having reviewed and approved this document, authorizes Trenesha Fultz-Mimms, who is the Federal Register Liaison, to electronically sign this document for purposes of publication in the **Federal Register**.

Trenesha Fultz-Mimms,

Federal Register Liaison, Centers for Medicare & Medicaid Services.

[FR Doc. 2025–20329 Filed 11–18–25; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–8089–N]

RIN 0938–AV54

Medicare Program; CY 2026 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

SUMMARY: This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year (CY) 2026 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts. For CY 2026, the inpatient hospital deductible will be $1,736. The daily coinsurance amounts for CY 2026 will be as follows: $434 for the 61st through 90th day of hospitalization in a benefit period; $868 for lifetime reserve days; and $217 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period.

DATES: The deductible and coinsurance amounts announced in this notice are effective on January 1, 2026.

FOR FURTHER INFORMATION CONTACT: Suzanne Codespote, (410) 786–7737 or Yaminee Thaker (410) 786–7921.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1813 of the Social Security Act (the Act) provides for an inpatient hospital deductible to be subtracted from the amount payable by Medicare for inpatient hospital services furnished to a beneficiary. It also provides for certain coinsurance amounts to be subtracted from the amounts payable by Medicare for inpatient hospital and extended care services. Section 1813(b)(2) of the Act requires the Secretary of the Department of Health and Human Services (the Secretary) to determine and publish each year the amount of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts applicable for services furnished in the following calendar year (CY).

II. Computing the Inpatient Hospital Deductible for CY 2026

Section 1813(b) of the Act prescribes the method for computing the amount of the inpatient hospital deductible. The inpatient hospital deductible is an amount equal to the inpatient hospital deductible for the preceding CY, adjusted by the Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B) of the Act) used for updating the payment rates to hospitals for discharges in the fiscal year (FY) that begins on October 1 of the same preceding CY, and adjusted to reflect changes in real casemix. The adjustment to reflect real casemix is determined on the basis of the most recent case-mix data available. The amount determined under this formula is rounded to the nearest multiple of $4 (or, if midway between two multiples of $4, to the next higher multiple of $4).

Under section 1886(b)(3)(B)(i)(XX) of the Act, the percentage increase used to update the payment rates for FY 2026 for hospitals paid under the inpatient prospective payment system (IPPS) is the IPPS operating market basket percentage increase, otherwise known as the IPPS market basket update, reduced by an adjustment based on changes in the economy-wide productivity (productivity adjustment) (see section 1886(b)(3)(B)(xi)(II) of the Act). Under section 1886(b)(3)(B)(viii) of the Act, for FY 2026, the applicable percentage increase for hospitals that do not submit quality data as specified by the Secretary is reduced by one quarter of the market basket update. We are estimating that after accounting for those hospitals receiving the lower market basket update in the payment-weighted average update, the calculated deductible will not be affected, since the majority of hospitals submit quality data and receive the full market basket update. Section 1886(b)(3)(B)(ix) of the Act requires that any hospital that is not a meaningful electronic health record (EHR) user (as defined in section 1886(n)(3) of the Act) will have three-quarters of the market basket update reduced by 100 percent for FY 2017 and each subsequent FY. We are estimating that after accounting for these hospitals receiving the lower market basket update, the calculated deductible will not be affected, since the majority of hospitals are meaningful EHR users and are expected to receive the full market basket update.

Under section 1886 of the Act, the percentage increase used to update the payment rates (or target amounts, as applicable) for FY 2026 for hospitals excluded from the inpatient prospective payment system is as follows:

- The percentage increase for long term care hospitals (LTCH) is the LTCH market basket percentage increase reduced by the productivity adjustment (see section 1886(m)(3)(A) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments and the site-neutral payment rates (see section 1886(m)(5) and (6) of the Act).
- The percentage increase for inpatient rehabilitation facilities (IRF) is the IRF market basket percentage increase reduced by the productivity adjustment in accordance with section 1886(j)(3)(C)(ii)(I) of the Act. In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(j)(7) of the Act).
- The percentage increase used to update the payment rate for inpatient psychiatric facilities (IPF) is the IPF market basket percentage increase reduced by the productivity adjustment (see section 1886(s)(2)(A)(i) of the Act). In addition, these hospitals may also be impacted by the quality reporting adjustments (see section 1886(s)(4) of the Act).
- The percentage increase used to update the target amounts for other types of hospitals that are excluded from the inpatient prospective payment system and that are paid on a reasonable cost basis, subject to a rate-of-increase ceiling, is the IPPS operating market basket percentage increase, which is described at section 1886(b)(3)(B)(ii)(VIII) of the Act and 42 CFR 413.40(c)(3). These other types of hospitals include cancer hospitals, children's hospitals, extended neoplastic disease care hospitals, and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico.

The IPPS operating market basket percentage increase for FY 2026 is 3.3 percent and the productivity adjustment is 0.7 percentage point, as announced in the final rule that appeared in the **Federal Register** on August 04, 2025 entitled, ''Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS) and the

Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year (FY) 2026 Rates; Changes to the FY 2025 IPPS Rates Due to Court Decision; Requirements for Quality Programs; and Other Policy Changes; Health Data, Technology, and Interoperability: Electronic Prescribing, Real-Time Prescription Benefit and Electronic Prior Authorization'' (90 FR 36536). Therefore, the percentage increase for hospitals paid under the inpatient prospective payment system that submit quality data and are meaningful EHR users is 2.6 percent (that is, the FY 2026 IPPS operating market basket update of 3.3 percent less the productivity adjustment of 0.7 percentage point). The average payment percentage increase for hospitals excluded from the inpatient prospective payment system is 2.7 percent. This average includes long term care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities and other hospitals excluded from the inpatient prospective payment system. Weighting these percentages in accordance with payment volume, our best estimate of the payment-weighted average of the increases in the payment rates for FY 2026 is 2.62 percent.

To develop the adjustment to reflect changes in real casemix, we first calculated an average casemix for each hospital that reflects the relative costliness of that hospital's mix of cases compared to those of other hospitals. We then computed the change in average casemix for hospitals paid under the Medicare inpatient prospective payment system in FY 2025 compared to FY 2024. (We excluded from this calculation hospitals whose payments are not based on the inpatient prospective payment system because their payments are based on alternate prospective payment systems or reasonable costs.) We used Medicare bills from prospective payment hospitals that we received as of July 2025. These bills represent a total of about 5.4 million Medicare discharges for FY 2025 and provide the most recent case-mix- data available at this time. Based on these bills, the change in average casemix in FY 2025 -is 0.9 percent. Based on these bills and past experience, we expect the overall FY 2025 casemix change to be 0.9 percent as the year progresses and more FY 2025 data become available.

Section 1813(b) of the Act requires that the inpatient hospital deductible be adjusted only by that portion of the case mix change that is determined to be real. Real casemix is that portion of casemix that is due to changes in the mix of cases and not due to coding optimization. We are assuming that this increase in casemix is real and not a result of coding optimization.

Thus, the estimate of the payment-weighted average of the applicable percentage increases used for updating the payment rates is 2.62 percent, and the real case-mix adjustment factor for the deductible is 0.9 percent. Therefore, using the statutory formula as stated in section 1813(b) of the Act, we calculate the inpatient hospital deductible for services furnished in CY 2025 to be $1,736. This deductible amount is determined by multiplying $1,676 (the inpatient hospital deductible for CY 2025 (89 FR 68986)) by the payment-weighted average increase in the payment rates of 1.0262 multiplied by the increase in real casemix of 1.009, which equals $1,735.39 and is rounded to $1,736 (based on rounding to the nearest multiple of 4).

III. Computing the Inpatient Hospital and Extended Care Services Coinsurance Amounts for CY 2026

The coinsurance amounts provided for in section 1813 of the Act are defined as fixed percentages of the inpatient hospital deductible for services furnished in the same CY. The increase in the deductible generates increases in the coinsurance amounts. For inpatient hospital and extended care services furnished in CY 2026, in accordance with the fixed percentages defined in the law, the daily coinsurance for the 61st through 90th day of hospitalization in a benefit period will be $434 (one-fourth of the inpatient hospital deductible as stated in section 1813(a)(1)(A) of the Act); the daily coinsurance for lifetime reserve days will be $868 (one-half of the inpatient hospital deductible as stated in section 1813(a)(1)(B) of the Act); and the daily coinsurance for the 21st through 100th day of extended care services in a skilled nursing facility (SNF) in a benefit period will be $217 (one-eighth of the inpatient hospital deductible as stated in section 1813(a)(3) of the Act).

IV. Cost to Medicare Beneficiaries

Table 1 summarizes the deductible and coinsurance amounts for CYs 2025 and 2026, as well as the number of each that is estimated to be paid.

TABLE 1—MEDICARE PART A DEDUCTIBLE AND COINSURANCE AMOUNTS FOR CYS 2025 AND 2026

Type of cost sharing	Value		Number paid (in millions)	
	2025	2026	2025	2026
Inpatient hospital deductible	$1,676	$1,736	5.55	5.63
Daily coinsurance for 61st—90th day	419	434	1.39	1.41
Daily coinsurance for lifetime reserve days	838	868	0.71	0.72
SNF coinsurance	209.50	217.00	28.33	28.88

The estimated total increase in costs to beneficiaries is about $860 million (rounded to the nearest $10 million) due to: (1) the increase in the deductible and coinsurance amounts; and (2) the change in the number of deductibles and daily coinsurance amounts paid. We determine the increase in cost to beneficiaries by calculating the difference between the 2025 and 2026 deductible and coinsurance amounts multiplied by the estimated change in the number of deductible and coinsurance amounts paid.

V. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment prior to a rule taking effect in accordance with section 1871 of the Act. Section 1871(a)(2) of the Act provides that no rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under Medicare shall take effect unless it is promulgated through notice and comment rulemaking. Unless there is a statutory exception, section 1871(b)(1) of the Act generally requires the Secretary to

provide for notice of a proposed rule in the **Federal Register** and provide a period of not less than 60 days for public comment before establishing or changing a substantive legal standard regarding the matters enumerated by the statute. Section 1871(b)(2)(C) of the Act provides exceptions from the notice and 60-day comment period, under the good cause standard set forth in 5 U.S.C. 553(b)(B). Section 553(b)(B) authorizes an agency to dispense with notice and comment rulemaking for good cause if the agency makes a finding that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest.

The annual inpatient hospital deductible and the hospital and extended care services coinsurance amounts announcement set forth in this notice does not establish or change a substantive legal standard regarding the matters enumerated by the statute or constitute a substantive rule which would be subject to the notice requirements in section 1871(b) of the Act. However, to the extent that an opportunity for public notice and comment could be construed as required for this notice, we find good cause to waive this requirement.

Section 1813(b)(2) of the Act requires publication of the inpatient hospital deductible and the hospital and extended care services coinsurance amounts between September 1 and September 15 of the year preceding the year to which they will apply. Further, the statute requires that the agency determine and publish the inpatient hospital deductible and hospital and extended care services coinsurance amounts for each CY in accordance with the statutory formulae, and we are simply notifying the public of the changes to the deductible and coinsurance amounts for CY 2026. We have calculated the inpatient hospital deductible and hospital and extended care services coinsurance amounts as directed by the statute; the statute establishes both when the deductible and coinsurance amounts must be published and the information that the Secretary must factor into the deductible and coinsurance amounts, so we do not have any discretion in that regard. We find notice and comment procedures to be unnecessary for this notice, and we find good cause to waive such procedures under section 553(b)(B) and section 1871(b)(2)(C) of the Act, if such procedures may be construed to be required at all. Through this notice, we are simply notifying the public of the updates to the inpatient hospital deductible and the hospital and extended care services coinsurance amounts, in accordance with the statute, for CY 2026.

VI. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VII. Regulatory Impact Analysis

We have prepared this Regulatory Impact Analysis (RIA) section in the interest of ensuring that the impacts of this notice are fully understood.

A. Statement of Need

This notice announces the Medicare Part A inpatient hospital deductible and associated coinsurance amounts for hospital and extended care services applicable for care provided in CY 2026, as required by section 1813 of the Act. It also responds to section 1813(b)(2) of the Act, which requires the Secretary to provide for publication of these amounts in the **Federal Register** between September 1 and September 15 of the year preceding the year to which they will apply. As this statutory provision prescribes a detailed methodology for calculating these amounts, we do not have the discretion to adopt an alternative approach to these issues.

B. Overall Impact

We have examined the impacts of this notice as required by Executive Order 12866, ''Regulatory Planning and Review''; Executive Order 13132, ''Federalism''; Executive Order 13563, ''Improving Regulation and Regulatory Review''; Executive Order 14192, ''Unleashing Prosperity Through Deregulation''; the Regulatory Flexibility Act (RFA) (Pub. L. 96–354); section 1102(b) of the Social Security Act; section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts). Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as any regulatory action that is likely to result in a rule that may: (1) have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, or the President's priorities.

A regulatory impact analysis (RIA) must be prepared for a regulatory action that is significant under section 3(f)(1) of E.O. 12866. As stated in section IV. of this notice, we estimate that the total increase in costs to beneficiaries is about $860 million due to: (1) the increase in the deductible and coinsurance amounts; and (2) the change in the number of deductibles and daily coinsurance amounts paid. Based on our estimates, OIRA has determined this notice is significant under section 3(f)(1). Accordingly, we have prepared an RIA that to the best of our ability presents the costs and benefits of this notice.

In accordance with subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act), OIRA has determined that this notice meets the criteria set forth in 5 U.S.C. 804(2). For the reasons given, however, we find for good cause that notice and public procedure are impracticable, unnecessary, and contrary to the public interest and have determined that this policy will take effect on January 1, 2026, pursuant to 5 U.S.C. 808(2).

C. Accounting Statement and Table

As required by OMB Circular A–4 (available at *https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/circulars/A4/a-4.pdf*), in Table 2, we have prepared an accounting statement showing the estimated total increase in costs to beneficiaries of about $860 million. As stated in section IV. of this notice, we determined the increase in cost to beneficiaries by calculating the difference between the 2025 and 2026 deductible and coinsurance amounts multiplied by the estimated change in the number of deductible and coinsurance amounts paid.

TABLE 2—ESTIMATED TRANSFERS FOR CY 2026 DEDUCTIBLE AND COINSURANCE AMOUNTS

Category	Transfers	Period covered
Annualized Monetized Transfers.	$860 million	2026
From Whom to Whom.	Beneficiaries to Providers.	

D. Regulatory Flexibility Act

The RFA requires agencies to analyze options for regulatory relief of small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration's definition of a small business (having revenues of less than $9.0 million to $47.0 million in any 1 year). Individuals and States are not included in the definition of a small entity. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2026 and will have an impact on the Medicare beneficiaries. As a result, we are not preparing an analysis for the RFA because the Secretary has certified that this notice will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare an RIA if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. This annual notice announces the Medicare Part A deductible and coinsurance amounts for CY 2026 and will have an impact on the Medicare beneficiaries. As a result, we are not preparing an analysis for section 1102(b) of the Act because the Secretary has certified that this notice will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2025, that threshold is approximately $187 million. This notice would not impose a mandate that will result in the expenditure by State, local, and Tribal Governments, in the aggregate, or by the private sector, of more than $187 million in any 1 year.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This notice will not have a substantial direct effect on State or local governments, preempt State law, or otherwise have Federalism implications.

G. Congressional Review

This notice is subject to the Congressional Review Act and has been transmitted to the Congress and the Government Accountability Office's Comptroller General for review.

Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, approved this document on October 31, 2025.

Robert F. Kennedy, Jr.,

Secretary, Department of Health and Human Services.

[FR Doc. 2025–20249 Filed 11–14–25; 4:45 pm]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Submission to OMB for Review and Approval; Public Comment Request; HRSA Ryan White HIV/AIDS Program HIV Quality Measures Module, OMB No. 0906–0022—Revision

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, HRSA submitted an Information Collection Request (ICR) to the Office of Management and Budget (OMB) for review and approval. Comments submitted during the first public review of this ICR will be provided to OMB. OMB will accept further comments from the public during the review and approval period. OMB may act on HRSA's ICR only after the 30-day comment period for this notice has closed.

DATES: Comments on this ICR should be received no later than December 19, 2025.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this information collection by selecting ''Currently under Review—Open for Public Comments'' or by using the search function.

FOR FURTHER INFORMATION CONTACT: To request a copy of the clearance requests submitted to OMB for review, email Samantha Miller, the HRSA Information Collection Clearance Officer, at *paperwork@hrsa.gov* or call (301) 443–3983.

SUPPLEMENTARY INFORMATION:

Information Collection Request Title: HRSA Ryan White HIV/AIDS Program HIV Quality Measures Module, OMB No. 0906–0022—Revision.

Abstract: HRSA's Ryan White HIV/AIDS Program (RWHAP) funds and coordinates with cities, states, and local clinics/community-based organizations to deliver efficient and effective HIV care, treatment, and support to low-income people with HIV. Since 1990, RWHAP has developed a comprehensive system of safety net providers who deliver high-quality direct health care and support services to over half a million people with HIV—more than 50 percent of all people with diagnosed HIV in the United States.

RWHAP Parts A, B, C, and D recipients and subrecipients must follow statutory requirements for the establishment of clinical quality management programs to assess the extent to which their HIV services are consistent with the most recent HHS Clinical Treatment guidelines and to develop strategies to improve access to quality HIV services. In support of these requirements, HRSA created the HIV Quality Measures (HIVQM) Module as an online tool to assist recipients in meeting the clinical quality management program requirement by allowing recipients to input data for the HRSA performance measures. HRSA maintains over 40 performance measures across the following categories: (1) core, (2) all ages, (3) adolescent/adult, (4) pediatric HIV, (5) HIV-exposed children, (6) medical case management, (7) oral health, (8) AIDS Drug Assistance Program, and (9)