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CMS Proposes 2.4% Increase in Hospital Inpatient Payments and Key Policy Reforms for FY 2026 (CMS-1833-P)

On April 11, 2025, the Centers for Medicare & Medicaid Services (CMS) issued the fiscal year (FY) 2026 Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System proposed rule. CMS released a fact sheet and a press release accompanying the rule.

The rule proposes to:

- increase hospital operating payment rates by 2.4 percent,[1]
- recalibrate MS-DRGs using updated claims and cost data,
- increase uncompensated care payments to disproportionate share hospitals (DSHs) by 26 percent,
- discontinue the hospital low-wage index policy and implement a budget-neutral transitional adjustment for affected low-wage index hospitals,
- clarify existing policy for calculating full-time equivalent (FTE) resident counts and caps for direct and indirect graduate medical education (GME) payments,
- update quality programs, including measure removals, MA integration, COVID-19 phase-out, and data submission updates,
- provide New Technology Add-on Payments (NTAPs) for 26 continuing and 43 new technologies with new transparency and documentation requirements,
- increase Long-Term Care Hospital (LTCH) payments by 2.5 percent,
- remove social determinants of health (SDOH) data elements from the LTCH quality reporting program,
- codify changes to the Extraordinary Circumstances Exception (ECE) policy,
- revise and update the mandatory Transforming Episode Accountability Model (TEAM), and
- solicit stakeholder feedback on implementing Executive Order 14192 on Medicare deregulation and burden reduction.

This proposed rule is scheduled to be published in the *Federal Register* on April 30, 2025, and comments are due by 5:00 pm EDT on June 10, 2025.

[1] For general acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record (EHR) users.

CMS PROPOSES 2.4% IPPS PAYMENT RATE INCREASE AND PROJECTS $4 BILLION BOOST IN FY2026 HOSPITAL REIMBURSEMENTS

The Inpatient Prospective Payment System (IPPS) per-discharge payment is based on two national standardized base payment rates, one for operating costs and the other for capital-related costs. CMS adjusts each of these rates for geographic, case-mix, and other factors.

For FY 2026, CMS proposes a 2.4 percent increase in its operating payment rates for general acute care hospitals that submitted quality data and were meaningful electronic health record (EHR) users (see Tables 1 and 2). This increase is based on a projected 3.2 percent market basket update for FY 2026, offset by a 0.8 percentage point reduction for productivity.[2] The proposal also includes rebasing and revising both the IPPS operating and capital market baskets to reflect a 2023 base year. As part of this update, CMS proposes a national labor-related share of 66 percent.

Overall, CMS anticipates that the total hospital payments under the IPPS will rise by approximately $4 billion in FY 2026. This figure includes an estimated $1.5 billion increase in Medicare uncompensated care payments for hospitals that qualify for disproportionate share hospital (DSH) adjustments. CMS is also projecting that payments for cases involving new medical technologies will grow by about $234 million, largely due to the continuation of new technology add-on payments. Lastly, unless Congress acts to extend them, special payment adjustments for Medicare-Dependent Hospitals (MDHs) and low-volume hospitals are set to expire after September 30, 2025. If renewed, these payments are projected to total approximately $500 million in FY 2026.

Hospital stakeholders, including the American Hospital Association[3] and the Federation of American Hospitals,[4] have pushed back, arguing the proposed increase falls short of what is needed to sustain care delivery amid persistent financial pressures.

[2] The MFP adjustment is a 10-year moving average of changes in annual economy-wide private nonfarm business multifactor productivity.
[3] https://www.aha.org/news/headline/2025-04-11-cms-issues-hospital-ipps-proposed-rule-fy-2026
[4] https://www.fah.org/blog/here-we-go-again-fah-leader-reacts-to-release-of-ipps-proposed-rule/

Table 1. Proposed Update Factors for Hospital Operating Payment Rates (FY 2026)[5]

Submitted Quality Data	Meaningful EHR User	Gross FY2023 Market Basket	Adjustment for Failure to Submit Quality Data	Adjustment for Failure to be Meaningful EHR User	Multifactor Productivity Adjustment[6]	Net Increase in Operating Payment Rates
Yes	Yes	+3.2	0.0	0.0	-0.8	**+2.4**
No	Yes	+3.2	-0.8	0.0	-0.8	**+1.6**
Yes	No	+3.2	0.0	-2.4	-0.8	**0.0**
No	No	+3.2	-0.8	-2.4	-0.8	**-0.8**

Table 2. Standardized Operating Amounts (FY 2026)[7]

Submitted Quality Data	Meaningful EHR User	Standardized Operating Amounts (Wage Index > 1)		Standardized Operating Amounts (Wage Index <= 1)	
		Labor	Non-Labor	Labor	Non-Labor
Yes	Yes	$4,511.41	$2,324.06	$4,237.99	$2,597.48
No	Yes	$4,476.16	$2,305.90	$4,204.88	$2,577.18
Yes	No	$4,405.67	$2,269.59	$4,138.66	$2,536.60
No	No	$4,370.43	$2,251.43	$4,105.55	$2,516.31

Capital-Related Payments

The capital Federal rate for each hospital discharge in FY 2026 is calculated using this formula:

- **Capital-Related Payment** = (Standard Federal Rate) x (DRG Weight) x (Geographic Adjustment Factor [GAF]) x (Cost-of-Living Adjustment [COLA] for hospitals located in Alaska and Hawaii) x (1 + Capital DSH Adjustment Factor + Capital IME Adjustment Factor, if applicable)[8]

For FY 2026, CMS proposes a capital outlier adjustment factor of 0.9587, representing a 0.11 percent increase over FY 2025.

[5] See the Table on page 1,354 of the unpublished rule. Does not include applicable increases for Puerto Rico IPPS hospitals.
[6] Section 3401 of the Patient Protection and Affordable Care Act, Pub. L. 111-148, requires market basket updates under the Medicare prospective payment system to be reduced annually by the MFP adjustment.
[7] See the Table on page 1,238 of the unpublished proposed rule.
[8] Hospitals also may receive outlier payments for high-cost cases that qualify under thresholds established for each fiscal year.

CMS PROPOSES FY 2026 MS-DRG RECALIBRATION USING UPDATED CLAIMS AND COST DATA, SEEKS PUBLIC FEEDBACK ON METHODOLOGY

CMS proposes recalibrating the MS-DRG relative weights for FY 2026 using FY 2024 Medicare Provider Analysis and Review (MedPAR) claims data and FY 2023 Medicare cost reports. The methodology standardizes charges across 19 cost centers, excludes Medicare Advantage and certain non-qualifying claims, and adjusts for geographic and payment-related variations. CMS also continues its policy of resetting Present on Admission (POA) indicators to ensure accurate weight-setting and avoid skewed payment rates due to hospital-acquired conditions. To maintain consistency and accuracy, adjustments were made for transplant acquisition costs, statistical outliers, and non-monotonicity in DRG severity levels (e.g. where the mean cost in the higher severity level is less than the mean cost in the lower severity level) Public comments are invited on these proposed updates and methodologies.

UNCOMPENSATED CARE PAYMENTS TO DSH HOSPITALS PROPOSED TO RISE 26% IN FY 2026

Hospitals that receive Medicare disproportionate share hospital (DSH) receive two separate payments:

1. 25 percent of the amount they previously would have received under Section 1886(d)(5)(F) of the Social Security Act (Act) for DSH; and
2. An additional payment for uncompensated care (UC) as determined by the product of three factors:

    - **Factor 1**: 75 percent of the payments that would otherwise be made under Section 1886(d)(5)(F) of the Act,
    - **Factor 2**: 1 minus the percent change in the percent of individuals who are uninsured, and
    - **Factor 3**: a hospital's UC amount relative to all DSH hospitals expressed as a percentage.

CMS proposes its calculations for Factor 1 and Factor 2 and methodological approach for Factor 3 in this rule.

1. **Factor 1:** CMS proposes that Factor 1 for FY 2026 will be $11.761 billion.
2. **Factor 2:** CMS proposes that Factor 2 for FY 2026 will be 60.71 percent.
3. **Factor 3:** For FY 2026, for calculating Factor 3, CMS proposes to use data from the three most recent years of audited cost reports: FY 2020, FY 2021, and FY 2022. The methodology for Factor 3 is the same as used in FY 2025.

Proposed FY 2026 uncompensated care payments and supplemented payments total approximately $7.291 billion, an increase of approximately 26.01 percent from FY 2025.

CMS PROPOSES TO DISCONTINUE LOW-WAGE INDEX POLICY

The wage index reflects the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. To determine a hospital's labor market area, CMS uses Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget (OMB). In this rule, CMS proposes revisions to implement its annual update of the wage index, including proposing to use wage data from cost reporting periods beginning in FY 2022, and other adjustments and applications related to calculating the FY 2026 wage index.

Discontinuation of Low Wage Index Policy

Under the FY 2020 IPPS/LTCH PPS final rule, CMS finalized a temporary policy to address wage index disparities affecting low-wage index hospitals, many of which are rural hospitals. This policy increased wage indexes for hospitals with a wage index below the 25th percentile by half the difference between the hospital's wage index and the 25th percentile wage index. Following a court decision requiring this policy to be vacated (*Bridgeport Hosp. v. Becerra,* 108 F.4th 882, 887–91 & n.6 (D.C. Cir. 2024), CMS published an Interim Final Action with Comment for the FY 2025 IPPS Final Rule to address how CMS would remove the policy. For FY 2026, CMS proposes to discontinue this low wage index policy and proposes a budget-neutral narrow transitional exception for low-wage index hospitals that would be significantly impacted by the removal of this policy for FY 2026. This transitional policy is similar to what was implemented via the FY 2025 Interim Final Action with comment.

Other wage index policies with a budget neutral impact include:

- the permanent cap policy, which was finalized in the FY 2023 IPPS/LTCH PPS final rule and prevents any hospital from having a wage index below 95 percent of its wage index for the previous fiscal year. For FY 2026, the budget neutrality adjustment associated with this policy would be .993116.
- the rural floor, which was implemented as part of the Balanced Budget Act of 1997 and mandates that wage indexes for urban hospitals in a state cannot be lower than said state's rural area wage index. In the FY 2024 IPPS/LTCH PPS final rule, CMS finalized that rural reclassified hospitals be treated the same as geographically rural hospitals for wage index calculation purposes. For FY 2026, the budget neutrality adjustment associated with this policy would be .985942.
- Medicare Geographic Classification Review Board (MGCRB) reclassifications, which were implemented as part of the Omnibus Budget Reconciliation Act of 1989 and

allow hospitals to apply to be reclassified to a higher wage index area. For FY 2026, the budget neutrality adjustment associated with this policy would be .976960.

CMS CLARIFIES GME AND IME FTE CALCULATIONS, OPENS APPLICATIONS FOR REDISTRIBUTED RESIDENCY SLOTS FOLLOWING HOSPITAL CLOSURES

CMS clarifies its existing policy for calculating full-time equivalent (FTE) resident counts and caps for direct GME and indirect medical education (IME) payments, particularly for cost reporting periods other than 12 months. While GME FTEs are prorated to reflect a 12-month equivalent using 365 or 366 days, IME FTEs are based on the actual number of days in the reporting period. No policy changes were proposed. Equations for the counts are shown below:

$$Unweighted\ Direct\ GME\ FTE\ Count = Product\ of\ \left[\left(\frac{Allowable\ days\ in\ a\ rotation}{Total\ days\ in\ the\ rotation}\right)\ x\ \left(\frac{Total\ days\ in\ the\ rotation}{365}\right)\right]$$

$$IME\ FTE\ Count = Product\ of\ \left[\left(\frac{Allowable\ days\ in\ a\ rotation}{Total\ days\ in\ the\ rotation}\right)\ x\ \left(\frac{Total\ days\ in\ the\ rotation}{Days\ in\ Cost\ Reporting\ Period}\right)\right]$$

Additionally, CMS issued public notices of the closures of Wahiawa General Hospital (HI) and Carney Hospital (MA), launching Rounds 24 and 25 of the Section 5506 GME slot redistribution process. Hospitals have 90 days from the notice to apply for available residency slots using the MEARIS system, with applications due by **July 10, 2025**.

Critical Access Hospitals (CAHs) and Rural Emergency Hospitals (REHs) remain excluded from the GME policy and calculations in this proposed rule.

HOSPITAL INPATIENT QUALITY REPORTING PROGRAM

The Hospital Inpatient Quality Reporting (IQR) Program aims to enhance healthcare quality through a pay-for-reporting model. Hospitals failing to meet program requirements face reductions in their Annual Payment Update under the Inpatient Prospective Payment System (IPPS). In this proposed rule, CMS proposes several significant adjustments to the IQR Program.

Four Measures Proposed for Removal

With a focus on reducing provider burden, and the end of the COVID-19 Public Health Emergency in April 2023, CMS proposes removing four measures from the program. All measures removals would begin with the CY2024 reporting period/FY 2026 payment determination:

1. Hospital Commitment to Health Equity
2. COVID-19 Vaccination Coverage among Healthcare Personnel
3. Screening for Social Drivers of Health
4. Screen Positive Rate for Social Drivers of Health

Request for Information on Measure Concepts under Consideration

CMS is seeking feedback on well-being and nutrition measures for future potential inclusion in the program. Both requests cast a wide net for feedback, including potential assessments for both sleep and physical activity, which CMS identifies as helping support nutritional status.

Proposed Refinements and Technical Updates to Two Measures

CMS outlines proposed refinements and technical updates to two measures for 2023-2025 reporting period and FY2027 payment determination: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization, and Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (COMP-HIP-KNEE). For both measures, CMS proposes to expand the eligible population to include Medicare Advantage (MA) patients and shorten the performance period from three to two years. CMS also announced the updated risk model will utilize International Classification of Diseases (ICD)-10 codes instead of Hierarchical Condition Categories (HCCs). The inclusion of the MA population would add approximately 34.4 million beneficiaries currently ineligible for the measure, offering additional points of comparison between MA and traditional Medicare, as well as increasing measure reliability. A shortened performance period would also provide both consumers and hospitals with more recent data, while maintaining a satisfactory level of reliability according to CMS testing.

Other Proposed Changes and Removal of the COVID-19 Exclusion

Beginning in FY 2027, CMS removes the COVID-19 exclusion from all Hospital IQR measures with the conclusion of the COVID-19 Public Health Emergency in 2023. CMS also proposes changes to the Form, Time, Manner, and Timing of Hospital IQR data submission, a decrease in the Hybrid Measures CCDE and Linking Variable Submission Thresholds beginning in FY 2028.

HOSPITAL-ACQUIRED CONDITION REDUCTION PROGRAM

The Hospital-Acquired Condition Reduction Program (HACRP) penalizes hospitals that rank in the bottom quartile nationally on a set of six quality measures related to hospital-acquired conditions. Beyond routine updates to calculation of the standardized infection ratio, there are no substantive changes to the HACRP in this proposed rule.

HOSPITAL READMISSIONS REDUCTION PROGRAM

In the Hospital Readmissions Reduction Program (HRRP), CMS applies up to a three percent payment reduction to hospitals based on their performance on six procedure-specific readmission measures. CMS announced two technical updates to the program beginning with the FY2027 program year for all measures: removal of the COVID-19 exclusion and an update to the risk model replacing existing Hierarchical Condition Categories (HCCs) with International Classification of Diseases (ICD)-10 codes. CMS also outlined two wide-ranging proposed changes for public comment. These recommendations are designed to increase the measure populations, increase validity and reliability, and to provide more up to date data for consumers and providers. All proposed changes would begin in the FY2027 program year:

- Integration of Medicare Advantage (MA) beneficiaries into all measures, and
- Reduction of the applicable period used to calculate excess readmission rations (ERRs) and payment adjustment factors from three to two years.

MEDICARE PROMOTING INTEROPERABILITY PROGRAM

In the Medicare Promoting Interoperability (PI) Program, CMS proposes maintaining the minimum electronic health record (EHR) reporting period from any continuous 90-day period to the 180-day period established for CY 2024. Codifying this change is designed to provide stability for providers and their vendors to further develop and maintain their EHR systems. Additionally, to encourage additional security policies and efforts to modernize health infrastructure, CMS recommends modifications to the Security Risk Analysis and Safety Assurance Factors for EHR Resilience (SAFER) Guides measure; and adoption of an optional bonus measure for Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA). All measure changes would begin with the CY2026 reporting period.

CMS also released a Request for Information (RFI) on the Query of Prescription Drug Monitoring Program (PDMP) measure. CMS specifically requests feedback regarding the potential for transitioning this measure from attestation-based to performance based, recommendations for alternative measures to assess utilization of PDMPs, and solicits concepts for new PDMP-based measures. Any changes to this measure, or the introduction of new measure(s), would be conducted through rulemaking.

HOSPITAL VALUE-BASED PURCHASING PROGRAM

The Hospital Value-Based Purchasing (VBP) Program operates under a budget-neutral framework, in which participating hospitals' base operating DRG payments are reduced by 2

percent each fiscal year. The withheld funds are then redistributed back to hospitals as value-based incentive payments.

CMS proposes several updates to the Hospital-level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (COMP-HIP-KNEE) beginning with the FY2033 program year, including the addition of MA patients, and shortening the performance period from three to two years. These changes would expand the measure population while increasing reliability and validity, as well as providing more timely data for consumers and providers.

CMS also removes the COVID-19 exclusion for all measures and will begin utilizing International Classification of Diseases (ICD)-10 codes instead of existing Hierarchical Condition Categories (HCCs). Both changes will take effect with the FY2027 program year. CMS also provided a technical update to standardized infection ratio calculation for the five National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures and established new performance standards for other measures to accommodate proposed technical changes.

PPS-EXEMPT CANCER HOSPITAL QUALITY REPORTING PROGRAM

For the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, CMS proposes to remove the Hospital Commitment to Health Equity measure and two Social Drivers of Health measures citing provider burden, and to begin publicly reporting program data on both the Provider Data Catalog and Care Compare. All measure removals would be effective for the CY 2024 reporting period / FY 2026 program year.

CMS PROPOSES TO CODIFY CHANGES TO THE EXTRAORDINARY CIRCUMSTANCES EXCEPTION POLICY

CMS proposes formalizing its Extraordinary Circumstances Exception (ECE) policy, which allows hospitals to request relief from quality reporting requirements due to events beyond their control. Under current ECE regulations, an exception may be granted for circumstances such as natural disasters or systemic problems with CMS data collection systems that directly affect the ability of facilities to submit data. Hospitals can request an ECE for multiple programs based on the same extraordinary circumstance using one ECE request form, including IQR, VBP, PCHQR, and HAC Reduction. CMS proposes to codify the ECE policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital. Extraordinary circumstances are "defined as an event beyond the control of a hospital (for example a natural or man-made disaster such as a hurricane,

tornado, earthquake, terrorist attack, or bombing)—that affected the ability of the hospital comply with one or more applicable reporting requirements with respect to a fiscal year."[9] While the process for requesting or granting an ECE will remain the same as the current process, CMS proposes to codify the following:

- a hospital may request an ECE within 30 calendar days of the date that the extraordinary circumstance occurred;
- CMS retains the authority to grant an ECE as a form of relief at any time after the extraordinary circumstance has occurred;
- CMS will notify the requestor with a decision, in writing, via email. If granted an ECE, the written decision will state if the hospital is **exempted from, or granted an extension to comply with,** one or more reporting requirements.

CMS CONSIDERS 69 TECHNOLOGIES FOR ADD-ON PAYMENTS FOR FY 2026 AND PROVIDES CLARIFICATIONS ON NTAP POLICIES FOR FY 2027

The new technology add-on payment (NTAP) program allows for an additional payment for medical services or technologies that are found to be: (1) new; (2) disproportionately costly to the existing MS-DRG; and (3) a substantial clinical improvement.

Under the traditional NTAP pathway, CMS proposes for FY 2026 to continue NTAPs for 26 technologies[10] and discontinue NTAPs for 13 technologies.[11] Regarding new applications under the traditional pathway, CMS considers 14 new applications for FY 2026. The agency also considers 29 new alternative pathway NTAP applications, 27 with Breakthrough Device designation and 2 with Qualified Infectious Disease Product (QIDP) designation. CMS did not receive any applications for technologies approved through the Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD) pathway.

CMS also provides additional clarification regarding NTAP applications submitted beginning FY 2027:

- Specifically, in recognition that the Food and Drug Administration (FDA) does not conduct a new filing review for New Drug Applications (NDA) or Biologics License Applications (BLA) that were the subject of a Complete Response Letter (CRL) and were subsequently resubmitted to FDA under a new review cycle, beginning with the NTAPs submitted for FY 2027, applicants must provide to CMS a copy of the

[9] Page 713 of the unpublished rule.
[10] See Table II.E-01.A and Table II.E-01.B in the proposed rule.
[11] See Table II.E.-02 in the proposed rule.

resubmission acknowledgement letter from FDA that indicates that FDA considers the resubmission to be sufficient to restart a review clock and provides the new goal date for FDA review of the application. The agency urges applicants to provide the most up-to-date documentation that indicates FDA has determined that the application is sufficiently complete to allow for substantive review by FDA.

- In addition, to improve and streamline the NTAP evaluation process and support transparency and engagement, beginning with NTAP applications submitted for FY 2027, CMS indicates that it intends to include certain cost criterion information in its public posting of NTAP applications. Note the agency indicates that to be consistent with current policy, cost and volume information will not be publicly posted though it may still be summarized and discussed in the proposed rule as part of the summaries in the proposed and final rules. Specifically, beginning with the FY 2027 applications, the public posting of NTAPs will include the applicant's explanation of the cost analysis methodology, including the step-by-step explanation of the columns used in the cost analysis spreadsheet attachment, any optional comments provided by the applicant, and information about the case weighted threshold and final inflated case weighted standardized charge per case, as is currently subject to discussion in the cost criterion analysis for each eligible application in the proposed rule. The cost analysis spreadsheet attachment and other charge values provided in the applicant's responses would not be included in the public posting.

CMS PROPOSES 2.5% INCREASE FOR PAYMENTS TO LONG TERM CARE HOSPITALS

LTCHs are excluded from the IPPS and are paid under their unique payment system because of the difference in complexity, resource utilization and length of stay factors. For FY 2026, CMS estimates that the aggregate LTCH prospective payment system (PPS) payments will increase by approximately 2.5% or $61 million, with projected $52 million increase for standard Federal payment rate cases and $9 million increase for site neutral payment rate cases.

CMS proposes an LTCH PPS standard Federal payment rate of $50,728.77 for FY 2026. The proposed rule affects 330 LTCHs nationwide, for discharges occurring on or after October 1, 2025. Additionally, CMS expects a 0.3% decrease in high-cost outlier payments.

CMS PROPOSES TO REMOVE SDOH DATA ELEMENTS FROM THE LTCH QUALITY REPORTING PROGRAM

LTCHs must submit data on quality measures and standardized patient assessment data. If an LTCH has not submitted data according to the LTCH Quality Reporting Program (QRP)

requirements, the LTCH will receive a reduction of 2 percentage points to its annual payment update. CMS proposes to remove all four Social Determinants of Health (SDOH) data elements from the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) beginning with the FY 2028 LTCH QRP (on or after October 1,2026 reporting period). These SDOH data elements were all added in FY 2025 and are collected as part of the standardized patient assessment data, including a patient's living situation, food, and utilities. CMS states this removal will save LTCHs $552.52 per LTCH.

CMS also proposes to modify the reporting requirements for COVID19 Vaccine: Percent of Patients/Residents Who Are Up to Date measure to exclude patients who have expired in the LTCH (e.g., passed away) beginning in the FY 2028 LTCH QRP.

CMS requests for information on the following topics with regards to the LTCH QRP:

(1) future measure concepts for the LTCH QRP;
(2) revisions to the data submission deadlines for assessment data collected for the LTCH QRP; and
(3) advancing digital quality measurement (dQM) in the LTCH QRP

PROPOSED CHANGES TO THE TRANSFORMING EPISODE ACCOUNTABILITY MODEL

The Transforming Episode Accountability Team Model (TEAM) is a five-year, episode-based payment model that is mandatory for selected hospitals. The model will run from January 1, 2026, to December 31, 2030, and aims to improve patient experience from surgery through recovery by facilitating care coordination and transition. TEAM will test five surgical episodes including Coronary Artery Bypass Graft Surgery (CABG), Lower Extremity Joint Replacement (LEJR), Major Bowel Procedure, Surgical Hip/Femur Fracture Treatment (SHFFT), and Spinal Fusion. CMS announced hospitals selected for participation in September 2024. CMS estimates savings of $481 million to the Medicare program across the five performance years of the model.

The proposed modifications address participation, quality measurement, target pricing, and care delivery.[12]

- **Participation:** CMS proposes implementing a limited deferment period for new hospitals and hospitals that begin to meet the definition of TEAM, under which these hospitals would not need to immediately participate in the model for at least one performance year. CMS also proposes that a hospital that no longer meets the

[12] Applied Policy has created a separate summary on the proposed TEAM model modifications.

definition of a TEAM participant would cease its TEAM participation effective on the date it no longer meets the criteria. Finally, CMS proposes to address the end of the Medicare dependent hospital (MDH) designation.

- **Quality Measurement:** CMS proposes to add the Information Transfer Patient Reported Outcome-based Performance Measure (Information Transfer PRO-PM) to the quality measure set for the model beginning in Performance Year 2, with the goal of capturing information on the quality of care in the outpatient setting. CMS also proposes applying a neutral quality measure score for model participants with insufficient data. CMS seeks comments on whether the TEAM program should align the hybrid hospital-wide readmission measure to the hospital IQR program but does not propose any changes.
- **Target Pricing:** CMS proposes multiple changes related to target pricing, including replacing the Area Deprivation Index (ADI) with the Community Deprivation Index (CDI). The CDI will be a factor-weighted composite measure of 18 variables collected from the Census Bureau and is intended to better represent beneficiary-level deprivation in urban areas. Other proposals related to pricing include developing a methodology to construct target prices when there are coding changes, reconstructing the normalization factor and prospective trend factor, using a 180-day lookback period and HCC version 28 for risk adjustment, and aligning the date ranged use for episode attribution.
- **Care Delivery:** CMS proposes to expand the Skilled Nursing Facility 3-Day Rule Waiver. CMS also proposes to remove health equity plans and health-related social needs reporting and the Decarbonization and Resilience Initiative, all of which were voluntary. CMS states that the removal of these policies is to align with the new Administration's priorities and to reduce the burden on TEAM participants.

CMS seeks comment on policies related to Indian Health Service hospital outpatient episodes, low volume hospitals, standardized prices and reconciliation amounts, and primary care services referral requirement but does not propose new updates on these topics.

CMS ISSUES RFI TO SUPPORT TRUMP EXECUTIVE ORDER ON DEREGULATION AND MEDICARE BURDEN REDUCTION

On January 31, 2025, President Trump signed Executive Order 14192, "Unleashing Prosperity Through Deregulation,"[13] outlining a policy goal to substantially reduce the cost

[13] EO 14192, Unleashing Prosperity Through Deregulation

of regulatory compliance to promote economic growth, national security, and quality of life. In alignment with this directive, CMS includes a Request for Information (RFI) in the proposed rule to gather public feedback on ways to simplify regulations and ease burdens for stakeholders in the Medicare program.

The RFI highlights long-standing concerns about overlapping and duplicative requirements, such as reporting obligations and Conditions of Participation (CoPs), that may offer limited value while increasing compliance costs. CMS seeks feedback on how to streamline these rules, reduce unnecessary documentation, and eliminate redundancy with state-level requirements or private insurer mandates.

This Medicare-specific RFI is part of a broader federal push for deregulation. On April 9, 2025, the White House launched multiple efforts to identify and rescind rules deemed burdensome, unlawful, or anti-competitive:

- An Office of Management and Budget (OMB) RFI with a faster deadline (May 12), focused on identifying outdated or unauthorized regulations.
- An Executive Order on reducing anti-competitive barriers, directing agencies to propose modifications to regulations that restrict market entry or limit competition.
- A memo directing agencies to repeal unlawful regulations without public comment, where justified under the "good cause" exception of the Administrative Procedure Act.

With both the CMS RFI and the OMB RFI now open, stakeholders have multiple avenues to advocate for regulatory relief, particularly in areas where Medicare rules overlap with broader federal or state mandates.

Public comments on the CMS RFI can be submitted at: https://www.cms.gov/medicare-regulatory-relief-rfi.

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