in the quality of care provided to patients. Removing this measure from the PCHQR Program is an effective way to accomplish this goal. Our priority is a re-focus on measurable clinical outcomes as well as identifying quality measures on topics of prevention and well-being. It may be costly for hospitals to continue reporting on the HCHE measure, and removal of this measure would make room in the program's measure set to enhance the program's focus on measurable clinical outcomes. We acknowledge that some hospitals may have expended resources to implement some or all of the activities described in the HCHE measure attestation statements in order to be able to attest "yes" for measure reporting purposes, however, hospitals that had already implemented such activities prior to adoption of the measure would have been able to attest "yes" without expending similar resources.

If finalized, any HCHE measure data received by CMS would not be used for public reporting purposes.

We invite public comment on our proposal to remove the HCHE measure from the PCHQR Program beginning with the CY 2024 reporting period/FY 2026 program year.

b. Proposed Removal of Two Social Drivers of Health Measures Beginning With CY 2024 Reporting Period/FY 2026 Program Year and for Subsequent Years

We propose to remove two social drivers of health (SDOH) process measures from the PCHQR Program beginning with the CY 2024 reporting period/FY 2026 program year:

- Screening for Social Drivers of Health measure (adopted in the FY 2024 IPPS/LTCH PPS final rule (88 FR 59210 through 59219)); and
- Screen Positive Rate for Social Drivers of Health measure (adopted in the FY 2024 IPPS/LTCH PPS final rule (88 FR 59219 through 59222)).

We propose to remove the SDOH measures beginning with the CY 2024 reporting period/FY 2026 program year under removal Factor 8, the costs associated with the measure outweigh the benefit of its continued use in the program. We have previously heard from some hospitals concerned with the costs and resources associated with screening patients via manual processes, manually storing such data, training hospital staff, and altering workflows for these measures. In the FY 2023 and FY 2024 IPPS/LTCH PPS final rules, we estimated a total annual burden of 101 hours across all PCHs at a cost of $2,092 to screen all patients in accordance with measure specifications for Screening for Social Drivers of Health measure (88 FR 59317 through 59318). For Screen Positive Rate for Social Drivers of Health measure, we estimated a total annual burden of 2 hours across all PCHs at a cost of $90 (88 FR 59318). Further, we note that these measures document an administrative process and report aggregate level results, and do not shed light on the extent to which providers are ultimately connecting patients with resources or services and whether patients are benefiting from these screenings. We have concluded that the costs of the continued use of these measures in the PCHQR Program outweigh the benefits to beneficiaries and providers. Removal of these measures would alleviate the burden on hospitals to manually screen each patient and submit data each reporting cycle, allowing hospitals to focus resources on measurable clinical outcomes. This will also remove the patient burden associated with repeated SDOH screenings across multiple healthcare facilities. We acknowledge that some hospitals may have expended resources to implement SDOH screenings, however, hospitals that had already implemented such screenings prior to adoption of the measures would not have expended similar resources. The objectives of the PCHQR Program continue to incentivize the improvement of care quality and health outcomes for all patients through transparency and use of appropriate quality measures.

If finalized, any SDOH measure data received by CMS would not be used for public reporting purposes.

We invite public comment on our proposal to remove the SDOH measure from the PCHQR Program beginning with the CY 2024 reporting period/FY 2026 program year.

c. Summary of Previously Adopted PCHQR Program Measures for the CY 2026 Reporting Period/FY 2028 Program Year and Subsequent Years

Table X.D.–01 summarizes the previously adopted measures for the PCHQR Program measure set beginning with the CY 2026 reporting period/FY 2028 program year.

TABLE X.D.–01—PREVIOUSLY ADOPTED MEASURES FOR THE PCHQR PROGRAM MEASURE SET BEGINNING WITH THE CY 2026 REPORTING PERIOD/FY 2028 PROGRAM YEAR

Short name	Consensus-based entity (CBE) No.	Measure name
Safety and Healthcare-Associated Infection (HAI) Measures		
CAUTI*	0138	National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure.
CLABSI*	0139	NHSN Central line-associated Bloodstream Infection (CLABSI) Outcome Measure.
Flu HCP Vaccination	0431	Influenza Vaccination Coverage Among Healthcare Personnel (HCP).
COVID–19 HCP Vaccination	N/A	COVID–19 Vaccination Coverage Among HCP.
Colon and Abdominal Hysterectomy SSI	0753	American College of Surgeons—Centers for Disease Control and Prevention (ACS–CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure (currently includes SSIs following Colon Surgery and Abdominal Hysterectomy Surgery).
MRSA*	1716	NHSN Facility-wide Inpatient Hospital-onset Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure.
CDI*	1717	NHSN Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure.
N/A	N/A	Patient Safety Structural Measure.
Clinical Process/Oncology Care Measures		
EOL-Chemo	0210	Proportion of Patients Who Died from Cancer—Receiving Chemotherapy in the Last 14 Days of Life.

TABLE X.C.4—MEASURES FOR THE FY 2029 PAYMENT DETERMINATION AND FOR SUBSEQUENT YEARS—Continued

Short name	Measure name	CBE *
STK–2	Discharged on Antithrombotic Therapy	0435e
STK–3	Anticoagulation Therapy for Atrial Fibrillation/Flutter	0436e
STK–5	Antithrombotic Therapy by the End of Hospital Day Two	0438e
VTE–1	Venous Thromboembolism Prophylaxis	0371e
VTE–2	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372e
HH–HYPO	Hospital Harm—Severe Hypoglycemia Measure	3503e
HH–HYPER	Hospital Harm—Severe Hyperglycemia Measure	3533e
HH–ORAE	Hospital Harm—Opioid-Related Adverse Events	3501e
HH–PI	Hospital Harm—Pressure Injury	3498e
HH–AKI	Hospital Harm—Acute Kidney Injury	3713e
HH–FI	Hospital Harm—Falls with Injury	4120e
HH–RF	Hospital Harm—Postoperative Respiratory Failure	4130e
MCS *******	Malnutrition Care Score	3592e
IP-ExRad	Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults.	3663e
Patient Experience of Care Survey Measures		
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems Survey	0166 (0228)
Patient-Reported Outcome Performance Measures		
THA/TKA PRO–PM	Hospital-Level Total Hip Arthroplasty and/or Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (PRO–PM).	3559
Process Measures		
SDOH–1 **	Screening for Social Drivers of Health	N/A
SDOH–2 **	Screen Positive Rate for Social Drivers of Health	N/A

* We note that inclusion of a CBE number neither indicates endorsement or lack of endorsement. More information about current endorsement status can be found on the Partnership for Quality Measurement website: *https://p4qm.org/measures*.

** In this proposed rule, we propose removing the HCP COVID–19 Vaccination measure, the HCHE measure, and the SDOH measures beginning with the FY 2026 payment determination. We refer readers to section X.C.4. of the preamble of this proposed rule for more detailed discussion on proposed measure removals.

*** We are updating our NHSN measures in alignment with CDC's efforts to rebaseline using CY 2022 data. We refer readers to section VI.M.2.b. of the preamble of this proposed rule for more detailed discussion of technical updates to rebaseline CDC's NHSN Healthcare-Associated Infection measures for the HAC Reduction Program.

**** The Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications measure short name has been updated to Inpatient Surgical Complications Mortality Rate.

***** In this proposed rule, we propose refinements to the MORT–30–STK and the COMP–HIP–KNEE measures beginning with the FY 2027 payment determination. We refer readers to sections X.C.3.a. and X.C.3.b., respectively, of the preamble of this proposed rule for more detailed discussion.

****** In this proposed rule, we propose modified reporting thresholds for linking variables and CCDEs beginning with the FY 2028 payment determination and subsequent years. In the FY 2025 OPPS/ASC final rule (89 FR 94495 through 94499) we finalized an extension of voluntary reporting of linking variables and core clinical data elements for the Hybrid HWR measure and the Hybrid HWM measure for the FY 2026 and FY 2027 payment determinations. We refer readers to section X.C.7.c. of the preamble of this proposed rule for more detailed discussion.

******* The eCQM previously named Global Malnutrition Composite Score has been updated to Malnutrition Care Score. The short name has subsequently been updated to MCS eCQM.

7. Proposed Updates to the Form, Manner, and Timing of Hospital IQR Program Data Submission

We propose changes to our reporting and submission requirements for eCQMs and hybrid measures. We provide more details on these proposals in the subsequent sections. We are not proposing changes to the following requirements, and we have therefore omitted the following subsections from the Form, Manner, and Timing of Quality Data Submission section: procedural requirements; data submission requirements for chart-abstracted measures; sampling and case thresholds for chart-abstracted measures; HCAHPS Survey administration and submission requirements; data submission requirements for structural measures; data submission and reporting requirements for CDC NHSN measures; and data submission and reporting requirements for Patient-Reported Outcome-Based Performance Measures (PRO–PMs). We refer readers to the QualityNet website at: *https://qualitynet.cms.gov/inpatient/iqr* (or other successor CMS designated websites) for more details on the Hospital IQR Program data submission and procedural requirements.

a. Background

Sections 1886(b)(3)(B)(viii)(I) and (b)(3)(B)(viii)(II) of the Act state that the applicable percentage increase for FY 2015 and each subsequent year shall be reduced by one-quarter of such applicable percentage increase (determined without regard to section 1886(b)(3)(B)(ix), (xi), or (xii) of the Act) for any subsection (d) hospital that does not submit data required to be submitted on measures specified by the Secretary in a form and manner and at a time specified by the Secretary. To participate successfully in the Hospital IQR Program, hospitals must comply with the specific procedural, data collection, submission, and validation requirements that we specify for the program.

b. Maintenance of Technical Specifications for Quality Measures

Section 412.140(c)(1) of title 42 of the Code of Federal Regulations (CFR) generally requires that a subsection (d) hospital participating in the Hospital IQR Program must submit to CMS data

*** We are updating our NHSN measures in alignment with CDC's efforts to rebaseline using CY 2022 data. We refer readers to section VI.M.2.b. of the preamble of this proposed rule for more detailed discussion of technical updates to rebaseline CDC's NHSN Healthcare-Associated Infection measures for the HAC Reduction Program.

**** The Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications measure short name has been updated to Inpatient Surgical Complications Mortality Rate.

***** In this proposed rule, we propose refinements to the MORT–30–STK and the COMP–HIP–KNEE measures beginning with the FY 2027 payment determination. We refer readers to sections X.C.3.a. and X.C.3.b., respectively, of the preamble of this proposed rule for more detailed discussion.

****** In this proposed rule, we propose modified reporting thresholds for linking variables and CCDEs beginning with the FY 2028 payment determination and subsequent years. In the FY 2025 OPPS/ASC final rule (89 FR 94495 through 94499) we finalized an extension of voluntary reporting of linking variables and core clinical data elements for the Hybrid HWR measure and the Hybrid HWM measure for the FY 2026 and FY 2027 payment determinations. We refer readers to section X.C.7.c. of the preamble of this proposed rule for more detailed discussion.

******* The eCQM previously named Global Malnutrition Composite Score has been updated to Malnutrition Care Score. The short name has subsequently been updated to MCS eCQM.

c. Summary of Previously Finalized and Proposed Hospital IQR Program Measures for the FY 2029 Payment Determination and for Subsequent Years

This table summarizes the proposed and previously finalized Hospital IQR Program measure set for the FY 2029 payment determination and for subsequent years:

TABLE X.C.4—MEASURES FOR THE FY 2029 PAYMENT DETERMINATION AND FOR SUBSEQUENT YEARS

Short name	Measure name	CBE*
National Healthcare Safety Network Measures		
HCP Influenza Vaccination	Influenza Vaccination Coverage Among Healthcare Personnel	0431
HCP COVID–19 Vaccination**	COVID–19 Vaccination Coverage Among Healthcare Personnel	3636
CAUTI-Onc***	Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio Stratified for Oncology Locations.	0138
CLABSI-Onc***	Central Line-Associated Bloodstream Infection (CLABSI) Standardized Infection Ratio Stratified for Oncology Locations.	0139
Claims-Based Patient Safety Measures		
Inpatient Surgical Complications Mortality Rate****.	Thirty-day Risk-Standardized Death Rate among Surgical Inpatients with Complications.	4125
Claims-Based Mortality/Complications Measures		
MORT–30–STK*****	Hospital 30-Day, All-Cause, Risk Standardized Mortality- Rate (RSMR) Following Acute Ischemic Stroke Hospitalization with Claims-Based Risk Adjustment for Stroke Severity.	4595
COMP–HIP–KNEE*****	Hospital-Level, Risk-Standardized Complication Rate (RSCR) Following Elective Primary THA and/or TKA.	1550
Claims-Based Coordination of Care Measures		
AMI Excess Days	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	2881
HF Excess Days	Excess Days in Acute Care after Hospitalization for Heart Failure	2880
PN Excess Days	Excess Days in Acute Care after Hospitalization for Pneumonia	2882
Claims and Electronic Data Measures		
Hybrid HWM******	Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Measure (HWM)	3502e
Hybrid HWR******	Hybrid Hospital-Wide All-Cause Readmission Measure (HWR)	2879e
Chart-Abstracted Clinical Process of Care Measures		
SEP–1	Severe Sepsis and Septic Shock: Management Bundle (Composite Measure)	0500
Structural Measures		
Maternal Morbidity	Maternal Morbidity Structural Measure	N/A
Age Friendly Hospital	Age Friendly Hospital Measure	N/A
Patient Safety	Patient Safety Structural Measure	N/A
HCHE**	Hospital Commitment to Health Equity	N/A
Electronic Clinical Quality Measures (eCQMs)		
Safe Use of Opioids	Safe Use of Opioids—Concurrent Prescribing	3316e
PC–02	Cesarean Birth	0471e
PC–07	Severe Obstetric Complications	3687e

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 495, and 512

[CMS–1833–P]

RIN 0938–AV45

Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals; make changes relating to Medicare graduate medical education (GME) for teaching hospitals; update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs); update and make changes to requirements for certain quality programs; and make other policy-related changes.

DATES: To be assured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. EDT on June 10, 2025.

ADDRESSES: In commenting, please refer to file code CMS–1833–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may (and we encourage you to) submit electronic comments on this regulation to *https://www.regulations.gov.* Follow the instructions under the "submit a comment" tab.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1833–P, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments via express or overnight mail to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1833–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

For information on viewing public comments, we refer readers to the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Donald Thompson, and Michele Hudson, (410) 786–4487 or *DAC@cms.hhs.gov*, Operating Prospective Payment, MS–DRG Relative Weights, Wage Index, Hospital Geographic Reclassifications, Graduate Medical Education, Capital Prospective Payment, Excluded Hospitals, Medicare Disproportionate Share Hospital (DSH) Payment Adjustment, Sole Community Hospitals (SCHs), Medicare-Dependent Small Rural Hospital (MDH) Program, Low-Volume Hospital Payment Adjustment, and Inpatient Critical Access Hospital (CAH) Issues.

Emily Lipkin, Jim Mildenberger and Hyeyoung Kim, *DAC@cms.hhs.gov*, Long-Term Care Hospital Prospective Payment System and MS–LTC–DRG Relative Weights Issues.

Lily Yuan, *NewTech@cms.hhs.gov*, New Technology Add-On Payments Issues.

Mady Hue, *marilu.hue@cms.hhs.gov*, and Andrea Hazeley, *andrea.hazeley@cms.hhs.gov*, MS–DRG Classifications Issues.

Radhika Puri, *Radhika.puri@cms.hhs.gov*, Rural Community Hospital Demonstration Program Issues.

Jeris Smith, *jeris.smith@cms.hhs.gov*, Frontier Community Health Integration Project (FCHIP) Demonstration Issues.

Lang Le, *lang.le@cms.hhs.gov*, Hospital Readmissions Reduction Program—Administration Issues.

Ngozi Uzokwe, *ngozi.uzokwe@cms.hhs.gov*, Hospital Readmissions Reduction Program—Measures Issues.

Jennifer Tate, *jennifer.tate@cms.hhs.gov*, Hospital-Acquired Condition Reduction Program—Administration Issues.

Ngozi Uzokwe, *ngozi.uzokwe@cms.hhs.gov*, Hospital-Acquired Condition Reduction Program—Measures Issues.

Julia Venanzi, *julia.venanzi@cms.hhs.gov*, Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program—Administration Issues.

Melissa Hager, *melissa.hager@cms.hhs.gov*, and Ngozi Uzokwe, *ngozi.uzokwe@cms.hhs.gov*—Hospital Inpatient Quality Reporting Program and Hospital Value-Based Purchasing Program—Measures Issues Except Hospital Consumer Assessment of Healthcare Providers and Systems Issues.

Elizabeth Goldstein, *elizabeth.goldstein@cms.hhs.gov*, Hospital Inpatient Quality Reporting and Hospital Value-Based Purchasing—Hospital Consumer Assessment of Healthcare Providers and Systems Measures Issues.

Jennifer Tate, *jennifer.tate@cms.hhs.gov*, PPS-Exempt Cancer Hospital Quality Reporting—Administration Issues.

Kristina Rabarison, *Kristina.Rabarison@cms.hhs.gov*, PPS-Exempt Cancer Hospital Quality Reporting Program-Measure Issues.

Ariel Cress, *Ariel.Cress@cms.hhs.gov*, Long-Term Care Hospital Quality Reporting Program—Administration Issues.

Jessica Warren, *jessica.warren@cms.hhs.gov*, and Lisa Marie Gomez, *LisaMarie.Gomez1@cms.hhs.gov*, Medicare Promoting Interoperability Program.

Bridget Dickensheets, *bridget.dickensheets@cms.hhs.gov* and Mollie Knight, *mollie.knight@cms.hhs.gov*, IPPS Market Basket Rebasing.

CMMI_TEAM@cms.hhs.gov, Transforming Episode Accountability Model (TEAM).

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *https://www.regulations.gov.* Follow the search instructions on that website to view public comments. CMS will not post on *Regulations.gov* public comments that make threats to individuals or institutions or suggest that the commenter will take actions to harm an individual. CMS continues to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

Plain Language Summary: In accordance with 5 U.S.C. 553(b)(4), a

plain language summary of this proposed rule may be found at *https://www.regulations.gov/*.

Deregulation Request for Information (RFI): On January 31, 2025, President Trump issued Executive Order (E.O.) 14192 "Unleashing Prosperity Through Deregulation," which states the Administration policy to significantly reduce the private expenditures required to comply with Federal regulations to secure America's economic prosperity and national security and the highest possible quality of life for each citizen. We would like public input on approaches and opportunities to streamline regulations and reduce administrative burdens on providers, suppliers, beneficiaries, and other interested parties participating in the Medicare program. CMS has made available an RFI at *https://www.cms.gov/medicare-regulatory-relief-rfi*. Please submit all comments in response to this RFI through the provided weblink.

Tables Available on the CMS Website

The IPPS tables for this fiscal year (FY) 2026 proposed rule are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html*. Click on the link on the left side of the screen titled "FY 2026 IPPS Proposed rule Home Page" or "Acute Inpatient—Files for Download." The LTCH PPS tables for this FY 2026 proposed rule are available on the CMS website at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/index.html* under the list item for Regulation Number CMS–1833–P. For further details on the contents of the tables referenced in this proposed rule, we refer readers to section VI. of the Addendum to this FY 2026 IPPS/LTCH PPS proposed rule.

Readers who experience any problems accessing any of the tables that are posted on the CMS websites, as previously identified, should contact *Michael Treitel, DAC@cms.hhs.gov.*

I. Executive Summary and Background

A. Executive Summary

1. Purpose and Legal Authority

This FY 2026 IPPS/LTCH PPS proposed rule would make payment and policy changes under the Medicare inpatient prospective payment system (IPPS) for operating and capital-related costs of acute care hospitals as well as for certain hospitals and hospital units excluded from the IPPS. In addition, it would make payment and policy changes for inpatient hospital services provided by long-term care hospitals (LTCHs) under the long-term care hospital prospective payment system (LTCH PPS). This proposed rule also would make policy changes to programs associated with Medicare IPPS hospitals, IPPS-excluded hospitals, and LTCHs. We are also proposing changes relating to Medicare graduate medical education (GME) for teaching hospitals.

We are proposing several changes across pay for performance programs. In the Hospital Value-Based Purchasing (VBP) Program, we are proposing modifications to the Hospital-Level Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Complications measure beginning with the FY 2033 program year. We are also providing notice of the technical update to the five National Healthcare Safety Network (NHSN) Healthcare Associated Infection (HAI) measures beginning with the FY 2028 program year, and the technical update to remove the COVID–19 exclusion from the six measures in the Clinical Outcomes domain beginning with the FY 2027 program year. Lastly, we provide previously and newly established performance standards for the FY 2028 through FY 2031 program years for the Hospital VBP Program. In the Hospital Acquired-Conditions (HAC) Reduction Program, we are also providing notice of the technical update to the five Centers for Disease Control National Control (CDC) NHSN healthcare-associated infection (HAI) measures. In the Hospital Readmissions Reduction Program, we are proposing to add Medicare Advantage (MA) beneficiaries to the six Hospital Readmissions Reduction Program (HRRP) measures and make corresponding administrative updates.

In the PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR), we are proposing to modify the public reporting requirements and remove three existing measures.

In the Hospital Inpatient Quality Reporting (IQR) Program, we are proposing to modify four existing quality measures and remove four existing measures.

We also are proposing to update and codify the Extraordinary Circumstances Exception (ECE) policy to clarify that CMS has the discretion to grant an extension in response to an ECE request from a hospital in the Hospital IQR, Hospital Readmissions Reduction, PCHQR, HAC Reduction, and Hospital VBP Programs.

In the Medicare Promoting Interoperability Program, we are proposing to define the electronic health record (EHR) reporting period in CY 2026 and subsequent years as a minimum of any continuous 180-day period within that calendar year for eligible hospitals and CAHs participating in the Medicare Promoting Interoperability Program and to make corresponding revisions at 42 CFR 495.4. We are proposing to modify the Security Risk Analysis measure beginning with the EHR reporting period in CY 2026. We are proposing to modify the Safety Assurance Factors for EHR Resilience (SAFER) Guides measure beginning with the EHR reporting period in CY 2026. We are proposing to add an optional bonus measure under the Public Health and Clinical Data Exchange objective for reporting data to a public health agency (PHA) using the Trusted Exchange Framework and Common Agreement (TEFCA) beginning with the EHR reporting period in CY 2026.

In the LTCH Quality Reporting Program (QRP), we are proposing to remove one item from the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) with respect to patients who have expired in the LTCH. We are also proposing to remove four Social Determinant of Health (SDOH) standardized patient assessment data elements from the LCDS. Next, we are proposing to amend the reconsideration request process in the LTCH QRP. Finally, we include Requests for Information (RFIs) on: (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.

The Transforming Episode Accountability Model (TEAM), a mandatory alternative payment model that was finalized in the FY 2025 IPPS/LTCH PPS final rule (89 FR 68986), aims to improve beneficiary care through financial accountability for episodes categories that begin with one of the following procedures: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion. TEAM will test whether financial accountability for these episode categories reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. In this proposed rule, we are proposing updates to TEAM that would modify policies affecting participation of new hospitals, quality measure and assessment, the construction of target prices, the removal of certain health reporting elements, the expansion of the Skilled