National Rural Health Association

Fiscal Year (FY) 2026 Inpatient Prospective Payment System Final Rule

The Centers for Medicare and Medicaid Services (CMS) recently released its FY 2026 Inpatient Prospective Payment System (IPPS) final rule. Please find CMS' fact sheet here and NRHA's summary of major rural relevant provisions below. For reference, please find our comment on the proposed rule here.

The final rule updates Medicare payment policies and rates for acute care hospitals. The rule outlines changes for hospital operating and capital payments, modifies various quality and interoperability programs, and finalizes important policies affecting rural providers. CMS projects the rule will result in an overall increase of approximately $5 billion in FY 2026 hospital payments.

If you have any questions or concerns, contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel (amckinley@ruralhealth.us).

Key provisions include:

Payment update. CMS finalized a **2.6% payment increase** for hospitals. This payment update reflects a projected market basket increase of 3.3%, offset by a -0.7% productivity adjustment. Rural hospitals are anticipated to receive a payment increase closer to 2.9% after considering the 2.6% increase, outlier adjustment, potential Medicare Dependent Hospital expiration, uncompensated care payments, and wage index changes. In addition, CMS has rebased the market basket to reflect a 2023 base year and updated the national labor-related share to 66%.

CMS estimates these changes will increase overall hospital payments by approximately $5 billion in FY 2026. Included in this projection is an estimated $2.0 billion increase in Medicare uncompensated care payments to Disproportionate Share Hospitals (DSHs). **CMS also expects to provide about $192 million in new technology add-on payments.**

Low wage index. In the FY 2020 IPPS rule, CMS finalized the low wage index policy that increased wage index values for hospitals below the 25th percentile for wage index values for a fiscal year. These hospitals receive an increase of half the difference between the otherwise applicable final wage index for the year and the 25th percentile wage index value for the year across all hospitals.

CMS finalized its proposal to discontinue the low wage index hospital policy beginning in FY 2026. This action follows the July 2024 decision by the D.C. Circuit Court of Appeals in *Bridgeport Hospital v. Becerra*, which held that CMS lacked the statutory authority to maintain the policy. The policy aims to improve hospitals' wage index values, many of which are rural.

To mitigate the financial impact of discontinuation, CMS is finalizing a transitional, budget-neutral policy. Hospitals that benefitted from the FY 2024 low wage index policy and experience a decrease of more than 9.75% in their wage index for FY 2026 will receive an adjustment. These hospitals will have their FY 2026 wage index increased to 90.25% of their FY 2024 value. This transitional payment mechanism was previously adopted in the FY 2025 interim final rule and is now codified without modification.

Extension of MDH designation and LVH adjustment. CMS has implemented a statutory extension of the Medicare-Dependent Hospital (MDH) and Low-Volume Hospital (LVH) adjustments through September 30, 2025. Without further legislative action, these enhanced payments will expire. If extended, CMS estimates that MDHs and LVHs would receive approximately $500 million in FY 2026.

TEAM model. The Transforming Episode Accountability Model (TEAM) is a mandatory, five-year, episode-based alternate payment model that CMS finalized in the rule. The model will run from January 1, 2026, to December 31, 2030. The model holds selected IPPS hospitals accountable for the cost and quality of care for beneficiaries undergoing one of five surgical procedures (Coronary Artery Bypass Grafting, Lower Extremity Joint Replacement, Surgical Hip and Femur Fracture Treatment, Spinal Fusion and Major Bowel Procedure), from the hospital stay through 30 days post-discharge.

As a reminder, TEAM will have three participation tracks: Track 1 will have no downside risk and lower levels of reward for the first year, or up to three years for safety net hospitals; Track 2 will be associated with lower levels of risk and reward for certain TEAM participants, such as safety net hospitals or rural hospitals, for years 2 through 5; and Track 3 will be associated with higher levels of risk and reward for years 1 through 5.

Hospitals located in selected metropolitan and micropolitan core-based statistical areas (CBSAs) are required to participate. Rural hospitals located outside of selected CBSAs are exempt. Find a list of TEAM participants here.

Changes to the TEAM model that CMS finalized include:

- A one-year deferral period for newly eligible hospitals, like Critical Access Hospitals that convert to IPPS status, after December 31, 2024.
- Expanding the 3-day Skilled Nursing Facility (SNF) rule waiver to include admissions to swing beds, improving access to post-acute care in rural communities.
- MDHs will continue to qualify for participation in Track 2 of TEAM, which includes lower levels of financial risk, provided that their MDH designation is active at the time of track selection. However, if the MDH designation expires prior to track selection, hospitals that are required to participate in TEAM and previously had an MDH designation may still be eligible for track 2 by nature of being a rural hospital, safety net hospital, or sole community hospital.
    - CMS estimates that there are 25 MDHs eligible for participation in TEAM. Only 4 MDHs would not be eligible for lower risk by participating in Track 2 if the MDH designation expires.
- A low volume policy that removes downside risk for any episode category in which a hospital had fewer than 31 episodes during the 3-year baseline.
- Excluding Indian Health Service and tribal hospitals from TEAM participation.

Find more information on the model on the TEAM webpage.

Hospital Inpatient Quality Reporting (IQR) Program. CMS finalized several updates to the IQR Program. Four measures will be removed beginning with the CY 2024 reporting period for FY 2026 payment determination: Hospital Commitment to Health Equity, COVID-19 Vaccination Coverage among Healthcare Personnel, Screening for Social Drivers of Health, and Screen Positive Rate for Social Drivers of Health.

CMS is also modifying two existing measures. The Stroke Mortality and THA/TKA Complications, to include Medicare Advantage patients and to shorten the performance period from three to two years. Additionally, CMS will update the risk adjustment methodology for these measures to use ICD-10 codes instead of Hierarchical Condition Categories (HCCs).

CMS is codifying an update to the Extraordinary Circumstances Exception (ECE) policy. The deadline to submit ECE requests is extended from 30 to 60 days.

Medicare Promoting Interoperability Program. CMS finalized policy changes to modernize the Medicare Promoting Interoperability Program. Beginning in CY 2026, the EHR reporting period will be any continuous 180-day period. Hospitals must attest to having completed both security risk analysis and security risk management. Completion of all eight SAFER Guides annually will be mandatory.

A new optional bonus measure under the Public Health and Clinical Data Exchange objective will reward hospitals for using the Trusted Exchange Framework and Common Agreement (TEFCA) for public health data exchange. CMS also seeks feedback on transitioning attestation-based measures to performance-based metrics and on enhancing data completeness and interoperability across health systems.