American College of Radiology™

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

On Thursday, July 31, the Centers for Medicare and Medicaid Services (CMS) released the fiscal year (FY) 2026 Hospital Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System Final Rule. The final rule provides updates for Medicare fee-for-service payment rates and policies for inpatient hospitals and long-term care hospitals for FY 2026. CMS pays acute care for inpatient stays under the IPPS. Under this payment system, CMS sets base payment rates for inpatient stays based on the patient's diagnosis and severity of illness. Subject to certain adjustments, a hospital receives a single payment for the case based on the payment classification assigned at discharge through Medicare Severity Diagnosis-Related Groups (MS-DRGs). These finalized changes take effect on October 1, 2025.

Finalized Payment for FY 2026

CMS finalized a base FY 2025 update of +2.6%. This is based on a market basket update of 3.3% and the multifactor productivity (MPF) adjustment, which CMS estimates to be a 0.7 percentage point reduction. CMS finalized a neutral adjustment (0 percent update) for hospitals that submit quality data and are not considered "meaningful EHR users," finalized an update of 1.7 percent for hospitals that fail to submit quality data but are considered "meaningful EHR users". For hospitals that fail to submit quality data and are not considered "meaningful EHR users" have a finalized update of -0.7%.

For FY 2026, CMS expects the changes in operating and capital IPPS payment rates will generally increase hospital payments by $5 billion. CMS also estimates that additional payments for inpatient cases involving new medical technologies will increase by approximately $192 million in FY 2026, primarily driven by the continuation of new technology add-on payments for several technologies.

Data Used in Rate Setting

CMS finalized the proposal to use the FY 2024 Medicare Provider Analysis and Review (MedPAR) claims file as well as the Medicare cost report data files from the March 2025 update of the FY 2023 Healthcare Cost Report Information System (HCRIS) dataset for purposes of FY 2026 ratesetting. This is consistent with CMS's historical practice of using the HCRIS dataset that is 3 years prior to the IPPS fiscal year.

Market-Based MS-DRG Relative Weight: Finalized Policy Changes

CMS calculated the final FY 2026 relative weights based on 19 cost-to-charge (CCR) ratios. The finalized methodology uses claims data in the FY 2024 MedPAR file and data from the FY 2023 Medicare cost reports. The charges for each of the 19 cost groups for each claim were standardized to remove the effects of differences in area wage levels, indirect

medical education (IME) and disproportionate share hospital (DSH) payments, and for hospitals located in Alaska and Hawaii, the applicable cost-of-living adjustment.

Development of National Average Cost-To-Charge Ratios (CCRs)
The finalized 19 national average CCRs for FY 2026 are set forth in Table 5 of the rule:

National Average CCRs	
Group	**CCR**
Routine Days	0.394
Intensive Days	0.335
Drugs and Cellular Therapies	0.177
Supplies & Equipment	0.297
Implantable Devices	0.255
Inhalation Therapy	0.148
Therapy Services	0.256
Anesthesia	0.071
Labor & Delivery	0.373
Operating Room	0.153
Cardiology	0.086
Cardiac Catheterization	0.098
Laboratory	0.098
Radiology	0.123
MRIs	0.065
CT Scans	0.032
Emergency Room	0.139
Blood & Blood Products	0.230
Other Services	0.327

Finalized Update to the IPPS Labor-Related Share
CMS finalized the proposal 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 2023-based IPPS market basket, CMS calculated a labor-related share of 66.0 percent, which they are finalizing to use for discharges occurring on or after October 1, 2025. The finalized labor-related share of 66.0 percent is 1.6 percentage points lower than the current labor-related share of 67.6 percent. As discussed in section IVB.3. of the preamble of this final rule, this downward revision to the labor-related share is primarily the result of incorporating the more recent 2023 Medicare cost report data for Wages and Salaries, Employee Benefits, and Contract Labor costs. This is partially offset by an increase in the Professional Fees: Labor-Related cost weight.

Finalized FY 2026 Applications for New Technology Add-On Payments
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 FDA approval requirements; and 4 applicants withdrew their applications prior to the issuance of the FY 2026 IPPS proposed rule. Subsequently, prior to the issuance of this final rule, 7 additional applicants withdrew their applications or did not meet the May 1 deadline for FDA clearance. Of the remaining 22 applications, 20 of the technologies received a Breakthrough Device designation from FDA.

Transition for the Discontinuation of the Low Wage Index Hospital Policy
In response to a court ruling that invalidated the FY 2020 low wage index hospital policy, CMS is discontinuing the low wage index hospital policy starting in FY 2026. To ease the transition, CMS is implementing a budget-neutral exception for significantly affected hospitals and finalizing related provisions from the FY 2025 interim rule without changes.

Finalized Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2026
Medicare makes DSH payments to IPPS hospitals that serve a high percentage of certain low-income patients. The total amount of uncompensated care payments ($7.14 billion) combined with supplement payments for IHS/Tribal hospitals and Puerto Rico hospitals ($100.6 million) is $7.241 billion. This is a 25.1 percent increase (about $1.455 billion) from FY 2025 payments.

Transforming Episode Accountability Model (TEAM)
The TEAM model, finalized in the FY 2025 IPPS/LTCH PPS rule, is a mandatory alternative payment model designed to improve care quality and reduce Medicare costs. It focuses on episodes initiated by specific procedures, including coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedures, surgical hip/femur fracture treatment (SHFFT), and spinal fusions. The model promotes financial accountability for these episodes to test cost reduction and quality improvement.

In this FY 2026 final rule, CMS is updating TEAM with changes including:

- Policies for new hospital participation
- Adjustments to quality measures and assessments
- Revisions to target price construction
- Removal of certain health reporting elements
- Expansion of the Skilled Nursing Facility (SNF) 3-Day Rule
- Elimination of the Decarbonization and Resilience Initiative (DRI)

The five-year mandatory episode-based payment model will run from January 1, 2026, to December 31, 2030. Selected acute care hospitals will take responsibility for the cost and quality of care from a hospital-based surgery through the first 30 days after the patient's surgery. These updates aim to strengthen TEAM's incentives for improving beneficiary care and reducing Medicare spending.

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