Annual Regulatory Update

FFY 2026 IPPS and CY 2026 OPPS Final Rule

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Agenda

1. Introduction
2. FFY 2026 IPPS Final Rule Payment Update
3. Low Volume, Medicare Dependent, and Rural Hospitals
4. Strategic Reimbursement Areas Update (Wage Index, S-10, Medicare DSH, GME)
5. Other Items (Proposed CY26 OPPS; TEAM; Cost Report Changes)
6. Discussion and Questions

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2026 IPPS Final Rule – Published July 31, 2025

Market Basket Increase to 2.6% - from 2.4% in Proposed Rule

Medicare Dependent Hospital (MDH) status set to expire September 30, 2025, Low Volume Adjustment (LVA) reverts to 2010 criteria

Wage Index Changes – Discontinuation of Low Wage Index Policy, CMS to introduce transitional support

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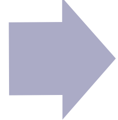
IPPS Rate update FFY26

FFY 2026 **Proposed** Rule increased the IPPS payment rates by 2.4% for hospitals that fully adhere to Inpatient Quality Reporting (IQR) and are meaningful users



FFY 2026 **Final Rule** increases the IPPS payment rates by 2.6% for hospitals that fully adhere to Inpatient Quality Reporting (IQR) and are meaningful users

Overall payments are expected to increase by $5.0 billion in FY 2026 for acute care hospitals

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IPPS Payment Rate Updates

How do we get to the 2.6 % Increase?

3.3% Market Basket Update

Less 0.7% Productivity Adjustment

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Table VI.B-01

Final FFY 2026 IPPS Hospital Rate Update

FFY 2026 Final	W/ Quality & Meaningful Use	W/ Quality W/O Meaningful Use	W/O Quality W/ Meaningful Use	W/O Quality & W/O Meaningful Use
Market basket rate of increase	3.3%	3.3%	3.3%	3.3%
Adjustment if no quality data submitted			-0.825%	-0.825%
Adjustment if not a meaningful user		-2.475%		-2.475%
MFP adjustment	-0.70%	-0.70%	-0.70%	-0.70%
Change to standardized amount	2.60%	0.125%	1.775%	-0.70%

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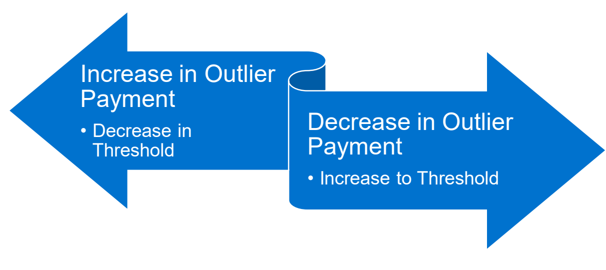
Outlier Threshold

Final FFY 2026 IPPS Rate

CMS models outlier payments as 5.1% of operating DRG payments.

- CMS proposed a fixed loss acute outlier threshold of $44,305 for FFY 2026.
- The FFY 2026 final rule threshold is $40,937.
- The FFY 2025 final rule threshold was $46,217.



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Outlier Payments Reconciliation
Final FFY 2026 IPPS Rate

- Outlier payments are potentially subject to retroactive reconciliation by the MAC.
- Cost reports beginning on or after 10/1/24 thresholds are:
  - Outlier payments > $500,000.
  - 20 percent or greater change (plus or minus) in paid versus actual cost-to-charge ratio.
  - All new hospitals will be subject to outlier reconciliation for their first cost report year, regardless of amount of outlier payments or change in cost-to-charge ratio.
- Previous thresholds:
  - Outlier payments > $500,000.
  - 10 percentage point or greater change (plus or minus) in paid versus actual cost-to-charge ratio.

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Changes to MS-DRG Classifications and Relative Weights
Final FFY 2026 IPPS Rate

- Recalibration for the MS-DRG relative weights for FY 2026 will use FY 2024 MedPAR claims data and FY 2023 Medicare Cost Reports.
- The methodology standardizes charges across 19 cost centers, excludes MA and certain nonqualifying claims, and adjusts for geographic and payment-related variations.
- Adjustments were made for transplant acquisition costs and statistical outliers.
- Added five new Medicare Severity Diagnosis Related Groups (MS-DRGs) while deleting six MS-DRGs, with most changes within Major Diagnostic Category 05, Diseases and Disorders of the Circulatory System.

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New Technology Add-On Payment (NTAP) Program
Final FFY 2026 IPPS Rate

- The New Technology Add-on Payment (NTAP) program will increase by an estimated $192 million, primarily driven by continuation of new technology add-on payments for several technologies.
- A determination of whether a technology is in its two- to three-year newness period now will be based on the start of the federal fiscal year instead of April 1.
- Beginning with NTAP applications submitted for FY 2027, the public posting 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, and any optional comments provided by the applicant.

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Hospital Inpatient Quality Reporting (IQR) Program
Final FFY 2026 Payment Rate

CMS removes four measures and modifies four measures in CY 2026 in the IQR program.

- Removals: As of the end of the 2024 reporting period, CMS removes four measures related to health equity and COVID-19:
  - Hospital Commitment to Health Equity
  - COVID-19 Vaccination Coverage Among Healthcare Personnel
  - Screening for Social Drivers of Health
  - Screen Positive Rate for Social Drivers of Health
- Modifications: CMS finalizes including Medicare Advantage (MA) data and shortens the measure application period from three to two years for:
  - Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
  - Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Ischemic Stroke Hospitalization With Claims-Based Risk Adjustment for Stroke Severity
  - For Hybrid Hospital-Wide Readmission (HWR) and Hybrid Hospital-Wide Mortality (HWM), CMS lowers the submission thresholds to allow for up to two missing laboratory results and vital signs, reducing the core clinical data elements submission requirement to 70% or more of discharges, and reducing the submission requirement of linking variables to 70% or more of discharges.

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Value-Based Purchasing Program (VBP) Updates
Final FFY 2026 Payment Rates

CMS finalizes these proposed changes to the VBP program:

- Removing the health equity adjustment from the scoring methodology from the program in FY 2026.
- Modifying the Hospital-Level RSCR Following Elective Primary THA and/or TKA measure for the FY 2033 program year.
- Updating the Hospital-Level RSCR Following Elective Primary THA and/or TKA measure's risk adjustment model.
- Updating the five condition- and procedure-specific mortality measures and the THA/TKA Complications measure to include patients with a principal or secondary diagnosis of COVID-19 in the measures' numerators and denominators for the FY 2027 program year.
- Updating the CDC NHSN HAI chart-abstracted measures with the new 2022 baseline used in the FY 2029 program year and subsequent years to calculate performance standards and calculate and publicly report measure scores.

CMS estimates the VBP program will redistribute approximately $1.7 billion in FY 2026.

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Hospital Readmissions Reduction Program (HRRP) Updates
Final FFY 2026 Payment Rates

CMS finalizes the following changes applicable to all six measures included in the HRRP:

- MA Data: Incorporate MA patient data into the calculation of HRRP measures. However, MA data will not be included in the calculations of aggregate payments for excess readmissions.
- COVID-19 Exclusions: Remove COVID-19 risk adjustment and exclusions from readmission measure calculations.
- Applicable Period: Reduce the measure performance period from three to two years beginning with the FY 2027 program year.
- Extraordinary Circumstances Exception (ECE) Policy: Clarify that CMS has the discretion to grant extensions of an ECE in response to a hospital's request.

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Medicare Promoting Interoperability Program Updates
Final FFY 2026 Payment Rates

Impact of not attesting for meaningful use: PPS hospitals are subject to a 75% reduction of the MS-DRG base rate market basket update, while CAH's reimbursement is reduced from 101% to 100% of reasonable cost.

CMS finalizes these proposed changes to the Medicare Promoting Interoperability Program:

- 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 (consistent with PY).
- 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 did not make any changes to the previously finalized performance-based scoring threshold of 80 points, beginning with the EHR reporting period in CY 2026.

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Final FFY 2026 Wage Index

- CMS will continue the use of the Office of Management and Budget (OMB) delineations from 2015 that were set forth in FFY2025, based on the 2020 census.
- Final occupational mix adjusted National average hourly wage $59.92 ($55.97 in FFY2025)
- Quartile adjustment “ Low Wage Index Hospital Policy” will be discontinued for FFY2026 and future years – CMS to implement transition policy for impacted hospitals
- Imputed floor and State Frontier Floor policies continue
- Permanent cap on wage index decrease to continue (5%)

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Low Wage Index Hospital Policy

- CMS will discontinue with the low wage index hospital policy for FFY 2026.
- On July 23, 2024, the D.C. Circuit Court of Appeals ruled on the case *Bridgeport Hosp. v. Becerra* stating that CMS did not have the authority to implement the low wage index policy.
  - Courts agreed with plaintiffs, policy violates the statues since the benefiting hospital area paid a wage index that does not actually reflect their wage levels relative to the national average
- CMS first issued an interim final rule discontinuing the policy on October 3, 2024

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Low Wage Index Hospital Policy

- Rule states that the low wage index policy will be discontinued for FFY2026 **and future years**
  - CMS stated it would likely take a change to the Medicare statutes to reinstate the policy
  - To realign IPPS and OPPS wage index values, CMS proposes to eliminate the low wage index hospital policy under the OPPS and use the IPPS wage index in CY 2026 and subsequent years.
- **Transitional Policy: All hospitals will receive the greater of their FY2026 wage index or 90.25% of their FY2024 wage index**
- Significant comments from both sides
  - Many agree that the policy was unlawful, but are concerned about the impact to low wage hospitals

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Other Wage Index Items

- Wage Index audits for FFY 2027 are underway – stay current on audit requests
  - Keep an eye out for questions and requests as you may not have much time to respond
  - Keep responses in email or follow up with an email to make sure you have a trail of documentation if needed for appeal
- MGCRB reclassification requests were due 9/2/25 to be effective starting 10/1/26

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National Average Historical Trend

FEDERAL YEAR	INCREASE FROM PRIOR YEAR
2010	4.0%
2011	4.3%
2012	3.7%
2013	3.4%
2014	2.4%
2015	2.3%
2016	2.5%
2017	2.2%

FEDERAL YEAR	INCREASE FROM PRIOR YEAR
2018	2.2%
2019	2.1%
2020	2.9%
2021	2.4%
2022	2.7%
2023	2.7%
2024	5.5%
2025	**9.2%**

And for FFY 2026…..

4.9% Increase

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Low Volume Adjustment

- Criteria will revert to 2010 methodology effective October 1, 2025
  - 25 miles between nearest proximity hospital
  - Less than 200 Total Discharges
- Federal legislation would be required to change this.
- For FY 2025, hospitals had to request low-volume status by September 1,2024 to be effective for discharges initially occurring October 1, 2024, through December 31, 2024, and with subsequent legislative extension through September 30, 2025.

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Low Volume Adjustment

Fiscal Years	Road Miles	Total Discharges	Payment Adjustment
2019 through 2025	>15	< = 500	0.25
		> 500 < 3,800	0.25 – [0.25/3300] * (number of total discharges -500) = (95/330) – (number of total discharges/13,200)
2026 and subsequent years	>25	< 200	0.25

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Medicare Dependent Hospitals

The MDH status was not extended beyond FFY 2025.

Starting October 1, 2025, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid solely on the Federal rate. Federal legislation would be required to reinstate the MDH program.

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Rural Hospital Updates

- One Big Beautiful Bill Act (OBBA) Rural Transformation Fund
  - **Fund Overview and Purpose**
    - The $50 billion OBBA Rural Transformation Fund aims to stabilize and transform rural healthcare from 2026 to 2030, administered by CMS.
  - **Funding Distribution and Eligibility**
    - Annual $10 billion funding splits evenly between approved state plans and CMS formula-based distribution.
    - One time application by states
  - **Eligible Uses of Funds**
    - Funds support chronic disease management, expanding rural health workforce, technology adoption, clinician recruitment, and innovative care models.
    - State is allowed to retain 10% for administrative functions

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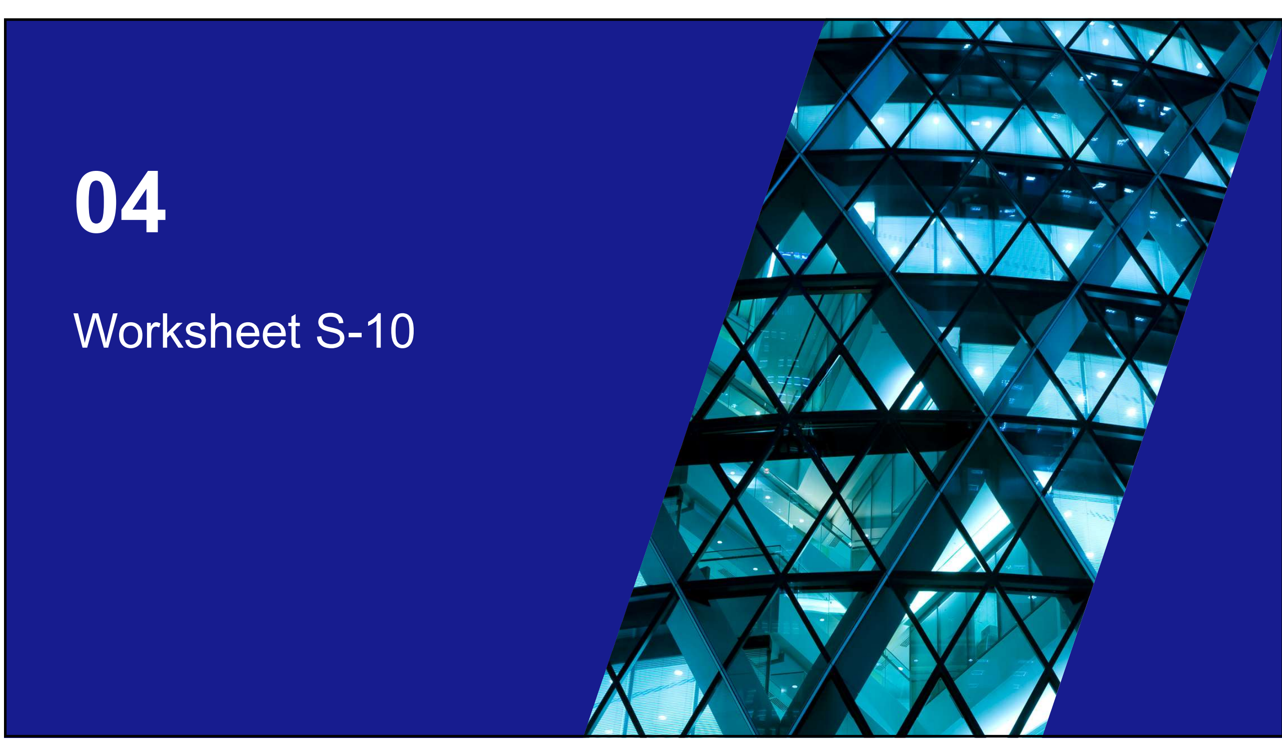

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IPPS Final Rule

- **Estimated DSH (Factor 1)**
  - FFY 2024 = $10,015,191,022
  - FFY 2025 = $10,509,750,000
  - FFY 2026 = $12,412,500,000
- **Factor 2**
  - FFY 2024 = 59.29%
  - FFY 2025 = 54.29%
  - FFY 2026 = 62.14% (discussed further next)
- **Uncompensated Care Pool**
  - FFY 2024 = $5,938,006,757
  - FFY 2025 = $5,705,743,275
  - FFY2026 = $7,713,127,500

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IPPS Final Rule (cont.)

- CMS chose to use the most recent data from NHEA to update uninsured projections in the final rule
- The updated data expects that the uninsured percentage will increase for CY26, 8.7% up from 7.7% in CY25.

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IPPS Final Rule (cont.)

Future uncompensated care payments will be based on:

FY2025	FY2026	FY2027
Factor 3 = Average of FY2019, FY2020 & FY2021 Reports	Factor 3 = Average of FY2020, FY2021 & FY2022 Reports	Factor 3 = Average of FY2021, FY2022 & FY2023 Reports

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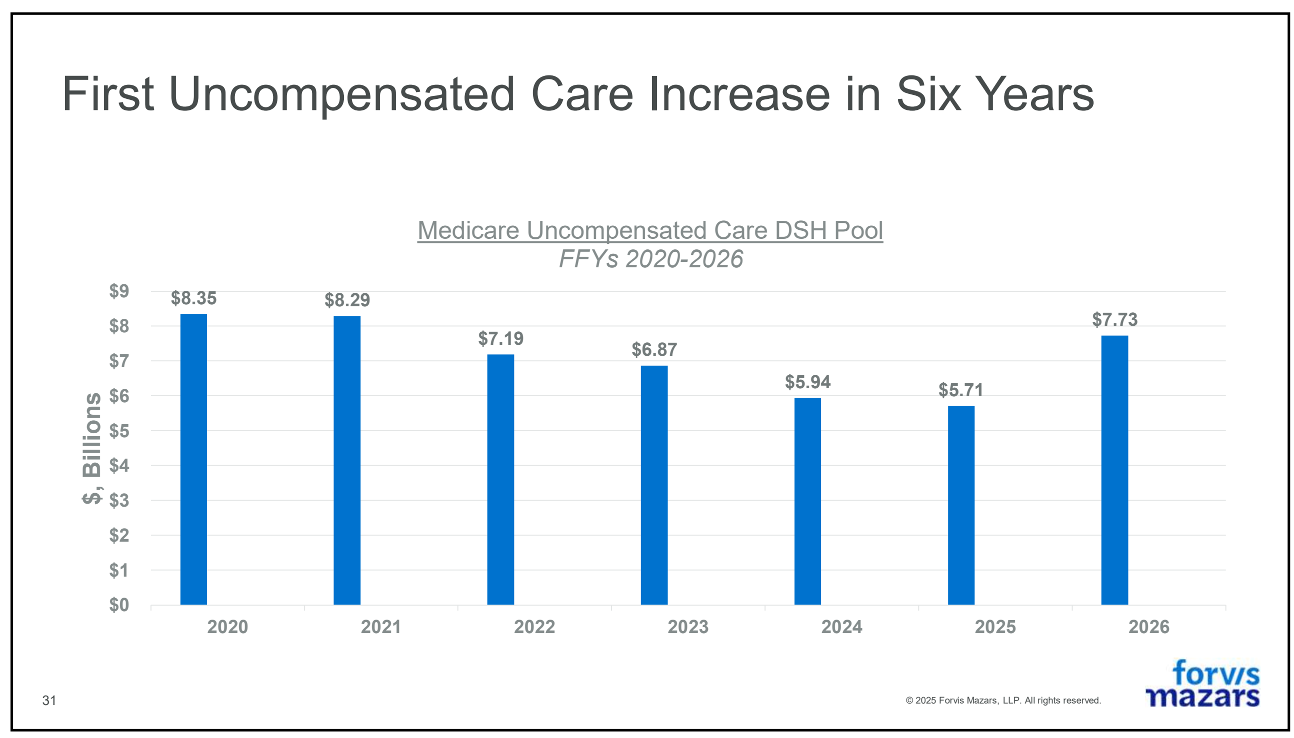

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Future Changes

- Many commenters stated that the calculations for the final rule do not take into account other policy changes that could dramatically impact the uninsured rate, such as:
  - Expiration of American Rescue Plan’s Marketplace enhanced premium tax credits
  - Unwinding of Medicaid continuous coverage protections
  - Potential restrictions on Medicaid and marketplace insurance access
  - Impact of the OBBA (One Big Beautiful Bill Act), such as Medicaid work reporting requirements

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IPPS Final Rule - Other DSH Related Updates

FFY 2025:

- Impact on Medicare DSH Payment Adjustment of Implementation of New OMB Labor Market Delineations.
- Withdrawal of 42 CFR 412.106 (FY 2004 and Prior Fiscal Years) to the Extent it Included Only "Covered Days" in the SSI Ratio.

FFY 2026:

- CMS did not issue major DSH-related changes with the IPPS rule, but did provide a refresher on the baseline regulations and calculation of Medicare DSH Payments
  - 25% Empirical DSH Payment
  - 75% Uncompensated Care Payment

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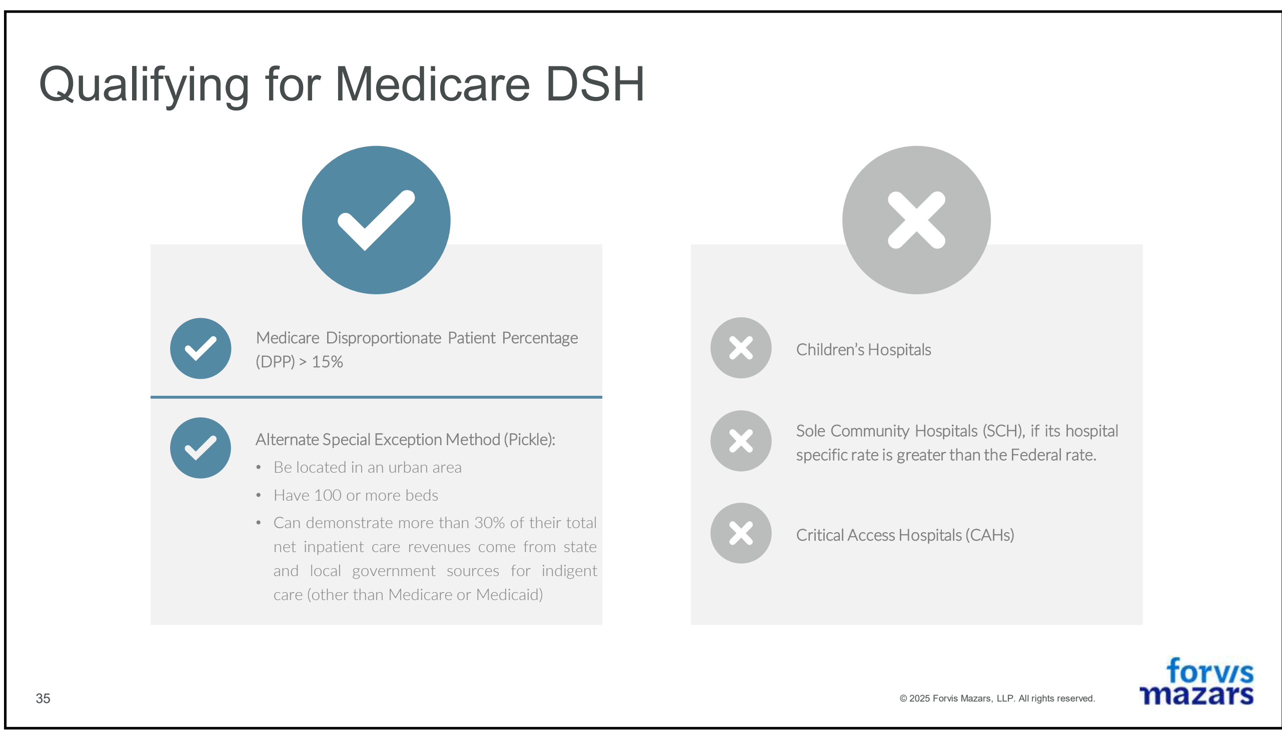

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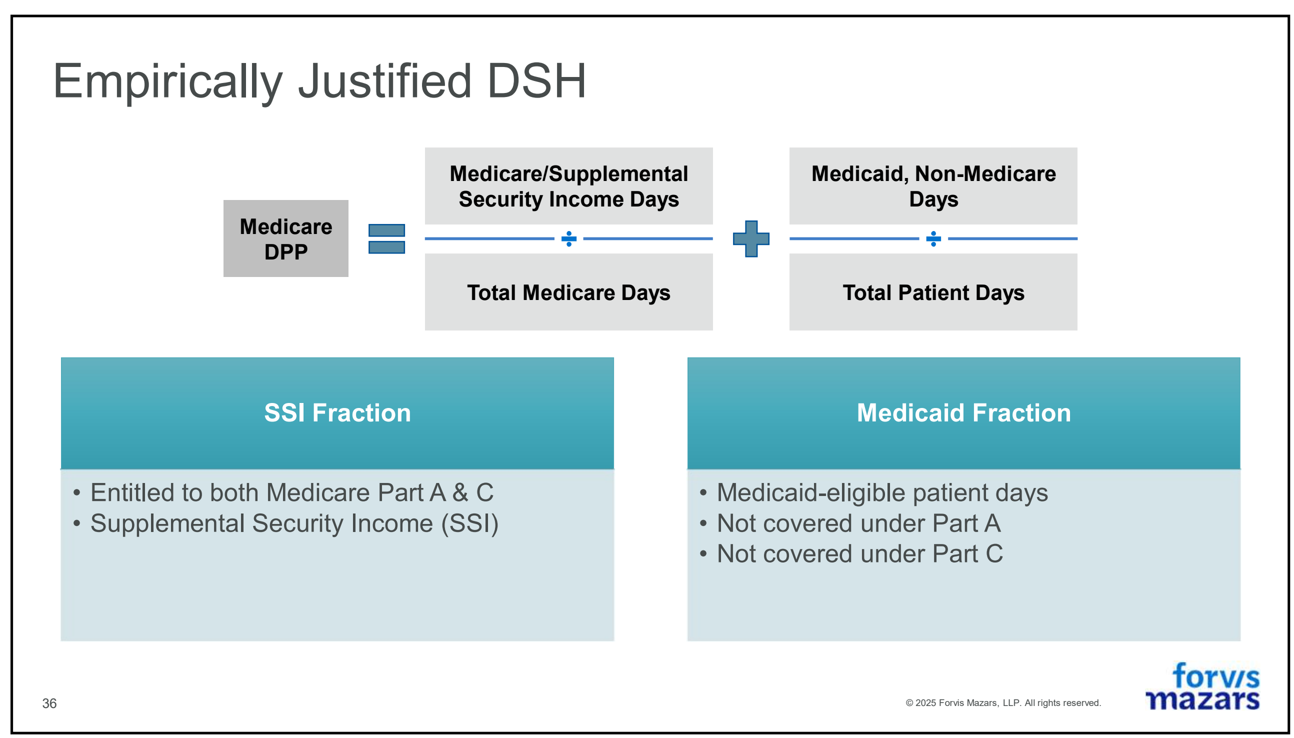

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Recent Medicare DSH Legislative Trends

Several DSH related Protest Items remain:

- **Medicaid Fraction**
  - Recommend protesting Waiver days in applicable states after 10/1/2023
  - Include dual-eligible Part C days in numerator
- **SSI Fraction**
  - Protest to include “non-paid but entitled” SSI days in numerator
  - Protest SSI data match issues (Recent California decision)
  - Protest Part C days to exclude from SSI ratio (Allina decision)

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Recent Medicare DSH Legislative Trends

Advocate Christ v. Kennedy

- The U.S. Supreme Court issued its opinion in *Advocate Christ Medical Center v. Kennedy* on April 29, 2025.
- “Entitled to supplemental security income benefits” for purposes of the Medicare DSH only includes individuals eligible to receive an SSI cash payment during the month of hospitalization.
- The more than 200 hospitals in Advocate Christ had argued for a more expansive reading that would encompass all patients enrolled in the SSI program, regardless of whether those patients were eligible to receive a cash benefit in the particular month.
- While the Supreme Court’s rejection of the hospitals’ broad argument was certainly a loss for DSH hospitals, the Supreme Court explicitly left open the question of whether CMS’ current policies accurately capture all patients who are eligible to receive SSI payments, and that issue will likely continue to be litigated.

Source - Vital Law Wolters Kluwer Reimbursement Advisor, Vol. 40, No. 11, July 2025

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Graduate Medical Education

- Section 4122 of the Consolidated Appropriations Act, 2023 (CAA, 2023)
  - Allocation of an additional 200 Medicare-funded residency positions to train new physicians, with at least 100 for psychiatry or its subspecialties.
  - Applications for these slots were due March 31, 2025 with notification from CMS of slot awards by January 31, 2026
- Positions effective on July 1, 2026
- Deadline is March 31, 2026 for fifth/final round of CAA-2021, Section 126 requests for additional 200 residency positions

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Graduate Medical Education

- Bipartisan Physician Reduction Shortage Act of 2025:
  - Bill would make available an additional 14,000 (2,000 annually) slots over seven years from 2026-2032
  - Bill would authorize $63.6 million in grant funding for new rural residency programs

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Graduate Medical Education

- CMS still has not finalized proposed definition of “new residency program”
  - CMS is currently gathering comments on defining the newness of a residency program

- CMS issued clarification on IME/DGME calculations for the following instances:
  - Overall calculation of FTE counts
  - Calculating FTE caps for cost reporting periods other than twelve months
  - Calculating the three-year rolling average for cost reporting periods of unequal lengths

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NAHE Reasonable Cost Payment

- In the 2026 proposed rule, CMS proposed significant changes to the formula for calculating net cost for NAHE programs.
- Tried to limit the types of indirect costs eligible to be included in the net cost calculation

Current Policy: Net Cost = total (direct + indirect costs) - tuition

Proposed Policy: Net Cost = (direct costs – tuition) + indirect costs

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NAHE Reasonable Cost Payment

- Direct and indirect costs are proportionally linked – as direct costs increase, indirect costs increase as well, resulting in higher reimbursement. Deducting tuition from direct costs would result in lower indirect costs being allocated as well.

- Proposed changes are the result of a D.C. Circuit court decision *Mercy St. Vincent Medical Center v. Becerra* – CMS was trying to calculate reimbursement using their updated policy
  - Court ruled that direct costs have no impact on tuition

- CMS received extensive comments on this issue, and has decided not to finalize changes to the policy at this time

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OPPS Conversion Factor

The proposed OPPS conversion factor increases 2.4% over the prior year.

CY 2025 Final vs. CY 2026 Proposed
Outpatient Prospective Payment System Conversion Factor

Final CY 2025	Proposed CY 2026	Percent Change
$87.382	$89.958	+2.4%

*Percentage changes calculated net of productivity and budget neutrality adjustments.
**Proposed CY 2026 conversion factor for providers subject to 340B recoupment.

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Accelerated Recoupment of Increased Payments for Non-Drug Services

- Starting in CY 2026, CMS proposes increasing the recoupment adjustment from 0.5% (finalized in the 2025 OPPS rule) to 2% for providers that received increased payments for non-drug services from CY 2018 through 2022 (340B OPPS Payment Remedy).This is projected to shorten the recoupment period by approximately 10 years—from 2041 to 2031.
- CMS estimates the recoupment will reduce payments by $1.1 billion in CY 2026 for providers subject to the 340B remedy offset.

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Outpatient Drug Pricing Survey

- CMS will issue a drug cost acquisition survey for covered hospital outpatient drugs. The survey will open in late 2025 and close in early 2026.
- CMS will use the survey results for payment rates for covered outpatient drugs in the 2027 OPPS rule. This would likely result in a reprisal of payment reductions for separately payable Part B drugs acquired under the 340B program.

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Site-Neutral Payment for Drug Administration Services in Excepted HOPDs

- Beginning in CY 2026, CMS proposes to pay for drug administration services provided in excepted off-campus HOPDs at the physician fee schedule equivalent—40% of the applicable Ambulatory Payment Classification (APC) rate.
- If finalized, the policy will apply to APCs 5961 through 5964.
- CMS proposes to exempt rural sole community hospitals from this policy.
- In addition, CMS requests feedback on expanding the site-neutral clinic visit policy to apply to clinic services provided in on-campus HOPDs.

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Phaseout of the Inpatient Only (IPO) List

- Beginning in CY 2026 and completing in CY 2029, CMS proposes phasing out the IPO list over three years by removing 285 CPT codes, mostly for musculoskeletal services.
- Correspondingly, CMS proposes creating a seven-level Musculoskeletal Procedures APC to which it will assign procedures removed from the list based on applicable estimated cost.
- CMS proposes continuing to exempt procedures removed from the IPO list from medical review activities to assess compliance with the Two-Midnight rule until the HHS secretary determines that the service or procedure is more commonly performed in the outpatient setting for the Medicare population.

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340B Program Concerns

- On August 1, 2025, the Health Resources and Services Administration (HRSA) announced its 340B rebate model guidance, which implements a relatively narrow pilot program focusing on the 10 drugs subject to Medicare drug price negotiations for 2026.
- This is voluntary for manufacturers.
- Covered entities will need to submit the required data to access the 340B price via rebate on selected drugs under approved manufacturer plans.
- Implications for 340B Covered Entities:
  - Potential for cash flow disruption.
  - Limited time to set up a "rebate cycle" to capture and submit the necessary data.
  - Covered entities will need experience managing rebates and setting up systems of control to manage workflows.

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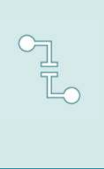
What Is TEAM?

- Transforming Episode Accountability Model was finalized in the FFY 2026 IPPS Final Rule displayed on July 31, 2025.

Mandatory for selected acute care hospitals

Goal is to improve quality of care for Medicare beneficiaries undergoing certain high-cost surgeries while reducing costs


Purpose is to address fragmented care that leads to complications in recovery, avoidable hospitalization, & increased spending

Emphasis on improving health equity & access to high-quality care for people in underserved areas

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TEAM Overview

Five-year mandatory bundled payment model

- Duration: 1/1/2026-12/31/2030
- Selection based on geographic regions
- Medicare FFS Population Only

Focus on surgical care

- Five inpatient/outpatient surgical episode groups selected
- Site-neutral target prices for spinal fusion and LEJR

30-day episodes

- Participants responsible for total cost of care for the inpatient stay/outpatient procedure plus 30 days post-discharge
- Revenue cycle is not disrupted

Glide path to risk

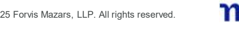
- Upside only in year one
- 5% - 20% downside risk in subsequent years based on hospital type

Relationship to other APMs

- Medicare ACO beneficiaries can trigger TEAM episodes
- Current BPCI-A and CJR participants could opt in to participation if their region was not selected (10 opt ins)

Key Model Requirements

- Notify beneficiaries of participation in TEAM
- Screen beneficiaries for health-related social needs
- Provide referral to primary care before discharge

54 

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TEAM Updates
FY2026 IPPS Final Rule

Low Volume Policy
- No downside risk for episode groups with fewer than 31 episodes during the baseline period (2022–2024 for PY1)

HCC Adjustments
- Lengthening the lookback period to 180 days for patient-specific target price adjustments
- Transitioning to HCC Version 28

Trend Factor Update
- Refining the prospective trend factor to better reflect annual changes in total cost of care

SNF 3-Day Waiver Expansion
- Now includes swing beds, increasing flexibility in post-acute care

PCP Referral Requirement
- Moving forward with the requirement; patient must be referred to their established PCP if one exists; if the patient does not have an established PCP, referral to any supplier of primary care services is sufficient

Spinal Fusion DRG Mapping
- Updating DRG codes to reflect new spinal fusion classifications.

THA/TKA PRO-PM Reporting
- Starting in Performance Year 3 (2028), includes the Information Transfer PRO-PM to align with Hospital OQR reporting.

Voluntary Reporting Removal
- HRSN Data Reporting; HRSN screening remains mandatory
- Health Equity Plans
- Decarbonization and Resilience Initiative

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CBSAs Selected for TEAM

- CMS selected 188 of 803 eligible CBSAs for TEAM
- More than 700 hospitals with surgical episodes
- ~200K cases per year
- $481M Expected Savings

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Preparing for Participation in TEAM

If your hospital was selected for TEAM or is eligible to opt in:

- Determine your organization's current state in TEAM episodes & areas for improvement to develop an outlook of performance in the model
- Implement strategies to improve performance in areas identified in current state assessment & comply with model requirements
- Track performance & identify areas for improvement across the care continuum

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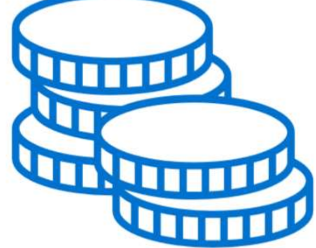
Why Preparing for TEAM Matters
… and the time to act is now!

Mandatory means mandatory

Pace of change and implementation matters



CMS projects netting $368M over five-year model

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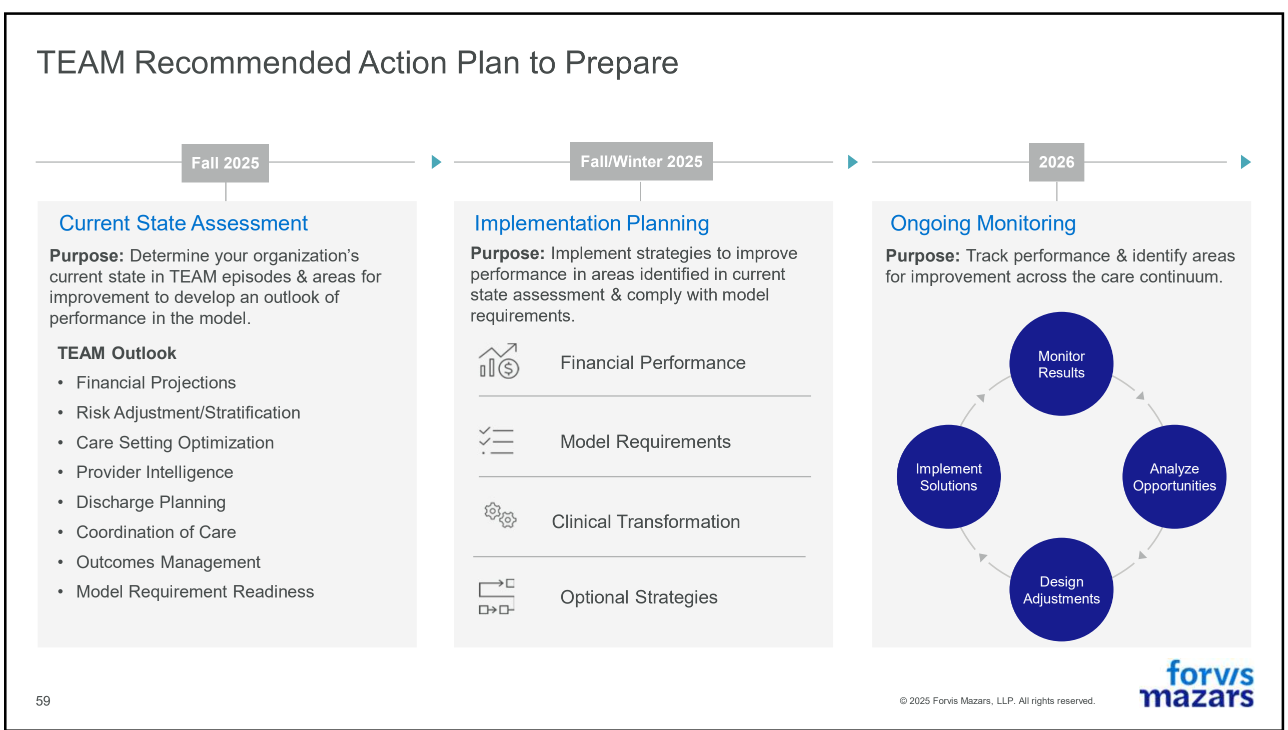

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Request for Information – Medicare Regulatory Relief

- In response to an Executive Order from President Trump, CMS introduced an RFI in the 2026 proposed rule requesting public comment and feedback around the following:
  - Streamlining Regulatory Requirements
  - Opportunities to Reduce Administrative Burden of Reporting and Documentation
  - Identification of Duplicative Requirements
  - General Recommendations/Comments
- CMS did not respond to any comments in the final rule and invited stakeholders to continue to submit responses on the online form

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Upcoming Cost Report Changes

Reporting Requirement for Medicare Advantage Negotiated Rates

- Beginning January 1, 2026 (for cost report periods ending on or after January 1, 2026), CMS proposes requiring hospitals to report the median of their negotiated Medicare Advantage rates for each MS-DRG for all plans.
- This data would come from the most recent version of the hospital's price transparency Machine Readable File (MRF).
- Critical access hospitals are excluded from this requirement.
- CMS intends to use this data to set MS-DRG weights effective for FY 2029.
- Instructions are currently under development.

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Upcoming Cost Report Changes

Stockpiling Essential Medicines

- Certain hospitals are eligible for separate payment for the cost of maintaining a stockpile of essential medicines.
- Qualifying Hospitals: Independent hospitals with 100 or fewer beds.
- What's Covered: Additional costs necessary to establish/maintain a six-month buffer stock of one or more of 86 essential medicines.
- Payment Amount: Medicare inpatient share of the cost associated with establishing/maintaining the buffer stock.
- When: Cost report periods beginning on or after October 1, 2024.

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Upcoming Cost Report Changes

Rural Health Clinics

- RHC Productivity Standards - Elimination of the provider productivity standards - effective for cost reporting periods ending after December 31, 2024.
- Payment for Preventive Vaccine Costs - RHCs will be allowed to bill for the administration of preventive vaccines (pneumococcal, influenza, hepatitis B, and COVID-19) - effective for dates of service beginning on or after July 1, 2025.
  - Payments for these claims will be made according to Part B preventive vaccine payment rates in other settings, to be annually reconciled with the facilities' actual vaccine costs on their cost reports.
  - Intent is to improve the timeliness of payment for preventive vaccine administration in RHCs.

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Questions?

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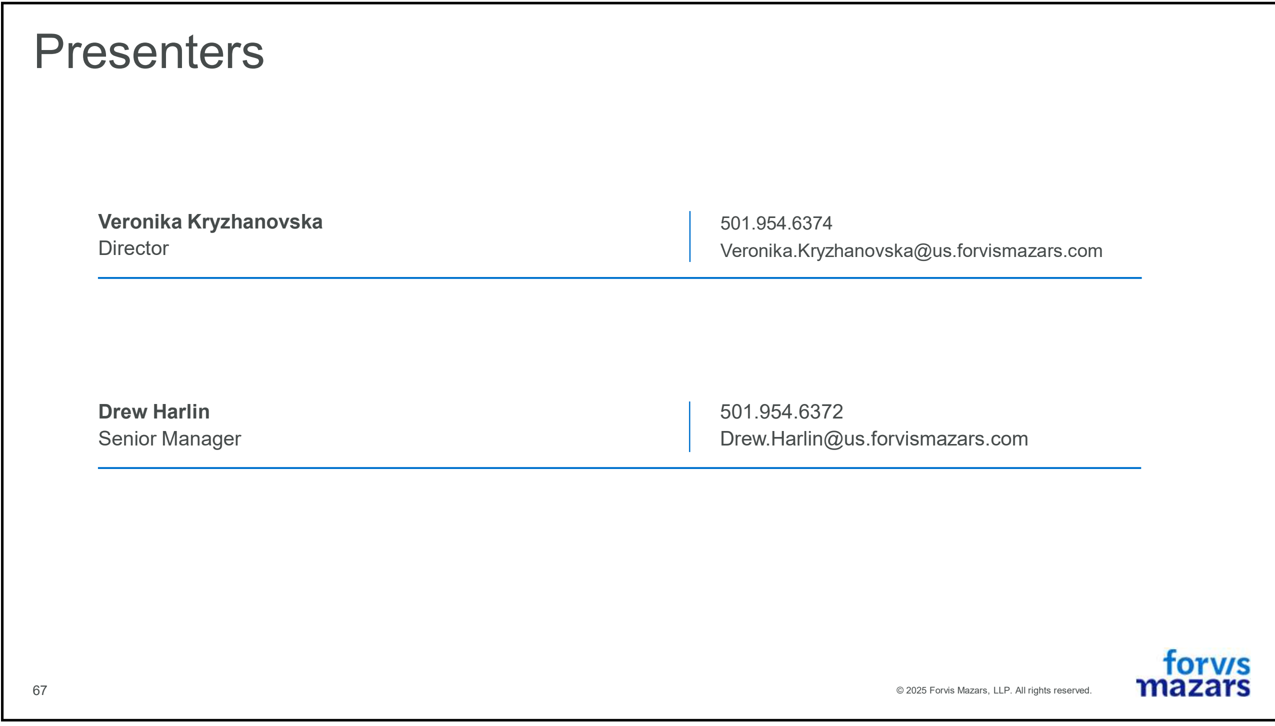

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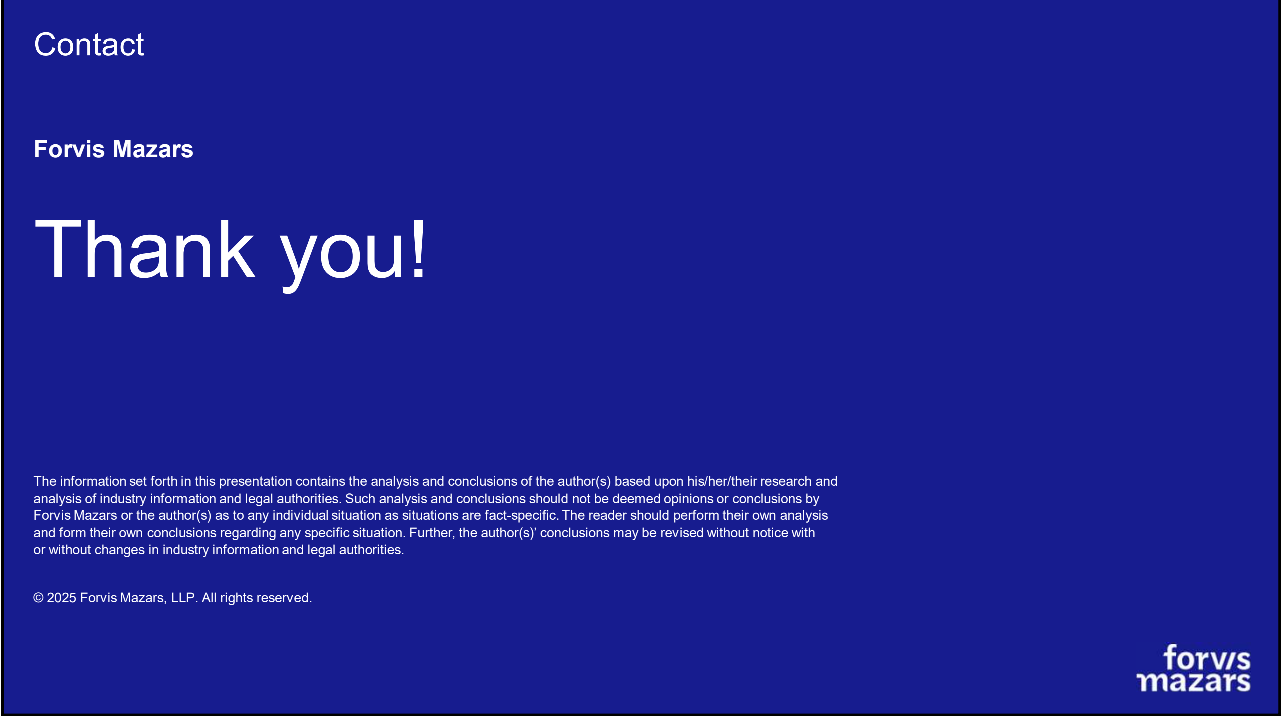

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