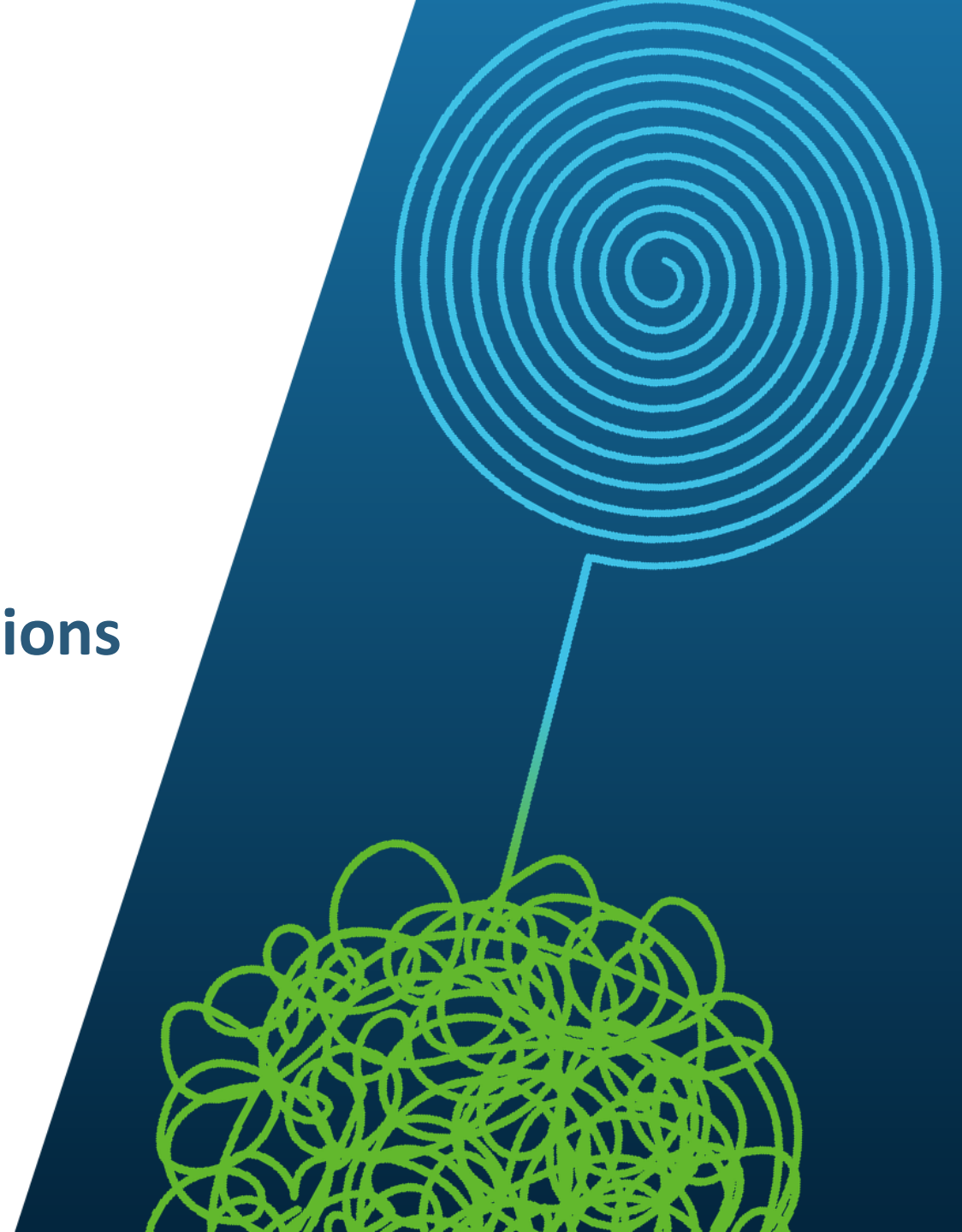
Healthcare Regulatory Roundup #100

FY 2026 Final Rules:
Key Takeaways and Strategic Implications

August 27, 2025



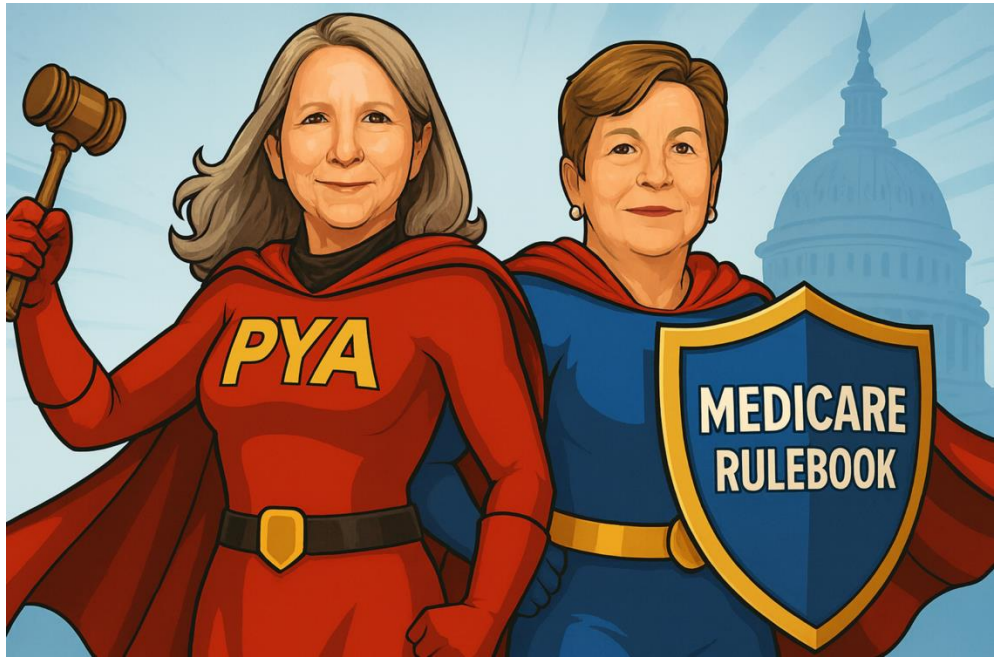
Housekeeping

1. Enlarge, rearrange, or close panels as you prefer
2. Copy of presentation slides available in **Resources Panel**
   - Attendees will receive e-mail later today with .pdf and link to webinar recording
   - Slides and recordings from all HCRR webinars available at https://www.pyapc.com/insights
3. Enter questions in **Q&A Panel**
   - If question not addressed during webinar, will follow-up via e-mail
4. Following webinar, please remain online to complete brief survey and to post any questions or comments

HCRR Episode 100!

Introductions

Martie Ross
mross@pyapc.com



Kathy Reep
kreep@pyapc.com

PYA
pyapc.com
800.270.9629

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Today's Agenda

1. FY 2026 Hospital Inpatient PPS Final Rule – Payment Rates and Related Matters
2. FY 2026 Hospital Inpatient Final Rule – Quality Reporting, Value-Based Purchasing, Promoting Interoperability
3. FY 2026 Hospital Inpatient PPS Final Rule – TEAM Changes
4. FY 2026 Skilled Nursing Facility PPS Final Rule
5. FY 2026 Inpatient Psychiatric Facility PPS Final Rule
6. FY 2026 Inpatient Rehabilitation Facility PPS Final Rule
7. FY 2026 Hospice Payment Rate
8. 340B Drug Rebate Program

1. FY 2026 Hospital Inpatient PPS Final Rule Payment Rates and Related Matters

IPPS Payment Update

- Rebases and revises IPPS operating and capital market basket to reflect 2023 base year
  - 2.6% increase in base rate, based on market basket increase of 3.3% less 0.7 percentage point productivity adjustment (vs. 2.9% increase for FY 2025)
  - Did not accept commenters' concerns regarding use of BLS Employment Cost Index to measure labor costs
- Applies national labor-related share of 66% (i.e., portion subject to wage index adjustment) for hospitals with wage index >1.0 (currently 67.6%)
  - Remains at 62% for hospitals with wage index of ≤1.0
  - Discontinues low-wage index hospital policy
    - But includes budget-neutral transitional exception policy for FY 2026 to help hospitals significantly impacted by discontinuation

Other Payment-Related Issues

- Increases capital payment rate to $524.15 (currently $510.51)
- Decreases IPPS outlier threshold to $40,397 (currently $46,152)
- Increases payments for DSH and uncompensated care by $2B
- Approves ~$192M increase in new technology add-on payments
- Did not finalize proposed technical changes to calculation of net nursing and allied health education costs
  - As proposed, would have impacted allocation of Administrative and General costs by reducing share of direct costs relative to other hospital departments

IPPS Payment Rates

TABLE 1A.— NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (66.0 PERCENT LABOR SHARE/34.0 PERCENT NONLABOR SHARE IF WAGE INDEX IS GREATER THAN 1)--FY 2026 FINAL RULE

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.6 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.125 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.775 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.7 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,456.72	$2,295.89	$4,349.21	$2,240.51	$4,420.88	$2,277.43	$4,313.38	$2,222.05

TABLE 1B.— NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX IS LESS THAN OR EQUAL TO 1)—FY 2026 FINAL RULE

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.6 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.125 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.775 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.7 Percent)	
Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor	Labor	Nonlabor
$4,186.62	$2,565.99	$4,085.63	$2,504.09	$4,152.95	$2,545.36	$4,051.97	$2,483.46

Market-Based MS-DRG Relative Weight Data Collection

- Included in CY 2026 proposed OPPS rule
- Would require hospitals to report median of payer-specific negotiated "charges" that hospital has disclosed for all MAOs on most recent machine-readable file
  - Collection would begin with cost reporting periods ending on or after 01/01/2026
  - Intended to reduce reliance on hospital chargemaster for setting inpatient rates
  - Would be used to calculate MS-DRG relative weights to reflect relative market-based pricing
    - Intend to use new methodology beginning in FY 2029

Unclear how this change will impact MS-DRG payment rates (and thus hospital revenues and Medicare spending)

LTCH PPS Payment Update

- Update of 2.7% to LTCH PPS
- Increase in LTCH outlier threshold from $77,048 to $78,936
  - Significantly lower than proposed threshold of $91,247

TABLE 1E.— LTCH PPS STANDARD FEDERAL PAYMENT RATE--FY 2026 FINAL RULE

	Full Update (2.7 Percent)	Reduced Update* (0.7 Percent)
Standard Federal Rate	$50,824.51	$49,834.74

* For LTCHs that fail to submit quality reporting data for FY 2026 in accordance with the LTCH Quality Reporting Program (LTCH QRP), the annual update is reduced by 2.0 percentage points as required by section 1886(m)(5) of the Act.

2. FY 2026 Hospital Inpatient Final Rule
Quality Reporting, Promoting Interoperability, Value-Based Purchasing

Hospital Inpatient Quality Reporting (IQR) Program

- Hospital subject to 25% reduction in market basket update if fail to submit timely and complete data on IQR measures
- Finalized IQR Program changes:

1. Modify 4 existing measures:
    - For 2 measures, include MA patient cohort data and shorten performance period from 3 to 2 years:
        - Risk-Standardized Complication Rate Following Elective Primary THA/TKA beginning with FY 2027 payment determination (4/1/2023 – 3/31/2025 performance period)
        - 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization beginning with FY 2027 payment determination (7/1/2023 – 6/30/2025 performance period)
    - For 2 measures, modifications to reporting requirements:
        - Hybrid Hospital-Wide Readmission Rate for FY 2028 payment determination (7/1/2025 – 6/30/2026 reporting period)
        - Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Rate for FY 2028 payment determination (7/1/2025 – 6/30/2026 reporting period)

Finalized IQR Program Changes, Con't

2. Remove COVID-19 diagnosed patients measure denominator exclusions beginning with FY 2027 program year
3. Remove 4 existing measures for FY 2026 payment determination
    - Hospital Commitment to Health Equity
    - Screening for Social Drivers of Health
    - Screen Positive Rate for Social Drivers of Health
    - COVID–19 Vaccination Coverage among Healthcare Personnel
4. Update and codify Extraordinary Circumstances Exception (ECE) policy to clarify that CMS may extend time for data submission in response to ECE request

Promoting Interoperability Program

- PPS hospitals that fail to report subject to 75% reduction in market basket update, while CAHs' reimbursement reduced from 101% to 100% of reasonable costs
- Finalized PI Program changes:
  1. Amend regulatory definition of 'EHR reporting period for a payment adjustment year' as minimum of any continuous 180-day period within calendar year
     - Codifying change from 90-day period in CY 2024
  2. Modify Security Risk Analysis measure to require hospitals/CAHs to attest "yes" to having conducted security risk management activities (in addition to attesting "yes" to having conducted security risk analysis)
     - Required implementation specification for risk analysis and risk management under HIPAA Security Rule
  3. Modify SAFER Guides measure by requiring hospitals/CAHs to attest "yes" to completing annual self-assessment using 8 SAFER Guides published in January 2025
  4. Add optional bonus measure to Public Health and Clinical Data Exchange objective for submission of health information to public health agency using Trusted Exchange Framework and Common Agreement (TEFCA)

Hospital Readmission Reduction Program

- Hospital with higher-than-expected 30-day readmission rates penalized up to 3% of hospital's base Medicare inpatient payments
- Finalized HRR Program changes:
  1. Refine all six readmission measures to include MA patient cohort data beginning with FY 2027 program year
     - Did not finalize proposal to include MA data in calculations of aggregate payments for excess readmissions due to data reliability concerns raised by commenters (would have increased number of hospitals subject to penalty)
  2. Reduce applicable period from 3 years to 2 years
     - E.g., FY 2027 program determination based on admission dates from 7/1/2023 to 6/30/2025 (vs. 7/1/2022 through 6/30/2025)
  3. Remove COVID-19 diagnosed patients measure denominator exclusion from all six readmission measures beginning in FY 2027 program year
  4. Update ECE policy to give CMS discretion to grant extension of deadlines for data submission

Hospital Value-Based Purchasing Program

- Across-the-board 2% withhold of Medicare payments (~$1.7B) redistributed to top performers on 14 measures across 4 domains
  - Person and community engagement, safety, clinical outcomes, cost savings and efficiency
- Finalized VBP Program changes
  1. Modify THA/TKA Complications measure beginning in FY 2033 program year
     - Include MA patient cohort data; change performance period from 3 years to 2 years (4/1/2029 to 3/31/2031)
  2. Remove COVID-19 exclusion from clinical outcomes domain measures beginning in FY 2027 program year
  3. Technical update to 4 CDC NHSN HAI measures in safety domain beginning in FY 2028 program year
  4. Remove Health Equity Adjustment for hospitals serving higher percentage of dual eligibles
  5. Provide previously and newly established performance standards for the FY 2028 – FY 2031 program years
  6. Update ECE policy to give CMS discretion to grant extension for data submission

Hospital Acquired Condition (HAC) Reduction Program

- 1% reduction in payment for all Medicare discharges for hospitals in worst-performing quartile on HAC measures
- No proposed changes to HAC measures except technical update to CDC NHSN HAI Measures (CAUTI, CDI, CLABSI, and MRSA)
  - Implement changes to the standard population data used to calculate the standardized infection ratio beginning in FY2025
- Update ECE policy to give CMS discretion to grant extension for data submission

3. FY 2026 Hospital Inpatient PPS Final Rule
TEAM Changes

TEAM Basics

Surgical Episode	Inpatient MS-DRGs	Outpatient HCPCS Codes
Coronary Artery Bypass Graft	231-236	
Lower Extremity Joint Replacement	469, 470, 521, 522	27447, 27130, 27702
Major Bowel Procedures	329-331	
Surgical Hip/Femur Fracture Treatment	480-482	
Spinal Fusion	402, 426-430, 447-448, 450-451, 471-473	22551, 22554, 22612, 22630, 22633

- 5-year mandatory episodic payment model beginning 01/01/2026
- Selected hospitals assume responsibility for the cost and quality of care furnished from surgery through first 30 days after beneficiary leaves the hospital
  - Receive reconciliation payment if under target price
  - Liable for payment to CMS if exceed benchmark
- Encourage collaboration with physicians, post-acute care providers

Preliminary Target Prices

- Prior to start of each performance year, calculate price-standardized average hospital spending by episode type (MS-DRG/HCPCS code) for 9 census regions
  - Use 3 years of historical data (e.g., 2026 based on 2022-24 data)
    - Year 1 = 17%; Year 2 = 33%; Year 3 = 50%
  - Exclude outlier episodes (≥ 99th percentile) and costs within episodes for specified unrelated items/services (e.g., certain inpatient admissions)
  - Apply prospective trend to performance year to account for changes in healthcare spending between baseline period and performance year
  - Apply applicable discount factor (CMS' guaranteed savings)
    - 1.5% for major bowel and CABG
    - 2.0% for LEJR, SHFFT, and spinal fusion

Annual Reconciliation Process

- For each qualifying episode, calculate performance year spend
  - Same methodology used to calculate preliminary target prices
- For each qualifying episode, calculate reconciliation target price
  - Adjust preliminary target price by applying risk adjustment factors
  - Apply normalization factor to account for changes in beneficiary health status/demographics
  - Apply retrospective trend factor to estimate realized changes in spending patterns during performance year (not to exceed +/- 3% of prospective trend factor)
- Calculate reconciliation amount by subtracting total reconciliation target price from total performance year spend
- Calculate Quality Composite Score (QCS) adjustment percentage and adjust reconciliation amount accordingly, subject to applicable percentage cap
- Apply stop loss/stop gain limits to determine final payment/re-payment amount

Annual Reconciliation Process – Low Volume Hospital

- Had proposed multiple options for low volume hospital policy in proposed rule
- If hospital has < 31 episodes in episode category during 3-year baseline period, still reconcile episodes during corresponding performance year, but hospital will not face downside risk in that category
  - Opportunity to receive reconciliation payment for low-volume episodes
  - Remain accountable for performance in episode types in categories for which low volume threshold is exceeded
- Will reset each year, as baseline period changes

Primary Care Referral Requirement

- Two options:
  1. Hospital discharge planning process must include referral to established primary care service supplier of primary care services as recorded on admission to hospital or hospital outpatient department
  2. If no supplier recorded, hospital discharge planning process must include referral to supplier identified by hospital
     - Must account for beneficiary preferences in making such referral (e.g., supplier's location in relation to beneficiary's place of residence)
- Referral must be made prior to or at time of discharge
- No obligation to schedule appointment or confirm beneficiary followed up with supplier

12 Technical Changes

1. Limited deferment period for new hospitals
2. Track 2 participation eligibility for hospitals currently designated as Medicare Dependent Hospitals
3. Adding Information Transfer Patient Reported Outcome-based Performance Measure in PY3
4. Applying neutral quality measure score for hospitals with insufficient quality data
5. Methodology to construct target prices to account for coding changes
6. Reconstructing the normalization factor and prospective trend factor
7. Replace Area Deprivation Index with Community Deprivation Index
8. Lookback period and HCC v28 for beneficiary risk adjustment
9. Aligning date range used for episode attribution
10. Removing voluntary health equity plan submission and health-related social needs data reporting
11. Expanding SNF 3-Day Rule Waiver to include swing beds
12. Removing Decarbonization and Resilience Initiative

4. FY 2026 Skilled Nursing Facility PPS Final Rule

Payment Update

- Updates payment rates by 3.2% (vs. 4.2% update for FFY 2025)
  - Based on SNF market basket increase of 3.3%, *plus 0.6% market basket forecast error adjustment* and less 0.7 percentage point productivity adjustment
  - Market-basket revised to reflect 2022 base year
- Finalized 34 changes to Patient-Driven Payment Model (PDPM) code mapping to maintain consistency with ICD-10 coding guidance
  - Allows providers to provide more accurate, consistent, and appropriate primary diagnoses that meet criteria for skilled intervention during a Part A SNF stay

SNF Quality Reporting Program

- Reverse last years' addition of 4 standardized patient assessment data elements:
  - Living situation, food (2 elements), utilities
  - Previously adopted SDOH-related data elements remain
- Amend reconsideration policy and process:
  - Allow SNFs to request extension to file request for reconsideration of noncompliance determination if SNF impacted by extraordinary circumstance beyond its control
  - Update bases on which CMS can grant reconsideration request

SNF Value-Based Purchasing Program

- Remove Health Equity Adjustment to benefit SNFs that serve higher proportions of dual eligibles
- Apply previously finalized scoring methodology to SNF Within-Stay Potentially Preventable Readmission measure beginning with FY 2028 program year (1st year measure will be applied)
- Adopt reconsideration process to allow SNFs to appeal CMS' initial decisions for Review and Correction requests prior to any affected data being publicly available
- Provide estimated performance standards for FY 2028 and FY 2029 program years

5. FY 2026 Inpatient Psychiatric Facility PPS Final Rule

Payment Update

- Updates payment rates by 2.4% based on 2021 data (vs. 2.8% increase for FFY 2025)
  - Uses 2021-based IPF market basket increase of 3.2% less 0.8 percentage point productivity adjustment
  - Reflects change in base rate from $876.53 to $892.87
- Labor-related share of 79% (currently 78.8%)
- Fixed-dollar loss threshold for outliers set at $39,360 (currently $38,110)
- Changes to IPF PPS facility-level adjustments for teaching status and rural location
  - Rural location = 18% adjustment to the rates (currently 17%)
  - Teaching status = 0.7957 adjustment to rates (currently 0.5150)
  - Changes will be implemented in a budget-neutral manner

IPF Quality Reporting Program

1. Remove 4 existing measures for FY 2026 payment determination:
   - Hospital Commitment to Health Equity
   - Screening for Social Drivers of Health
   - Screen Positive Rate for Social Drivers of Health
   - COVID–19 Vaccination Coverage among Healthcare Personnel
2. Modify reporting period for 30-Day Risk-Standardized All-Cause Emergency Department Visit Following Inpatient Psychiatric Facility Discharge measure
   - From one-year (calendar year) to two-year (fiscal year) period
3. Update ECE policy to give CMS discretion to grant extension for data submission

6. FY 2026 Inpatient Rehabilitation Facility PPS Final Rule

Payment Update

- Updates payment rates by 2.6% (vs. 3.0% update for FFY 2025)
  - Based on IRF market basket increase of 3.3% less 0.8 percentage point productivity adjustment
  - Conversion factor set at $19,371 (current rate = $18,907)
  - Continues labor-related share at 74.4%
- Decreases outlier threshold from $12,043 to $10,062 (had been proposed at $11,971)

IRF Quality Reporting Program

1. Remove two measures for program year 2026
   - COVID-19 Vaccination Coverage among Healthcare Personnel
   - COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
2. Reverse last years' addition of 4 standardized patient assessment data elements
   - Living situation, food (2 elements), utilities
   - Previously adopted SDOH-related data elements remain
3. Amend reconsideration policy and process
   - Allow SNFs to request extension to file request for reconsideration of noncompliance determination if SNF impacted by extraordinary circumstance beyond its control
   - Update bases on which CMS can grant reconsideration request

7. FY 2026 Hospice Payment Rate Update

Rate Setting

- Updates payment rates by 2.6% (vs. 2.9% update for FFY 2025)
  - Based on inpatient PPS market basket less productivity
- FFY 2026 Rates
  - Routine home care days 1-60: $230.83 (currently $224.62)
  - Routine home care days 61+: $181.94 (currently $176.92)
  - Continuous home care: $1,674.29 (currently $1,618.59)
  - Inpatient respite care: $532.48 (currently $518.78)
  - General inpatient care: $1,199.86 (currently $1,170.04)
- Increases hospice cap to $35,361.44 (currently $34,465.34)

Policy Clarifications

- Physician member of interdisciplinary group may recommend admission to hospice care
  - Aligns with certification regulations and CoPs
  - Previous requirement allowed only medical director or physician designee to recommend admission
- Clarifies that hospice face-to-face encounter attestation must include physician/practitioner signature and date
  - Signed and dated clinical note will suffice; separate document not required – reduces administrative burden

Hospice Quality Reporting Program

- New CMS submission and reporting system (iQIES) will begin accepting data from Hospice Outcomes and Patient Evaluation (HOPE) instrument on 10/01/2025, in line with start of HOPE data collection.
  - Provider reports will also be available in new system beginning 10/1/2025
  - QIES system will stop accepting HIS records for hospice admissions and discharges prior to 10/1/2025 (including any corrections) on 2/15/2026

8. 340B Rebate Program

340B Drug Program Subject to Scrutiny

- Legislators have proposed reporting requirements on use of funds, program integrity audits, and national clearinghouse to prevent duplicate discounts
- Many manufacturers have imposed restrictions on Covered Entities' (CEs) access to 340B pricing under their contract pharmacy arrangements
  - Several states have enacted legislation to protect Covered Entities access to 340B pricing
- CMS now conducting new pricing survey, anticipated to result in reduced Medicare payments for 340B acquired drugs
  - Similar to ASP less 22.5% pricing from January 2018 to September 2022
- Program oversight expected to shift from HRSA to CMS
  - Expect more stringent reporting and auditing requirements

340B Drug Rebate Pilot Program

- Drug manufacturers attempted to implement rebate model, but courts required prior HHS approval
- Under pilot program announced July 31, manufacturers may require CEs to purchase drugs at wholesale acquisition price and then submit claims data to receive rebates
- Now limited to drugs listed on CMS Medicare Drug Price Negotiation Selected Drug List, although HRSA indicated willingness to expand program
- Timeline:
  - HRSA accepting comments through 09/02/2025 → https://www.federalregister.gov/documents/2025/08/01/2025-14619/340b-program-notice-application-process-for-the-340b-rebate-model-pilot-program#addresses
  - Manufacturers to submit plans to HRSA by 09/15/2025
  - HRSA to notify approved manufacturers by 10/15/2025
  - Pilot begins 01/01/2026

Pilot Program Operations

- Manufacturers must provide CEs with at least 60 days' advance notice before rebate model begins + clear instructions for registration
- Manufacturers must pay all IT and administrative costs related to data submission, provide responsive technical support/customer service through IT platform and dedicated contact
- IT systems must filter for only required data and provide real-time claim status updates
- CEs must submit rebate claims within 45 days post-dispensing (with flexibility for special cases)
- Manufacturer must issue rebates or denials (with supporting documentation provided) within 10 days of claim submission.
  - Cannot deny rebate due to concerns about diversion or Medicaid duplicate discounts
- Manufacturers subject to reporting requirements on rebate activity (claim processing times, delays, denials, other relevant metrics)

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September 10, 2025; 11 am – 12 pm ET
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October 1, 2025; 11 am – 12 pm ET
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