CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13398	**Date: September 4, 2025**
	Change Request 14203

SUBJECT: Fiscal Year (FY) 2026 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

I. SUMMARY OF CHANGES: The purpose of this recurring Change Request (CR) is to provide the FY 2026 update to the IPPS and LTCH PPS. This recurring update notification applies to chapter 3, section 20.2.3.1.

EFFECTIVE DATE: October 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 6, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/150.4/Qualification Criterion for LTCHs

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

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II. GENERAL INFORMATION

A. Background: The Social Security Amendments of 1983 (P.L. 98-21) provided for the establishment of a Prospective Payment System (PPS) for Medicare payment of inpatient hospital services. In addition, the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA), as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), required that a budget neutral, per discharge PPS for LTCHs based on Diagnosis-Related Groups (DRGs) be implemented for cost reporting periods beginning on or after October 1, 2002. The Centers for Medicare & Medicaid Services (CMS) is required to make updates to these prospective payment systems annually. This CR outlines those changes for FY 2026.

B. Policy: The following policy changes for FY 2026 went on display on August 1, 2025, and appear in the Federal Register on August 4, 2025. All items covered in this instruction are effective for hospital discharges occurring on or after October 1, 2025, through September 30, 2026, unless otherwise noted.

New IPPS and LTCH PPS Pricer software packages will be released that include the updated rates/factors/policies that are effective for claims with discharges occurring on or after October 1, 2025, through September 30, 2026. The newly revised Pricer programs shall be installed timely to ensure accurate payments for IPPS and LTCH PPS claims.

The FY 2026 Final Rule Data Files, FY 2026 Final Rule Tables, and FY 2026 MAC Implementation Files referenced throughout this CR are available on the CMS website. Medicare Administrative Contractors (MACs) shall use these files (when not otherwise specified) which are available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page.

Alternatively, the files on the webpage listed above are also available on the CMS website at http://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 Final Rule Home Page” or the link titled “Acute Inpatient--Files for Download” (and select ‘Files for FY 2026 Final Rule’).

<u>IPPS FY 2026 Update</u>

A. FY 2026 IPPS Rates and Factors

For the Operating Rates/Standardized Amounts and the Federal Capital Rate, refer to Tables 1A-C and Table 1D, respectively, of the FY 2026 IPPS/LTCH PPS Final Rule, available on the FY 2026 Final Rule Tables webpage. For other IPPS factors, including applicable percentage increase, budget neutrality factors, High Cost Outlier (HCO) threshold, and Cost-of-Living adjustment (COLA) factors, refer to MAC Implementation File 1 available on the FY 2026 MAC Implementation Files webpage.

B. Medicare Severity - Diagnosis Related Group (MS-DRG) Grouper and Medicare Code Editor (MCE) Changes

The Grouper Contractor, Solventum (formerly 3M Health Information Systems (3M-HIS)), developed the new International Classification of Diseases Tenth Revision (ICD-10) MS-DRG Grouper, Version 43.0, software package effective for discharges on or after October 1, 2025. The GROUPER assigns each case into an MS-DRG on the basis of the reported diagnosis and procedure codes and demographic information (that is age, sex, and discharge status). The ICD-10 MCE Version 43.0, which is also developed by Solventum, uses edits for the ICD-10 codes reported to validate correct coding on claims for discharges on or after October 1, 2025.

For discharges occurring on or after October 1, 2025, the Fiscal Intermediary Shared System (FISS) calls the appropriate GROUPER based on discharge date. Medicare contractors received the GROUPER documentation August 2025.

For discharges occurring on or after October 1, 2025, the MCE selects the proper internal code edit tables based on discharge date. Medicare contractors received the MCE documentation in August 2025. Note that the MCE version continues to match the Grouper version.

CMS deleted six MS-DRGs and finalized five new MS-DRGs, decreasing the number of MS-DRGs by one, for a total of 772 for FY 2026.

The ICD-10 MS-DRG V43.0 Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V43 manual located on the MS-DRG Classifications and Software webpage (at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software) reflect the complete documentation of the GROUPER logic for the FY 2026 ICD-10 MS-DRGs and Medicare Code Edits.

See MAC Implementation File 6 for the complete list of new MS-DRGs for FY 2026.

C. Replaced Devices Offered without Cost or with a Credit

A hospital's IPPS payment is reduced, for specified MS-DRGs, when the implantation of a device is replaced without cost or with a credit equal to 50 percent or more of the cost of the replacement device. New MS-DRGs are added to the list subject to the policy for payment under the IPPS for replaced devices offered without cost or with credit when they are formed from procedures previously assigned to MS- DRGs that were already on the list.

See MAC Implementation File 7 for the complete list of MS-DRGs covered under the Replaced Devices Offered without Cost or with a Credit in FY 2026.

D. Post-acute Transfer and Special Payment Policy

The changes to MS-DRGs for FY 2026 have been evaluated against the general post-acute care transfer policy criteria using the FY 2024 MedPAR data according to the regulations under Sec. 412.4 (c). As a result of this review, no MS-DRGs will be added to or removed from the list of MS-DRGs subject to either the post-acute care or the special payment policies.

See Table 5 of the FY 2026 IPPS/LTCH PPS Final Rule for a listing of all Post-acute and Special Post-acute MS-DRGs available on the FY 2026 Final Rule Tables webpage.

E. New Technology Add-On Payment Policy

For FY 2026, 27 new technology add-on payments will continue and 26 new technology add-on payments are approved to begin. One additional technology was granted conditional approval pending the Food and Drug Administration (FDA) marketing authorization. *Additional instructions will be issued if FDA marketing authorization is granted in time for FY 2026 payments under the conditional approval policy*. For more information on FY 2026 new technology add-on payments, specifically regarding the technologies either continuing to receive payments or beginning to receive payments, refer to MAC Implementation File 8 available on the FY 2026 MAC Implementation Files webpage. MAC Implementation File 8 also includes information regarding technologies no longer eligible to receive new technology add-on payments.

F. FY 2026 Labor Related Share Percentage

The labor-related share under the IPPS is used to determine the proportion of the national IPPS base operating payment rate to which the area wage index is applied. Under current law, hospitals receive payment based on either a 62-percent labor-related share, or the labor-related share estimated from time to time by the Secretary, depending on which labor-related share resulted in a higher payment.

For FY 2026, we finalized an update to the labor-related share estimated from time to time by the Secretary for discharges occurring on or after October 1, 2025. For all IPPS hospitals (including Puerto Rico hospitals) whose wage indexes are greater than 1.000, for FY 2026, the wage index will be applied to the labor-related share of the operating national standardized amount using the updated labor-related share found in MAC Implementation File 1 available on the FY 2026 MAC Implementation Files webpage. No MAC action is necessary as Pricer will apply the updated labor-related share for FY 2026.

G. Cost of Living Adjustment (COLA) for Hospitals Paid Under the IPPS

There are no changes to the COLA factors for FY 2026. For reference, a table showing the applicable COLAs that are effective for discharges occurring on or after October 1, 2025, can be found in the FY 2026 IPPS/LTCH PPS final rule and in MAC Implementation File 1 available on the FY 2026 MAC Implementation Files webpage. (We note, the same COLA factors are used under the IPPS and the LTCH PPS for FY 2026.)

H. Updating the Provider Specific File (PSF) for Wage Index, Reclassifications and Redesignations and Wage Index Changes and Issues

MACs shall update the PSF by following the steps, in order, in the file on the FY 2026 MAC Implementation Files webpage ("Instructions to fill out the PSF for the Wage Index and Reclassifications.pdf" in MAC Implementation File 5) to determine the appropriate wage index and other payments. We note, the file "Instructions to fill out the PSF for the Wage Index and Reclassifications.pdf" includes steps to update the PSF to ensure that IPPS payments for hospitals with reclassifications and redesignations are paid appropriately.

Medicare contractors shall follow the instructions in the policy section and on the FY 2026 MAC Implementation Files webpage to update the PSF and ensure that the Core-Based Statistical Area (CBSA) is assigned properly for all IPPS providers.

For hospitals located in rural counties that are deemed Lugar counties on Table 4B (that is, counties redesignated under section 1886(d)(8)(B) of the Act), MACs must verify and ensure that a hospital's Lugar status is applied appropriately. See MAC Implementation File 5 for complete details on how to fill-out the PSF for such hospitals.

As established in the final rule, for FY 2026, the following policies will apply to the wage index:

- Apply a 5 percent cap for FY 2026 on any decrease in a hospital's final wage index from the hospital's final wage index in FY 2025.

- For FY 2026 and subsequent fiscal years, after considering the D.C. Circuit's decision in Bridgeport Hosp. v. Becerra, we are finalizing (in the FY 2026 IPPS/LTCH final rule) to discontinue the low wage index hospital policy. We also are finalizing (in the FY 2026 IPPS/LTCH final rule) a transitional exception to the calculation of FY 2026 IPPS payments for low wage index hospitals significantly impacted by the discontinuation of the low wage index hospital policy.

Per Change Request 11707, we created two PSF fields, the Supplemental Wage Index field (data element 63) and the Supplemental Wage Index Flag (data element 64). For FY 2026, for all hospitals eligible for the 5 percent cap, the Supplemental Wage Index Flag (data element 64) must be "1" and the Supplemental Wage Index field (data element 63) shall equal the wage index in Table 2 in the column labeled "FY 2025 Wage Index" to implement the 5 percent cap policy. These fields are used by the Pricer to determine the 5 percent cap on the decrease in a hospital's wage index, as applicable. Under the 5 percent cap policy, new hospitals that opened during FY 2026 are not eligible for the 5 percent cap. Therefore, for newly opened hospitals in FY 2026, the Supplemental Wage Index Flag field (data element 64) shall be blank and the value in the Supplemental Wage Index field (data element 63) shall be zeroes. For hospitals not listed on Table 2 (other than new hospitals opened in FY 2026) or any other issues, see MAC Implementation File 5 available on the FY 2026 MAC Implementation Files webpage for complete instructions.

The transitional exception policy for FY 2026 applies to certain hospitals that benefitted from the FY 2024 low wage index hospital policy. For those eligible hospitals, we compare the hospital's FY 2026 wage index to the hospital's FY 2024 wage index. If the hospital's FY 2026 wage index is decreasing by more than 9.75 percent from the hospital's FY 2024 wage index, then the transitional payment exception for FY 2026 for that hospital is equal to the additional FY 2026 amount the hospital would be paid under the IPPS if its FY 2026 wage index were equal to 90.25 percent (95 percent for FY 2025 * 95 percent for FY 2026) of its FY 2024 wage index.

In order for Pricer to apply the transitional payment policy in FY 2026, it is necessary to use the Special Payment Indicator (data element 33) field and Special Wage Index field (data element 38) in the PSF. MACs shall use the spreadsheet titled "FY 2026 MAC Table 2 PSF Guide.xlsx" (which is included with MAC Implementation File 5) to identify hospitals eligible for the transitional payment policy. Hospitals eligible for the transition payment policy will have a "1" or "2 in the column titled "Special Payment Indicator field (Data Element 33)".

For hospitals eligible for the transitional payment policy in FY 2026, per the "FY 2026 MAC Table 2 PSF Guide.xlsx" spreadsheet, enter a "1" or "2" from the column titled "Special Payment Indicator field (Data Element 33)" in data element 33 of the PSF and enter the wage index from the column titled "Special Wage Index field (data element 38)" in data element 38 of the PSF.

For all other hospitals that are not eligible for the transitional payment policy in FY 2026, if a MAC believes use of a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the

Special Wage Index field (data element 38) is necessary for FY 2026, the MAC shall seek approval from the CMS Central Office prior to entering a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38). We refer MACs to the FY 2026 MAC Implementation Files webpage and the file "Instructions to fill out the PSF for the Wage Index and Reclassifications" for complete details for filling in the PSF regarding ALL circumstances related to the wage index.

I. Sole Community Hospitals (SCHs) and Medicare-Dependent, Small Rural Hospital (MDH) Program

1. Updating the Hospital Specific (HSP) Rate in the PSF

For FY 2026, MACs must update the Hospital-Specific (HSP) amount in the PSF for all SCHs and MDHs. While the MDH program is set to expire under current law as of October 1, 2025, we are nevertheless instructing MACs to update the HSP rates for purposes of having rates for SCHs and MDHs in the PSF that are uniformly updated. The HSP amount must be updated from FY 2018 dollars to FY 2025 dollars by applying an update factor of 1.18513 to the current HSP amount in the PSF before entering this final amount in the PSF with an effective date of October 1, 2025. The factor of 1.18513 represents the product of all of the annual market basket updates (i.e., applicable percentage increases) and the DRG budget neutrality factors for FYs 2019 through 2025. PRICER will apply the update and DRG budget neutrality factor to the HSP amount for FY 2026.

2. MDH Program Expiration

The special payment provisions provided to a Medicare Dependent Small Rural Hospital (MDH) are not authorized by statute beyond FY 2025. Therefore, beginning October 1, 2025, all hospitals that previously qualified for MDH status will no longer have MDH status and will be paid based solely on the Federal rate. (We note that, our SCH policy at Subsection (§)412.92(b) allows MDHs to apply for SCH status and be paid as such under certain conditions, following the expiration of the MDH program.) Provider Types 14 and 15 are no longer valid beginning FY 2026, and contractors shall update the PSF accordingly to reflect the appropriate provider type with an effective date of October 1, 2025.

J. Multicampus Hospitals

CMS allocates wages and hours to the CBSA in which, a hospital campus is located when a multicampus hospital has campuses located in different CBSAs. Medicare payment to a hospital is based on the geographic location of the hospital facility at which the discharge occurred. Therefore, if a hospital has a campus or campuses in different CBSAs, the MAC adds a suffix to the CMS Certification Number (CCN) of the hospital in the PSF, to identify and denote a subcampus in a different CBSA, so that the appropriate wage index associated with each campus's geographic location can be assigned and used for payment for Medicare discharges from each respective campus. Also, note that, under certain circumstances, it is permissible for individual campuses to have reclassifications to another CBSA, in which case, the appropriate reclassified CBSA and wage index needs to be noted in the PSF (see MAC Implementation File 5). In general, subordinate campuses are subject to the same rules regarding withdrawals and cancellations of reclassifications as main providers. In addition, if MACs learn of additional mergers during FY 2026 in which a multicampus hospital with inpatient campuses located in different CBSAs is created, please contact WageIndex@cms.hhs.gov for instructions.

K. Treatment of Hospitals Redesignated Under Section 1886(d)(8)(B) of the Act (Lugar Hospitals) Other Than for Wage Index Purposes

42 Code of Federal Regulations (CFR) 412.64(b)(3)(ii) implements section 1886(d)(8)(B) of the Act, which redesignates certain rural counties adjacent to one or more urban areas as urban for the purposes of payment under the IPPS. (These counties are commonly referred to as "Lugar counties".) Accordingly, hospitals located in Lugar counties are deemed to be located in an urban area and their IPPS payments under section 1886(d) of the Act are determined based upon the urban area to which they are redesignated.

Table 4B lists all "Lugar" counties for FY 2026. **MACs shall review the urban/rural status of all hospitals located in a "Lugar" county for FY 2026 and as such are deemed urban (except as described below)**.

For purposes of IPPS provider type or hospital status determinations (other than for determining a hospital's wage index, which is addressed above in section I.I,), MACs shall ensure they are taking into account the Lugar status of the hospitals and determining the payment and/or hospital status appropriately. Lugar counties that are deemed urban are listed on Table 4B of each fiscal year's IPPS final rule (or correcting document, as applicable). **MACs shall verify whether a hospital is located in a Lugar county based on the list of counties in Table 4B. MACs shall not rely on Table 2 to determine whether a hospital has Lugar status** as hospital statuses can change. **Note:** MACs shall also verify whether the hospital has an urban-to-rural 412.103 reclassification which impacts the hospital's urban/rural status. Hospitals located in a Lugar county with active 412.103 reclassifications are considered rural for IPPS payment purposes that are dependent on urban/rural status. Also, hospitals that waive Lugar status to receive the out-migration adjustment are considered rural for IPPS payment purposes that are dependent on urban/rural status. For a list of hospitals that waived Lugar status for FY 2026, see MAC Implementation File 5. (Note, the list of hospitals that waived Lugar status can change each Fiscal Year.)

For example, MACs shall determine whether the hospital is located in a Lugar county when determining eligibility for SCH or MDH classification. In the absence of an active 412.103 reclassification or a waiver of Lugar status to receive the out-migration adjustment, a hospital that is located in a Lugar county is considered urban for this purpose.

L. Low-Volume Hospitals – Criteria and Payment Adjustments for FY 2026

The temporary changes to the low-volume hospital payment adjustment originally provided by the Affordable Care Act, and extended by subsequent legislation, which expanded the definition of a low-volume hospital and modified the methodology for determining the payment adjustment for hospitals meeting that definition, is currently effective through September 30, 2025. Under current law, beginning on October 1, 2025, the low-volume hospital qualifying criteria and payment adjustment methodology will revert to that which was in effect prior to the amendments made by the Affordable Care Act and subsequent legislation (that is, the low-volume hospital payment adjustment policy in effect for FYs 2005 through 2010). The regulations implementing the hospital payment adjustment policy are at § 412.101.

For FY 2026, a hospital must make a written request for low-volume hospital status that is received by its MAC no later than September 1, 2025, in order for the applicable 25 percent low-volume payment adjustment to be applied to payments for its discharges beginning on or after October 1, 2025. Under this procedure, a hospital that qualified for the low-volume hospital payment adjustment for FY 2025 may continue to receive a low-volume hospital payment adjustment for FY 2026 without reapplying if it meets both the discharge criterion (that is, less than 200 discharges total, including both Medicare and non-Medicare discharges) and the mileage criterion applicable for FY 2026. Accordingly, for FY 2026, such a hospital must send written verification that is received by its MAC no later than September 1, 2025, stating that it meets the mileage criterion applicable for FY 2026, which is increasing to 25 miles. If a hospital's written request for low-volume hospital status for FY 2026 is received after September 1, 2025, and if the MAC determines the hospital meets the criteria to qualify as a low-volume hospital, the MAC would apply the low-volume hospital payment adjustment to determine the payment for the hospital's FY 2026 discharges, effective prospectively within 30 days of the date of the MAC's low-volume hospital status determination.

For FY 2026 discharges, the Pricer will calculate the low-volume hospital payment adjustment for hospitals that have a value of 'Y' in the low-volume indicator field on the PSF using the adjustment factor value in the LV Adjustment Factor field on the PSF. Therefore, if a hospital qualifies for the low-volume hospital payment adjustment for FY 2026, the MAC shall ensure the low-volume indicator field on the PSF (position 74 – temporary relief indicator) holds a value of 'Y'. For such hospitals, the MAC shall also update the LV Adjustment Factor field on the PSF (positions 252 - 258) to hold the value of 0.25, consistent with low-

volume hospital payment adjustment for FY 2026. Likewise, if a hospital qualified for the low-volume hospital payment adjustment for FY 2025 but no longer meets the low-volume hospital definition for FY 2026, and therefore the hospital is no longer eligible to receive a low-volume hospital payment adjustment effective October 1, 2025, the MAC shall update the low-volume indicator field to hold a value of 'blank' and update the LV Adjustment Factor on the PSF to hold a value of 'blank'. **Note, due to the change in the definition of low-volume hospital beginning in FY 2026, MACs must update the low-volume indicator field and the LV Adjustment Factor field on the PSF to hold a value of 'blank' for any current low-volume hospitals that no longer meet the applicable low-volume hospital criteria beginning in FY 2026.**

M. Medicare Advantage (MA) Nursing and Allied Health (NAH) Education Payments – Rates for Calendar Year (CY) 2024

Under 42 CFR 413.87, hospitals that operate approved nursing or allied health education programs and receive Medicare reasonable cost reimbursement for these programs and treat Medicare Advantage enrollees receive additional payments. Determining a hospital's NAH MA payment essentially involves applying a ratio of the hospital-specific NAH Part A payments, total inpatient days, and MA inpatient days, to national totals of those same amounts, from cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year. The formula is as follows:

(((Hospital NAH pass-through payment/ Hospital Part A Inpatient Days) * Hospital MA Inpatient Days) / ((National NAH pass-through payment/ National Part A Inpatient Days) * National MA Inpatient Days)) * Current Year Payment Pool.

In the FY 2026 IPPS/LTCH PPS final rule, we published the final national rates and percentages and their data sources for CY 2024. MACs shall use these rates to make MA N&AH payments and Direct Graduate Medical Education (DGME) payments to applicable providers for portions of cost reporting periods occurring in CY 2024.

N. Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed on the following CMS QualityNet website: https://www.qualitynet.org/inpatient/iqr/apu. A/B MACs shall enter a '1' in file position 139 (Hospital Quality Indicator) for each hospital that will receive the quality initiative bonus. The field shall be left blank for hospitals that will receive the statutory reduction under the Hospital Inpatient Quality Reporting (IQR) Program. Should a provider later be determined to have met the criteria after the publication of this list, they will be added to the website, and MACs shall update the provider file as needed. A list of hospitals that will receive the statutory reduction to the annual payment update for FY 2026 under the Hospital IQR Program are found in MAC Implementation File 3, available on the FY 2026 MAC Implementation Files webpage.

For new hospitals, A/B MACs shall enter a '1' in the PSF and provide information to the Inpatient and Outpatient Healthcare Quality Systems Development and Program Support (HQSD & PS) Contractor (SC) as soon as possible so that the Inpatient HQSD & PS SC can enter the provider information into the Program Resource System and follow through with ensuring provider participation with the requirements for quality data reporting. This allows the Inpatient HQSD & PS SC the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital IQR Program reporting requirements. The MACs shall provide this information monthly to the Inpatient HQSD & PS SC. It shall include State Code, Medicare Accept Date, Provider Name, Contact Name, and email address (if available), Provider ID number, physical address, and Telephone Number.

O. Hospital-Acquired Condition (HAC) Reduction Program

CMS expects to issue the final list of hospitals that are subject to the HAC Reduction Program for FY 2026 to MACs in mid-September 2025.

Upon receipt of the final list of hospitals that are subject to the HAC Reduction Program for FY 2026, MACs shall update the "HAC Reduction Indicator" field in the PSF with an effective date of October 1, 2025, as follows, and then release the claims:

- For hospitals in the list of hospitals subject to the HAC Reduction Program for FY 2026 that have a "Y" in Column D (Worst-Performing Quartile), enter a "Y" in the "HAC Reduction Indicator" field (data element 56) in the PSF;

- For hospitals in the list of hospitals subject to the HAC Reduction Program for FY 2026 that have an "N" in Column D (Worst-Performing Quartile), enter an "N" in the "HAC Reduction Indicator" field (data element 56) in the PSF.

P. Hospital Value-Based Purchasing (VBP) Program

For FY 2026, CMS will implement the base operating MS-DRG payment amount reduction and the value-based incentive payment adjustments as a single value-based incentive payment adjustment factor applied to claims for discharges occurring in FY 2026. CMS expects to post the final value-based incentive payment adjustment factors for FY 2026 by mid-September in Table 16B of the FY 2026 IPPS/LTCH PPS final rule (which will be available through the Internet on the FY 2026 IPPS/LTCH PPS final rule Tables webpage). (MACs will receive subsequent communication when value-based incentive payment adjustment factors for FY 2026 in Table 16B are available).

Upon receipt of this file, the MACs must update the Hospital VBP Program participant indicator (VBP Participant) to hold a value of 'Y' if the provider is included in the Hospital VBP Program and the claims processing contractors must update the Hospital VBP Program adjustment field (VBP Adjustment) to input the value-based incentive payment adjustment factor. Note that the values listed in Table 16A of the FY 2026 IPPS/LTCH PPS final rule are proxy values. These values are not to be used to adjust payments.

Until CMS issues final values in Table 16B, contractors shall enter 'N' in the VBP Participant field.

Q. Hospital Readmissions Reduction Program (HRRP)

CMS expects to post the HRRP payment adjustment factors for FY 2026 in mid-September 2025 in Table 15 of the FY 2026 IPPS/LTCH PPS final rule (which are available via the Internet on the FY 2026 IPPS/LTCH PPS Final Rule Tables webpage). (MACs will receive subsequent communication when the HRRP payment adjustment factors for FY 2026 in Table 15 are available.) Hospitals that are not subject to a reduction under the HRRP in FY 2026 (such as Maryland hospitals), have an HRRP payment adjustment factor of 1.0000. For FY 2026, hospitals should only have an HRRP payment adjustment factor between 1.0000 and 0.9700. (Note the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) field in the PSF refers to the HRRP payment adjustment factor.)

Upon receipt of this file, the MACs shall update the Hospital Readmissions Reduction Program participant (HRR Indicator) and/or the Hospital Readmissions Reduction Program adjustment (HRR Adjustment) fields in the PSF with an effective date of October 1, 2025, as follows:

- If a provider has an HRRP payment adjustment factor on Table 15, MACs shall input a value of '1' in the HRR Indicator field and enter the HRRP payment adjustment factor in the HRR Adjustment field.

- If a provider is not listed on Table 15, MACs shall input a value of '0' in the HRR Indicator field and leave the HRR Adjustment field blank.

Until CMS issues final values, contractors shall enter '0' in the HRR Indicator field.

R. Medicare Disproportionate Share Hospitals (DSH) Program

Medicare DSH Payment Adjustment Implementation of New Office of Management and Budget (OMB) Labor Market Delineations

The hospitals that are located in urban counties that are becoming rural under our adoption of the new OMB delineations in the FY 2025 IPPS/LTCH PPS final rule, are subject to a transition for their Medicare DSH payment. For a hospital with more than 99 beds and less than 500 beds that was redesignated from urban to rural, it would be subject to a DSH payment adjustment cap of 12 percent. Under the transition, per the regulations at §412.102, for the first year after a hospital loses urban status, the hospital will receive an additional payment that equals two-thirds of the difference between DSH payment before its redesignation from urban to rural and the DSH payment otherwise applicable to the hospital subsequent to its redesignation from urban to rural. In the second year after a hospital loses urban status, the hospital will receive an additional payment that equals one third of the difference between the DSH payments applicable to the hospital before its redesignation from urban to rural and the DSH payments otherwise applicable to the hospital subsequent to its redesignation from urban to rural. This adjustment will be determined at cost report settlement. In determining the claim payment, the PRICER will only apply the DSH payment adjusted based on its urban/rural status according to the redesignation.

Uncompensated Care Payments

In the FY 2026 IPPS/LTCH PPS Final Rule, CMS finalized a Factor 3 for each Medicare DSH hospital representing its relative share of the total uncompensated care payment amount to be paid to Medicare DSH hospitals along with a total uncompensated care payment amount. Interim uncompensated care payments will continue to be paid on the claim as an estimated per claim amount to the hospitals that have been projected to receive Medicare DSH payments in FY 2026. The estimate Per Claim Amount and Projected DSH Eligibility for each Subsection (d) hospital and Subsection (d) Puerto Rico hospital are located in the Medicare DSH Supplemental Data File for FY 2026, which is available via the Internet on the FY 2026 Final Rule Data Files webpage.

MACs shall enter the updated estimated per claim uncompensated care payment amounts or if the hospital is an IHS/Tribal hospital or a hospital located in Puerto Rico, enter the total of the estimated per discharge Uncompensated Care Payment (UCP) amount and estimated per discharge supplemental payment amount, in data element 57 in the PSF from the FY 2026 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File. For IHS/Tribal hospitals and hospitals located in Puerto Rico, the total amount from the DSH Supplemental Data File is the combined total for both uncompensated care payment per discharge amount and the supplemental payment per discharge amount (see section T below for additional information). The interim estimated uncompensated care payments that are paid on a per claim basis will be reconciled at cost report settlement with the total uncompensated care payment amount displayed in the Medicare DSH Supplemental Data File. The interim estimated supplemental payments that are paid on a per claim basis will be reconciled at cost report settlement using the total supplemental payment displayed in the Medicare DSH Supplemental Data File.

Hospitals Without Prospective FY 2026 Factor 3 Calculation (New Hospitals, Uncompensated Care Trim and Newly Merged Hospitals)

For FY 2026, new hospitals for uncompensated care payment purposes, that is, hospitals with CCNs established after October 1, 2021, that are determined to be eligible for Medicare DSH at cost report settlement will have their Factor 3 calculated using the uncompensated care costs from the hospital's FY 2026 cost report, as reported on Line 30 of Worksheet S-10 (annualized, if needed) as the numerator. The denominator used for this calculation can be found in the FY 2026 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description. Then, Factor 3 is multiplied by a scaling factor and multiplied by the total uncompensated care payment amount finalized in the FY 2026 IPPS Final Rule to determine the total uncompensated care payment amount to be paid to the hospital, if the hospital is determined DSH eligible at cost report settlement.

For new hospitals, newly merged hospitals, and hospitals subject to the Uncompensated Care Data Trim, the MAC shall apply a scaling factor for the Factor 3 calculation, if the hospital is determined DSH eligible at cost report settlement. The scaling factor used for the calculation can be found in the FY 2026 IPPS/LTCH PPS Final Rule Medicare DSH Supplemental Data File's first tab, File Layout, in the variable Factor 3 description or in the MAC Implementation File 1 available on the FY 2026 MAC Implementation Files webpage.

If a new hospital has a Cost-to-Charge Ratio (CCR) on line 1 of Worksheet S-10 in excess of the threshold in MAC Implementation File 1, MACs shall contact Section3133DSH@cms.hhs.gov for further instructions on how to calculate the uncompensated care costs for the numerator. MACs can refer to the Medicare DSH Supplemental Data File on the CMS website to confirm whether a hospital should be treated as a new hospital for purposes of DSH uncompensated care payments. However, CMS notes, it is possible that there will be additional new hospitals during FY 2026, and therefore those would not be available to be listed on the Medicare DSH Supplemental Date File.

In the FY 2026 final rule, CMS continued an additional Uncompensated Care Data Trim for hospitals that were not projected DSH eligible for purposes of interim uncompensated care payments. Similar to new hospitals, the hospitals impacted by this new trim do not have a Factor 3 listed in the FY 2026 Medicare DSH Supplemental File. If the hospital, subject to the data trim, is ultimately determined DSH eligible at cost report settlement, then the MAC shall review Worksheet S-10 and calculate a Factor 3 from the hospital's FY 2026 cost report's Worksheet S-10 line 30 divided by the national uncompensated care cost denominator.

For FY 2026, newly merged hospitals, e.g., hospitals that have a merger during FY 2026 or mergers not known at the time of development of the final rule, will have their interim uncompensated care payments reconciled at cost report settlement by the MAC.

Voluntary Request of Per Discharge Amount of Interim Uncompensated Care Payments

For FY 2026, CMS used a 3-year average of the number of discharges for a hospital to produce an estimate of the amount of the uncompensated care payment per discharge. Specifically, the hospital's total uncompensated care payment amount is divided by the hospital's historical 3-year average of discharges computed using the most recent available data. The result of that calculation is a per discharge payment amount that is used to make interim uncompensated care payments to each projected DSH eligible hospital. The interim uncompensated care payments made to the hospital during the fiscal year are reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal FY.

Under this policy, if a hospital submits a request to its MAC for a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the beginning of the Federal FY and/or once during the Federal FY, then the MAC shall review the request. The hospital must provide supporting documentation demonstrating there would likely be a significant recoupment (for example, 10 percent or more of the hospital's total uncompensated care payment or at least $100,000) at cost report settlement if the per discharge amount were not lowered. Examples include, but are not limited to, the following:

1. a request showing a large projected increase in discharges during the FY to support reduction of its per discharge uncompensated care payment amount.
2. a request that its per discharge uncompensated care payment amount be reduced to zero midyear if the hospital's interim uncompensated care payments during the year have already surpassed the total uncompensated care payment calculated for the hospital.

The MAC shall evaluate the request for strictly reducing the per discharge uncompensated payment amount and the supporting documentation before the beginning of the Federal FY and/or with midyear request when the 2-year average of discharges is lower than hospital's projected FY 2026 discharges. If following review

of the request and the supporting documentation, the MAC agrees that there likely would be significant recoupment of the hospital's interim Medicare uncompensated care payments at cost report settlement, the only change that would be made would be to lower the per discharge amount either to the amount requested by the hospital or another amount determined by the MAC to be appropriate to reduce the likelihood of a substantial recoupment at cost report settlement.

The hospital's request does not change how the total uncompensated care payment amount shall be reconciled at cost report settlement. The interim uncompensated care payments made to the hospital during the FY are still reconciled following the end of the year to ensure that the final payment amount is consistent with the hospital's prospectively determined uncompensated care payment for the Federal FY.

S. Supplemental Payment for Indian Health Service and Tribal Hospitals and Hospitals Located in Puerto Rico

For the supplemental payment for IHS and Tribal hospitals and hospitals located in Puerto Rico, we based eligibility to receive interim supplemental payments on a projection of DSH eligibility for the applicable FY. The DSH Supplemental Data File includes the combined interim uncompensated care payment and interim supplemental payment.

The MAC shall make a final determination with respect to a hospital's eligibility to receive the supplemental payment for a FY, in conjunction with its final determination of the hospital's eligibility for DSH payments and uncompensated care payments for that FY. If a hospital is determined not to be DSH eligible for a FY, then the hospital would not be eligible to receive a supplemental payment for that FY.

The MAC shall reconcile the interim supplemental payments at cost report settlement to ensure that the DSH eligible hospital receives the full amount of the supplemental payment that was determined prior to the start of the FY. Projected DSH eligible hospitals have a total supplemental payment available in the Medicare DSH Supplemental Data File.

Consistent with the process used for uncompensated care payments cost reporting periods that span multiple Federal FYs, a pro rata supplemental payment calculation must be made if the hospital's cost reporting period differs from the Federal FY. Thus, the final supplemental payment amounts to be included on a cost report spanning two Federal FYs are the pro rata share of the supplemental payment associated with each Federal FY. This pro rata share is determined based on the proportion of the applicable Federal FY that is included in that cost reporting period.

T. Outlier Payments

IPPS Statewide Average CCRs

Tables 8A and 8B contain the FY 2026 Statewide average operating and capital Cost-to-Charge Ratios (CCRs) for urban and rural hospitals. Tables 8A and 8B are available on the FY 2026 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.84(i)(3)(iv)(C), for FY 2026, Statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18).
2. Hospitals with an operating or capital cost-to-charge ratio that is in excess of 3 standard deviations above the corresponding national geometric mean. This mean is recalculated annually by CMS and published in the annual notice of prospective payment rates issued in accordance with §412.8(b). For FY 2026 operating CCR and capital CCR trim values, refer to MAC Implementation File 1 available on the FY 2026 MAC Implementation Files webpage.
3. Hospitals for whom accurate data with which to calculate either an operating or capital cost-to-charge ratio (or both) are not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 20.1.2.1 of chapter 3 of Pub. 100-04, Medicare Claims Processing Manual.

Additionally, for all hospitals, use of an operating and/or capital CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

U. Payment Adjustment for Certain Immunotherapy Cases in MS-DRG 018

CMS makes an adjustment to the payment amount for certain immunotherapy cases that group to MS-DRG 018. For reference, see MAC Implementation File 1 available on the FY 2026 MAC Implementation Files webpage for the FY 2026 MS-DRG weighting factor used for such discharges.

Under this policy, a payment adjustment will be applied to claims that group to MS-DRG 018 and (a) include ICD-10-CM diagnosis code Z00.6, (b) when there is expanded access use of immunotherapy, or (c) the immunotherapy product is not purchased in the usual manner, such as obtained at no cost. When the CAR T-cell therapy or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product, the payment adjustment will not be applied in calculating the payment for the case.

In a case where there was expanded access use of CAR T-cell therapy or other immunotherapy products, the provider may submit condition code "90" on the claim so that the Pricer will apply the payment adjustment in calculating the payment for the case. To notify the MAC of a case where the CAR T-cell therapy or other immunotherapy product is purchased in the usual manner, but the case involves a clinical trial of a different product (and ICD-10-CM diagnosis code Z00.6 on the claim), the provider may enter a Billing Note NTE02 "Diff Prod Clin Trial" on the electronic claim 837I or a remark "Diff Prod Clin Trial" on a paper claim, and the claims processing system shall append payer-only condition code "ZC" so that the Pricer will not apply the payment adjustment in calculating the payment for the case. To notify the MAC of a case where the CAR T-cell therapy or other immunotherapy product is not purchased in the usual manner, such as provided at no cost, the provider may enter billing note "PROD NO COST" on the electronic claim 837I or a remark "PROD NO COST" on a paper or Direct Data Entry (DDE) claim, and the Shared System Maintainer (SSM) shall populate condition code ZD so that the IPPS Pricer will apply the payment adjustment in calculating the payment for the case.

V. IPPS Add-on Payment for Certain End-Stage Renal Disease (ESRD) Discharges

CMS provides an additional payment to a hospital for inpatient services provided to certain Medicare beneficiaries with ESRD who receive a dialysis treatment during a hospital stay, if the hospital's ESRD Medicare beneficiary discharges, excluding discharges classified into the MS DRGs listed at § 412.104(a), where the beneficiary received dialysis services during the inpatient stay, are 10 percent or more of its total Medicare discharges.

Under the regulations at § 412.104, the annual CY ESRD PPS base rate (as published in the applicable CY ESRD PPS final rule or subsequent corrections, as applicable) multiplied by three is used to calculate the ESRD add-on payment for hospital cost reporting periods that begin during the Federal FY for the same year. Specifically, the CY 2026 ESRD PPS base rate will be used for all cost reports beginning during Federal FY 2026 (that is, for cost reporting periods starting on or after October 1, 2025, through September 30, 2026).

The applicable ESRD base rate effective for cost reporting periods beginning on or after October 1, 2025 can be found in the MAC Implementation File 3 available on the FY 2026 MAC Implementation Files webpage after the issuance of the CY 2026 ESRD PPS final rule, which is expected by early November 2025.

LTCH PPS FY 2026 Update

A. FY 2026 LTCH PPS Rates and Factors

The FY 2026 LTCH PPS Standard Federal Rates are located in Table 1E available on the FY 2026 Final Rule Tables webpage. Other FY 2026 LTCH PPS Factors can be found in MAC Implementation File 2 available on the FY 2026 MAC Implementation File webpage.

The LTCH PPS Pricer has been updated with the Version 43 MS-LTC-DRG table, weights and factors, effective for discharges occurring on or after October 1, 2025, and on or before September 30, 2026.

B. Discharge Payment Percentage

Beginning with LTCHs' FY 2016 cost reporting periods, the statute requires LTCHs to be notified of their "Discharge Payment Percentage" (DPP), which is the ratio (expressed as a percentage) of the LTCHs' FFS discharges which received LTCH PPS standard Federal rate payment to the LTCHs' total number of LTCH PPS discharges. MACs shall continue to provide notification to the LTCH of its DPP upon settlement of the cost report. MACs may use the form letter available on the Internet at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/LongTermCareHospitalPPS/download.html to notify LTCHs of their discharge payment percentage. CMS notes Business Requirements (BRs) 11361.11 and 11361.11.1 continue to apply.

Section 1886(m)(6)(C)(ii)(I) of the Act, requires that, for cost reporting periods beginning on or after October 1, 2019, any LTCH with a discharge payment percentage for the cost reporting period that is not at least 50 percent be informed of such a fact; and section 1886(m)(6)(C)(ii)(II) of the Act requires that all of the LTCH's discharges in each successive cost reporting period be paid the payment amount that would apply under subsection (d) for the discharge if the hospital were a subsection (d) hospital, subject to the LTCH's compliance with the process for reinstatement provided for by section 1886(m)(6)(C)(iii) of the Act. CMS notes BRs 11616.11, 11616.11.1. 11616.11.2 and 11616.11.3 continue to apply, subject to the provisions of Section 3711(b)(1) of the CARES Act for the duration of the COVID-19 public health emergency period, which expired at the end of the day on May 11, 2023. (Refer to Change Request 11742 for additional implementation on information on section 3711(b)(1) of the CARES Act.)

C. LTCH Quality Reporting (LTCHQR) Program

Under the Long-Term Care Hospital Quality Reporting (LTCHQR) Program, for FY 2026, the annual update to a standard Federal rate will continue to be reduced by 2.0 percentage points if a LTCH does not submit quality-reporting data in accordance with the LTCHQR Program for that year. MACs will receive more information under separate cover.

D. Provider Specific File (PSF)

The PSF required fields for all provider types, which require a PSF can be found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 3, §20.2.3.1 and Addendum A. Update the Inpatient PSF for each LTCH as needed, and update all applicable fields for LTCHs effective October 1, 2025, or effective with cost reporting periods that begin on or after October 1, 2025, or upon receipt of an as-filed (tentatively) settled cost report.

LTCH Statewide Average CCRs

Table 8C contains the FY 2026 Statewide average LTCH total CCRs for urban and rural LTCHs. Table 8C is available on the FY 2026 Final Rule Tables webpage. Per the regulations in 42 CFR sections 412.525(a)(4)(iv)(C) and 412.529(f)(4)(iii), for FY 2026, Statewide average CCRs are used in the following instances:

1. New hospitals that have not yet submitted their first Medicare cost report. (For this purpose, a new hospital is defined as an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR section 489.18).

2. LTCHs with a total CCR in excess of the applicable maximum CCR threshold (that is, the LTCH total CCR ceiling, which is calculated as 3 standard deviations from the national geometric average CCR). For the FY 2026 LTCH total CCR ceiling, refer to MAC Implementation File 2 available on the FY 2026 MAC Implementation Files webpage.

3. Any hospital for which data to calculate a CCR is not available.

NOTE: Hospitals and/or MACs can request an alternative CCR to the statewide average CCR per the instructions in section 150.24 of chapter 3 of Pub. 100-04, Medicare Claims Processing Manual.

Additionally, for all LTCHs, use of a total CCR of 0.0 or any other alternative CCR requires approval from the CMS Central Office.

LTCH Wage Indexes

For FY 2026, a 5 percent cap is applied to any decrease in an LTCH's wage index from its FY 2025 wage index. A list of LTCHs whose FY 2026 LTCH PPS wage index decreased by more than 5 percent along with their capped FY 2026 LTCH PPS wage index value can be found on the FY 2026 MAC Implementation Files webpage. For these LTCHs, MACs will enter into the PSF a '1' in the Special Payment Indicator field (data element 33) and the LTCH's capped FY 2026 LTCH PPS wage index value in the Special Wage Index field (data element 38). For all other LTCHs, MACs will ensure the Special Payment Indicator field and the Special Wage Index field are blank. We note that hospitals newly classified as an LTCH during FY 2026 are not eligible for the 5 percent cap. If a MAC believes that an LTCH is either incorrectly included or excluded from the list of LTCHs that receive the 5 percent cap for the FY 2026 LTCH PPS wage index, please contact LTCHPPS@cms.hhs.gov for further instructions.

For FY 2026, a 5 percent cap will also be applied to any decrease in an LTCH's applicable IPPS comparable wage index from its FY 2025 applicable IPPS comparable wage index. A list of LTCHs whose FY 2026 applicable IPPS comparable wage index decreased by more than 5-percent along with their capped FY 2026 applicable IPPS comparable wage index value can be found on the FY 2026 MAC Implementation Files webpage. For these LTCHs, MACs will enter into the PSF a '2' in the Supplemental Wage Index Flag field (data element 64) and the LTCH's capped FY 2026 applicable IPPS comparable wage index value in the Supplemental Wage Index field (data element 63). For all other LTCHs, MACs will ensure the Supplemental Wage Index Flag field and the Supplemental Wage Index field are blank. We note that hospitals newly classified as an LTCH during FY 2026 are not eligible for the 5 percent cap. If a MAC believes that an LTCH is either incorrectly included or excluded from the list of LTCHs that receive the 5 percent cap for the FY 2026 applicable IPPS comparable wage index, please contact LTCHPPS@cms.hhs.gov for further instructions.

Additionally, for all LTCHs, MACs shall ensure that the County Code field in the PSF (Data Element 60) is updated with the correct Federal Information Processing Series (FIPS) code.

E. Cost of Living Adjustment (COLA) under the LTCH PPS

There are no updates to the COLAs for FY 2026. The COLAs effective for discharges occurring on or after October 1, 2025 can be found in the FY 2026 IPPS/LTCH PPS final rule and are also located in MAC Implementation File 2 available on the FY 2026 MAC Implementation Files webpage. (We note, the same COLA factors are used under the IPPS and the LTCH PPS for FY 2026.)

F. LTCH Qualifying Period Policy Manual Update

Prior to a hospital being classified as an LTCH, the hospital must first participate in Medicare as a hospital (typically a hospital paid under the IPPS) during which time ALOS data is gathered. This data is used to determine whether the hospital has an ALOS of greater than 25 days, which is required to be classified as an LTCH. We codified our in the regulations at 42 CFR 412.23(e)(3) in the FY 2025 IPPS/LTCH PPS Final Rule. We are updating our manual to reflect this policy.

Hospitals Excluded from the IPPS

The update to extended neoplastic disease care hospital's target amount is the applicable annual rate-of increase percentage specified in § 413.40(c)(3), which is equal to the percentage increase projected by the hospital market basket index. In the FY 2026 IPPS/LTCH PPS final rule, we established an update to an extended neoplastic disease care hospital's target amount for FY 2026 of 3.3 percent.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14203.1	Contractors shall access the IPPS Pricer via the Cloud to pay FY 2026 IPPS payment rates on claims with discharge dates on or after October 1, 2025.	X								
14203.2	Contractors shall access the LTCH PPS Pricer via the Cloud to pay FY 2026 LTCH payment rates on claims with discharge dates on or after October 1, 2025.	X								
14203.3	The Medicare contractor shall install and edit claims with the MCE version 43.0 and Grouper version 43.0 software with the implementation of the FY 2026 October quarterly release.					X				
14203.4	The Medicare contractor shall establish yearly recurring hours to allow for updates to the list of ICD-10-CM diagnosis codes that are exempt from reporting Present on Admission (POA). **NOTE:** The list of ICD-10-CM diagnosis codes exempt from reporting POA are displayed on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Payment/HospitalAcqCond/Coding.html.									
14203.5	Medicare contractors shall inform the Quality Improvement Organization (QIO) of any new hospital that has opened for hospital quality purposes.	X								
14203.6	Medicare contractors shall update ALL relevant portions of the PSF in accordance with this CR prior to the implementation of the FY 2026 IPPS and LTCH PPS Pricers.	X								
14203.6.1	Medicare contractors shall follow the instructions in the policy section and on the FY 2026 MAC Implementation Files webpage to update the PSF and ensure that the CBSA is assigned properly for all IPPS and LTCH PPS providers. **NOTE**: MACs shall follow these instructions for the following: All current IPPS hospitals; any new hospitals that open during FY 2026; or any change of hospital status during FY 2026.	X								
14203.6.2	Medicare contractors shall follow the instructions in the policy section of this CR to ensure that no IPPS provider has an operating CCR or a capital CCR in the PSF that is in excess of the FY 2026 applicable IPPS CCR ceilings. Additionally, use of an operating and/or capital CCR of 0.0 requires approval from the CMS Central Office.	X								
14203.6.3	Medicare contractors shall follow the instructions in the policy section of this CR to ensure that no LTCH has a total CCR in the PSF that is in excess of the FY 2026 total CCR ceiling. Additionally, use of a total CCR of 0.0 requires approval from	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the CMS Central Office.									
14203.6.4	MACs shall ensure they are taking into account the Lugar status of a hospital and apply the payment and/or hospital status appropriately. **NOTE:** See instructions in sections H and K for complete details.	X								
14203.6.5	For LTCHs, Medicare contractors shall ensure that the County Code field in the PSF (Data Element 60) is updated with the correct Federal Information Processing Series (FIPS) code.	X								
14203.7	Medicare contractors shall be aware that a hospital may request a lower per discharge interim uncompensated care payment amount, including a reduction to zero, once before the beginning of the Federal fiscal year and/or once during the Federal fiscal year, as described in the policy section.	X								
14203.7.1	Medicare contractors shall evaluate the request for reducing the per discharge uncompensated payment amount and the supporting documentation, and update the PSF, if applicable, as described in the policy section.	X								
14203.7.2	Medicare contractors shall review Worksheet S-10 for new hospitals and hospitals subject to the new trim, if the hospital(s) is determined DSH eligible at cost report settlement. Additionally, if such a hospital is determined to be DSH eligible, Medicare contractors shall calculate a Factor 3 based on the Worksheet S-10 from the hospital's FY 2026 cost report.	X								
14203.8	Medicare contractors shall ensure that the Fiscal Year Beginning Date	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	field in the PSF (Data Element 4, Position 25) is updated as applicable with the correct date.									
14203.9	Medicare contractors shall be aware of any manual updates included within this CR.	X								
14203.10	The CWF shall update and edit Informational Unsolicited Response (IUR) 7272 and 7800 as necessary for the post-acute DRGs listed in Table 5 of the IPPS Final Rule when changes are made.								X	
14203.11	MACs shall update the Hospital-Specific (HSP) amount in the PSF for all SCHs and MDHs as described in the IPPS policy section of this CR.	X								
14203.12	Unless otherwise instructed by CMS, MACs shall seek approval from the CMS Central Office to use a “1” or “2” in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38).	X								
14203.13	For FY 2026 (discharges on or after October 1, 2025), for hospitals paid under the IPPS, for all hospitals eligible for the 5 percent cap or the transitional payment exception, the MAC shall enter a “1” in the Supplemental Wage Index Flag field (data element 64) and the Supplemental Wage Index field (data element 63) shall be equal the wage index in Table 2 in the column labeled “FY 2025 Wage Index”. **NOTE:** Under the 5 percent cap policy, new hospitals that opened during FY 2026 are not eligible for the 5 percent cap. Therefore, for newly opened hospitals in FY 2026, the Supplemental Wage Index Flag field (data element 64) shall be	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	blank and the value in the Supplemental Wage Index field (data element 63) shall be zeroes. For hospitals not listed on Table 2 (other than new hospitals opened in FY 2026) or any other issues, see MAC Implementation File 5 available on the FY 2026 MAC Implementation Files webpage for complete instructions.									
14203.13.1	MACs shall use the spreadsheet titled "FY 2026 MAC Table 2 PSF Guide.xlsx" (which is included with MAC Implementation File 5) to identify hospitals eligible for the transitional payment policy in FY 2026. Hospitals eligible for the transition payment policy will have a "1" or "2 in the column titled "Special Payment Indicator field (Data Element 33)"	X								
14203.13.2	For hospitals eligible for the transitional payment policy in FY 2026, per the "FY 2026 MAC Table 2 PSF Guide.xlsx" spreadsheet, MACs shall enter a "1" or "2" from the column titled "Special Payment Indicator field (Data Element 33)" in data element 33 of the PSF and enter the wage index from the column titled "Special Wage Index field (data element 38)" in data element 38 of the PSF. **Note:** For hospitals that are not eligible for the transitional payment policy in FY 2026, MACs shall seek approval from the CMS Central Office to use a "1" or "2" in the Special Payment Indicator (data element 33) field and a wage index value in the Special Wage Index field (data element 38).	X								
14203.14	For FY 2026 (discharges on or after October 1, 2025), for hospitals paid under the LTCH PPS, for all LTCHs	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	receiving the 5 percent cap on their FY 2026 LTCH PPS wage index, the MAC shall enter a "1" in the Special Payment Indicator field (data element 33) and the LTCH's capped FY 2026 LTCH PPS wage index value in the Special Wage Index field (data element 38). For all LTCHs not receiving the 5 percent cap on their FY 2026 LTCH PPS wage index, the MAC shall ensure the Special Payment Indicator field and the Special Wage Index field are blank. **NOTE:** See MAC Implementation File 9 available on the FY 2026 MAC Implementation Files webpage for complete instructions.									
14203.15	For FY 2026 (discharges on or after October 1, 2025), for hospitals paid under the LTCH PPS, for all LTCHs receiving the 5 percent cap on their FY 2026 applicable IPPS comparable wage index, the MAC shall enter a '2' in the Supplemental Wage Index Flag field (data element 64) and the LTCH's capped FY 2026 applicable IPPS comparable wage index value in the Supplemental Wage Index field (data element 63). For all LTCHs not receiving the 5 percent cap on their FY 2026 applicable IPPS comparable wage index, the MAC shall ensure the Supplemental Wage Index Flag field and the Supplemental Wage Index field are blank. **NOTE:** See MAC Implementation File 9 available on the FY 2026 MAC Implementation Files webpage for complete instructions.	X								
14203.16	MACs shall enter a 'Y' in Data Element 58 (Electronic Health Records (EHR) Program Reduction)	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	in the PSF if the hospital (including Puerto Rico hospitals) is subject to a reduction due to NOT being an EHR meaningful user.									
14203.17	Effective October 1, 2025, Medicare contractors shall update the low-volume indicator (position 74 - temporary relief indicator) and the LV Adjustment Factor field in the PSF (positions 252 - 258) for providers that meet the low-volume hospital discharge and mileage criteria as described in the policy section, and for providers that no longer qualify as a low-volume hospital as described in the policy section.	X								
14203.18	Due to the expiration of the Medicare dependent hospital (MDH) program, effective October 1, 2025, Medicare contractors shall update the provider type in the PSF (positions 55-56) for providers classified as MDHs. Providers with a provider type value of '14' shall be updated to '00' and providers with a provider type value of '15' shall be updated to '07'.	X								
14203.19	The Medicare contractors shall follow the instructions in the policy section of this CR in order to update the IPPS add-on payment for certain ESRD discharges for cost reporting periods beginning on or after October 1, 2025.	X								

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

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(Rev. 13398; Issued: 09-04-25)

150.4 - Qualification Criterion for LTCHs

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Under the LTCH PPS, the greater than 25-day average length of stay (ALOS) calculation is based only on a hospital's Medicare inpatients, counting total medically necessary days, not only covered days.

The Medicare *inpatient ALOS* is calculated by dividing the total number of covered and noncovered days of care provided to Medicare patients, by the Medicare discharges occurring during that period.

The ALOS policy is codified in the regulations at 42 CFR 412.23(e)(3) (a special policy applicable for cost reporting periods beginning on or after July 1, 2004 but before July 1, 2005 can be found at 42 CFR 412.23(e)(3)(ii)).

Generally, the determination regarding a hospital's ALOS is based on the hospital's most recently filed cost report. However, for purposes of LTCH classification in certain circumstances (as described below), data from the most recent 6-month period are used. When the ALOS is determined, the A/B MAC will make one, single calculation for the entire period (i.e., qualifying period, cure period or cost reporting period, as applicable).

For cost reporting periods beginning on or after October 1, 2015, days and discharges paid under the site neutral payment rate or paid under a Medicare Advantage Plan (Medicare Part C) are not included in the calculation of the Medicare inpatient average length of stay. For cost reporting periods beginning on or after October 1, 2019, the Medicare inpatient days and discharges that are associated with patients discharged from an excluded unit of the hospital will not be included in the calculation of the Medicare inpatient average length of stay.

If the *discharge involves* days of care furnished during two or more separate cost reporting periods, that is, an admission during one cost reporting period and a discharge during a future cost reporting period, the total number of days of the stay are considered to have occurred during the cost reporting period during which the patient was discharged.

Prior to a hospital being classified as an LTCH, the hospital must first participate in Medicare as a hospital (typically a hospital paid under the IPPS) during which time ALOS data is gathered. This data is used to determine whether the hospital has a Medicare inpatient ALOS of greater than 25 days, which is required to be classified as an LTCH. The period during which a hospital seeks to establish the required ALOS is referred to as a "qualifying period." The qualifying period is the 6-month period immediately preceding the hospital's conversion to an LTCH, and the requisite ALOS must be demonstrated based on patient data from

at least 5 consecutive months of this period. For example, for a hospital seeking to become an LTCH effective January 1, 2025, the qualifying period would be July 1, 2024 through December 31, 2024 (that is, the 6 months immediately preceding the conversion to an LTCH). In order for the hospital to convert to an LTCH, the ALOS must be demonstrated for a period of at least 5 consecutive months (for example, July 1, 2024 through November 30, 2024 or July 15, 2024 to December 14, 2024) of the 6 month qualifying period. The ALOS is calculated for the entire qualifying period, not for each individual month within the qualifying period. The regulations for the calculation of the ALOS for hospitals seeking to become LTCHs can be found in 42 CFR 412.23(e)(4), including satellite facilities and remote locations of hospitals seeking to become new LTCHs.

CMS requires on-going monitoring of LTCH compliance with the above requirements as well as notification by A/B MACs (A) regarding this compliance. If the hospital does not meet the ALOS requirements (including for the "cure period" described below), the loss of LTCH classification would be effective at the start of the hospital's cost reporting period that begins after the ALOS determination, consistent with 42 CFR 412.23(i). At cost report settlement, the A/B MACs calculate the ALOS for each LTCH for that cost report period (the ALOS is calculated for the entire period, not for each individual month withing the cost reporting period). If the A/B MAC determines that the ALOS for the period is not greater than 25 days, the A/B MAC notifies the LTCH of its failure to maintain the required ALOS. In such a case, the A/B MAC calculates the ALOS for the LTCH during its "cure period," a period of at least 5 consecutive months of the 6-month period immediately preceding the cost reporting period beginning after the A/B MAC determined that the ALOS for a cost reporting period was not greater than 25 days. (See 42 CFR 412.23(e)(3)(iii).) For example, an LTCH's ALOS for its January 1, 2023 through December 31, 2023 cost reporting period was determined to be 21 days in June 2024. The hospital's next cost reporting period will begin January 1, 2025. The cure period for that LTCH would be July 1, 2024 through December 31, 2024 (that is, the 6 months immediately preceding the cost reporting period beginning after the determination was made that the LTCH did not maintain the required ALOS). In order for the hospital to continue to participate in Medicare as an LTCH, the ALOS must be demonstrated for a period of at least 5 consecutive months (for example, July 1, 2024 through November 30, 2024 or July 15, 2024 to December 14, 2024) of the cure period.

For cost reporting periods beginning on or after October 1, 2011, an LTCH that is going to undergo a change of ownership must notify its A/B MAC within 30 days of the effective date of such change of ownership . After the change of ownership, the hospital will continue to be excluded from the IPPS as an LTCH for the cost reporting period following the change of ownership only if, for the period of at least 5 months of the 6 months immediately preceding the change of ownership, the hospital meets the required ALOS (the calculation is done for the whole period, not each individual months within the period). (See 42 CFR 412.23(e)(3)(v).) A/B MACs shall not process a change of ownership for an LTCH without first ensuring that this requirement is met.