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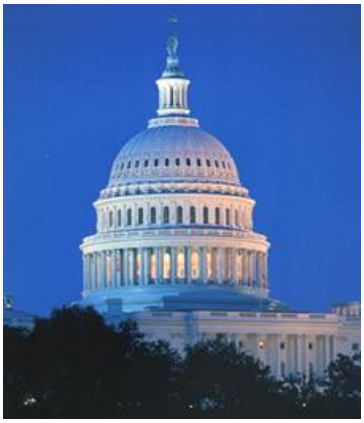
An Analysis and Commentary on Federal Health Care Issues
by Larry Goldberg

April 14, 2025

CMS Releases Proposed FY 2026 IPPS and LTCH Rule



The The Centers for Medicare and Medicaid Services (CMS) have issued a proposed 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 1,361-page document is currently on public display at the ***Federal Register*** office and is scheduled for publication on April 30.

The display version is available at: https://public-inspection.federalregister.gov/2025-06271.pdf.

A 60-day comment period ending June 10 is provided.

The IPPS tables for the FY 2026 proposed rule are 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 Proposed rule Home Page" or "Acute Inpatient—Files for Download."
The LTCH tables are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html under the list item for Regulation Number CMS-1833-P

Comment

Again, there is no table of contents, there is much repetitive unneeded citations, and there is much unneeded historical information. Basically, the rule is disjointed and fragmented. As is customary, we are adding page numbers based on the display version.

There are errors in the material.

Overall, for FY 2026, CMS expects the proposed changes in operating and capital IPPS payment rates — in addition to other changes — will generally increase hospital payments by $4 billion. This includes a projected increase in Medicare uncompensated care payments to disproportionate share hospitals in FY 2026 of approximately $1.5 billion. Subject to determinations on applications for additional payments for inpatient cases involving new medical technologies, CMS estimates that additional payments for inpatient cases involving new medical technologies will increase by approximately $234

million in FY 2026, primarily driven by the continuation of new technology add-on payments for several technologies.

Under current law, additional payments for Medicare-Dependent Hospitals (MDHs) and the temporary change in payments for low-volume hospitals will expire September 30, 2025. In the past, legislation has extended these payments, and if Congress were to extend such, again, CMS estimates that these hospitals would receive payments of approximately $0.5 billion in FY 2026.

This analysis does not follow the rule's organization.

Many payment issues can be found in the rule's Addendum (beginning on page 1,112).

EXECUTIVE SUMMARY (Page 12)

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

a. Proposed 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.

CMS proposes to discontinue the low wage index hospital policy for FY 2026 and subsequent years. In addition, CMS proposes to adopt 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 proposed 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.

b. Update to the IPPS Labor-Related Share

CMS is proposing to rebase and revise the 2018-based IPPS market basket to reflect a 2023 base year. In addition, using the cost category weights from the proposed 2023-based IPPS market basket, CMS has calculated a labor-related share of 66.0 percent, which it is proposing to use for discharges occurring on or after October 1, 2025. The proposed labor-related share of 66.0 percent is 1.6 percentage points lower than the current labor-related share of 67.6 percent.

c. Hospital Readmission Reduction Program

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 proposing the following policies: (1) Refine all six readmission measures to add Medicare Advantage patient cohort data; (2) remove the COVID-19 diagnosed patients measure denominator exclusion from the six readmission measures, beginning with the FY 2026 program year; (3) reduce the applicable period from 3-years to 2-years and update codified regulation language; (4) modify the diagnosis-related group (DRG) payment ratios in the payment adjustment formula to include MA beneficiaries; and (5) 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.

d. Hospital Acquired Condition (HAC) Reduction Program

Section 1886(p) of the Act establishes 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 proposing 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.

e. Hospital Value-Based Purchasing (VBP) Program

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 proposing modifications to the Hospital-Level Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Complications measure beginning with the FY 2033 program year. 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 2028 program year.

f. Hospital Inpatient Quality Reporting (IQR) Program

CMS is proposing refinements/ 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 proposing to remove 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 Healthcare Personnel (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.

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

CMS is proposing 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 proposing 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 payment determination.

Comment

These and other proposed changes can also be found in the Summary of Costs and Benefits below.

Summary of Costs and Benefits (Page 12)

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Proposed 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 proposing to use 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 proposes to make this policy budget neutral through an adjustment applied to the standardized amounts for all hospitals.
Proposed Update to the IPPS Labor-Related Share	As discussed in section IV, CMS is proposing to rebase and revise the 2018-based IPPS market basket to reflect a 2023 base year. In addition, using the cost category weights from the proposed 2023-based IPPS market basket, CMS calculated a labor-related share of 66.0 percent, which CMS is proposing to use for discharges occurring on or after October 1, 2025. The proposed labor-related share of 66.0 percent is 1.6 percentage points lower than the current labor-related share of 67.6 percent.
Proposed Update to the IPPS Payment Rates and Other Payment Policies	As discussed in Appendix A, acute care hospitals are estimated to experience an increase of approximately **$4.0 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.
Proposed Update to the LTCH PPS Payment Rates and Other Payment Policies	As discussed in Appendix A, based on the best available data for the 328 LTCHs in CMS' database, CMS estimates that the proposed 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 **$61 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.**
Proposed 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 660,577 hours and $18,008,959 to the information collection burden for the FY 2026 payment determination or subsequent years.

Provision Description	Description of Costs, Transfers, Savings, and Benefits
Proposed 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 maximum decrease of 153 hours and $7,765 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 would result in a total information collection burden increase of 4 hours and $187.60 associated with updates to the reconsideration policy. CMS estimates that its proposed changes for the FY 2028 LTCH QRP would result in a decrease of 2,633.51 hours associated with the policies and updated burden estimates and a total cost decrease of approximately $180,016.80.
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 proposed 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 $481 million across the 5 performance years.

PROPOSED CHANGES TO THE PROSPECTIVE PAYMENT RATES (Pages 638, and Addendum Page 1,168)

Proposed Changes in the Inpatient Hospital Update for FY 2026 (§ 412.64(d)) (Page 638)
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 -0.8 percent in accordance with section 1886(b)(3)(B)(xi)(II) of the Act.

CMS is proposing to base the FY 2026 market basket update used to determine the applicable percentage increase for the IPPS on IHS Global Inc.'s (IGI's) fourth quarter 2024 forecast of the proposed 2023-based IPPS market basket rate-of-increase with historical data through third quarter 2024, which is estimated to be 3.2 percent. (Page 639)

For FY 2026, CMS is proposing a productivity adjustment of 0.8 percent. Therefore, the market basket update equals **2.4 percent**. (3.2-0.8=2.4)

CMS displays four possible applicable percentage increases as shown in the following table. (Page 640)

Proposed FY 2026 Applicable Percentage Increases For the IPPS

FY 2025	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
Proposed Market Basket Rate-of-Increase	3.2	3.2	3.2	3.2
Proposed Adjustment for Failure to Submit Quality Data (Reduction of ¼ of market basket increase)	0.0	0.0	-0.8	-0.8
Proposed Adjustment for Failure to be a Meaningful EHR (Reduction of ¾ of market basket)	0.0	-2.4	0	-2.4
MFP Adjustment	-0.8	-0.8	-0.8	-0.8
Applicable Percentage Increase Applied to Standardized Amount	**2.4**	**0.0**	**1.6**	**-0.8**

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 1,168) illustrates the changes from the current FY 2025 national standardized amounts to the proposed FY 2026 national standardized amounts.

The $6,605.47 amounts are 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 proposed FY 2026 adjustments.

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

Changes from the Current FY 2025 Standardized Amounts to the Proposed FY 2026 Standardized Amounts

	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 2024 Geographic Reclassification Budget Neutrality (0.971295) 2. FY 2024 Operating Outlier Offset (0.949) 3. FY 2024 Rural Demonstration Budget Neutrality Factor (0.999463) 4. FY 2024 Lowest Quartile Budget Neutrality Factor (0.997402) 5. FY 2024 Cap Policy Wage Index Budget Neutrality Factor (0.999645)	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	1.0240	1.0000	1.0160	0.99200

	Hospital Submitted Quality Data and is a Meaningful EHR User	Hospital Submitted Quality Data and is NOT a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User
Proposed FY 2026 MS-DRG Reclassification and Recalibration Budget Neutrality Factor Before Cap	0.998422	0.998422	0.998422	0.998422
Proposed FY 2026 Cap Policy MS–DRG Weight Budget Neutrality Factor	0.999938	0.999938	0.999938	0.999938
Proposed FY 2026 Wage Index Budget NeutralityFactor	1.001273	1.001273	1.001273	1.001273
Proposed FY 2026 Reclassification Budget Neutrality Factor	0.976960	0.976960	0.976960	0.976960
Proposed FY 2026 Cap Policy Wage Index Budget Neutrality Factor	0.993116	0.993116	0.993116	0.993116
Proposed Transition for the Discontinuation of the Low Wage Index Hospital Policy Budget Neutrality Factor	0.999741	0.999741	0.999741	0.999741
Proposed FY 2026 RCH Demonstration Budget Neutrality Factor	0.999548	0.999548	0.999548	0.999548
FY 2025 Rural Demonstration Budget Neutrality Factor	0.999810	0.999810	0.999810	0.999810
Proposed FY 2026 Operating Outlier Factor	0.949	0.949	0.949	0.949
Totals	$6,835.47	$6,675.26	$6,782.06	$6,621.86
National Standardized Amount for FY2025 if Wage Index is Greater Than 1.0000; Labor/Non-Labor Share Percentage (66/34)	**Labor: $4,511.41 Nonlabor: $2,324.06**	**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 FY2025 if Wage Index is Less Than or Equal to 1.0000; Labor/Non-Labor Share Percentage (62/38)	**Labor: $4,237.99 Nonlabor: $2,597.48**	**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

This year, CMS has not provided the estimated number of hospitals (1) failing to submit required quality information, (2) not being a meaningful EHR user, or (3) both.

Proposed Changes to the IPPS for Capital-Related Costs (Pages 757 & 1,179)

The proposed national capital Federal rate for FY 2026 is **$528.95**.

	FY 2025	Proposed FY 2026	Change	Percent Change
Update Factor[1]	1.0310	1.0260	1.0260	2.60
GAF/DRG Adjustment Factor[1]	0.9854	1.0121	1.0121	1.21
GAF Cap/Transition Adjustment Factor[2]	0.9992	0.9927	0.9935	-0.65
Outlier Adjustment Factor[3]	0.9577	0.9587	1.0011	0.11
Capital Federal Rate	$512.14	**$528.95**	1.0328	3.28[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 proposed 1.0121 GAF/DRG budget neutrality adjustment factor for FY 2025 is a net change of 1.0121 (or 1.21 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 proposed FY 2026 GAF Cap/Transition budget neutrality adjustment factor is 0.9927/0.9992 or 0.9935 (or -0.65 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 proposed FY 2026 outlier adjustment factor is 0.9587/0.9577 or 1.0011 (or 0.11 percent).
4 Percent change may not sum due to rounding.

Proposed Outlier Payments (Page 1,155)

"Our current estimate, using available FY 2024 claims data, is that actual outlier payments for FY 2024 were approximately 5.13 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 1,165)

CMS is proposing 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 **$44,305.** The current threshold is $46,217 (Refer 09/30/2024 ***Federal Register***). (Page 1,163)

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 absolutely ridiculous and absurd. There is a need to make adjustments for 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.

Changes to Payment Rates for Excluded Hospitals: Rate-of-Increase Percentages for FY 2025 (Pages 760 & 1,196)

Payments for services furnished in children's hospitals, 11 cancer hospitals, and hospitals located outside the 50 States, the District of Columbia and Puerto Rico are excluded from the IPPS and are paid on the basis of reasonable costs subject to a rate-of-increase ceiling.

The proposed rate of ceiling increase is **3.2 percent**, in accordance with the applicable regulations at 42 CFR 413.40.

CHANGES TO THE HOSPITAL AREA WAGE INDEX FOR ACUTE CARE HOSPITALS (Page 486)

Cost Reporting Periods beginning in FY 2022 for FY 2026 Wage Index (Page 489)

The proposed 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).

CMS says it plans to post the final wage index data Public Use Files (PUFs) on April 30, 2025. The April 2025 PUFs are made available solely for the limited purpose of identifying any potential errors made by CMS or the MAC in the entry of the final wage index data that resulted from the correction process (the process for disputing revisions submitted to CMS by the MACs by March 21, 2025, and the process for disputing data corrections made by CMS that did not arise from a hospital's request for wage data revisions.

Proposed Occupational Mix Adjustment to the FY 2026 Wage Index (Page 511)

CMS says the proposed FY 2026 Occupational Mix *Adjusted* National Average Hourly Wage is **$57.63** (Page 514).

The proposed 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	$35.06
National Nurse Aide, Orderly, and Attendant	$23.53
National Medical Assistant	$23.15
National Nurse Category	$50.12

Hospital Redesignations and Reclassifications (Page 516)

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 521)

There are 639 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 280 hospitals approved for wage index reclassifications in FY 2024 that will continue for FY 2026, and 278 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, (1,197 hospitals) (approximately 36 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 530)

Rural Floor

Section 4410(a) of the Balanced Budget Act of 1997 (Pub. L. 105–33) 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 565 hospitals would receive the rural floor in FY 2026.

Imputed Floor (Page 532)

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. (Page 553)

State Frontier Floor for FY 2026 (Page 534)

CMS is not proposing any changes to the frontier floor policy for FY 2026. In this proposed rule, 40 hospitals would receive the frontier floor value of 1.0000 for their FY 2026 proposed 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 537)

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 proposes to discontinue the low wage index hospital policy for FY 2026 and subsequent years.

CMS' policy increased the wage index for hospitals with a wage index value below the 25th percentile wage index value for a fiscal year by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year across all hospitals (the low wage index hospital policy).

CMS now proposes to adopt 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.

In the FY 2023 IPPS/LTCH PPS final rule CMS finalized a wage index cap policy and associated budget neutrality adjustment for FY 2023 and subsequent fiscal years. Under this policy, CMS applies a 5.0 percent cap on any decrease to a hospital's wage index from its wage index in the prior FY, regardless of the circumstances causing the decline. A hospital's wage index will not be less than 95 percent of its final wage index for the prior FY. (Page 539)

CMS will compare the hospital's proposed 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 proposed 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.

CMS notes this proposed transitional payment exception would be applied after the application of the 5.0 percent cap described at 42 CFR 412.64(h)(7). (Page 544)

OTHER PROPOSED DECISIONS AND CHANGES TO THE IPPS FOR OPERATING COSTS (Page 630)

Rural Referral Centers (RRCs) Annual Updates to Case-Mix Index (CMI) and Discharge Criteria (§ 412.96) (Page 645)

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

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

- **1.7802** (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	Case-MixIndex Values
1. New England (CT, ME, MA, NH, RI, VT)	1.49900
2. Middle Atlantic (PA, NJ, NY)	1.56165
3. East North Central (IL, IN, MI, OH, WI)	1.61750
4. West North Central (IA, KS, MN, MO, NE, ND, SD)	1.73965
5. South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)	1.63500
6. East South Central (AL, KY, MS, TN)	1.59010
7. West South Central (AR, LA, OK, TX)	1.78085
8. Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)	1.80920
9. Pacific (AK, CA, HI, OR, WA)	1.7793

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, under this proposed rule, 5,000 discharges is the minimum criterion for all hospitals, except for osteopathic hospitals for which the minimum criterion is 3,000 discharges.

Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101) (Page 650)

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.

"Section 1886(d)(12)(B) of the Act requires, for discharges occurring in FYs 2005 through 2010 and for discharges occurring in FY 2026 and subsequent years, that the Secretary determine an applicable percentage increase for low-volume hospitals based on the "empirical relationship" between the standardized cost-per-case for such hospitals and the total number of discharges of such hospitals and the amount of the additional incremental costs (if any) that are associated with such number of discharges." (Page 654)

"Absent further Congressional action, 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."

OK, is it 200 discharges or 800 discharges. It appears nobody is reviewing this material. The answer appears to be 200 based on the following:

"Based on an analysis we conducted for the FY 2005 IPPS final rule, a 25-percent low-volume adjustment to all qualifying hospitals with less than 200 discharges was found to be most consistent with the statutory requirement to provide relief for low-volume hospitals where there is empirical evidence that higher incremental costs are associated with low numbers of total discharges. (Under the policy we established in that same final rule, hospitals with between 200 and 799 discharges do not receive a low-volume hospital adjustment.)" (Page 654)

Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108) (Page 659)

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 663)

This is a detailed section with much devoted to counting of FTEs, Calculating Full-time Equivalent Counts and Caps for Cost Reporting Periods Other than Twelve Months. (Page 664)

Reasonable Cost Payment for Nursing and Allied Health Education Programs (§413.85 and 413.87) (Page 678)

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 proposed national rates and percentages, and their data sources, are set forth in the table below. CMS intends to update these numbers in the FY 2026 final rule based on the latest available cost report data.

Proposed CY 2024 NAH MA Rates	Proposed CY 2024	SOURCE
NAH Pass-Through	$281,853,426	Cost reports ending in FY 2022 HCRIS
Part A Inpatient Days	75,303,913	Cost reports ending in FY 2022 HCRIS
MA Inpatient Days	16,305,155	Cost reports ending in FY 2022 HCRIS
Part A Direct GME	$3,085,013,941	CY 2022 HCRIS + CPI-U + MA enrollment
MA Direct GME	$2,565,628,319	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	2.34%	Pool/MA direct GME

Proposed Payment Adjustment for Certain Immunotherapy Cases (§§ 412.85 and 412.312) (Page 690)

For FY 2026, CMS is proposing to continue to apply an adjustment to the payment amount for expanded access use of immunotherapy and applicable clinical trial cases that group to MS-DRG 018, calculated using the same methodology, as modified in the FY 2024 IPPS/LTCH PPS final rule.

Hospital Readmissions Reduction Program Updates and Changes (Page 695)

CMS proposes to adopt substantive updates to:

> (1) the Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization;
> (2) Hospital 30-Day, All-Cause, RSRR Following Heart Failure (HF) Hospitalization;
> (3) Hospital 30-Day, All-Cause, RSRR Following Pneumonia (PN) Hospitalization;
> (4) Hospital-Level, 30-Day, All-Cause, RSRR Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization;
> (5) Hospital 30-Day, All-Cause, RSRR Following Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) Hospitalization; and
> (6) Hospital 30-Day, All-Cause, RSRR Following Coronary Artery Bypass Graft (CABG) Surgery measures, hereinafter referred to as the Hospital Readmissions Reduction Program measure set, beginning with the FY 2027 Program Year.

The proposed updates to the Hospital Readmissions Reduction Program measure set would include integrating MA beneficiaries into each measure's cohorts and reducing the applicable period from a three-year period to a two-year period.

Including MA beneficiaries in hospital outcome measures would help ensure that "hospital quality would be measured across all Medicare beneficiaries and not just the Fee-For-Service (FFS) population." In 2024, 50 percent of eligible Medicare beneficiaries — or 34.3 million people — were covered by MA plans. It is projected that nearly two-thirds of all Medicare enrollees will be enrolled in MA plans by 2030. Consequently, using FFS-only beneficiaries may exclude a large segment of the focus population for quality measurement.

The estimated average change in Medicare savings per hospital from the proposed updates is $15,579, with 1,424 hospitals having a greater penalty amount and 1,547 hospitals having the same or lower penalty amount.

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

	Current methodology	Proposed updates	Difference between proposed updates and current methodology	Percentage difference between proposed updates and current methodology
Estimated total Medicare savings	$316,131,336	$357,264,092	$41,132,756	13%
Number of penalized hospitals	2,342	2,417	75	3%

Hospital Value-Based Purchasing (VBP) Program (Page 715)

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 FY 2026 is $1.7 billion.**

CMS is proposing refinements 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 proposing to remove 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 proposing 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.

The FY 2027 performance standards that CMS previously adopted for measures in this domain are unchanged because the applicable baseline period does not include COVID-19 impacted data after applying the national ECE. (Page 731)

CMS provides several future years of performance standards.

Hospital-Acquired Condition Reduction Program Updates and Changes (HACRP) (Page 742)

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 is not proposing to add or remove any measures in this proposed rule. (Page 743)
CMS estimates 732 hospitals will be impacted negatively. (Page 1,296)

REBASING AND REVISING OF THE HOSPITAL MARKET BASKETS FOR ACUTE CARE HOSPITALS
(Page 550)

CMS spends 43 pages explaining the factors used in updating and revising the hospital market basket.

A result of this update is a change to the large urban labor rate as noted in the table below. (Page 577)

Comparison of the 2018-Based Labor-Related Share and the Proposed 2023-Based Labor-Related Share

	2018-Based IPPS Market Basket Cost Weights	Proposed 2023-Based IPPS Market Basket Cost Weights
Wages and Salaries	41.2	40.6

	2018-Based IPPS Market Basket Cost Weights	Proposed 2023-Based IPPS Market Basket Cost Weights
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 593)

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

Proposed Calculation of Factor 1 for FY 2026 (Page 604)

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) January 2025 estimates of Medicare DSH payments for FY 2026 without regard to the application of section 1886(r)(1) of the Act is approximately $15.682 billion.

The estimate of empirically justified Medicare DSH payments for FY 2026, with the application of section 1886(r)(1) of the Act, is approximately $3.92 billion (or 25 percent of the total amount of estimated Medicare DSH payments for FY 2026).

CMS is determining that Factor 1 for FY 2026 would be **$11.761 billion**, which is equal to 75 percent of the total amount of estimated Medicare DSH payments for FY 2026 ($15.682 billion minus $3.92 billion).

Proposed *Calculation of Factor 2 for FY 2026* (Page 610)

The calculation of the proposed 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: 7.7 percent.
- Percent of individuals without insurance for CY 2026: 8.7 percent.

- Percent of individuals without insurance for FY 2026: (0.25 times 0.077) + (0.75 times 0.087) = 8.5 percent.

- FY 2026's proposed Factor 2 is calculated as 1 minus the percent change in the percent of individuals without insurance between CY 2013 and FY 2026.

- Proposed Factor 2 is as follows: 1 – |((0.14 – 0.085)/0.14)| = 1 – 0.3929 = 0.6071

CMS is proposing that Factor 2 for FY 2026 would be **60.71 percent**.

The proposed FY 2026 uncompensated care amount is equivalent to proposed Factor 1 multiplied by proposed Factor 2, is **$ 7,140,406,650**.

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" is $5.706 billion
- The Proposed FY 2026 pool would be $7.140 billion

The pool amount for FY 2026 would be $1.424 billion more than the current FY 2025 amount.

Calculation of Factor 3 for FY 2025 (Page 614)

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 623)

For purposes of this FY 2026 IPPS/LTCH PPS rule, CMS is using reports from the March 2025 HCRIS extract to calculate Factor 3.

Hospitals have 60 days from the date of public display (April 11) of the FY 2026 IPPS/LTCH PPS proposed rule in the ***Federal Register*** to review the table and supplemental data file published on the CMS website in conjunction with this proposed rule and to notify CMS in writing of issues related to mergers and/or to report potential upload discrepancies due to MAC mishandling of Worksheet S-10 data during the report submission process. (Page 629)

TOWARD DIGITAL QUALITY MEASUREMENT IN CMS QUALITY PROGRAMS – REQUEST FOR INFORMATION (Page 814)

CMS has previously issued requests for information (RFIs) on CMS' modernization of its digital quality measurement enterprise as part of its intention to transition to a fully digital landscape. In the FY 2026 IPPS/LTCH PPS proposed rule, CMS is issuing an RFI to gather comment on continued advancements to digital quality measurement and the use of the Health Level 7® Fast Healthcare Interoperability Resources® (FHIR®) standard. CMS is seeking comments on:

- The anticipated approach to FHIR-based electronic clinical quality measure (eCQM) reporting in quality reporting programs.
- The potential use of FHIR-based patient assessment instrument reporting for inpatient psychiatric facilities.

REQUIREMENTS FOR AND CHANGES TO THE HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM (Page 832)

CMS is requesting comments regarding measure concepts under consideration for future years, proposing to modify current quality measures, and proposing to remove four quality measures.

Specifically, CMS is requesting comment related to measure concepts focusing on well-being and nutrition for consideration in future years.

CMS is also proposing an update to the current Extraordinary Circumstances Exception (ECE) policy.

CMS is proposing 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 with Claims-Based Risk Adjustment for Stroke Severity to add Medicare Advantage patients to the current cohort of patients, shorten the performance period from three to two years, and make changes to the risk adjustment methodology. (Page 834)

(2) Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) to add Medicare Advantage patients to the current cohort of patients, shorten the performance period from three to two years, and change the risk adjustment methodology. (Page 843)

Proposed Modification to the Reporting of the Hybrid Hospital-Wide All-Cause Readmission(HWR) and Hybrid Hospital-Wide All-Cause Risk Standardized Mortality (HWM) Measures (Page 869)

Hybrid Hospital-Wide Readmission (HWR) and Hybrid Hospital-Wide Mortality (HWM) measures to lower the submission thresholds to allow for up to two missing laboratory results and up to two missing vital signs, reduce the core clinical data elements (CCDEs) submission requirement to 70 percent or more of discharges, and reduce the submission requirement of linking variables to 70 percent or more of discharges.

Proposed Removals in the Hospital IQR Program Measure Set (Page 856)

CMS proposes to remove four measures:

(1) Hospital Commitment to Health Equity measure beginning with the CY 2024 reporting period/FY 2026 payment determination; (Page 856)
(2) COVID-19 Vaccination Coverage among Healthcare Personnel measure beginning with the CY 2024 reporting period/FY 2026 payment determination; (Page 858)
(3) Screening for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 payment determination; and (Page 860)
(4) Screen Positive Rate for Social Drivers of Health measure beginning with the CY 2024 reporting period/FY 2026 payment determination. (Page 860)

Proposed Changes to the Long-Term Care Hospital Quality Reporting Program (LTCH QRP) (Page 883)

CMS is proposing to:

- Modify reporting requirements for the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure to exclude patients who have expired in the LTCH by removing an item on the LTCH expired discharge assessment instrument.
- Remove four SDOH-standardized patient assessment data elements to reduce the current burden. 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).
- Amend the reconsideration policy and process.
- Seek public comment 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.

PROPOSED CHANGES TO THE MEDICARE PROMOTING INTEROPERABILITY PROGRAM (Page 907)

CMS is proposing to:

- 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. (Page 907)
- 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. (Page 912)
- 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. (Page 916)
- 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. (Page 919)

Overview of Objectives and Measures for the Medicare Promoting Interoperability Program for the EHR Reporting Period in CY 2026 (Page 927)

The proposal contains 14 pages of Tables -- (X.F.-04) that lists objectives and measures for the Medicare Promoting Interoperability Program for the EHR reporting period in CY 2026, as revised to reflect the proposals in this proposed rule, and (X.F.-05) that lists the ONC Health IT Certification

Program certification criteria required to meet the Medicare Promoting Interoperability Program objectives and measures.

Clinical Quality Measurement for Eligible Hospitals and CAHs Participating in the Medicare Promoting Interoperability Program (Page 942)

Table X.F.-06. summarizes the previously finalized required and self-selected eCQMs available for eligible hospitals and CAHs to report under the Medicare Promoting Interoperability Program for the CY 2026 reporting period and subsequent years.

CMS is not proposing any changes to the previously finalized performance-based scoring threshold of 80 points, beginning with the EHR reporting period in CY 2026. (Page 925)

Request for Information (RFI) Regarding the Query of Prescription Drug Monitoring Program (PDMP) Measure (Page 943)

CMS is seeking public comments 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.

CHANGES TO THE MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (Page 35)

Changes to Specific MS-DRG Classifications (Page 37)

For this FY 2026 IPPS/LTCH PPS proposed rule, CMS' MS-DRG analysis was based on ICD-10 claims data from the September 2024 update of the FY 2024 MedPAR file, which contains hospital bills received from October 1, 2023 through September 30, 2024

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 47)

- Logic for MS-DRGs 023 through 027 (Page 55)

  CMS says it reviewed the claims data, and does not believe the data support creating a new MS-DRG for cases reporting the insertion of a chemotherapy implant and cases describing 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. (Page 59)

  Nonetheless, CMS is proposing to add procedure codes 00H001Z, 00H005Z, 00H031Z, and 00H041Z to the "Chemotherapy Implant" logic list in MS-DRGs 023 and 024, effective October 1, 2025. CMZS is also proposing to change the description of the logic list in MS-DRGs 023 and

024 from "Chemotherapy Implant" to "Antineoplastic Implant" to better reflect the GROUPER logic that includes ICD-10-PCS procedure codes describing antineoplastic agents implanted in the brain. (Page 62)

CMS examined MS-DRGs 020, 021, and 022 to reconsider the possibility of reassigning the cases reporting the insertion of an intracranial neurostimulator implant as it has been unable to identify another MS-DRG in MDC 01 that would be a more appropriate MS-DRG assignment for these cases based on the indication for and complexity of the procedures.(Page 74)

CMS is proposing to add 57 procedure codes "Intracranial Vascular Procedures" logic list, and the 66 diagnosis codes to the "Hemorrhage Principal Diagnosis" logic list of MS-DRGs 020, 021, and 022, effective October 1, 2025. (Page 75)

CMS is proposing to add 114 procedure code combinations to a new "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. CMS is also proposing to delete the "Major Device Implant," "Epilepsy Principal Diagnosis," "Neurostimulator" logic lists from MS-DRGs 023 and 024. CMS refers the reader to Table 6P.2e at:
https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps
for the list of the 114 ICD-10-PCS procedure code combinations it proposes to add to a new "Intracranial Neurostimulator Implant" logic list in MS-DRGs 020, 021, and 022.

Additionally, CMS is also proposing to delete the "Major Device Implant," "Epilepsy Principal Diagnosis," "Neurostimulator" logic lists from MS-DRGs 023 and 024. Lastly, for consistency, CMS is proposing 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," proposing 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," and proposing 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" to better reflect the assigned procedures effective October 1, 2025.
(Page 77)

- Hypertensive Encephalopathy (Page 78)

CMS is proposing to delete MS-DRGs 077, 078, and 079. Additionally, CMS is proposing 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. Lastly, for consistency, CMS is also proposing to change the titles of MS-DRGs 067, 068, and 069 from "Nonspecific CVA and Precerebral Occlusion without Infarction with MCC, with CC, and without CC/MCC, respectively" to "Precerebral Occlusion without Infarction with MCC, with CC, and without CC/MCC, respectively" and 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" to better reflect the assigned diagnoses. (Page 85)

- Encounter for Adjustment and Management of Implanted Devices of the Special Senses (Page 85)

  CMS is proposing to reassign ICD-10-CM diagnosis code Z45.31 from MS-DRGs 091, 092, and 093 to MDC 02 MS-DRG 123 (Neurological Eye Disorders). CMS is also proposing 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).

- Endovascular Aneurysm Repair (EVAR) with Iliac Branch Procedures (Page 87)

  For FY 2026, CMS is proposing to create new base MS-DRG 213 (Endovascular Abdominal Aorta Iliac Branch Procedures). (Page 93)

- Concomitant Single Valve Procedure with Open Surgical Ablation (Page 93)

  CMS is proposing to maintain the structure of MS-DRGs 216, 217, and 218 for FY 2026. CMS is also proposing 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 103)

- Transcatheter Aortic Valve Replacement Procedures for Aortic Regurgitation (Page 103)

  CMS is proposing to maintain the title of MS-DRGs 215 as "Other Heart Assist System Implant" for FY 2026. (Page 109)

- Percutaneous Coronary Atherectomy (Page 109)

  CMS is proposing to create two new MS-DRGs with a two-way severity level split for cases describing percutaneous or percutaneous endoscopic coronary atherectomy involving the insertion of an intraluminal device in MDC 05. CMS is also proposing to create a new base MS-DRG for cases describing percutaneous or percutaneous endoscopic coronary atherectomy without an intraluminal device. These proposed new MS-DRGs are MS-DRG 359 (Percutaneous Coronary Atherectomy with Intraluminal Device with MCC), proposed new MS-DRG 360 (Percutaneous Coronary Atherectomy with Intraluminal Device without MCC) and proposed new MS-DRG 318 (Percutaneous Coronary Atherectomy without Intraluminal Device). (Page 118)

- Complex Aortic Arch Procedures (Page 119)

  CMS is proposing to create a new MS-DRG to better differentiate the complex aortic arch procedures from other cases in their respective MS-DRGs, based on treatment difficulty, clinical similarity, and resource use. To compare and analyze the impact of our suggested modifications, CMS ran a simulation using the claims data from the September 2024 update of the FY 2024 MedPAR file.

  CMS is proposing to create a new base MS-DRG for cases reporting complex aortic arch procedures in MDC 05. The proposed new MS-DRG is proposed MS-DRG 209 (Complex Aortic Arch Procedures). (Page 133)

- Deep Vein Thrombophlebitis (Page 133)

  For FY 2026, CMS is proposing to delete MS-DRGs 294 and 295 and reassign 35 diagnosis codes describing deep vein thrombophlebitis to MS-DRGs 299, 300, and 301. (Page 137)

- Hip or Knee Procedures with Periprosthetic Joint Infection (Page 137)

  CMS is proposing 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). (Page 143)

- Arthroscopy (Page 143)

  For FY 2026, of the 47 procedure codes previously listed describing arthroscopy of various anatomic sites, CMS is proposing to:

  1. Reassign the 8 procedure codes describing arthroscopy of the shoulder or elbow joint to MS-DRGs 510, 511, and 512 (Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with MCC, with CC, and without CC/MCC, respectively)

  2. Reassign the 10 procedure codes describing arthroscopy of the hand or wrist joint to MS-DRGs 513 and 514 (Hand or Wrist Procedures, Except Major Thumb or Joint Procedures with CC/MCC and without CC/MCC, respectively)

  3. Reassign the 29 procedure codes describing arthroscopy of various vertebral joints and other musculoskeletal joints to MS-DRGs 515, 516, and 517 (Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) (Page 147)

- MS-DRG Logic for MS-DRGs 456, 457, and 458 (Page 147)

  CMS is proposing to add diagnosis codes to the logic list entitled "Spinal Curvature/Malignancy/Infection" in MS-DRGs 456, 457, and 458, effective October 1, 2025, for FY 2026. (Page 149)

  CMS is proposing to remove the eight diagnosis codes from the logic list entitled "Spinal Curvature/Malignancy/Infection" in MS-DRGs 456, 457, and 458, effective October 1, 2025, for FY 2026. (Page 150)

- Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989 (Page 150)

  CMS is proposing to move the cases reporting the procedures and/or principal diagnosis codes from MS-DRGs 981 through 983 or MS-DRGs 987 through 989 into one of the surgical MS-DRGs for the MDC into which the principal diagnosis or procedure is assigned. (Page 151)

  1. Control of bleeding in the Genitourinary Tract
  2. Removal of Infusion Device from Peritoneal Cavity
  3. For FY 2026 CMS is not proposing to move any cases reporting procedure codes from MS-DRGs 981 through 983 to MS-DRGs 987 through 989 or vice versa. (Page 156)

- Operating Room (O.R.) and Non-O.R. Procedures (Page 157)

  CMS continues to believe additional time is necessary as it continues to develop its process and methodology. (Page 159)

- Non-O.R. Procedures to O.R. Procedures (161)

  CMS is proposing to maintain the current non-O.R. designation of ICD-10-PCS procedure codes 0N9T0ZZ and 0N9V0ZZ. (Page 162)

  CMS is proposing to remove procedure code 0W950ZZ (Drainage of lower jaw, open approach) from the FY 2026 ICD-10 MS-DRGs Version 43 Definitions Manual in Appendix E--Operating Room Procedures and Procedure Code/MS-DRG Index as an O.R. procedure. (Page 163)

- Introduction of Paclitaxel-Coated Balloon Catheter Technology (Page 163)

  CMS continues to disagree with designating the procedure to delivery paclitaxel to a coronary vessel as identified by any one of the previously listed 16 procedure codes as O.R. procedures. (Page 167)

- Endoscopic Drainage of the Ureter with Drainage Device (Page 167)

  CMS is proposing to add procedure codes 0T9680Z, 0T9780Z, and 0T9880Z to the FY 2026 ICD-10 MS-DRG Version 43 Definitions Manual in Appendix E--Operating Room Procedures and Procedure Code/MS-DRG Index as O.R. procedures assigned to MS-DRG 264 (Other Circulatory System O.R. Procedures) in MDC 05 (Diseases and Disorders of the Circulatory System); MS-DRGs 656, 657, and 658 (Kidney and Ureter Procedures for Neoplasm, with MCC, with CC, and without CC/MCC, respectively) and MS-DRGs 659, 660, and 661 (Kidney and Ureter Procedures for Non-Neoplasm, with MCC, with CC, and without CC/MCC, respectively) in MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract); MS-DRGs 907, 908, and 909 (Other O.R. Procedures for Injuries with MCC, with CC, and without CC/MCC, respectively) in MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs); and MS-DRGs 957, 958, and 959 (Other O.R. Procedures for Multiple Significant Trauma with MCC, with CC, and without CC/MCC, respectively) in MDC 24 (Multiple Significant Trauma). (Page 168)

- Overview of Comprehensive CC/MCC Analysis (Page 169)

  CMS is not proposing any severity designation changes for FY 2026. (Page 174)

CMS is making available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html the following tables associated with this FY 2026 IPPS/LTCH PPS proposed rule: (Page 184)

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

Proposed Changes to MS–DRGs Subject to Post acute Care Transfer Policy and MS–DRG Special Payments Policies (§ 412.4) (Page 630)

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

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

Proposed 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: 9.654%)	FY 2025 Post acute Transfer Policy Status	Proposed Post acute Care Transfer Policy Status
209	Complex Aortic Arch Procedures	334	181*	34	10.2%	New	No
213	Endovascular Abdominal Aorta with Iliac Branch Procedures	1,163	185*	0	0%*	New	No
318	Percutaneous Coronary Atherectomy without Intraluminal Device	915	164*	7	0.8%*	New	No
359	Percutaneous Coronary Atherectomy with Intraluminal Device with MCC	3,027	876*	65	2.2%*	New	No
360	Percutaneous Coronary Atherectomy with Intraluminal Device without MCC	3,934	398*	36	0.9%*	New	No
321	Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ arteries/intraluminal devices	30,850	8710	798	2.6%*	No	No
322	Percutaneous Cardiovascular Procedures with Intraluminal Device without MCC	46,159	4254	0	0%*	No	No
403	Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC	1,250	1071	494	39.5%	New	Yes
404	Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection without MCC	2,400	1995	682	28.4%	New	Yes
463	Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders with MCC	3,477	2865	1244	35.8%	Yes	Yes
464	Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders with CC	4,959	3714	1124	22.7%	Yes	Yes
465	Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders without CC/MCC	1,357	688*	0	0%*	Yes	Yes**

* Indicates a current post acute care transfer policy criterion that the MS-DRG did not meet.

List of Proposed New or Revised MS-DRG's Subject to Review of Special Payment Policy Status for FY 2026 (Page 637)

Proposed New or Revised MS-DRG	MS-DRG Title	Geometric Mean Length of Stay	Average Charges of 1-Day Discharges	50 Percent of Average Charges for all Cases within MS-DRG	FY 2025 Special Payment Policy Status	Proposed Special Payment Policy Status
403	Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection with MCC	10.57	$0	$130,572	New	Yes*

Proposed New or Revised MS-DRG	MS-DRG Title	Geometric Mean Length of Stay	Average Charges of 1-Day Discharges	50 Percent of Average Charges for all Cases within MS-DRG	FY 2025 Special Payment Policy Status	Proposed Special Payment Policy Status
404	Hip or Knee Procedures with Principal Diagnosis of Periprosthetic Joint Infection without MCC	5.58	$87,126	$72,946	New	Yes
463	Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders with MCC	10.58	$58,384	$114,609	No	Yes*
464	Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders with CC	5.40	$71,548	$68,604	No	Yes
465	Wound Debridement and Skin Graft Except Hand for Musculoskeletal and Connective Tissue Disorders without MCC/CC	1.97	$69,981	$44,134	No	Yes*

* As described in the policy at 42 CFR 412.4(f)(6)(iv), MS–DRGs that share the same base MS–DRG will all qualify under the special payment

REPLACED DEVICES OFFERED WITHOUT COST OR WITH A CREDIT (Page 199)

CMS is proposing that if the applicable proposed MS-DRG changes are finalized, CMS also would add MS-DRGs 020, 021, and 022 and proposed 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 and make conforming changes to the titles of MS-DRGs 023 and 024 in the list of MS-DRGs subject to the policy.

The existing MS-DRGs currently subject to the replaced device policy is displayed in the rule's table on page 202.

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES FOR FY 2026 (Page 221)

Proposed 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 243)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Proposed 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

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Proposed Maximum NTAP Amount for FY 2026	Coding Used to Identify Cases Eligible for NTAP
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

Proposed 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 243)

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Proposed 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,

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Proposed Maximum NTAP Amount for FY 2026	*Coding Used to Identify Cases Eligible for NTAP*
						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*	*04/03/2024*	*10/01/2024*	*04/03/2027*	$2,812.50	XW0335A or XW0435A
12	*ZEVTERA™ (ceftobiprole medocaril); SAB indication*	*04/03/2024*	*10/01/2024*	*04/03/2027*	$8,625.00	XW0335A or XW0435A in combination with 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*

Proposed 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 247)

	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

	Technology	Newness Start Date	NTAP Start Date	3-year Anniversary Date of Entry onto U.S. Market	Previous Final Rule Citations
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
13	*SAINT Neuromodulation System*	*09/01/2022*	*10/01/2023*	*09/01/2025*	88 FR 58937 through 58939 89 FR 69120 through 69126

Proposed FY 2026 Applications for New Technology Add-On Payments (Traditional Pathway) (Page 248)

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, and 3 applicants withdrew their applications prior to the issuance of this proposed rule. CMS is addressing the remaining 14 applications. They are:

1. AUCATZYL® (obecabtagene autoleucel) (Page 249)
2. AURLUMYN™ (iloprost injection) (Page 261)
3. BREYANZI® (lisocabtagene maraleucel) (Page 269)
4. COBENFY™ (xanomeline and trospium chloride) (Page 279)
5. DuraGraft® (Vascular Conduit Solution) (Page 289)
6. FIBRYGA® (fibrinogen (human)) (Page 301)
7. GRAFAPEXTM (treosulfan) (Page 312)
8. IMDELLTRA™ (tarlatamab-dlle) (Page 325)
9. IntelliSep Test (Page 339)
10. Neuroguard IEP® 3-in-1 Carotid Stent and Post-Dilation Balloon System with Integrated Embolic Protection (Page 351)
11. RYSTIGGO® (rozanolixizumab-noli) (Page 362)
12. SYMVESS™ (acellular tissue engineered vessel-tyod) (Page 374)
13. TECELRA® (afamitresgene autoleucel) (Page 391)
14. ZIIHERA® (zanidatamab-hrii) (Page 399)

Proposed FY 2026 Applications for New Technology Add-On Payments (Alternative Pathways) (Page 408)

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 this proposed rule. Of the remaining 29 applications, 27 of the technologies

received a Breakthrough Device designation from FDA. The remaining 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 (Page 411)
2. AeroPace® System (Page 413)
3. AGENT™ Paclitaxel-Coated Balloon Catheter (Page 416)
4. alfapump® system (Page 418)
5. aprevo®-C cervical interbody fusion device (Page 420)
6. CERAMENT® G (Page 423)
7. Dexcom G7 Hospital Continuous Glucose Monitoring (CGM) System (Page 425)
8. DrugSorb-ATR Device (Page 429)
9. Emily's Care Nourish Test System (Model 1) (Page 430)
10. Esprit™ BTK Everolimus Eluting Resorbable Scaffold System (Page 436)
11. EUROPA™ Posterior Cervical Fusion System (Page 438)
12. iFuse TORQ TNT™ Implant System (Page 441)
13. Merit Wrapsody® Cell Impermeable Endoprosthesis (CIE) (Page 445)
14. Minima Stent System (Page 447)
15. MY01 Continuous Compartmental Pressure Monitor (Page 450)
16. Nelli Seizure Monitoring System (Page 452)
17. Positive Blood Culture (PBC) Separator with Selux AST System (Page 454)
18. PearlMatrix P-15 Peptide Enhanced Bone Graft (Page 457)
19. Provizio® SEM Scanner (Page 460)
20. RECELL® Autologous Cell Harvesting Device (Page 462)
21. restor3d TIDAL™ Fusion Cage (Page 465)
22. ShortCut™ (Page 468)
23. Spur Peripheral Retrievable Stent System (Page 469)
24. The WiSE CRT System (Page 471)
25. TriVerity Test (Page 472)
26. Ventura® Interatrial Shunt System (Page 475)
27. VITEK® REVEAL™ AST System (Page 478)

REVEAL™ AST System for FY 2026 (Page 480) – CMS has not included a number

Proposed Alternative Pathways for Qualified Infectious Disease Products (QIDPs) (Page 480)

1. EMBLAVEO™ (aztreonam-avibactam) (Page 481)
2. CONTEPO™ (fosfomycin) (Page 482)

PROPOSED CHANGES TO THE LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM (LTCH PPS) FOR FY 2026 (Pages 783 & 2,764)

Proposed Changes to the MS-LTC-DRGs for FY 2026 (Page 783 & 1,198)

The proposed MS-LTC-DRGs for FY 2026 are the same as the MS-DRGs being proposed for use under the IPPS for FY 2026.

Table 11, which is listed in section VI. of the Addendum, and is available via the Internet on the CMS website, lists the proposed MS-LTC-DRGs and their respective proposed relative weights, proposed

geometric mean length of stay, and proposed five-sixths of the geometric mean length of stay (used to identify SSO cases under § 412.529(a)) for FY 2026. (Page 806)

Proposed Annual Update to the LTCH PPS Standard Federal Payment Rate for FY 2026 (Page 809)

CMS is proposing to use the 2022-based LTCH market basket to update the LTCH PPS standard Federal payment rate for FY 2026.

Based on IGI's fourth quarter 2024 forecast, the proposed FY 2026 market basket percentage increase for the LTCH PPS using the 2022-based LTCH market basket is 3.4 percent. The proposed productivity adjustment for FY 2026 based on IGI's fourth quarter 2024 forecast is 0.8 percentage point. (Page 811)

CMS is establishing an annual market basket update to the LTCH PPS standard Federal payment rate for FY 2026 of **2.6 percent** (3.4-0.8=2.6). (Page 812)

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 0.6 percent.

Development of the Proposed FY 2026 LTCH PPS Standard Federal Payment Rate (Page 1,199)

CMS is proposing to apply an update factor of 1.026 to the FY 2025 LTCH PPS standard Federal payment rate of $49,383.26 to determine the proposed FY 2026 LTCH PPS standard Federal payment rate.

CMS has determined a proposed FY 2026 LTCH PPS standard Federal payment rate area wage level adjustment budget neutrality factor of 1.0012146. (Page 1,211)

Accordingly, CMS is proposing to establish an LTCH PPS standard Federal payment rate of **$50,728.77.** (calculated as $49,383.26 x 1.026 x 1.0012146) (Page 1,200)
For LTCHs that fail to submit quality . data, the LTCH PPS standard Federal payment rate is $49,739.90 (calculated as $49,383.26 x 1.006 x 1.0012146) 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.

Proposed Labor-Related Share for the LTCH PPS Standard Federal Payment Rate (Page 1,203)

CMS is proposing a total labor-related share for FY 2026 of **73.1 percent** (the sum of 69.2 percent for the labor-related share of operating costs and 3.9 percent for the labor-related share of capital-related costs).

Proposed Adjustment for LTCH PPS High-Cost Outlier (HCO) Cases (Page 1,214)

CMS is proposing a fixed-loss amount for LTCH PPS standard Federal payment rate cases for FY 2026 of **$91,247** that would result in estimated outlier payments projected to be equal to 7.975 percent of estimated FY 2026 payments for such cases. (Page 1,225)

The proposed fixed-loss amount for FY 2026 ($91,247) is approximately $14,000 higher than the fixed-loss amount for FY 2025 ($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 1,228)

CMS is proposing a fixed-loss amount for site neutral payment rate cases of $44,305, which is the same proposed FY 2026 IPPS fixed-loss amount.

OTHER PROVISIONS INCLUDED IN THIS PROPOSED RULE (Page 959)

TEAM is a 5-year mandatory alternative payment model tested by the CMS Innovation Center that will begin on January 1, 2026, and end on December 31, 2030. TEAM will test whether an episode-based pricing methodology linked with quality measure performance for select acute care hospitals reduces Medicare program expenditures while preserving or improving the quality of care for Medicare beneficiaries who initiate certain episode categories.

Specifically, TEAM will test five surgical episode categories: Coronary Artery Bypass Graft Surgery (CABG), Lower Extremity Joint Replacement (LEJR), Major Bowel Procedure, Surgical Hip/Femur Fracture Treatment (SHFFT), and Spinal Fusion.

The material in this discussion extends 86 pages. The initial rule regarding this item extended more than 700 pages. (Refer the final IPPS FY 2025 rule.)

Tables Referenced in this Proposed Rule are Generally Available through the Internet on the CMS Website

The following IPPS tables for this proposed rule 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."

1. **Table 1A-1E** (ZIP)**:** This excel spreadsheet contains the proposed FY 2026 Operating and Capital National Standardized Amounts.
2. **FY 2026 Proposed Rule Tables 2, 3 and 4A and 4B (Wage Index Tables)** (ZIP)**:**
   - Table 2- Proposed Case-Mix Index and Wage Index Table by CMS Certification Number (CCN)
   - Table 3- Proposed Wage Index Table by CBSA; Table 4A - Proposed List of Counties Eligible for the Out-Migration Adjustment under Section 1886(d)(13) of the Act
   - Table 4B - Proposed Counties Redesignated under Section 1886(d)(8)(B) of the Act (LUGAR COUNTIES)
3. **Table 5** (ZIP)**:** Proposed MS-DRGs, Relative Weighting Factors and Geometric and Arithmetic Mean Length of Stay
4. **Tables 6A-6J.2 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- Proposed Secondary Diagnosis Order Additions to the CC Exclusions List; Table 6G.2- Proposed Principal Diagnosis Order Additions to the CC Exclusions List;

   Table 6H.1- Proposed Secondary Diagnosis Order Deletions to the CC Exclusions List;
   Table 6H.2- Proposed Principal Diagnosis Order Deletions to the CC Exclusions List;
   Table 6I.1- Proposed Additions to the MCC List;
   Table 6J.1- Proposed Additions to the CC List; and Table 6J.2 – Proposed Deletions to the CC List.

   Tables 6P.1a-6P.8a (ICD-10-CM and ICD-10-PCS Codes for Proposed MS-DRG Changes): See summary tab in excel spreadsheet called "CMS-1833-P TABLE 6P ICD-10-CM and ICD-10-PCS Codes for Proposed MS-DRG Changes.xlsx" for a complete description of all tables.

5. **Tables 8A, 8B, and 8C** (ZIP)**:** Tables 8A and 8B contain the proposed FY 2026 IPPS operating and capital statewide average cost-to-charge-ratios. Table 8C contains the proposed FY 2026 LTCH statewide average cost-to-charge-ratios.
6. **FY 2026 Table 10** (ZIP)**:** Relevant ICD-10 Codes for Certain FY 2026 New Technology Add-On Payment Applications
7. **Table 15:** After hospitals have been given an opportunity to review and correct their calculations for FY 2026, we will post Table 15 (which will be available via the internet on the CMS website) to display the final FY 2026 readmissions payment adjustment factors, which will be applicable to discharges occurring on or after October 1, 2025. We expect Table 15 will be posted on the CMS website in the fall of 2025.
8. **Table 16A** (ZIP)**:** Updated Proxy Hospital Value-Based Purchasing (VBP) Program Adjustment Factors for FY 2026.
9. **Table 18** (ZIP)**:** Proposed FY 2026 Medicare DSH Uncompensated Care Payment Factor 3.

The following LTCH PPS tables for this FY 2025 final rule are available through the Internet on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html

Table 8C.— Final FY 2025 Statewide Average Total Cost-to-Charge Ratios (CCRs) for LTCHs (Urban and Rural)
Table 11.— Final MS-LTC-DRGs, Relative Weights, Geometric Average Length of Stay, and Short-Stay Outlier (SSO) Threshold for LTCH PPS Discharges Occurring from October 1, 2024, through September 30, 2025

Table 12A.— Final LTCH PPS Wage Index for Urban Areas for Discharges Occurring from October 1, 2024, through September 30, 2025
Table 12B.— Final LTCH PPS Wage Index for Rural Areas for Discharges Occurring from October 1, 2024, through September 30, 2025

FINAL COMMENTS

This 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 page number because the item has been broken into different areas.

This is another major rule issued without a table of contents with page numbering.

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.

The rule, like most, contains much redundant material and too much unneeded history. For example, material regarding LTCHs that begins on page 773 cites past history for 10 pages before changes for FY 2026 are mentioned.

As we write this analysis, many of the web links either do not work or send you to an area you are not looking for. For example, the link on page -- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-payment/AcuteInpatientPPS/index.html, takes you to the Inpatient & Long-Term Care Hospitals: FY 2025 Final Rule and not the FY 2006 proposed 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 PPS.