Guide to CMS Final FY 2026 Medicare Inpatient Prospective Payment Systems (IPPS) Regulations

NOVEMBER 2025

At A Glance

Healthcare organizations are facing an exceptionally challenging financial environment. Economic volatility, high interest rates, and persistent inflation have placed enormous pressure on healthcare margins. The addition of **Medicaid funding cuts** and program changes in the One Big Beautiful Bill Act makes it even more difficult for healthcare organizations to maintain financial stability. As hospital leaders prepare their financial forecasts and strategic plans for 2026, it's crucial that they understand what reimbursement will look like for their organization.

One area that is seeing major changes in the year ahead is Medicare reimbursement. Each year, the Centers for Medicare & Medicaid Services (CMS) issues a final rule updating the Medicare payment policies and rates under the Medicare hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS). The FY2 2026 final rule, which was issued on July 31, 2025, outlines multiple changes that will have a major impact on qualifying hospitals. In this guide, we'll explore these changes in detail and offer insights into how hospitals should respond.

FY 2026 IPPS & LTCH FINAL RULE HIGHLIGHTS:

- The increase in IPPS operating payments for FY 2026 is 2.6% and is estimated to be $5 billion.
- Uncompensated Care (UCC) and Disproportionate Share Hospital (DSH) payments, as well as other payments, are estimated to increase by over $2 billion.
- CMS rebased the IPPS operating and capital market baskets to 2023 base year and set the national labor-related share at 66%.
- The LTCH standard payment rate will rise by 2.7%, with overall LTCH PPS payments increasing by 3% (an estimated $72 million).
- The low wage index hospital policy is discontinued with a transitional exception for affected hospitals.
- Changes to the Transforming Episode Accountability Model (TEAM) are intended to improve care coordination, target price construction, and post-acute care access for selected surgical episodes.
- Quality Care Incentive changes will affect Medicare payments as follows:
  - Quality Reporting has been updated for FY 2026 to remove several quality measures, modify reporting requirements, and extend the Extraordinary Circumstances Exception (ECE) policy request period from 30 to 60 days.
  - Readmission measures are updated to include Medicare Advantage data and shorten the performance period.
  - COVID-19 exclusions are removed from readmission measures starting in FY 2027, while the hospital Commitment to Health Equity and Social Drivers of Health (SDoH) measures are removed for FY 2026.
  - The LTCH Quality Reporting Program (QRP) has been updated to reduce the reporting burden on participating hospitals by removing certain SDoH data elements.
  - The public reporting requirements and ECE policy for the PPS-Exempt Cancer Hospital Quality Reporting Program have been updated.

Table of Contents

FY 2026 FINALIZED RATES

Below is a table showing the final rate increases for FY 2026 based on four scenarios detailing whether the provider submits quality data and is a meaningful user of electronic health records (EHR) according to the Affordable Care Act (ACA). Please note that parentheticals denote negative numbers.

TABLE 1

FY 2026	Hospital Submitted Quality Data and Is a Meaningful EHR User	Hospital Submitted Quality Data and Is NOT a Meaningful EHR User	Hospital Did Not Submit Quality Data and Is a Meaningful EHR User	Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User
Market Basket Rate-of-Increase	3.3	3.3	3.3	3.3
Adjustment for Failure to Submit Quality Data per ACA	–	–	(0.825)	(0.825)
Adjustment for Failure to be a Meaningful EHR User per ACA	–	(2.475)	–	(2.475)
Multifactor Productivity (MFP) Adjustment under Section 1886(b)(3)(B)(xi) per ACA	(0.7)	(0.7)	(0.7)	(0.7)
Applicable Percentage Increase Applied to Standardized Amount	2.6	0.125	1.775	(0.7)
Increase in Operating Rates	2.6	0.125	1.775	(0.7)

Tables 1A and 1B show the updated National Adjusted Operating Standardized Amounts based on the rate updates per Table 1 For FY 2026. Please note that the full increase for a hospital that reports quality data and is a meaningful EHR user will be 2.9%.

TABLE 1A.

National Adjusted Operating Standardized Amounts; Labor/Nonlabor (66.0% Labor Share/34.0% Nonlabor Share If Wage Index Is Greater Than 1)

Hospital Submitted Quality Data and Is a Meaningful EHR User Update = 2.6%		Hospital Submitted Quality Data and Is NOT a Meaningful EHR User Update = 0.125%		Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User Update = 1.775%		Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User Update = 0.7%	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,456.72	$2,295.89	$4,349.21	$2,240.51	$4,420.88	$2,277.43	$4,313.38	$2,222.05

TABLE 1B.

National Adjusted Operating Standardized Amounts; Labor/Nonlabor (62% Labor Share/38% Nonlabor Share If Wage Index Is Less Than or Equal To 1)

Hospital Submitted Quality Data and Is a Meaningful EHR User Update = 2.6%		Hospital Submitted Quality Data and Is NOT a Meaningful EHR User Update = 0.125%		Hospital Did NOT Submit Quality Data and Is a Meaningful EHR User Update = 1.775%		Hospital Did NOT Submit Quality Data and Is NOT a Meaningful EHR User Update = 0.7%	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,186.16	$2,565.99	$4,085.63	$2,504.09	$4,152.95	$2,545.36	$4,051.97	$2,483.46

Capital Payments

Per Table 1C, the capital rate increased by $512.14 to $524.15 for FY 2026, which represents a 2.35% increase or approximately $250,000,000.

TABLE 1C.

Capital Standard Federal Payment Rate

	FY 2025 Rate	FY 2026 Rate
National	$512.14	$524.15

The rate increases, coupled with other changes to IPPS payment policies, will increase IPPS operating payments by approximately 2.6%. The overall increase in IPPS payments in FY 2026 will account for approximately $5 billion in increased Medicare payments as shown in Table 2. This change is significantly driven by the increase in IPPS rates as shown in Table 1.

TABLE 2

Estimated Increase in Operating Payments

Operating Payments/DSH/UCC/Capital	$3,308,000,000
DSH/UCC	$2,000,000,000
New Medical Technology	$192,000,000
MDH and LVA Not Extended by 12/31/2025	($500,000,000)
Estimated Increase in Operating Payments	**$5,000,000,000**

It is important to note that the combined IPPS Operating payment and Uncompensated Care (UCC) payments, which increased by $5,000,000,000, include a $2 billion increase in UCC payments as outlined in the (DSH) and UCC section of this summary.

The below summary of the FY 2026 IPPS Medicare rules highlights the changes that will drive the increased rates and additional Medicare payments for FY 2026.

The impacts do not include the 2% Medicare sequestration reduction. This reduction began in FY 2013 and would have run through 2028 without legislation to discontinue this reduction or increase the length of time it is in effect. The Coronavirus Aid, Relief, and Economic Security (CARES) Act passed for COVID-19 relief for healthcare providers temporarily halted the sequestration reduction beginning May 1, 2020 - December 31, 2020, thus extending the sequestration period through 2030 absent any further regulatory changes.

FY 2026 MEDICARE SEVERITY DIAGNOSIS RELATED GROUPS (MS-DRG) RELATIVE WEIGHTS

To calculate the Medicare Severity Diagnosis Related Groups (MS-DRG) relative weights for FY 2026, CMS used claims data from the FY 2024 MEDPAR file. The file includes diagnostic and procedure data for all Medicare inpatient bills as well as cost report data from the Healthcare Cost Report Information System (HCRIS) dataset, which is set three years prior to the IPPS fiscal year and based on FY 2023 Medicare cost reports. In FY 2026, as in prior years, CMS will update 19 national average cost-to-charge ratios (CCRs) based on the FY 2023 Medicare cost report data. The FY 2024 MEDPAR file that will be used for updating FY 2026 MS-DRGs is identified in Table 3.

TABLE 3

FY 2026 Final 19 Cost-to-Charge Ratios

Group	2026 Final 19 CCRs	Group	2026 Final 19 CCRs
Routine Days	0.394	Radiology	0.123
Intensive Days	0.335	MRI	0.065
Drugs	0.177	CT Scans	0.032
Supplies & Equipment	0.297	Emergency Room	0.139
Implantable Devices	0.255	Blood	0.23
Therapy Services	0.256	Other Services	0.327
Laboratory	0.098	Labor & Delivery	0.373
Operating Room	0.153	Inhalation Therapy	0.148
Cardiology	0.086	Anesthesia	0.071
Cardiac Catheterization	0.098		

MS-DRG Outlier Payments

For high-cost cases, further payments are made in addition to MS-DRG payments. To qualify, a case's costs must exceed the total of all applicable payments — including MS-DRG, indirect medical education (IME), DSH UCC, and new technology payments, plus the outlier threshold amount, which will be $40,397 for FY 2026. The outlier threshold is estimated to result in outlier payments that are 5.10% of operating DRG payments and 3.84% of capital payments.

To fund the operating and capital outlier payments, CMS will apply an adjustment of 0.949 to the operating standardized amount and 0.961594 to the capital federal rate.

EMPIRICALLY JUSTIFIED MEDICARE DSH PAYMENTS AND UCC PAYMENTS

Section 3133 of the ACA modified the Medicare DSH Payment methodology beginning in FY 2014. Also, beginning in FY 2014, DSH hospitals began receiving 25% of the amount they previously would have been reimbursed under the traditional Medicare DSH formula. The remaining 75% adjusted for the percentage of uninsured patients will be paid through the Uncompensated Care (UCC) Reimbursement methodology outlined below and updated for FY 2026.

FACTOR 1

Estimate of 75% (100% minus 25%) of Medicare DSH payments that would otherwise be made, in the absence of Section 1886(r) of the Act, for FY 2026:

$16,550,000,000 * 0.75 = $12,412,500,000 = Uncompensated Care Pool

$16,550,000,000 * 0.75 = $ 4,137,500,000 = Empirical DSH Payments

FACTOR 2

The ACA established Factor 2 in the calculation of the UCC payment. Specifically, the ACA provides that for FYs 2014, 2015, 2016, and 2017, a factor equal to 1 minus the percent change in the percentage of individuals under the age of 65 who are uninsured as determined by comparing the percentage of such individuals who are uninsured in 2013, the last year before coverage expansion under the ACA, to that same percent for the year in question.

Starting in FY 2018 and going forward, the ACA authorized the use of data sources other than Congressional Budget Office (CBO) estimates to determine the uninsured rate. Specifically, the data from CMS' Office of the Actuary (OACT) has been authorized as a data source. This data is derived as part of the development of the National Health Expenditure Accounts (NHEA) and represents official estimates of the economic activity within healthcare, according to CMS. Based on this data, the uninsured rate is estimated at 8.70% for 2026.

Using this information, the calculation of Factor 2 for FY 2026 is as follows:

1-((0.14-0.087)/0.14) = 1-0.3786 = 0.6214

FACTOR 3

Factor 3 is a hospital-specific value that identifies the share of the estimated UCC amount for each hospital receiving Medicare DSH payments.

The hospital's cost of UCC is from the Medicare cost report, WS S-10 Ln 30, and is comprised of the following elements:

- Cost of charity care (Line 23)
- Non-Medicare and non-reimbursable Medicare bad debt (Line 29)

CMS will use the data from FY 2020, 2021, and 2022 Medicare cost reports as these are the most recent audited data and the results of those audits are available for FY 2026. The methodology will average these three years for Factor 3 to determine the UCC costs.

TABLE 4

Empirically Justified Medicare DSH Payments and Uncompensated Care Payments

FYE	DSH Estimate	Factor 1 (75% of total DSH)	Percentage of Uninsured	Factor 2 Percentage	Factor 2 Dollar Amount
2014	$12,772,000,000	$9,579,000,000	17.00%	94.30%	$9,032,997,000
2015	$13,383,462,196	$10,037,596,647	13.75%	76.19%	$7,647,644,885
2016	$13,411,096,528	$10,058,322,396	11.50%	63.69%	$6,406,145,534
2017	$14,396,635,710	$10,797,467,782	10.00%	55.36%	$5,977,483,146
2018	$15,552,939,524	$11,664,704,643	8.15%	58.01%	$6,766,695,164
2019	$16,294,703,939	$12,221,027,954	9.48%	67.51%	$8,250,415,972
2020	$16,583,455,657	$12,437,591,743	9.40%	67.14%	$8,350,599,096
2021	$15,170,673,476	$11,378,005,107	10.02%	72.86%	$8,290,014,521
2022	13,984,752,728$	$10,488,564,546	9.60%	68.57%	$7,192,008,709
2023	$13,948,974,706	$10,461,731,029	9.20%	65.71%	$6,874,403,459
2024	$13,353,588,029	$10,015,191,022	8.30%	59.29%	$5,938,006,757
2025	$14,013,000,000	$10,509,750,000	7.70%	54.29%	$5,705,743,725
2026	$16,550,000,000	$12,412,500,000	8.70%	62.14%	$7,713,127,500

The projected increase in payments for UCC for FY 2026 from FY 2025 is $2 billion, or 35.18%, which is due to an increase in traditional Medicare DSH and a higher projected national uninsured rate. Since the inception of UCC payments (UCCP), CMS has decreased UCCP by 14,61% or $1,319,869,500. Although factor 2 increased this year, overall payments have decreased since the inception of the program. This makes S-10 reporting, as well as the accuracy of completing the Charity Care and Medicaid Eligible Days exhibits, critical to ensuring hospitals are properly reimbursed for serving low-income beneficiaries.

Other DSH Day Developments

In the FY 2024 IPPS Final Rule, CMS implemented a change to Section 1115 that reduced the number of patient days hospitals may include in the Medicaid fraction of the DSH payment calculation. The policy effectively decreased Medicare DSH payments, had potential downstream effects on 340B eligibility, and increased the risk that some hospitals would no longer qualify for DSH or UCC payments. After hospitals challenged the new rule, the courts ruled that the exclusion of Section 1115 waiver days was unlawful and violated the DSH statute. The decision vacated the exclusion rule and revoked it nationwide, allowing these days to be included in the Medicare DSH calculation. CMS is actively challenging this ruling.

In addition, the following areas require close monitoring amid ongoing disputes over the inclusion of waiver days in the Medicare Fraction or Medicaid Fraction:

Exhausted Part A Non-Covered Days

- June 2022: Becerra v. Empire Health Foundation
  - This ruling found that Medicare patients are entitled to Part A benefits even if Medicare is not paying for the hospital stay and therefore should be included in the Medicare fraction. As a result, hospitals will receive lower DSH payments.
  - In June 2023, CMS issued a final rule to apply this treatment retroactively to cost reporting periods beginning before FY 2014.
  - In September 2025, the U.S. District Court for the District of Columbia, in *Montefiore Medical Center v. Robert F. Kennedy*, ruled that the retroactive application of pre-2014 "entitled to benefits" adjustments was arbitrary and capricious, rendering the rule unlawful. Remedies for the unlawful rule will be decided based on briefs that are due in October 2025.
- April 2025: Advocate Christ Medical Center v. Kennedy
  - This ruling found that patient days are eligible for Supplemental Security Income (SSI) benefits only if the patient was receiving cash payments during the month of hospitalization. As a result, hospitals will receive lower DSH payments.
  - The Court has stated that Congress would need to amend the statute if the intention was to include all SSI patients.

Part C Days

- June 2019: Azar v. Allina Health Services
  - In this case, the Supreme Court determined that CMS had failed to follow its notice-and-comment policy regarding a rule related to Medicare payments that it had attempted to adopt and apply retroactively.
  - This rule, which was adopted in the 2014 IPPS rules, would include Part C days in the Medicare fraction of Medicare DSH payments, and that this policy would apply retroactively to 2012.
  - Because CMS violated its own notice-and-comment policy, the Supreme Court held that only the published fractions were a statement of fact and subject to notice and comment, meaning that HHS could not rely on the published fractions.
  - On June 7, 2023, CMS issued a final policy that states that Part C days should be included in the Medicare fraction of discharges prior to October 2013, with an effective date of August 8, 2023.
  - The Medicare Administrative Contractors (MACs) are now proceeding with settlements that have been on hold since 2020 and have issued Notices of Program Reimbursement (NPRs) and Revised NPRs for appeals and remands. It should be noted that policy is not a basis for reopening settled cost reports. Challenges based on this revised policy can be submitted through appeals of these NPRs.

340B DRUG DEVELOPMENTS

In the proposed Medicare Outpatient Prospective Payment System (OPPS) rules update for FY 2026, CMS proposes to accelerate the recoupment of $7.8 billion in overpayments from a **previous 340B drug policy** by increasing the annual reduction in the OPPS conversion factor for non-drug items and services from 0.5% to 2%. This accelerated offset, which will affect most hospitals, aims to recoup the full amount by 2031, rather than the previously estimated 2041. This recoupment affects both 340B and non-340B hospitals, except those that enrolled in Medicare after January 1, 2018.

FY 2026 WAGE INDEX

The labor portion of the IPPS payments is adjusted for differences in a hospital's cost of labor, which is known as the wage index adjustment. In updating prospective payments to hospitals, the standardized amounts need to be adjusted for differences in wage levels in a geographic area when compared to the national average hospital wage level.

In FY 2026, CMS has set the hospital IPPS national labor share at 66%, which represents a decrease from 67% in 2025. The decrease is due to the rebasing of the market basket, leveraging more current data from the 2023-based market basket. This change reflects a trend of non-labor cost growth outpacing labor costs.

The wage index information used for FY 2026 is from cost report periods beginning in FY 2022. The occupational mix information will be taken from the 2022 Occupational Mix Survey. The FY 2026 occupational mix adjusted national average hourly wage is $57.86.

Discontinuation of the Low Wage Index Hospital Policy

The low wage index hospital policy, which was designed to increase compensation for low wage hospitals by increasing their wage index values, was struck down on July 23, 2024, by the Court of Appeals for the D.C. Circuit. The Court agreed with an earlier court ruling finding the policy unlawful and vacated the regulation.

However, CMS is adopting a budget-neutral narrow transition exception for FY 2026 to provide short-term relief to hospitals that are significantly impacted by the rule's discontinuation. This exception applies to hospitals whose wage index for FY 2026 is decreasing by more than 9.75% from their FY 2024 wage index and caps changes to the IPPS payment at 90.25% of their FY 2024 wage index.

Rural Floor

The Medicare rural floor wage index was established to ensure that an urban hospitals' wage index would not be less than the wage index of hospitals located in rural areas of the state. This rule continues in FY 2026.

Imputed Rural Floor

The Medicare imputed rural floor wage index is a policy that ensures hospitals in all-urban states, which would otherwise have no rural floor for their wage index, receive a wage index no lower than the national rural average. This "imputed" floor applies to states without rural hospitals, providing a guaranteed minimum wage index value for urban hospitals in those areas to account for geographic differences in labor costs and prevent unfairly low payments. This policy continues in FY 2026.

MEDICAL EDUCATION

Graduate Medical Education (GME)

Hospitals with an approved teaching program are paid for the direct costs of graduate medical education (GME) based on the weighted number of residents, the Medicare patient load (which is the percentage of the hospital's Medicare inpatient days) in the Medicare cost reporting period, and the hospital's per resident amount.

The FY 2026 rule has not implemented significant changes for Medical Education. However, CMS has finalized a technical adjustment for GME calculation of full time equivalent (FTE) resident counts, which will affect the three-year rolling average for FTE counts. The rule clarifies how GME FTE counts are calculated when cost reports are not 12 months. The calculation must be based on hospital service days within the cost report period.

CMS is also finalizing technical changes to the calculation of FTE counts and caps. The adjustments are designed to prorate resident counts to reflect the appropriate length of the cost report. These changes were implemented for consistent calculations of resident counts used for reimbursement.

Indirect Medial Education (IME) Payment Adjustment Factor

Teaching hospitals receive an add-on payment to their DRG payment to reimburse hospitals for the increased cost of treatment compared to non-teaching hospitals. The IME formula has a multiplier factor used to calculate the IME payment. The factor is set each year by statute. The factor has been 1.35 for discharges occurring since FY 2008. The factor for FY 2026 will continue to be 1.35.

Nursing Allied Health

Hospitals that operate approved nursing and allied health programs are eligible for pass-through payments on a reasonable cost basis. These hospitals also receive add-on payments for Medicare Advantage (MA) plans. The final rule did not implement technical changes to the calculation of net nursing and allied health education costs. However, CMS does plan on analyzing comments that were received on this topic and incorporating input into future considerations around changes to these costs.

MEDICARE DEPENDENT HOSPITALS (MDH)

Medicare Dependent Hospital (MDH) status provides an extra payment to support small rural hospitals. These hospitals must have admissions from Medicare patients of at least 60%, have 100 or fewer beds, and cannot be a Sole Community Hospital. The MDH will then be paid the higher of the federal rate or the IPPS rate. They also receive an additional payment equal to 75% of the difference between that IPPS rate and the hospital's inflation-adjusted costs from its base year. Congress will have to renew the MDH status before December 31, 2025, or this status expires for discharges starting January 1, 2026.

LOW VOLUME HOSPITALS (LVH)

Hospitals that meet the criteria for low volume status receive an additional 25% payment adjustment based on the total per discharge payments. This includes Capital, DSH, IME, and outlier payments for hospitals with 500 or fewer discharges that are 15 minutes from the nearest hospital. The payment is reduced on a linear sliding scale for hospitals with more discharges, ending in a complete elimination of this payment for hospitals with more than 3,800 discharges in a fiscal year.

It's important to note that these criteria were updated for FYs 2019-2022. Previously, a hospital had to have less than 200 total discharges and be located more than 25 road miles from the nearest hospital. The updated criteria and additional payments continued for FY 2023 through the Further Continuing Appropriations and Extensions Act of 2023. The Consolidated Appropriations Act of 2024 continued the extension for FY 2024. Congress will have to act to further extend the modified definition of LVH before December 31, 2025, or the LVH will go back to the criteria that were effective prior to FY 2019.

Quality Star Rating Program

Under the Overall Hospital Quality Star Rating structure, CMS reports on measures comparing hospitals and publishes this information on the Hospital Compare website. In 2026, CMS is implementing several changes designed to respond to concerns that hospitals had high star ratings despite low patient safety ratings and to reflect a hospital's commitment to patient safety while encouraging further improvements. The changes are as follows:

- Increased patient safety emphasis will elevate the importance of the Safety of Care measure group
- Stage 1 for FY 2026 ratings will cap hospitals performing in the lowest quartile for the Safety of Care measure group at a 4-star rating regardless of performance data
- Stage 2 for FY 2027 and beyond will reduce the star rating by one for hospitals in the lowest quartile of Safety of Care

Hospital Readmissions Reduction Program (HRRP)

For FY 2026, CMS is implementing changes to the Hospital Readmissions Reduction Program (HRRP), which seeks to lower excess readmissions by reducing a hospital's base operating DRG payment when admissions exceed expected levels.

The final rule modifies the six readmission measures to include Medicare Advantage (MA) data in addition to Medicare fee-for-service (FFS) data; however, the MA data is not included in the calculations of aggregate payments for excess readmissions, meaning that penalties related to high readmissions rates are still solely based on Medicare FFS data. The annual reduction is capped at 3% for a payment adjustment factor of 97. CMS estimates that 78.20% (2,298 of 2,939 hospitals) will have their base operating DRG payments reduced by their FY 2026 hospital-specific payment adjustment factors.

Hospital Value Based Purchasing (VBP) Program

The Hospital Value Based Purchasing (VBP) Program provides hospitals with value-based incentives based on performance measures in a respective year. The payments are funded for FY 2026 based on a reduction of 2% to the base operating DRG payment for discharges occurring for that year. The pool of money will fund incentive payments based on a hospital's Total Performance Score (TPS).

Updates for FY 2026 include the following:

- The Health Equity Adjustment (HEA), which has been in effect since 2023, has been removed
- Budget neutrality is maintained by a 2% reduction that is redistributed to hospitals

Future changes to this program include:

- COVID-19 exclusions, which will be removed in FY 2027

Hospital-Acquired Conditions (HAC) Reduction Program

The Hospital-Acquired Conditions (HAC) Reduction Program incentivizes hospitals to minimize preventable complications. Hospitals ranking in the lowest-performing quartile (bottom 25%) receive a 1% reduction in Medicare payments. The FY 2026 program will result in no financial impact for 2026.

Hospital Inpatient Quality Reporting (IQR) Program

The Hospital Inpatient Quality Reporting Program (IQR) is a pay-for-reporting quality program that requires hospitals to submit data on quality measures to CMS each year. The publicly available data helps consumers make more informed decisions about healthcare options and encourages hospitals and clinicians to improve the quality of inpatient care. Hospitals that fail to comply with these requirements receive reduced payments, which amount to a 0.825 point reduction in the standard IPPS rate for FY 2026.

Changes to this program in FY 2026 include:

- The modification of four quality measures:
  - Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
  - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity
  - Hybrid Hospital-Wide Readmission (HWR)
  - Hybrid Hospital-Wide Mortality (HWM)
- The removal of four measures, beginning with the CY 2024 reporting period and the FY 2026 payment determination:
  - Hospital Commitment to Health Equity
  - COVID-19 Vaccination Coverage among Health Care Personnel
  - Screening for Social Drivers of Health
  - Screen Positive Rate for Social Drivers of Health
- A submission extension for Extraordinary Circumstances Exception (ECE) requests from 30 to 60 days. This is intended to provide more flexibility for submission delays during natural disasters or other extraordinary circumstances.

TRANSFORMING EPISODE ACCOUNTABILITY MODEL (TEAM)

TEAM is an accountable care organization (ACO) model where acute care hospitals in certain geographic regions are responsible for the cost of care for Medicare patients both during specified surgical procedures and for the duration of their post-procedure care. TEAM offers episode-based payments covering five expensive procedures:

- Lower Extremity Joint Replacement
- Surgical Hip Femur Fracture Treatment
- Spinal Fusion
- Coronary Artery Bypass Graft
- Major Bowel Procedure

TEAM is intended to reduce expenditures, enhance the quality of care, and incentivize coordination among healthcare providers for surgery and services for 30 days after the procedures. It is estimated that TEAM will save the Medicare program $368 million over five years.

The FY 2026 rule makes several updates to TEAM, including:

- Using patient-reported outcomes in an outpatient setting to capture quality measure performance without increasing the burden on participating hospitals
- Improving the target price construction for episodes
- Broadening the three-day Skilled Nursing Facility Rule waiver to increase patient access to post-acute care options

HEALTH EQUITY STRATEGY

While the final rule for Health Equity Strategy for Environmental, Social and Governance (ESG) expanded in FY 2025, there are major changes in the FY 2026 update, largely aimed at rolling back certain aspects of the program. These changes include:

- Removing the HEA from the Hospital VBP Program
- Removing Inpatient Measures for the HEA from the IQR, including Facility Commitment to Health Equity and measures related to SDoH

However, not all changes are aimed at rolling back the program. Other changes include:

- Incorporating Medicare Advantage (MA) data into the HRRP and Hospital-Wide All-Cause Readmission and Mortality models to account for disparities
- Making SDoH screening mandatory in outpatient settings for certain programs
- Making the Screen Positive Rate for Social Drivers of Health voluntary in FY 2026, but mandatory in FY 2027

LTCH PROSPECTIVE PAYMENT SYSTEM (PPS) PAYMENT RATES

LTCHs can receive reimbursement at one of two rates. Those that meet the exclusion criteria for site-neutral payments are reimbursed under the LTCH PPS standard federal payment rates. Those that do not meet these criteria are reimbursed at a lower site-neutral payment rate. The specific criteria include:

- The DRG Criterion: Case does not have primary diagnosis related to psychiatric diagnosis or rehabilitation
- The ICU Criterion: Case must be preceded by a discharge from an acute care hospital which included at least a three-day stay in an intensive care unit
- The Ventilator Criterion: Case must be preceded by discharge from an acute care hospital and the LTCH discharge must be based on at least 96 hours of ventilator services in the LTCH

An LTCH will be paid the PPS standard federal rate if the DRG criterion is met and either the ICU or the ventilator criterion is met.

In FY26, the LTCH PPS payment rate will increase by 2.7%, from $49,383.26 in FY 2025 to $50,824.51 in FY 2026. This increase is based on a 3.4% market basket update minus the 0.7% productivity adjustment. LTCHs that do not meet the quality program reporting requirements will receive a 2% decrease to the standard payment, reducing it to $49,834.74.

The High-Cost Outlier Threshold for LTCH IPPS will increase by 2.5%, from $77,048.00 in FY 2025 to $78,936.00 in FY 2026. The Site-Neutral Outlier Threshold amount will decrease from $46,152.00 in FY 2025 to $40,397.00 in FY 2026.

The overall LTCH standard rate increase is projected to be $72 million, primarily driven by the standard rate increase and the projected high-cost outlier payments with a smaller increase in site-neutral payments of an estimated $10 million.

TABLE 5

Increase in FY 2026 LTCH Payments

LTCH Site-Neutral Payments	$10 million
LTCH PPS Payments	$72 million
Overall LTCH Payment Increase	**$82 million**

FY 2026 Outpatient Prospective Payment System (OPPS) Proposed Rule Updates

In July of 2025, the CMS proposed an update to the Outpatient Prospective Payment System (OPPS) and the Medicare Ambulatory Surgical Center (ASC) payment system for calendar year 2026. Proposed changes to the rule include:

- Increasing 340B-related repayment from 0.5% to 2%
- Shortening the timeframe for recoupment of 340B lump sums to be fully repaid by 2031, reducing the original repayment timeframe by almost 10 years; total repayment equals $7.8 billion with $1.1 billion recouped in 2026
- Conducting OPPS Drug Acquisition Cost Survey to determine hospital acquisition costs for covered outpatient drugs; at the conclusion of the survey, take appropriate steps to align Medicare payment with acquisition costs
- Increasing payment to hospitals and ASCs meeting quality reporting requirements by 2.4%, or $1.61 billion, less the $1.1 billion 340b decrease, for an estimated final total of $510 million
- Introducing a 2% reduction in OPPS payments for hospitals that do not meet quality reporting requirements
- Eliminating the Inpatient Only (IPO) list to allow beneficiaries to experience lower costs in an outpatient setting and shorter recovery time
- Aligning reimbursement of drug administration services for excepted off-campus hospital outpatient departments (HOPDs) with rates for non-excepted off-campus HOPDs, basing payments on the applicable Physician Fee Schedule instead of the Ambulatory Payment Classification (APC) rate

Policy Spotlight: The Reconciliation Tax Bill

The Reconciliation Tax Bill introduces sweeping changes across the healthcare sector — impacting reimbursement, compliance, workforce strategy, capital planning, and the delivery of patient care.

READ THE FULL ARTICLE ▶

Office of Inspector General (OIG) Report on Medicare Administrative Contractors (MACs) Oversight

In March of 2025, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) issued a **report** based on their audit of Medicare Administrative Contractors' (MACs) compliance with cost report oversight requirements. The review found 287 audit issues in the following areas:

- Graduate Medical Education (GME) and Indirect Medical Education (IME) reimbursement
- Charge groupings and allocations to correct cost centers
- Nursing and Allied Health program costs
- Medicare/Medicaid bad debt reporting

In response to the report, MACs identified several issues driving these audit findings, including unclear guidance from CMS, lack of feedback on cost report reviews, training deficiencies, and workload challenges.

As part of the report, the OIG issued three recommendations:

- Increase transparency around MACs' processes with thorough explanation of Quality Assurance Surveillance Plan (QASP) results
- Provide additional training based on QASP results with a section on best practices used by MACs
- Update the audit program to provide a better understanding of CMS' expectations to allow evaluation on current requirements

Hospitals need to be prepared for increased audit scrutiny and more stringent reviews of their Medicare cost reports. To do so, we recommend that hospitals:

- Evaluate their preparation and review processes to ensure that the submitted cost report is accurate
- Be ready to defend cost reports by providing accurate and complete documentation around the preparation process and underlying assumptions
- Prepare for increased time and costs related to Medicare cost reporting

LOOKING AHEAD

The changes in the FY 2026 IPPS final rule, combined with other key policy shifts such as the Medicaid program cuts, mean that hospitals leaders will face a very different financial environment in 2026. To prepare for these changes, hospitals should consider taking the following steps:

- **Revise your financial forecasts.** Consider not only how IPPS will impact your finances, but other changes like Medicaid cuts, redetermination schedules, and work requirements. Variables to consider for your forecast include changes in the number of patients with insurance coverage, the potential for further interest rate cuts, and **expected increases in healthcare costs** outside of those accounted for under the Medical Care Consumer Price Index (CPI).
- **Develop and strengthen community outreach programs.** Changes to the Medicaid program may lead to greater healthcare costs over time as hospitals increasingly treat more acute patients who delayed care due to loss of insurance. Community outreach programs can prevent this by helping underinsured, uninsured, low-mobility, and vulnerable patients access care more easily.
- **Enhance your KPI tracking workflows.** The changes to TEAM and quality reporting programs demonstrate how much performance reporting can change from year to year. Rather than focusing solely on compliance requirements, consider what additional metrics would be useful to track for your operations. Improving your tracking will likely require rethinking tracking workflows, as well as investing in technology upgrades. However, the benefits are twofold: not only will you have more data to inform your decision making, but tracking improvements may also make it easier to comply with new reporting requirements year-to-year.
- **Know what you don't know.** Many of the changes we've outlined here are very technical in nature and can be difficult to apply in a practical way to your financial planning. Consider reaching out to an advisor with experience in Medicare reimbursement to help you understand how these changes will impact your organization and what opportunities are available to improve your financial stability.

Have questions about the FY 2026 IPPS rules?

REACH OUT TO OUR TEAM TODAY ▶

CONTACT US

CHAD KRCIL, CHFP, FHFMA
Managing Director
The BDO Center for Healthcare Excellence & Innovation
303-594-8888 / ckrcil@bdo.com

VENSON WALLIN, CPA, CGMA
Managing Director
The BDO Center for Healthcare Excellence & Innovation
804-873-0443 / vwallin@bdo.com

ABOUT THE BDO CENTER FOR HEALTHCARE EXCELLENCE & INNOVATION

The BDO Center for Healthcare Excellence & Innovation is devoted to helping healthcare organizations thrive, clinically, financially, and digitally We help clients redefine their strategies, operations and processes based on both patient-centric demands and rigorous best business practices—responding to the industry's new market disrupters, cost pressures and outcomes-based reimbursement models.

Our purpose is helping people thrive, every day. Together, we are focused on delivering exceptional and sustainable outcomes and value for our people, our clients and our communities. BDO is proud to be an ESOP company, reflecting a culture that puts people first. BDO professionals provide assurance, tax and advisory services for a diverse range of clients across the U.S. and in over 160 countries through our global organization.

BDO is the brand name for the BDO network and for each of the BDO Member Firms. BDO USA, P.C., a Virginia professional corporation, is the U.S. member of BDO International Limited, a UK company limited by guarantee, and forms part of the international BDO network of independent member firms. For more information, please visit: www.bdo.com.

© 2025 BDO USA, P.C. All rights reserved.