National Rural Health Association

Fiscal Year 2026 Inpatient Prospective Payment System Proposed Rule

On April 11, the Centers for Medicare and Medicaid Services (CMS) issued its fiscal year (FY) 2026 Inpatient Prospective Payment System (IPPS) proposed rule. Please find CMS' fact sheet here and NRHA's summary below.

NRHA will be commenting on the proposed rule. Comments are due **June 10, 2025**, via regulations.gov. If you have any questions or comments that you would like addressed in NRHA's response, please contact Alexa McKinley Abel (amckinley@ruralhealth.us) by May 27.

Major proposals include:

Payment update.

- CMS proposes to increase IPPS payments by 2.4%. Rural hospitals across the board will see about a 2.5% increase.
- Uncompensated care payments to disproportionate share hospitals (DSH) will increase in FY 2026 by approximately $1.5 billion overall.
- Congress extended Medicare-dependent hospitals (MDHs) and low-volume hospital payment adjustments through September 30, 2025, or through the rest of FY 2025. Another extension by Congress is needed to continue the programs. CMS projects that if legislation is enacted to further extend these designations, payments will total approximately $500 million.

Low wage index policy. Beginning in FY 2020, CMS implemented the low wage index policy, which bumped up the wage index for the bottom 25% of hospitals. This was meant to account for the growing disparity between high and low wage index hospitals likely due to using historical wage data. In July 2024, the D.C. Court of Appeals held that CMS did not have the authority to implement the low wage index policy. As a result, 323 rural hospitals saw lower wage indices in FY 2025.

To comply with the court's holding, CMS proposes to discontinue the low wage index policy. However, to help mitigate the effects of the low wage index policy ending, CMS proposes to adopt a transitional exception for hospitals that have been disproportionately impacted. The proposed policy would apply to hospitals that benefitted from the FY 2024 low wage index hospital policy and would compare the hospital's proposed FY 2026 wage index to the hospital's FY 2024 wage index.

If the hospital's proposed FY 2026 wage index would decrease by more than 9.75% from the Fy 2024 wage index, the hospital would receive a transitional payment 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.

Deregulation request for information (RFI). In the proposed rule, CMS announced that it is seeking responses to an RFI on Medicare regulatory relief. CMS seeks public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers. Responses are due June 10, 2025, via this form.

Transforming Episode Accountability Model (TEAM). CMS finalized TEAM in the FY 2025 rulemaking cycle, and it is set to launch in January 2026. TEAM is a 5-year mandatory, episode-based payment model for acute care hospitals within selected geographic areas. Find more background information on the model here. **CMS proposes several modifications to TEAM, including:**

- Any hospital that opens or is located in a mandatory CBSA and begins to satisfy the definition of a TEAM participant after December 31, 2024, would not be required to participate in TEAM immediately. These hospitals would have at least one full year of participation deferment before being required to join.
    - For example, a hospital that is currently a critical access hospital, and therefore not eligible for TEAM, and converts to PPS, and becomes eligible for TEAM.
- In FY 2025, CMS finalized a policy to allow TEAM participants to send eligible TEAM beneficiaries to skilled nursing facilities without a 3-day inpatient hospital stay. Now, to ensure access to care in rural areas, **CMS proposes to expand this 3-day stay waiver to admission to swing beds as well.**
- MDHs are eligible to participate in Track 2 of the model, which provides lower levels of upside and downside financial risk. Other hospitals eligible for this track are rural hospitals, safety net hospitals, and sole community hospitals. Seeing as the MDH designation is periodically up for an extension by Congress, CMS proposes to allow MDHs to qualify for Track 2 as long as the MDH program is active at the time that participation track selections are due.
    - CMS estimates that there are currently 25 MDHs that will participate in TEAM, 4 of which would not be eligible for Track 2 if the MDH program expires.
- CMS is not putting forth a low-volume policy after the agency decided not to finalize its proposal for hospitals with a low-volume of qualifying episodes in FY 2025. However, **CMS seeks comments on:**
    - Establishing a low-volume threshold for specific episode categories in a given performance year. If a hospital does not meet the low-volume threshold, the hospital would not be held accountable for any performance year episode spending in that episode category that exceeded the target price, effectively waiving downside risk.
    - Establishing a low-volume policy for rural and safety net hospitals only.
    - Establishing a low-volume policy where a hospital that did not meet the threshold in the baseline period, then it would not be accountable for any episodes during the performance year.
- For beneficiary level risk adjustment, CMS proposes to move from using Area Deprivation Index to Community Deprivation Index and proposes to rename the "social needs risk adjustment factor" to "beneficiary economic risk adjustment factor."
- CMS proposes to remove voluntary submission of health equity plans and health related social needs data and the voluntary collection of health related social needs screening and reporting.

Inpatient Hospital Quality Reporting Program (IHQRP). CMS proposes the following changes to the IHQRP:

- Removing 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 measures.
- Modifying Hospital 30-Day, All-Cause Risk-Standardized Mortality Rate Following Stroke Hospitalization to include Medicare Advantage beneficiaries.
- Modifying Hospital-Level, Risk-Standardized Complication Rate Following Elective Total Hip and/or Total Knee to include Medicare Advantage beneficiaries.

CMS also seeks comments on measure concepts related to well-being and nutrition for future consideration. CMS defines well-being as "a comprehensive approach to disease prevention and health promotion, as it integrates mental and physical health while emphasizing preventative care to proactively address potential health issues.