American College of Radiology™

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

On Friday, April 11th, 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 Proposed Rule. The proposed 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). Comments are due to CMS by June 10, 2025.

Proposed Payment for FY 2026
CMS proposes a base FY 2025 update of +2.4%. This is based on a market basket update of 3.2% and the multifactor productivity (MPF) adjustment, which CMS estimates to be a 0.8 percentage point reduction. CMS proposed a neutral adjustment (0 percent update) for hospitals that submit quality data and are not considered "meaningful EHR users," proposed update of 1.6 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 proposed update of -0.8%. For FY 2026, CMS expects the proposed changes in operating and capital IPPS payment rates will generally increase hospital payments by $4 billion.

Data Used in Rate Setting
CMS proposes to use the FY 2024 Medicare Provider Analysis and Review (MedPAR) claims file as well as the Medicare cost report data files from the December 2024 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: Proposed Policy Changes
CMS calculated the proposed FY 2026 relative weights based on 19 cost-to-charge (CCR) ratios. The proposed 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 proposed 19 national average CCRs for FY 2026 are set forth in Table 5:

HEADQUARTERS
1892 Preston White Drive
Reston, VA 20191
703-648-8900

GOVERNMENT RELATIONS
505 Ninth St. N.W.
Suite 910
Washington, DC 20004
202-223-1670

CENTER FOR RESEARCH AND INNOVATION
50 South 16th St., Suite 2800
Philadelphia, PA 19102
215-574-3150

ACR INSTITUTE FOR RADIOLOGIC PATHOLOGY
1100 Wayne Ave., Suite 1020
Silver Spring, MD 20910
703-648-8900

National Average CCRs	
Group	**CCR**
Routine Days	0.395
Intensive Days	0.341
Drugs and Cellular Therapies	0.179
Supplies & Equipment	0.304
Implantable Devices	0.265
Inhalation Therapy	0.149
Therapy Services	0.26
Anesthesia	0.074
Labor & Delivery	0.367
Operating Room	0.156
Cardiology	0.087
Cardiac Catheterization	0.100
Laboratory	0.099
Radiology	0.124
MRIs	0.066
CT Scans	0.032
Emergency Room	0.141
Blood & Blood Products	0.238
Other Services	0.330

Proposed Update to the IPPS Labor-Related Share

CMS proposes 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 they are 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. As discussed in section IVB.3. of the preamble of this proposed 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.

Proposed 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 this proposed rule. Of the remaining 29 applications, 27 of the technologies received a Breakthrough Device designation from FDA.

Transition for the Discontinuation of the Low Wage Index Hospital Policy
CMS will comply with a summer court order, and it will be discontinuing the low wage index hospital policy, which since FY 2020 has provided extra funds to hospitals whose workers earn lower wages to encourage higher pay. CMs is proposing a budget-neutral "narrow transitional exception" for those that would be significantly impacted by the discontinuation

Proposed 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 proposed 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.

Medicare Promoting Interoperability Program
The Medicare Promoting Interoperability Program encourages eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record (EHR) technology (CEHRT).

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.
- 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.
- 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.
- 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.

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.

CMS is also requesting information 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.

Hospital Value-Based Purchasing (VBP) Program

Hospital VBP Program Measures (p. 716)
Performance Standards for the Hospital VBP Program
CMS plans to set new hospital benchmarks and performance standards in the 2027-2030 program years. These standards will apply to quality measures in the Safety, Clinical Outcomes, and Efficiency and Cost Reduction domains. Technical updates to Clinical Outcomes measures begin in FY 2027, but the FY 2027 standards remain unchanged due to excluding COVID-19-impacted data under the national Extraordinary Circumstances Exception (ECE). CMS proposes new standards for the 2028 performance year, including measures in the Safety, Clinical Outcomes, and Efficiency and Cost Reduction domains.

CMS proposes to apply new standards to the 30-day mortality rate measures for conditions like acute myocardial infarction (AMI), heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG), and elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA). Standardizing these measures will support consistent and reliable performance assessment. For the Medicare Spending Per Beneficiary (MSPB) measure, CMS proposes benchmarks representing the mean of the lowest decile MSPB ratios across all hospitals during the performance period, encouraging cost efficiency. CMS also proposes expanding measure denominators to include Medicare Advantage patients, increasing the number captured in measure cohorts for better reliability.

Proposed Removal of the Health Equity Adjustment (HEA)from the Hospital VBP Program
CMS adopted the HEA in the FY 2024 IPPS/LTCH PPS final rule, rewarding top-performing hospitals serving higher proportions of dually eligible patients starting FY 2026. To streamline regulations and reduce burdens, CMS proposes removing the HEA and associated bonus points from the Hospital VBP program's total performance score.

Toward Digital Quality Measurement in the CMS Quality Programs – Request for Information (p. 815)

CMS updates and seeks feedback on transitioning to digital quality measurement (dQM), focusing on using HL7® FHIR® in eCQM reporting. CMS aims to develop new measures, implement FHIR, and transition existing eCQMs to FHIR-based eCQMs.

The RFI requests comments on FHIR-based eCQM implementation across CMS programs, including the Hospital IQR, Hospital OQR, and Medicare Promoting Interoperability Programs. The rule notes that the 2026 proposed Physician Fee Schedule will likely include an RFI on FHIR-based eCQM activities in MIPS and Medicare Shared Savings Plan (MSSP). Currently, the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults is the radiology-focused eCQM adopted by CMS into the Hospital IQR program, specified to use FHIR.

CMS plans to allow stakeholders to optimize systems during a transition period to FHIR-based eCQM reporting. It expects the same number of measures required for submission, but allows a two-year reporting option to move from the Quality Data Model (QDM) to FHIR.

The RFI seeks input on barriers to the FHIR transition, encouraging early adoption of eCQMs, and resources to support the transition.

Measure Concepts Under Consideration for Future Years in the Hospital IQR Program–Request for Information (RFI): Well-Being and Nutrition (p. 832)

CMS requests comments on well-being and nutrition measures for future Hospital IQR Program years, emphasizing disease prevention and health promotion. Well-being integrates mental and physical health, emphasizing preventative care. CMS promotes patient and family well-being and requests comments on tools and measures assessing overall health, happiness, and satisfaction in life, including emotional well-being, social connections, purpose, and fulfillment. CMS will consider feedback for future measure development.

Requirements for and Changes to the Hospital Inpatient Quality Reporting (IQR) Program (p. 834)

CMS proposes modifications to the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization measure, which inpatient radiology departments may influence. Changes include expanding inclusion criteria to Medicare Advantage patients, shortening the performance period from three to two years, improving the risk adjustment model using ICD-10 codes, and removing the exclusion of patients with a secondary diagnosis code for COVID-19.

Proposed Removals in the Hospital IQR Program Measure Set (p. 856)
CMS proposes removing four measures addressing health equity and social determinants of health starting CY 2024/FY 2026: 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 states these measures do not include quality improvement actions directly associated with clinical outcomes, their collection burden outweighs benefits, and they conflict with CMS plans to refocus on clinical outcomes.

Transforming Episode Accountability Model (TEAM)

The TEAM proposals would, among other things, capture quality measure performance in the outpatient setting without increasing participant burden, improve target price construction, and expand the three-day Skilled Nursing Facility Rule waiver, giving patients a wider choice of and access to post-acute care. In TEAM, selected acute care hospitals will coordinate care for patients with Original Medicare who are undergoing one of five surgical procedures. 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.