development. (From CMS fact sheet)

Changes to the Transforming Episode Accountability Model (TEAM) (Page 1,385)

In TEAM, selected acute care hospitals will coordinate care for patients with Original Medicare who are undergoing one of five surgical procedures. The five-year mandatory episode-based payment model will run from January 1, 2026, to December 31, 2030.

Selected acute care hospitals will take responsibility for the cost and quality of care from a hospital-based surgery through the first 30 days after the patient's surgery. The changes to TEAM include, but are not limited to, capturing quality measure performance using patient-reported outcomes in the outpatient setting without increasing participant burden, improving target price construction, and broadening the three-day Skilled Nursing Facility Rule waiver, giving patients a wider choice of and access to post-acute care. (From CMS fact sheet)

Tables Referenced in this Final Rule are Generally Available through the Internet on the CMS Website. CMS has provided the following;

The following IPPS tables are generally available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html. Click on the link on the left side of the screen titled "FY 2026 IPPS Rule Home Page" or "Acute Inpatient -Files- for Download." *[This cite takes you to the proposed rule]*

FY 2026 Final Rule Tables

1. **Table 1A-1E** (ZIP)**:** This excel spreadsheet contains the final FY 2026 Operating and Capital National Standardized Amounts.
2. **FY 2026 Tables 2, 3 and 4A and 4B (Wage Index Tables)(Final Rule)** (ZIP)**:**
   - Table 2- Case-Mix Index and Wage Index Table by CMS Certification Number (CCN)
   - Table 3- Wage Index Table by CBSA
   - Table 4A - List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act
   - Table 4B - Counties Redesignated under Section 1886(d)(8)(B) of the Act (LUGAR COUNTIES)
3. **Table 5** (ZIP)**:** MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay
4. **Tables 6A-6K and Tables 6P.1a-6P.8a** (ZIP)**:** Table 6A-New Diagnosis Codes; Table 6B-New Procedure Codes; Table 6C-Invalid Diagnosis Codes; Table 6D – Invalid Procedure Codes; Table 6E-Revised Diagnosis Code Titles; Table 6F – Revised Procedure Code Titles; Table 6G.1- Secondary Diagnosis Order Additions to the CC Exclusions List; Table 6G.2- Principal Diagnosis Order Additions to the CC Exclusions List; Table 6H.1- Secondary Diagnosis Order Deletions to the CC Exclusions List; Table 6H.2- Principal Diagnosis Order Deletions to the CC Exclusions List; Table 6I. – Complete MCC List; Table 6I.1- Additions to the MCC List; Table 6J. – Complete CC List; Table 6J.1- Additions to the CC List; and Table 6J.2 – Deletions to the CC List; Table 6K. – Complete CC Exclusions List.
5. **Tables 6P.1a-6P.8a (ICD-10-CM and ICD-10-PCS Codes for MS-DRG Changes):** See summary tab in excel spreadsheet called "CMS-1833-F TABLE 6P ICD-10-CM and ICD-10-PCS Codes for MS-DRG Changes.xlsx" for a complete description of all tables.
6. **Tables 8A, 8B, and 8C** (ZIP)**:** Tables 8A and 8B contain the FY 2026 IPPS operating and capital statewide average cost-to-charge-ratios. Table 8C contains the FY 2026 LTCH statewide average cost-to-charge-ratios.
7. **Table 10** (ZIP)**:** Relevant ICD-10 Codes for Certain FY 2026 New Technology Add-On Payments.
8. **Table 15:** FY 2026 Hospital Readmissions Reduction Program Payment Adjustment Factors: Table 15 of the final rule is not available at this time, as discussed in the final rule. After hospitals have been given an opportunity to review and correct their calculations for FY 2026, we will post Table 15 to display the final FY 2026 readmissions payment adjustment factors that will be applicable to discharges occurring on or after October 1, 2025.
9. **Tables 16A and 16B Hospital Value-Based Purchasing (VBP) Program Adjustment Factors:**
   - **Table 16A** (ZIP)**:** Contains updated proxy adjustment factors under the Hospital VBP Program that were calculated using historical baseline and performance periods. These proxies for the FY 2026 Hospital VBP payment adjustment factors will not be used to adjust hospital payments. This file includes the proxy adjustment factors published for the FY 2026 IPPS Final Rule (CMS-1833-F).
   - **Table 16B:** Contains the actual payment adjustment factors under the Hospital VBP Program for FY 2026. These actual factors are based on the finalized baseline and performance period for FY 2026 and will be used to adjust base operating DRG payments to eligible hospitals for discharges occurring in FY 2026. Note: Table 16B will be available in the Fall of 2025.
10. **Table 18** (ZIP)**:** FY 2026 Medicare DSH Uncompensated Care Payment Factor 3.

FINAL COMMENTS

This has been one of the more poorly written CMS rules I have reviewed in more than 50 years.

It has been an extremely frustrating rule to follow and more importantly to decipher. It is terribly fragmented with specific item information spread throughout the document. We have noted in our

numbering that a number of items have more than one page number because the item has been broken into different areas. Even though we have added multiple page sites, there are more we haven't shown.

There is simply too much material being cramped in a single document.

Again, this is another major rule issued without a table of contents and without page numbering. It makes finding material a challenge to say the least. It's interesting that some rules contain a table of contents while others do not. It suggests that CMS folks do not talk to each other. Even for the sake of boredom it would be helpful if all rules had the same layouts.

There are many errors which suggests nobody is reviewing the material.

The rule, like most, contains much redundant material and too much unneeded history. We ask again, why CMS needs to keep repeating items from years ago.

As we write this analysis, many of the web links either do not work or send you to an area you that is not correct. for. For example, the following link -- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/AcuteInpatientPPS/index.html, takes you to the Inpatient & Long-Term Care Hospitals: FY 2026 Proposed Rule and not the Final FY 2006 rule.

Finally, as we have noted on numerous occasions and in this proposal as well, it is absurd that CMS does not correct its estimations for outlier payments nor for market basket amounts. CMS continues to cite that retroactively correcting outlier estimations defeats a basic construct of the PPS system. No one is suggesting such corrections need to be made retroactively. CMS already has in place a prospective correction system for the skilled nursing facility market-basket forecasts. This year the SNF market basket is being adjusted upward by 0.6 percent because CMS' FY 2025 estimation was incorrect. I cannot recall CMS doing anything with regard to all the other PPS programs for such errors.

This analysis has not reflected all aspects being presented.

One must question if anyone reads the entire document.

Finally, we are adding a table of contents below that identifies most elements. It is intended to help you find specific items.

Fiscal Year 2026 – Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System and Policy Changes

Table of Contents:

As noted at the beginning of this analysis, there is no table of contents. Further, there are numerous places a topic maybe found. While we have added page numbers to the discussion, the order of our material does not follow the rule. Therefore, below is our table of contents.